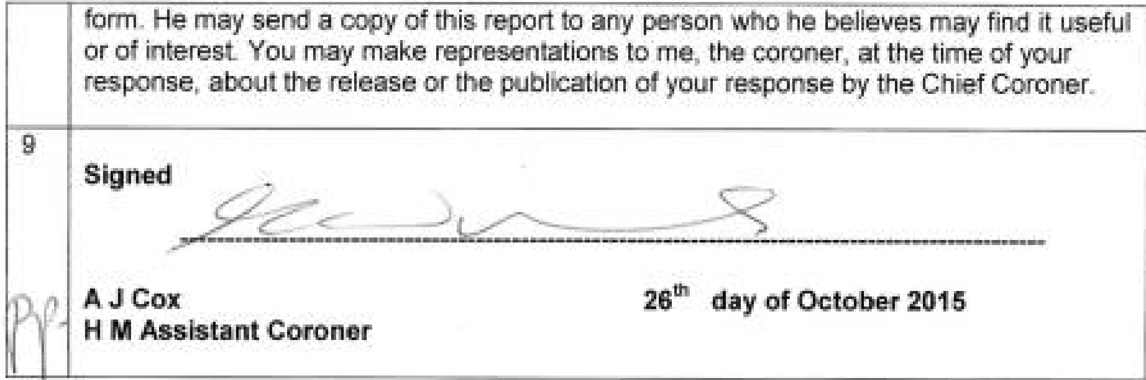
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Worcestershire Health and Care NHS Trust** **2.** **3.**
1	**CORONER** I am Andrew James Cox, Assistant Coroner, for the coroner area of Worcestershire
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 2 January 2013 I commenced an investigation into the death of Wayne Patrick O'NEILL then aged 34. The investigation concluded at the end of a jury inquest on 22 October 2015. The conclusion of the inquest was accidental the medical cause of death being 1(a) respiratory failure, 1(b) Broncho spasm following ingesting propranolol, 1(c) asthma .
4	**CIRCUMSTANCES OF THE DEATH** Mr O'Neill was a serving prisoner at HMP Long Lartin. He suffered a collapse in his cell from which he could not be resuscitated. He died on 2nd January 2013. The Jury recorded a medical cause of death of :- 1(a) respiratory failure 1(b) broncho spasm following ingesting propranolol 1(c) asthma
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. – (1) the evidence revealed that Mr O'Neill had died from one of two causes: either, as the jury found, he had taken propranolol illicitly which induced the broncho spasm that caused his respiratory failure. It is worth noting that Mr O'Neill had previously been prescribed propranolol and evidence was given at the inquest by a forensic psychiatrist that the fact it was contra indicated (given Mr O'Neill's asthma) appeared "to have been lost" to the prescribing clinicians at the time.

	The alternative cause of death was that Mr O'Neill died from acute cardiac failure induced by the combination of psychotropic medication prescribed to him including citalopram, Olanzapine and amitriptyline. An alert had previously been raised by the Medicines Healthcare Regulatory Authority warning against the prescribing of these drugs in combination. An attempt had been made to take Mr O'Neill off these drugs but subsequent clinicians had re-introduced them. It was not clear from the evidence that when Mr O'Neill was screened in reception following his transfer from HMP Birmingham to HMP Long Lartin the significance of these combinations of medication was recognised. Expert evidence was heard during the cause of the inquest notably from [redacted] a Cardiologist. He said there was a strong case for ECG traces to be performed on all prisoners in receipt of this medication. This would reveal whether there was any prolongation of the QT interval. The evidence revealed that an ECG trace had not been undertaken during the years that Mr O'Neill was an inmate at HMP Birmingham. A trace was arranged at HMP Long Lartin but had not taken place by the time of Mr O'Neill's death having only been requested as a matter of routine. The evidence suggested that the reason why the ECG was requested was due to an elevated pulse rate detected at the reception screen rather than recognition of the potentially toxic efforts of the prescribed medication. Evidence was given that obtaining an ECG trace is a simply, cheap and straight forward matter. It would seem sensible, accordingly for all the prisoners in receipt of this combination of medication to undergo ECG traces as part of the reception screening process. (2) (3)
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your Trust have the power to take such action. I have indicated about what you may feel to be a sensible way to proceed.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely on or before 21st December 2015. 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] 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	**Signed** **A J Cox** **26th day of October 2015** **H M Assistant Coroner**