	REGULATION 28 REPORT TO PREVENT **FUTURE DEATHSTHIS REPORT IS BEING SENT** **TO:** **1. [redacted], Chief Executive Officer, EMIS Health**
1	**CORONER** Susan Ridge, HM Assistant Coroner for Surrey.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5, to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** An inquest into the death of Matthew William Thomas Power was opened on 29 September 2022 and resumed and concluded on 14 June 2023. The medical cause of death given was: 1a. Mixed Drug Toxicity. And I determined that Matthew William Thomas POWER died on 17 June 2022 at 01:30 hours at a house in Redhill, Surrey having taken illicit and prescribed drugs over the previous 36 hours resulting in his death from mixed drug toxicity. My conclusion was this was a drug related death
4	**CIRCUMSTANCES OF THE DEATH** Mr Power was a 33 year old man living in supported accommodation. He had a history of mental health issues and had been diagnosed with Dissocial Personality Disorder. He also had a history of drug and alcohol abuse dating back to his teenage years. He had been known to take impulsive overdoses of drugs including prescription drugs ([redacted]). On the afternoon of 15 June 2022, Mr Power visited friends in the Redhill area and with them bought and took drugs throughout the next 36 hours until his death in the early hours of 17 June 2023. Toxicology revealed a very high level of cocaine (potentially lethal in itself). It also showed heroin, methadone (which was not prescribed) and codeine at levels that that any

	of those drugs could have been lethal on its own, but that each opioid was likely to have increased the toxic effects of the other. The codeine was from ingestion of co-codamol. Apart from his mental health medication, Mr Power was prescribed co-codamol for pain relief. He had been prescribed this medication both by his current (since 2020) and previous GPs. It was latterly prescribed [redacted] because of stockpiling concerns; he had frequently requested co-codamol. In evidence it was accepted that there had been errors in prescribing so that on 14 June 2022 Mr Power collected [redacted] co-codamol tablets from a local chemist (but not his usual chemist) whilst still receiving his regular prescriptions [redacted].
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 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. The GP practice uses EMIS for patient records and prescribing. From the evidence it appears that when one doctor ends a repeat prescription on EMIS, it remains in the 'pending' Medication Management box of the doctor to whom it was originally sent. Creating the risk, as in this case, that as a pending prescription it is actioned and issued instead of cancelled. 2. I heard evidence that the EMIS system appears to group prescriptions into the amount prescribed rather than simply recording when a prescription is issued. In this case there were different entries grouped as 100 tablets, 50 tablets, 30 tablets, and 24 tablets. Consequently, it was not clear to the duty doctor that the most recent prescriptions for co-codamol had been for a shorter course of only [redacted] tablets and as a result [redacted] tablets of co-codamol were prescribed and issued. 3. Evidence was given by the GP practice that to interrogate the EMIS system in order to ascertain what had actually been prescribed, issued and when, was a challenging task; it had taken 3 GPs and the in-house pharmacist to conduct the review.
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 21 August 2023. 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: Mr Powers family Greystone House Surgery Copy Also to: ICP Chair Surrey Heartlands Health and Care Partnership (Integrated Care System 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. I may also send a copy of your response to any other person who I believe may find ituseful or of interest. 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 usefulor of interest. You may make representations to me, the coroner, at the time of your response, aboutthe release or the publication of your response.
9	**Susan Ridge 26 June 2023**