Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **NHS England** **By Email**
1	**CORONER** I am Samantha GOWARD, Area Coroner for the coroner area of Norfolk
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 20 June 2024 I commenced an investigation into the death of Oliver James WINSON aged 33. The investigation concluded at the end of the inquest on 19 December 2024. **The medical cause of death was:** 1a) Cocaine Toxicity **The conclusion of the inquest was:** Drug related
4	**CIRCUMSTANCES OF THE DEATH** Oliver Winson was a 33 year old man who had a history of drug misuse and he was under the care off substance misuse services since December 2013. He had previously been diagnosed with a mixed anxiety and depressive disorder for which he was prescribed medication. In 2017 he was referred to the adult ADHD (attention deficit hyperactivity disorder) service as his GP was concerned that his attention span was limited, and he had become quite hyperactive. In a response to a request for further information, his GP confirmed that Mr Winson had been concerned for many years about his low attention span and found it difficult to concentrate and there were concerns that this might point to hyperactivity and drug related behaviour. He had a history of impulsive behaviour, and this led to a risk of him becoming aggressive and a risk of going back to significant drug abusing behaviour. The GP felt that he was at quite a high risk of significant harm to himself in the long run if he was not diagnosed and managed appropriately. As Mr Winson was under the care of the drug and alcohol service it was felt that someone in that team could see him so the referral was not accepted at that time. However, the service misuse team referred Mr Winson back to the mental health Trust on 19th June 2020 for an adult ADHD undiagnosed assessment. They confirmed that he had been abstinent from drugs for four to five years and was on daily methadone. The adult ADHD service said they would accept the referral on to the undiagnosed wait list but indicated he should remain abstinent from drugs to benefit from the service. At that time, it was indicated that the waiting list was likely to be in the region of two years. The substance misuse service regularly sought updates on the waiting list and were advised

	that this was very lengthy due to unprecedented referrals and that the COVID pandemic had also impacted on this. By May 2023 when seeking an update, the service raised the concern that it had taken five years and a lot of hard work for Mr Winson to get to the point that he was at and that they were concerned that his historic drug use was chaotic, and he was at risk of death by overdose. Sadly, Mr Winston did relapse into drug use and on 10th June 2024 police were called to his home address where he was found deceased and toxicology evidence confirmed drug use prior to death and that death was as a result of cocaine toxicity.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: Evidence received from the mental health Trust confirms that proactive steps have been taken by them to try and improve access and mitigate delays as far as possible and they provided details of some additional funding received from the local integrated care board in November 2021. Based on the evidence heard at inquest we know that this action in 2021 did not significantly reduce the waiting time, as at the time of his death Mr Winson had been waiting for four years. I also heard evidence that despite local and national efforts, the scale of demand for adult ADHD services is a system wide issue across the country. It is of concern that patients who have been identified specifically of being at risk as a result of undiagnosed and/or untreated ADHD (and it was also noted in the evidence that there is a shortage of medication for those patients who have been diagnosed) remain on significantly lengthy waiting lists during which time they are not receiving treatment, their condition is not monitored and there is a risk as with Mr Winson, that their condition may deterioration or lead to risk or harmful behaviour and death.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by February 13, 2025. 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: ▪ Mother of Oliver Winson ▪ Norfolk and Suffolk NHS Foundation Trust 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.

	I may also send a copy of your response to any person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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	**Dated: 20/12/2024**  **Samantha GOWARD** **Area Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH