Coroner ME Hassell
HM Senior Coroner
Inner North London

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) [redacted], President of the Royal College of Psychiatrists, 21 Prescot Street, London E1 8BB** **2) [redacted], Minister for Health and Social Care, 39 Victoria Street, London, SW1H 0EU**
1	**CORONER** I am Sarah Bourke, HM 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 29 August 2024, Senior Coroner Hassell, commenced an investigation into the death of Jacob Matthew WOODERSON (age 28 years). The investigation concluded at the end of the inquest on 23 May 2025. The conclusion of the inquest was that the medical cause of death was: 1a) Sudden arrhythmic death syndrome 2) Elvanse treatment for ADHD. I returned the following narrative conclusion: *Jacob Wooderson was 28 years old. He was diagnosed by a privately instructed Consultant Psychiatrist as having ADHD (inattentive subtype presentation) in*

	February 2024. He subsequently commenced Elvanse (Lisdexamfetamine) 30 mg. The dosage was increased to 50mg in June 2024 after an ECG, blood pressure, heart rate and other investigations were undertaken in accordance with national guidelines. In August 2024, Jacob increased his Elvanse dosage to 70mg. The blood pressure and heart rate information considered by his psychiatrist prior to prescribing 70mg Elvanse was previously submitted in June 2024 when Jacob was taking a 30 mg dosage. Following the increase to 70mg, Jacob reported problems with poor sleep and exhaustion to his friends. He collapsed and died at his home on 23 August 2024. The medical cause of his death was: 1a) sudden arrhythmic death syndrome; 2) Elvanse treatment for ADHD. The arrhythmia may have had a genetic cause or be linked to Jacob's medication. It is not possible to establish the precise cause of the arrhythmia on the balance of probabilities from the evidence before me. Jacob Wooderson was not given any clear written advice from his psychiatrist regarding the side effects of Elvanse or the steps to be taken if any adverse side effects presented. This was a missed opportunity for Jacob to have information which may have led him to seek medical advice which could in turn have led to a different outcome.
4	**CIRCUMSTANCES OF THE DEATH** In addition to the matters set out in the narrative conclusion, the evidence established that: Jacob Wooderson had long standing issues around memory, concentration and focus which led him to seek an ADHD assessment and treatment, which included the prescribing of Elvanse. The Toxicology evidence established that Elvanse (lisamphetamine) is a stimulant drug and that its use at any dose may result in cardiac effects including tachycardia, arrhythmias and potentially myocardial infarction. Increased heart rate and insomnia are consistent with the effects of amphetamine use even when taken therapeutically and particularly at the start of a new treatment (e.g. increased dosage) due to tolerance to that dose not being formed. The toxicologist's view was that if there is evidence that a cardiac event had occurred, it is possible that this was enhanced by the use of amphetamine, even if taken therapeutically. NICE guidance NG87 on the treatment and management of ADHD states at para 1.8.9 that where patients are prescribed medication for ADHD, prescribers should monitor heart rate and blood pressure and compare with the normal range for age before and after each dose change, and every 6 months.

	Jacob had video consultations with his psychiatrist. The psychiatrist's usual practice was to make handwritten notes during a consultation. These notes were then used to prepare a follow up letter to the patient. The handwritten notes of the consultation were then destroyed. Jacob's psychiatrist did not clearly document Jacob's baseline blood pressure and heart rate prior to starting Elvanse or after increasing the dosage to 50 mg. Similarly, the advice given to Jacob regarding adverse side effects of Elvanse was not recorded at any point. It also appears that Jacob was not sent any follow up letter after his Elvanse dosage increased to 70 mg Jacob increased his Elvanse dosage from 50 mg to 70 mg around 6 August 2024. Following that increase, he disclosed to his partner and friends that the 70 mg dosage of Elvanse made him "feel weird", caused insomnia and led him to feel exhausted. The psychiatrist said that if they had known of Jacob's symptoms on increasing the dosage to 70 mg, they would have advised him to stop taking Elvanse and reviewed his medication.
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) Elvanse is an amphetamine-based medication which can have fatal cardiac side effects. It is increasingly being prescribed in the NHS and in the private sector for ADHD symptoms. As the dosage of Elvanse may increase gradually over a period of months, there is the potential for a patient that has previously tolerated the medication to develop adverse side effects. Monitoring of heart rate and blood pressure may help identify serious side effects at an early stage. 2) Symptoms of ADHD can include forgetfulness and problems with inattention. Consequently, there is a risk that patients may not recall verbal advice regarding the adverse side effects of Elvanse, particularly if it is only given at the outset of treatment or is not followed up in writing. 3) The practice of remote consultations may mean that prescribers are reliant upon patients providing heart rate and blood pressure data outside of the consultation. Consequently, there is the potential for clinical decisions to be based on unreliable observations.

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 2 October 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: • Family of Jacob Wooderson • [redacted] 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. 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	**SARAH BOURKE** **HM Assistant Coroner** **6 August 2025**