CLYDE&CO

Attendance Note

Person Attending:	[redacted]
Attendance Date:	22 January 2024
Nature of Attendance:	Recording of Coroner's Summing up
Client/Matter Number:	[redacted]
Case Name:	[redacted] - Inquest of Mr Glenn Lockwood

Welcome back and thank you for bearing with me. Apologies I took slightly longer and anticipated. These are my findings and conclusions for the purpose of the Inquest.

Mr Lockwood had a known history of opioid dependence, spanning at least the last ten years according to the evidence of the GP, probably significantly longer, given what his family have told me today.

He was engaged with drug treatment and support services prior to his hospital admission on 14 April 2023. He was prescribed opioid replacement therapy which was to be collected daily.

In addition the GP confirms that Mr Lockwood was diagnosed with anxiety disorder in February 2021 and depressed mood in December 2022. I ought to say at this stage that the anxiety disorder diagnosis does pre-date February 2021 but the reason it is recorded as that date on the record is because that was when first registered with that practice. Glen's anxiety disorder was treated with Pregabalin which was last issued probably to Mr Lockwood on 5 April 2023 and the depressed mood was treated with Sertraline, also last issued on 5 April 2023.

The evidence suggests that Mr Lockwood's Pregabalin prescription was first put in place as I have said, by his GP in Essex prior to his move to London in 2021. [redacted] reviewed his Pregabalin prescription during a telephone consultation with Mr Lockwood on 9 March 2021. [redacted] tells me that at this review it was agreed that Pregabalin would be added to Mr Lockwood's repeat prescriptions because it appeared to control his anxiety symptoms well.

In August 2021 [redacted] received correspondence from Reset Drug and Alcohol Service which set out Mr Lockwood has failed to collect his daily opioid replacement therapy for a number of days, and reported that he had reverted to using both heroin and crack on a daily basis. Reset advised the surgery to avoid *"prescriptions of other opioid based medications without liaison with their team and to be cautious when prescribing other medications which may have potential for interaction as well care with regard to other medicines with potential for misuse".*

Mr Lockwood's next review took place on 15 December 2021 and no changes appear to have been made to his medication. [redacted] tells me that Mr Lockwood continued to request his prescriptions for Pregabalin on a monthly basis which were issued accordingly. No additional contact was made with the Practice by Glenn for a number of months.

On 24 June and 1 July 2022, the Practice attempted to contact Mr Lockwood by telephone to invite him to attend an annual routine substance misuse review. Mr Lockwood did not answer either call but a voicemail was left for him on each occasion. In addition a follow-up text message was sent to him on 1 July 2022.

On 12 July 2022 the Practice received an Accident and Emergency discharge summary. Essentially Glenn had been treated with antibiotics for cellulitis following an attempt to inject himself with [redacted] but missing the vein in his leg.

Glenn was seen in Accident and Emergency again on 22 September 2022 for a further episode of cellulitis with the lower limb, and a further course of antibiotics was prescribed. The Practice attempted to contact Glenn again on 24 October 2022 to invite him to a substance misuse review. There was no response on the voicemail that was left.

The Practice received further correspondence from Reset on 3 November 2022. The letter set out that Glenn had attended for an in-person review the previous day, when a plan was put in place to restart his Methadone because he had failed to engage previously, and the prescriptions had been withdrawn. The letter also confirmed that a mental health risk assessment had been conducted and there were no reported thoughts of self-harm or suicide.

Glenn attended the Practice on 7 December 2022 having requested a routine appointment. During that appointment Glenn reported feeling withdrawn, suffering from social anxiety and experiencing poor sleep. He disclosed at that appointment the smoking of cannabis and using heroin regularly albeit, he said, at lower levels than he had used in the past, because he was now receiving Methadone from Reset once more.

I am told by [redacted] that his Pregabalin was increased at that point to [redacted] milligrams twice daily. He did not report any thoughts of suicide or self-harm.

Glenn attended a follow-up appointment with [redacted] on 26 January 2023. During this appointment there appears to have been a degree of confusion about the level of Pregabalin that Mr Lockwood ought to have been taking. [redacted] states "It was agreed to change this to [redacted] milligrams three times daily, instead of going straight back to 300 milligrams twice daily. I was concerned regarding managing his ongoing anxiety yet I would not want him to risk issuing surplus medication to a patient with potential for misuse."

At the same appointment [redacted] also commenced Glenn on a prescription of [redacted] milligrams of Sertraline an anti-depressant. This was the last time that Glenn was seen in the Practice despite continued efforts to engage him. However a number of prescriptions I am told continued to be requested and issued by the Practice. Exactly what was issued is not clear despite the fact that the Practice undertook a serious event analysis. Further correspondence from the Practice appears to accept that there is some confusion and that the notes are not clear, and that a further serious event analysis is required.

In February 2023 Glenn was taken to Accident and Emergency by the police, following an overdose of Temazepam and Diazepam. Following a period of observation Glenn was discharged, and the discharge summary sent to the Practice confirmed that Mr Lockwood had no suicidal thoughts at that time. Neither of these medications were prescribed to Glenn at the time.

Reset have confirmed in the report to me that Glenn had missed three consecutive Methadone doses in February 2023. Following this he did attend a face-to-face medical restart appointment with [redacted] at Reset on 11 April 2023. At that appointment he reported using approximately [redacted] grams of [redacted] daily. He also told [redacted] that his recent hospital admission for a drug overdose was the result of an accidental overdose. A urine drug screening test was conducted by [redacted] and Glenn tested positive for opiates, [redacted] [redacted] commenced Glenn on an initial daily Methadone prescription of [redacted] millilitres on daily supervised consumption, to be increased over time to [redacted] millilitres per day.

I find that there is clear evidence that Mr Lockwood's engagement with his GP and Reset Addiction Service was somewhat sporadic. However, I note that there is no evidence to suggest that Glenn lacked mental capacity, and as such he was in entitled to make decision not to engage in treatment, even if those decisions later seemed unreasonable to others.

Another thing that is clear both from the medical evidence and from Glenn's own disclosures during appointments, is that throughout 2022 and up to the time of his last admission to hospital in April 2023, Glenn had clearly relapsed into the misuse of drugs. Those appear to have included more usual drugs for want of a better way of putting it, as well as illicitly obtained medication, that was ordinarily prescription only, such as the Diazepam referred to earlier.

[redacted] of the Royal London Hospital confirms that Glenn was brought to Accident and Emergency on 14 April 2023 having been found unresponsive on the platform of Westferry DRL station. He was treated for a suspected heroin overdose and moved to a ward on the eleventh floor.

[redacted] states the treatment seems to improve Mr Lockwood's condition, and his condition improved further overnight. [redacted] confirms that Mr Lockwood was seen by doctors on up to five separate occasions during this short admission. But despite this Mr Lockwood sought to discharge himself from hospital on the basis of having been in hospital for 24 hours without having seen a doctor. I have been provided with a copy of the self-discharge documentation signed by Glenn. As set out by [redacted], Glenn wrote words to the effect that he wanted to self-discharge because he needed to go to the pharmacy and because he had not been seen by a doctor for 24 hours. He reportedly says that he would return to A&E if his chest worsened. But the evidence from [redacted] is clear that there is no question had not been seen by doctors. Indeed, there is clear evidence that at least three separate doctors had seen Glenn numerous times throughout that short admission.

I then move on to the events of 16 April 2023 which is when for a short time at least the evidence becomes much less clear. What is clear from the London Ambulance Service records is that a 999 call was made regarding Glenn on the afternoon of 16 April 2023, and the call was connected at 13:41. On arrival of the ambulance at 13.47 paramedics were met by someone who purported to be a friend of Glenn. The London Ambulance Service documentation advises of the telephone number from which the 999 call was made. However during the course of my investigation I have not been able to identify who made that call, because the number relates to an unregistered mobile telephone which was confirmed in the evidence of [redacted], the Coroner's Officer.

The response time of the ambulance on that occasion is documented at less than six minutes, which is well within the target response time set for Category 1 lift threatening emergencies. I mention this simply because it answers one of the questions that you the family had asked me to consider.

Whoever the mystery friend with Glenn was, they stayed with him and commenced CPR as per the instructions provided by the London Ambulance Service call handler. It was evident that the numerous paramedics that attended Mr Lockwood worked tirelessly for well over an hour to attempt to resuscitate, stabilise and convey Glenn to hospital.

The further curious matter which needs to be mentioned at this stage is that the paramedics noted that Glenn's temperature was 27.2º Celsius and he was therefore hypothermic. However, he was noted to be in a warm environment and in appropriate clothing. As far as the paramedics were concerned there was no obviously clinical answer as to how Mr Lockwood's temperature had dropped to such a level. Unfortunately, having been unable to identify the potential witness to this fact, I cannot offer a definitive answer to that point either. I note that initial documentation provided a suggestion that Glenn's friend found him outside and then took him back inside before calling an ambulance. While this is possible, and it is also possible that Mr Lockwood collapse may have taken place elsewhere, I can make no formal finding in that regard in the absence of any reliable evidence. I also note the mismatch in the evidence between what paramedics were told by the mystery friend, and the view of [redacted] about the overdose that led to the hospital admission on 14 April 2023. The friend appears to have told paramedics that Glenn had overdosed on Pregabalin, whereas [redacted] worked on the assumption that it had been a heroine overdose.

On balance I consider that it is most likely to have been a heroin overdose. This is because [redacted] is clear that three doses of Naloxone were administered to seeming good effect, and I bear in mind that Naloxone had previously been provided to Glenn by Reset to self-administer in the event of accidental overdose, it being an antidote to opiates such as heroin.

In terms of Glenn's admission at Royal London Hospital thereafter, I consider that there is little for me to say. The medical evidence sets out in clear terms that Glenn's prognosis was not good from the outset, due to the length of time he was in cardiac arrest. He was showing clinical signs of hypoxic brain injury. Essentially following some improvement an attempt was made by the Adult Critical Care Unit to extubate Glenn but he was not able to sustain independent breathing at that time.

Further medical and neurological reviews came up with the possibility of inserting a tracheostomy. However, family concerns and subsequent medical concerns regarding Glenn's minimally conscious state was such that the medical decision was made with the support of Glenn's family that tracheostomy procedure should not be attempted. The decision was taken again with the support of Glenn's family to extubate him and place him on a palliative care pathway.

Glenn sadly died on 2 June 2023.

[redacted] conducted the post-mortem examination on behalf of the Coroner and also undertook numerous toxicological tests including the taking of hair samples. [redacted] offers a proposed medical cause of death in the following terms: -

1a – hypoxic brain injury, multiple organ failure and bronchopneumonia following cardiac arrest.
1b – mixed drug toxicity.

The proposed cause of death, if accepted, would mean that the underlying cause of Mr Lockwood's death was mixed drug toxicity.

Given the lack of direct evidence to suggest that Mr Lockwood took any form of drug in the relatively brief period after his self-discharge from hospital on 15 April 2023, this is something I have considered particularly carefully to avoid jumping to conclusions.

[redacted] was able to exclude traumatic injury as a cause of the hypoxic brain injury. He also notes that on examination Glenn's myocardial damage *"did not appear to be due to significant coronary artery atheroma".* In addition, he notes that cocaine can be a known cause of myocardial fibrosis. [redacted] report continues *"Toxicology reveals that Mr Lockwood had taken several compounds during the six months leading up to his death, with heroin and cocaine at levels associated with heavy use. Opiates can produce collapse or indeed fatality if taken in sufficient quantity due to severe respiratory depression/respiratory arrest. Cocaine can cause cardiac arrest or sudden death irrespective of its concentration."*

[redacted] is clear that the hypoxic brain injury, multiple organ failure and bronchopneumonia all developed as a result of the cardiac arrest. He concludes in light of the toxicology results *"It is therefore more likely than not that drug use and subsequent toxic effects are responsible for the cardiac arrest, either directly on the vital controlling centres of the brain, or indirectly via an action on the heart or coronary artery"*.

I see no reason to question the logic and medical reasoning employed by [redacted] and therefore accept his proposed cause of death. In doing so I have additionally borne in mind Mr Lockwood's self-discharge the day before his cardiac arrest in which he wrote of his need to go to the pharmacy. This indicates that having spent approximately 24 hours in hospital, Glenn was likely experiencing withdrawal from opiates and wishing to obtain his methadone prescription and

possibly take other substances which by his own admission a few days earlier at the Reset appointment, on 11 April 2023, he was taking on a daily basis.

Turning then to the formal Record of Inquest I record as follows: -

Box 1: Name of the deceased:

Glenn Anthony Lockwood.

Box 2: Medical cause of death –

1a. Hypoxic Brain Injury, multiple organ failure and bronchopneumonia following cardiac arrest.

1b. mixed drug toxicity.

Box 3: How, when and where the deceased came by their death:

Glenn Lockwood was admitted to hospital on 14 April 2023 following a suspected heroin overdose. On 15 April 2023 he self-discharged from hospital against medical advice. On 16 April 2023 Mr Lockwood had an out of hospital cardiac arrest. He was admitted to the Royal London Hospital and despite treatment he died in hospital on 2 June 2023.

Box 4 – Coroner's conclusion as to death:

Drug related death.

Finally, I considered whether my duty to issue a report aimed at preventing future death is engaged. In my view it is. I will be issuing a report to the Limehouse Practice on the basis that the evidence of their Serious Event Analysis provides insufficient reassurance that practices and procedures surrounding the prescribing and documentation of medication to patients has been sufficient addressed.

You as a family will also be provided with a copy of my report. The law also states that the Practice has 56 days to respond to the report.

That concludes the Inquest and all that remains if for me to offer you my sincere condolences for your loss.