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17th February 2026

Catherine McKenna
Area Coroner for Manchester North
HM Coroner's Court
Rochdale

Re: Response to Regulation 28 Report to Prevent Future Deaths

Deceased: Oliver Marc Robinson (born 13 July 1989, died 24 November 2023)

Reference: 20260058

Dear Ms McKenna,

We write in response to the Regulation 28 Report to Prevent Future Deaths dated 4 February 2026 concerning the death of Oliver Marc Robinson. This response is provided pursuant to Regulation 29 of the Coroners (Investigations) Regulations 2013.

Curaleaf Clinic acknowledges the tragic circumstances of Mr Robinson's death and extends its deepest sympathies to his family. Our thoughts remain with Mr Robinson's family and everyone affected by his death.

We have engaged seriously with your concerns and, as detailed below, had already concluded a comprehensive internal investigation and implemented material changes to our clinical governance, communication processes, and ongoing care *prior to the commencement of the inquest.* The findings of that internal investigation and the changes we had made were available to the Court both by way of documentary and oral evidence.

We note the conclusion in the Record of Inquest of death by misadventure, and the finding that Mr Robinson's emotional dysregulation was caused by multiple factors and psychosocial stressors including conflicts with housing and NHS services, debt, and a dependence on cannabis obtained through both illicit sources and by prescription. We further note the Court's finding that it is more likely than not that Mr Robinson did not intend the consequences of his actions.

We respect the coronial process and the important role it serves. We note the concerns raised and address each below.

1. Qualifications of the Prescribing Consultant Psychiatrist and Exhaustion of Treatment Options

Coroner's concern: *The Consultant Psychiatrist who reviewed Oliver at Curaleaf specialised in Child and Adolescent Psychiatry and had no Consultant level experience in treating adult patients with Oliver's complex presentation or in the type of treatments available for adult patients with treatment-resistant depression. Treatment options had not been exhausted at the time that medicinal cannabis was prescribed.*

We have engaged with this concern and respectfully disagree, for the reasons set out below.

Scope of Practice

[redacted] is a fully qualified Consultant Psychiatrist on the GMC Specialist Register [redacted]), admitted to the Specialist Register for Child and Adolescent Psychiatry in August 2020. We respectfully submit that characterisation of [redacted] as having "no Consultant level experience in treating adult patients" does not accurately reflect her training, qualifications, or clinical experience.

All Consultant Psychiatrists in the United Kingdom are required to complete several years of training in adult psychiatry before specialising. [redacted] worked extensively in adult psychiatry during her training and subsequently was employed as a Staff Grade doctor in adult psychiatry for three years, including two years in an adult crisis team after receiving her Certificate of Completion of Training. She also worked for five years in inpatient psychiatry and, during on-call duties, covered the entire hospital including adult patients. She is a Section 12(2) approved doctor, defined as a registered medical practitioner with special expertise in diagnosing or treating mental disorders, approved by the Secretary of State under the Mental Health Act 1983. She continues to undertake Mental Health Act assessments for adult patients in her role as a consultant psychiatrist.

[redacted] has been employed by Curaleaf Clinic since April 2021 and is one of the clinic's most experienced consultant psychiatrists. Prior to this case, there had been no formal complaints, serious incidents, or adverse events recorded in relation to patients under her care.

Critically, Mr Robinson's case was not managed by [redacted] in isolation. Curaleaf Clinic operates a formal multidisciplinary team (MDT) process through which every patient must be reviewed before a prescribing decision is made. No individual clinician may unilaterally initiate treatment with cannabis-based medicinal products (CBMPs). The MDT requires a

quorum comprising consultants from different medical specialities with experience in medical cannabis therapy, an advanced specialist pharmacist certified for independent prescribing, and the clinic's operations or medical director. The proceedings are formally minuted by the operations team.

Following the initial consultation, Mr Robinson's suitability for treatment was reviewed and approved at an MDT meeting on 5 May 2022. The MDT comprised of [redacted], another consultant psychiatrist (adult), a consultant medical physician, a consultant in palliative care, a consultant anaesthetist, and a specialist pharmacist certified for independent prescribing. The prescribing decision was a collective clinical decision made with the input of additional clinicians, not a unilateral decision by [redacted].

Exhaustion of Treatment Options

We dispute the assertion that treatment options had not been exhausted at the time CBMPs were prescribed. Mr Robinson had trialled the following medications: escitalopram, duloxetine, venlafaxine, reboxetine, mirtazapine, quetiapine, and aripiprazole. He also had a documented severe adverse reaction to amitriptyline. This represents treatment with all major classes of antidepressant medication, including selective serotonin reuptake inhibitors (SSRIs), serotonin–norepinephrine reuptake inhibitors (SNRIs), tetracyclic antidepressants, tricyclic antidepressants (TCAs), and antipsychotics for mood augmentation.

In addition, Mr Robinson had undergone extensive non-pharmacological treatments: referral to Improving Access to Psychological Therapies (IAPT), a one-month inpatient admission to the Priory Hospital Altrincham and associated therapies, outpatient cognitive behavioural therapy (CBT), advanced CBT group therapy, over 60 sessions of schema therapy, and eye movement desensitisation and reprocessing (EMDR). Despite this extensive treatment history, Mr Robinson continued to experience significant symptoms.

The remaining licensed pharmacological options — principally lithium and monoamine oxidase inhibitors — both carry substantial safety risks in themselves. Importantly, Mr Robinson did not wish to take these medications. A treatment that a patient refuses cannot be considered a viable therapeutic option. There were also pre-existing difficulties with medication compliance documented in his records, making the prescription of higher-risk medications a less appropriate course of action.

The regulatory framework under which CBMPs are prescribed requires that licensed treatments have been trialled and have not provided satisfactory improvement or have caused

side effects leading to poor adherence or discontinuation. That threshold was clearly met. The MHRA guidance does not require that *every possible* licensed treatment has been exhausted before CBMPs can be prescribed.

Mr Robinson was an adult with capacity who, after informed consent, chose to pursue a consultation to assess whether CBMPs could manage his symptoms. He self-referred to the clinic. As part of the consent process, Mr Robinson signed a treatment agreement which set out the responsibilities of both patient and clinician, including transparency about potential side effects, the requirement to inform the clinician of any concurrent substance use, and an undertaking to abstain from illicit cannabis. It is important to contextualise this: Mr Robinson had been using illicit cannabis prior to attending the clinic, which carries materially different risks from prescribed, pharmaceutical-grade CBMPs administered under clinical supervision in controlled dosages. The treatment agreement was designed to transition him from unregulated use to monitored, clinically directed treatment.

Clinical outcome measures demonstrated significant improvement during treatment. Mr Robinson's patient-reported outcome measures, collected through the UK Medical Cannabis Registry, showed that his Patient Health Questionnaire-9 depression score fell from 23 (severe depression) at baseline to 8 (mild depression) at his last assessment. This 15-point reduction exceeds the five-point threshold for a clinically significant improvement.

2. Reliance on an Out-of-Date GP Summary Care Record and Incomplete Information

Coroner's concern: *Curaleaf's initial prescribing decision was based on an out-of-date GP summary care record and without the knowledge that Oliver was under the care of a Consultant Psychiatrist at the Priory. As such the prescribing decision was based on incomplete information.*

The Summary Care Record (SCR) was less than a year old when reviewed by the MDT, and we do not accept that this resulted in a materially flawed prescribing decision.

The SCR that was available contained the clinical information necessary for the assessment of Mr Robinson's eligibility for CBMPs: namely, his objective diagnosis of depression and the record of licensed medications that had been trialled without sustained benefit. The prescribing clinician also took a detailed clinical history directly from Mr Robinson, who had capacity, and [redacted] specifically asked about any changes or updates to his care or medications. It is important to note that the SCR is a nationally managed record produced by NHS systems. Its currency depends on when information is uploaded by the patient's GP practice. Private healthcare providers, including Curaleaf Clinic, do not control how

frequently SCRs are updated. To characterise the prescribing decision as having been based on "incomplete information", without acknowledging the inherent limitations of the SCR system, presents an incomplete picture.

The Priory was aware that Mr Robinson was prescribed CBMPs, as he had informed his consultant psychiatrist of this. No communication was received by Curaleaf Clinic from the Priory, nor did the Priory contact the clinic to raise any concerns about the prescription.

Throughout Mr Robinson's treatment at the clinic the decision to prescribe and the medications he was prescribed was communicated to his GP via formal electronic letters, as is standard practice. The GP was aware of this and wrote a letter detailing their knowledge of his prescription.

Despite other parties being aware of Mr Robinson's prescription for CBMPs, Curaleaf Clinic was not contacted by these other agencies to raise concerns if those concerns were present at the time.

Once Curaleaf Clinic became aware of the involvement of other psychiatrists in Mr Robinson's care, efforts were made to contact them to corroborate the information provided by Mr Robinson.

Internal Investigation Findings and Actions Taken

Our internal investigation identified the reliance on SCRs as an area for improvement. The following changes were implemented prior to the inquest:

- Curaleaf Clinic was amongst the first specialised medical cannabis clinics to implement access to the NHS National Care Records Service (NCRS / Spine), enabling clinicians to obtain contemporaneous clinical information directly to support both initial assessments and ongoing care.
- For patients under Community Mental Health Team (CMHT) care, the clinic's established process now requires that contact is made with the CMHT and that a decision to prescribe is not made until this has been confirmed.
- The clinic has reinforced the importance of documenting the clinical information available at the point of decision-making, with cases involving incomplete external information considered through MDT discussion and wider clinical governance processes.

3. Communication with Treating Psychiatrists

Coroner's concern: *Once Curaleaf Clinic became aware that Oliver had been reviewed by Consultant Psychiatrists at the Priory and the NHS, it did not communicate directly with them or seek to inform themselves of the treating Psychiatrists' views.*

We acknowledge that, with the benefit of hindsight, more proactive steps could have been taken by Curaleaf Clinic to establish direct communication with Mr Robinson's other treating psychiatrists. However, the concern, as framed, attributes the communication failure exclusively to Curaleaf Clinic. Communication is a two-way process. Throughout Mr Robinson's treatment, Curaleaf Clinic routinely sent clinic letters to his GP after each consultation and expressly invited collaboration with other healthcare professionals. When Mr Robinson informed [redacted] that another psychiatrist was involved in his care, she asked him to provide the relevant contact details. He agreed to do so but did not subsequently provide this information. Mr Robinson himself made efforts to facilitate communication between his healthcare providers. On 14 July 2023, he sent an email to his NHS psychiatrist, copying Curaleaf Clinic, requesting that his clinic notes be shared. Curaleaf acknowledged this communication and awaited the notes, but they were not received. On reflection Curaleaf Clinic could have taken a more proactive approach by initiating contact with the NHS psychiatrist following the non-response to this communication.

We respectfully observe that a finding of communication failure has only been directed at Curaleaf Clinic. As highlighted by way of documentary and oral evidence heard by the Court, the Priory and Mr Robinson's NHS psychiatrist were aware that Mr Robinson was prescribed CBMPs, as he had informed them of this.

The GMC provides guidance that all medical professionals have a duty to raise concerns where they believe that patient safety or care is being compromised by the practice of colleagues or systems, policies and procedures. As highlighted, no commmunications were received from any outside party during the time Mr Robinson was treated by Curaleaf Clinic to indicate they had any concerns about his prescription.

Internal Investigation Findings and Actions Taken

Our internal investigation identified that opportunities to establish direct communication with third-party psychiatrists were missed. The following changes were implemented prior to the inquest:

- System changes have been introduced to the clinic's electronic health record to record and monitor whether a patient is under CMHT care or the care of an external psychiatrist, and to log engagement with those services.
- For patients under CMHT care, explicit consent or non-objection from the CMHT is now obtained before commencing treatment with CBMPs.
- These processes have been incorporated into the clinic's regular audit cycle and form part of the high-risk patient pathway.

4. Whether the Continuation of Medicinal Cannabis Acted as an Obstacle to Appropriate Psychiatric and Addictions Care

Coroner's concern: *The continuation of prescriptions for medicinal cannabis acted as an obstacle to Oliver receiving appropriate psychiatric and addictions care.*

We have reflected on the highlight concern and dispute this characterisation.

Psychiatric Care

Throughout the period of his treatment with CBMPs, Mr Robinson remained under the care of his GP, who continued to prescribe his conventional psychiatric medications. He was also seen by psychiatrists at the Priory and by the NHS. The CBMP prescription did not displace or prevent any of these engagements.

Mr Robinson's patient-reported outcome measures provide objective evidence that his condition improved during treatment with CBMPs. His Patient Health Questionnaire-9 depression score fell from 23 (severe depression) at baseline at the commencement of treatment to 8 (mild depression) by July 2023 — a clinically significant improvement.

The Record of Inquest recognises that Mr Robinson's emotional dysregulation was caused by multiple factors and psychosocial stressors. The evidence heard at inquest included financial difficulties, homelessness, loss of his driving licence, relationship breakdown, and conflict with both NHS services and housing services. To characterise the CBMP prescription as "an obstacle" to care, without giving equivalent weight to these well-documented psychosocial factors, does not reflect the complexity of the case.

Internal Investigation Findings and Actions Taken

Curaleaf Clinic has reflected carefully on the concerns raised in this case. The following changes have been implemented:

- The clinic has reviewed its approach to patients with complex psychiatric presentations and reinforced the importance of coordination with external mental health services, including CMHTs, where applicable.
- Where a patient is receiving care from a CMHT or other relevant services, the clinic seeks to support coordinated care by communicating with those services (with patient consent) and ensuring that CBMP treatment proceeds only where appropriate ongoing care arrangements are in place.
- These considerations are addressed through MDT discussion and the clinic's established clinical governance framework.

Conclusion

Curaleaf Clinic has reflected carefully on the circumstances of this case. As set out above, we had already identified – and provided evidence about – the key areas for improvement through our own internal investigation and had implemented material changes to our clinical governance, communication, and shared-care processes before the inquest commenced.

We remain committed to continuous improvement, robust clinical governance, and constructive engagement with coronial and regulatory processes. Our priority is, and always has been, the delivery of responsible, clinically led care within established medical and regulatory frameworks, with the aim of ensuring the safety of all our patients.

We trust that this response addresses the matters raised in the Regulation 28 report.

Our thoughts and sincerest sympathies remain with Mr Robinson's family and loved ones at this time.

Yours sincerely,

Curaleaf Clinic

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