

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [REDACTED] Chief Executive, Medicines and Healthcare products Regulatory Agency (MHRA), 10 South Colonnade, London E14 4PU
1	CORONER I am Dr Julian Morris, senior 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 28 July 2020, I commenced an investigation into the death of Lee Derek Jamie ADAMS, aged 36. The investigation concluded at the end of the inquest on 7 November 2025. The conclusion of the inquest was that: [taken from Section 4 of the Record of Inquest] Lee was suffering from a long term depressive illness. He also partook in on-line gambling. On 24.7.2020 he took an excessive number of propranolol tablets, intending to take his own life. In the preceding few months - in Covid lockdown - he had become increasingly reliant and involved with gambling. He was contacted in late March about his deposits, he had stated he was fine. He continued to gamble. He was not identified as being at increased risk. I concluded Lee's medical cause of death [Section 2] to be: 1a. Cardiac arrhythmia 1b. Propranolol overdose 1c. Gambling disorder II. Depressive illness
4	CIRCUMSTANCES OF THE DEATH Lee was at home alone and had been gambling extensively over the evening/night/ early morning of 23/24 July 2020. The last time propranolol had been given by prescription was in 2017; it was not clear where he had obtained the medication. He called 999 in the early hours saying he had taken some [REDACTED] tablets of unknown origin, an ambulance was dispatched arriving on scene some 10 minutes later and then with him 23 minutes later. As, by that time, Lee had been unable to let the crew in and the police were tasked with assisting and gaining entry. By the time of entry, Lee status had deteriorated significantly: seizing and with shallow breathing. In a short time, CPR had to commence. At this stage the tableted medication was still unknown; naloxone was given once, to no effect. Sadly, he was pronounced dead at 03.39 Subsequent post-mortem and toxicology revealing the presence of propranolol in Lee stomach and blood. Expert evidence provided to the court was that once the significant amount of Beta-Blocker had been taken (propranolol) the outcome was inevitable; there being no opportunity to save his life.

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 send the report: The MATTERS OF CONCERN, and heard by the court were as follows: (1) Propranolol is absorbed quickly (the court heard within 30-60 minutes of ingestion) and dose related. (2) As a drug it is very effective in what it is prescribed for being used for, for example, in the community to treat hypertension, anxiety and migraines. BUT unfortunately, it is highly toxic at even small doses. (3) There is no specific anti-dote to a propranolol overdose, the only form of treatment is supportive and therefore hospital based. (4) Doctors and specifically GPs should be aware of the consequences, at relatively small doses, of excess propranolol ingestion; especially when there is no specific anti-dote and treatment is restricted to supportive measures only.				
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 Friday 15th of May 2026. 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] (Family Representative) – Leigh Day Solicitors [REDACTED] (GP Representative) – Clyde & Co Solicitors [REDACTED] – Bevan Brittan Solicitors [REDACTED] – Keystone Law, Counsel [REDACTED] I have also sent it to Royal College of Psychiatrists – Addictions Faculty and Gambling Commission who may find it useful or of interest. 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. 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.				
9	<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">[DATE]</td> <td style="width: 50%;">[SIGNED BY CORONER]</td> </tr> <tr> <td>20.03.25</td> <td>Dr Julian Morris, Senior Coroner</td> </tr> </table>	[DATE]	[SIGNED BY CORONER]	20.03.25	Dr Julian Morris, Senior Coroner
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