REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Curaleaf Clinic, 10 Harley Street, London, W1G 9QY**
1	**CORONER** I am Catherine McKenna, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 29 November 2023 an investigation into the death of Oliver Marc Robinson was commenced. The investigation concluded at the end of the inquest on 30 January 2026, 1recorded a conclusion of Misadventure.
4	**CIRCUMSTANCES OF DEATH** Oliver Robinson was 34 years old when his body was discovered at his home address on 24 November 2023. He died by means of self-ligature which he had tied at a time when he was experiencing acute emotional dysregulation. The Court found that his actions in tying the ligature were undertaken as a means of communicating distress rather than with an intention to end his life. The Court also found that Oliver's emotional dysregulation was caused by multiple factors and psychosocial stressors including conflicts with housing and NHS services, debt and a physical and psychological dependence on cannabis which he was obtaining through illicit sources and by way of a prescription from a private clinic. Oliver had enrolled on the UK Medical Cannabis Registry research study run by Curaleaf Clinic in April 2022 and received prescriptions for medicinal cannabis for the treatment of treatment-resistant depression between 7 May 2022 and 17 November 2023. During this time, there were periods when he could not afford to pay for the prescription of medicinal cannabis and would use illicit cannabis as a substitute. Oliver had a background history of addictive tendencies which included excessive cannabis use. He had been under the care of a Consultant Psychiatrist at the Priory Clinic between September 2019 and September 2022 who had diagnosed him with depression but was of the view that by January/February 2022 Oliver's addictive behaviours were the larger problem impacting on his mood. Oliver declined the addictions programme that was offered by the Psychiatrist at that time. Following an assessment by an NHS Consultant Psychiatrist in April 2023, Oliver was given a dual diagnosis of Recurrent Depressive Disorder and Mental and Behavioural Disorder due to Cannabinoid Dependency. Notwithstanding this context, Curaleaf clinic continued to issue prescriptions for medicinal cannabis to Oliver.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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) The Consultant Psychiatrist who reviewed Oliverat 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. (2) 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.

	(3) 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. (4) The continuation of prescriptions for medicinal cannabis acted as an obstacle to Oliver receiving appropriate psychiatric and addictions care.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 **23 April 2026** I, the Area 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 namely:- • Family of the Deceased • The Priory • Pennine Care NHS Foundation Trust • [redacted] I have also sent a copy of this report to organisation that may find it of interest: • Care Quality Commission • Health Research Authority 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 from. 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.
	Date: 4 February 2026 Signed: [redacted]