Regulation 28: Prevention of Future Deaths report

Glenn Anthony LOCKWOOD (died 02.06.2023)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Managing Partners The Limehouse Practice Gill Street Health Centre 11 Gill Street London E14 8HQ**
1	**CORONER** I am Ian Potter, assistant coroner, for the coroner area of Inner North London.
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 9 June 2023, an investigation was commenced into the death of GLENN ANTHONY LOCKWOOD, then aged 48 years. The investigation concluded at the end of an inquest, heard by me, on 15 November 2023. The conclusion of the inquest was drug related death, the medical cause of death being: 1a hypoxic brain injury, multiple organ failure and bronchopneumonia following cardiac arrest 1b mixed drug toxicity
4	**CIRCUMSTANCES OF THE DEATH** (1) Mr Lockwood was a known drug user, registered with The Limehouse Practice since February 2021. He did not always engage well. Mr Lockwood was prescribed Pregabalin throughout the time he was registered with The Limehouse Practice. (2) He was receiving support and treatment from a local drug and alcohol support service, which took over prescribing for his opiate replacement therapy, and regularly updated The Limehouse Practice about Mr Lockwood's treatment and engagement. (3) Mr Lockwood was found unresponsive on the platform of Westferry DLR station on 14 April 2023 and conveyed to hospital where he was

	treated for a suspected [redacted] overdose. He responded to naloxone, but discharged himself from hospital (against medical advice) on 15 April 2023. (4) On 16 April 2023, Mr Lockwood had an out of hospital cardiac arrest and following extensive resuscitation efforts, was conveyed to hospital by ambulance. (5) Despite treatment in hospital, Mr Lockwood died on 2 June 2023.
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 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:- (1) Mr Lockwood's drug treatment provider wrote to his GP in August 2021 to advise caution "with regard to other medicines with potential for abuse." According to the British National Formulary, Pregabalin should be monitored for "signs of abuse". The evidence I received did not reassure me that sufficient steps were taken to monitor for signs of Pregabalin abuse, particularly in a patient with known history of drug abuse. (2) The statement I received from Mr Lockwood's GP alluded to the fact that there were possible record keeping and prescribing issues surrounding Mr Lockwood's prescriptions for Pregabalin. As a result, a Serious Event Analysis was conducted. In response to written queries from me, The Limehouse Practice responded by email on 14 November 2023. That email alluded to potential errors within the Serious Event Analysis and stated that the Serious Event Analysis would be re-opened and revisited. As such, I am not reassured that relevant risks have fully explored and/or any required action(s) taken.
6	**ACTION SHOULD BE TAKEN** In my opinion 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 by 12 January 2024. 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**

<table>
<tr><td></td><td>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

(a) [redacted] (Glenn Lockwood's parents).

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.</td></tr>
<tr><td>9</td><td>

Ian Potter
HM Assistant Coroner, Inner North London
17 November 2023</td></tr>
</table>