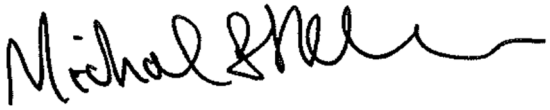
Her Majesty's Senior Coroner
District of the East Riding of Yorkshire and Kingston upon Hull
Professor Paul Marks BA LLM MD FRCS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Professor Sir Bruce Keogh, National Medical Director - NHS England; Mr Kevin Philips, Chief Medical Officer – Hull and East Yorkshire NHS Trust; [redacted], Medical Director – Local Medical Committee;
1	**CORONER** I am Michael L S Mellun, HM Assistant Coroner for the East Riding and Kingston upon Hull
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 16th June 2017, I commenced an investigation into the death of Stuart Andrew WALLS. The investigation concluded at the end of the Inquest on 30th November 2017. The conclusion of the Inquest was a Narrative Conclusion. It was: Stuart Andrew WALLS was found dead on the 12th March 2017 in room 38 of The Crossings, Great Union Street, Hull. He died as a result of drug poisoning due to the combined effects of prescribed medication. The medical cause of death was 1a) Drug Poisoning.
4	**CIRCUMSTANCES OF THE DEATH** Stuart WALLS had been a resident at The Crossings since September 2016. Staff stated that he had been known as a drug user, principally heroin, but they have said over the weeks before his death he had been clean (drug free) and had stopped taking drugs. They said that Stuart had been a different person over those last few weeks and had been visiting the gym a lot. To the extent he had complained that his back had started to hurt. Staff and his doctor had apparently told him to take it easier in the gym as he was in there constantly. Stuart was last seen alive by a staff member on the 11th March 2017 at approximately 07:30 hours. At this time he was described as appearing fine and well. Stuart was not seen until 13:15 hours the next day, 12th March 2017 when staff carried out a welfare check. The staff entered Stuart's room because there was no reply to knocking. Stuart was found fully clothed lying on his left hand side, apparently deceased. A staff member called for help and immediately commenced CPR. However, Stuart's body felt cold and paramedics who attended pronounced that life was extinct. A number of prescribed medicines were found in his room, there was also a small amount of herbal substance believed to be cannabis. There were no visible injuries that would suggest a

	suspicious death and a post-mortem examination, together with full toxicological analysis was required.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows. Stuart died as a result of drug poisoning. However, there was no evidence of illicit drug use (other than cannabis which the Consultant Histopathologist confirmed had not played a part in the death). All prescribed drugs in his blood were within the therapeutic range. The Consultant Histopathologist explained that the prescribed drugs had combined in a synergistic effect, acting together to poison Stuart. My concern is that in the prescription of medication, particularly those that act on the central nervous system and affect respiration control, full account should be taken of the totality of drugs prescribed and their potential synergistic effect. The reasons for my concern are: Four prescription drugs namely Diazepam, Pregabalin, Amitriptyline and Promethazine were all found at a level consistent with therapeutic use. Each of these alone was at a level not expected to kill however each can exacerbate the effect of the other. I understood from the evidence that each of the drugs have a direct effect on the central nervous system. In particular a depressive effect on respiration. The Consultant Histopathologist confirmed this to be the case. In addition to those prescribed drugs, methadone was also prescribed at 60 mg daily. That is well within normal prescription range. It was found at a level of 507ng/mL in blood. Methadone also has an effect on the central nervous system and is another respiratory depressor. The toxicology report said: *"….the deceased was prescribed 60mg of methadone daily. It has been reported that in 20 long-term opiate addicts who were administered a mean oral dose of 60mg methadone (range 10-225mg), the peak blood methadone concentrations ranged between 124-1255 ng/mL. It has been reported that in a study of 18 patients maintained on methadone 7.5 to 130 mg daily for at least 2 months, peak plasma concentrations of 69-698 ng/ml (pre-dose concentrations: 44-614 ng/ml) were achieved in 3 hours. The blood methadone level in the deceased was 507 ng/mL which may, therefore, reflect therapeutic use".* It is of course, not known how much methadone Stuart had taken or when. However, properly taking the prescribed dose could still achieve the recorded level. To put the amount of methadone into context, the toxicology evidence indicated a therapeutic range of 75 – 1100 ng/ml in blood; a toxic range of 200 – 2000 ng/ml and a fatal range of 400 – 2000 ng/ml. A level of tolerance builds with regular use. Methadone is a potent opioid narcotic analgesic and would also have a synergistic effect together with the other four drugs mentioned above. Therefore, even taking the properly prescribed medication as prescribed could have led to the situation that resulted in the death of Stuart WALLS. That is, drugs properly prescribed and properly taken could achieve a level, acting synergistically, that caused drug toxicity sufficient to cause death.

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 the **2nd February 2018**. 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. Your response should be sent to: The Coroner's Court and Offices The Guildhall Alfred Gelder Street Kingston upon Hull HU1 2AA Email: coronersoffice@hullcc.gov.uk
8	**COPIES and PUBLICATION** I have sent a copy of my report to: HHJ Mark Lucraft QC, HM Chief Coroner; Professor Sir Bruce Keogh, National Medical Director - NHS England; Mr Kevin Philips, Chief Medical Officer – Hull and East Yorkshire NHS Trust; [redacted], Medical Director – Local Medical Committee; [redacted], General Practitioner – Princess Avenue Medical Centre; [redacted], Mother of the Deceased. 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. 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.
9	 Signature_____ 08/12/2017 Michael L S Mellun **East Riding and Kingston-upon-Hull**