	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. National Medical Director, NHS England**
1	**CORONER** I am David Manknell KC, Assistant Coroner, for the coroner area of London Inner South
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 7 August 2020 an inquest was opened into the death of Joshua Arthur Stafford Delaney. The inquest was concluded on 28 March 2024. The medical cause of death was Propranolol toxicity. The jury's conclusion at the inquest was a narrative conclusion, including a conclusion that the deceased took an overdose while conscious of what he was doing and that he intended to end his life, but that after the act he regretted his decision.
4	**CIRCUMSTANCES OF THE DEATH** The deceased, aged 19 at the time of his death, was a young man with a history of mental illness and suicidal ideation, and who had made previous suicide attempts. During the year prior to the index events, he had been prescribed Mirtazapine for anxiety and to help with sleep. Following his discharge from the Community Mental Health Team, he attended his GP in October 2019, with symptoms of anxiety and physical symptoms including palpitations and tachycardia. He was prescribed Propranolol [redacted] to be taken [redacted] times a day for [redacted] days, and given [redacted] tablets for this purpose. He was given further prescriptions of [redacted] tablets of Propranolol at the beginning of November 2019, and again on 4 January 2020. He had seen his GP in early December 2019, who had intended that the deceased move to taking Propranolol 'as required' in order to wean him off its use. In the early hours of 19 January 2020, the deceased took a large overdose of Propranolol, estimated by the toxicologist to have been [redacted], and was found collapsed. Despite prolonged attempts at resuscitation by the paramedics and in hospital, he died on 19 January 2020.
5	**<u>CORONER'S CONCERNS</u>** During the course of the investigation and 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. – The evidence of the General Practitioner in this case was to the effect that prior to this death, neither he nor his colleagues were aware that Propranolol carried any significant risk of death through deliberate overdose. The evidence of the doctor in question was that because of this specific incident, there has been a change in their approach to

	prescribing of Propranolol at his GP surgery, with smaller quantities prescribed to patients who might be at risk of taking an overdose. Shortly after this incident (11 February 2020) there was, coincidentally, an article in the British Medical Journal in respect of Propranolol, (*"Doctors and paramedics must be better prepared to deal with propranolol overdoses").* However, the doctor's evidence in the inquest was that he did not believe that GPs generally were currently aware of the risk of Propranolol overdoses. The evidence from the Consultant Psychiatrist from the Community Mental Health Team was that they would not usually prescribe Propranolol, and he also considered that GPs may not be aware of the overdose risk posed by the drug. The inquest also heard from the toxicologist, who gave evidence that her anecdotal experience was that there had in recent years been a significant number of deaths caused by Propranolol overdoses. In the circumstances, I am concerned that doctors in General Practice may not be aware of the risks of fatal overdose from Propranolol, and that in the absence of greater awareness by GPs, the prescription of quantities of Propranolol to those at risk may cause future deaths.
6.	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 3 June 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** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted], the South London and Maudsley NHS Foundation Trust, and the Metropolitan Police. 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	**8 April 2024**