REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Essex Partnership University Trust The Lodge Runwell Wickford Essex SS11 7XX NHS England
1	**CORONER** I am Area Coroner for Essex
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	**INQUEST**
4	Benjamin Lee Stroud died on the 19th March 2021 at an address in Charlotte Way in Witham, Essex. He lived alone but had a partner who saw him regularly. He had a previous medical history of recreational drugs, including steroids and cannabis, he was recently diagnosed as insulin dependent diabetic, and had undergone a kidney transplant. He fell and injured his back at work, and developed a dependence on pain medication, some of which were purchased

on the internet. His mental health issues increased as a result of his psychical health problems.

His partner spoke to him on the evening of the 18th March 2021, he seemed to be low around his job, a job which he did not like.
Mr Stroud was found at his home address the following day, deceased, and around him were empty blister packets of medication, and empty insulin pens. He was pronounced dead at the scene by paramedics. There were no suspicious Circumstances and no third party involvement and the police provided a full report and gave evidence at the inquest.

A Post Mortem was undertaken and the Cause of Death was 1a. Multiple Drug toxicity.

The toxicology report found the following: -

The concentrations of the opioid drug tramadol, and its metabolite o-desmethyltramadol, are very high and well within the ranges encountered in individuals who died from excessive tramadol use alone.
There is evidence for the use of alprazolam in the hours prior to death. The concentration of alprazolam is higher than typically encountered in its recreational use and is within the ranges encountered in fatalities attributed to alprazolam use alone. However, it is equally within the range encountered in blood samples taken in life from impaired drivers. Nevertheless alprazolam may enhance the sedative effects of tramadol, increasing the risk of death. Alpha-hydroxyalprazolam is an alprazolam metabolite.

There is also evidence for the use of the hallucinogenic compounds dimethyltryptamine (N,N-dimethyltryptamine or DMT) and bufotenine in the hours prior to death. These compounds have low acute toxicity themselves, however there use may contributed to any serotoninergic effects of tramadol, further increasing the risk of death.

There is evidence in the urine for prior nitrazepam, clonazepam, propranolol and mirtazapine use. Their absence from the blood makes their use in the hours immediately prior to death unlikely. 7-aminonitrazepam is a nitrazepam metabolite. Desmethylmirtazapine is a mirtazapine metabolite.

There is evidence of omeprazole use in the hours prior to death. Omeprazole has low acute toxicity, and hence it has not been measured in the blood.

There is also evidence in the urine for the prior use of compounds containing or metabolised to codeine and morphine. The absence of these compounds from the blood does not suggest their use in the hours immediately prior to death. Hydrocodone is a codeine metabolite. Morphine glucuronides are morphine metabolites.

The blood sample received was unsuitable for the measurement of insulin. However, all forms of insulin (bothendogenous and exogenous) are rapidly degraded in post-mortem blood samples due to their gross haemolysis. Therefore, measurement of insulin in post-mortem samples rarely yields useful information. Circumstantial evidence of insulin excess is therefore key in cases such as this.

	Mr Stroud had been admitted from Accident and Emergency under sec 2 of the Mental Health Act between the 16th and the 24th January 2021, to the Lindon Centre, he was released under the ambit of The Gables and had been seen by a psychiatrist whilst under sec 2. This appeared from the evidence to be the only time he was seen by such a person. On the 22nd February 2021, he took an overdose of insulin, however as his partner is a nurse, he didn't attend hospital as she knew what to do. A PSIIR report and action plan was completed, and the author of the report attended the inquest to give evidence. Mr Stroud's partner also gave evidence, and it was clear from her account that she had been begging the Care Coordinator for Mr Stroud to have an appointment with the Psychiatrist, which did not occur and from the evidence of EPUT, it was clear that Mr Stroud's Care Coordinator did not make any referral to the MDT, despite his escalating psychosis, it was also clear from the evidence that none of the conversations with Mr Stroud's Care Coordinator were recorded. The action plan stated that one of the actions implemented since Mr Stroud's death was that 'all communications with the client should be recorded' I made strong recommendations that this should also include all communications from the clients partners and families to be recorded.
5	**CORONER'S CONCERNS** During the course of the inquest, it 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. – That in **all** cases must go before the MDT, the evidence in this inquest, made it clear that had Mr Stroud's case had been discussed at an MDT then more help would have been made available to him, that he would have been seen by a psychiatrist and may have prevented his death. On the evidence from EPUT and the PSIIR it was clear that the Care Coordinator makes the decisions as to whether to refer a case to the MDT, in this case, no entries were made around the rational for none referral and no explanation was provided at the inquest. This is not the first time this issue has arisen at an Inquest and the reliance on a Care Coordinator to make a clinical decision and no written explanation provided on any clinical notes documented appears to be a way of working. If these practices continue there is a real risk of future deaths occurring.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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, April 26th 2022, 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 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	**Date. 8th February 2022** **Name** **Michelle Brown** **HM Area Coroner Essex - OBE**