



MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON

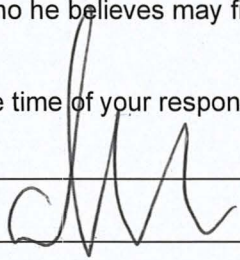
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 14161785

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. [REDACTED], Acting CEO, North East London Foundation Trust, Goodmayes Hospital, Goodmayes, Ilford, IG3 8XJ2. [REDACTED] – High St Surgery, 219 High Street, Hornchurch, RM11 3XT
1	<p>CORONER</p> <p>I am Graeme Irvine, acting senior coroner, for the coroner area of East London</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 19th June 2021 I commenced an investigation into the death of Michael John Vince, 62 years old. The investigation concluded at the end of the inquest on 22nd June 2022. I made a determination of a Open conclusion along with a short narrative;</p> <p><i>"On 19th June 2021 Mr Michael John Vince was found unresponsive at his home address having taken a voluntary overdose [REDACTED]. Despite the best efforts of his friends and emergency services he was declared dead later that day. It has not been possible to determine Mr Vince's intent."</i></p> <p>The medical cause of death was:</p> <ol style="list-style-type: none">1a. [REDACTED] toxicity

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Vince was a patient of the community mental health team, receiving treatment for schizo-affective disorder. One of Mr Vince's medications was [REDACTED], prescribed for insomnia.</p> <p>In the days prior to his death, Mr Vince appeared low in mood and during an assessment by a paramedic, complained about his inability to sleep and his anxiety [REDACTED]</p> <p>On 19th June 2021 Mr Vince was found deceased having apparently taken an overdose [REDACTED]. Toxicology found a level [REDACTED] in Mr Vince's bloodstream twenty times higher than therapeutic levels.</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the inquest the evidence 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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none"> 1. The NICE guidelines for [REDACTED] indicate that it is a suitable medication for the short term treatment of insomnia, it advises against prolonged use due to risk of tolerance and withdrawal symptoms. Mr Vince is said to have been prescribed [REDACTED] for 20 years. 2. No evidence exists to support that Mr Vince's GP or community mental health team meaningfully reviewed his prescription [REDACTED] 3. Evidence of Mr Vince's dependence upon [REDACTED] was not shared by his GP with the mental health trust. 4. The frequency with which Mr Vince was administering his PRN [REDACTED] was never monitored.
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th August 2022. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: The family of Mr Vince, The Care Quality Commission, The General Medical Council, The Secretary of State for Health & Social Care. I have also sent it to the local Director of Public Health who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p>

	<p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>[DATE] 27th June 2022 [SIGNED BY CORONER] </p>

