

Addison House & Barbara Castle Surgery

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Web site: www.addison-surgery.nhs.uk

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| Addison House Health Centre Hamstel Road Harlow Essex CM20 1DS | Barbara Castle Health Centre Broadley Road Harlow Essex CM19 5SJ |
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Partners:
[REDACTED]
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03 November 2025

Prevention of Future Deaths Report (Regulation 28)

HM Area Coroner for Essex Sean Horstead

Seax House
Essex County Council
Victoria Road South
Chelmsford
CM1 1LX

Re: Prevention of Future Deaths Report (Regulation 28)

In the matter of: Late Mark Smith, Date of Death: 5/3/24

Coroner's Area: Essex

Thank you for your Report of 24/9/25 concerning the tragic death of Mark Smith. We extend our sincere condolences to his family and friends.

We acknowledge the profound seriousness of this matter and appreciate the concerns you have raised. We are committed to learning from this event and implementing robust changes to minimise the risk of such a tragedy occurring in the future.

This letter constitutes our formal response, as required within 56 days, detailing the actions we have taken and propose to take.

Response to Matters of Concern:

We address each of your specific concerns as follows:

Evidence was received from two GP Partners at Mr Smith's GP Practice. Both GPs confirmed that at the time of Mr Smith's involvement with the

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Practice continuing up to and including the date of the inquest, there continued to be no system, policy or process in place, to ensure that vulnerable patients with a history of addiction and/or self-harm and/or suicidal ideation and/or prescription medication overdose received or receive appropriate medication reviews to consider the frequency and volume of repeat prescribed medication.

There were safety provisions within the Practice's repeat prescribing policy at the time of late Mark Smith's death with multiple documented restrictions of inappropriate high risk medication requests by Mr Smith.

The Practice has updated and strengthened the risk assessment provisions of repeat prescribing for identified patients with self-harm or suicide risk as well as monitoring of same with enhanced medication reviews/risk assessments.

It was conceded, accordingly, that there was - and remained - no policy or procedure in place to mitigate the clear risk involved in GPs prescribing unnecessarily excessive quantities of (potentially dangerous) prescription medication (at inappropriate frequency) to a clearly vulnerable cohort of patients, and therefore no policy or procedure is in place to minimise the danger of stockpiling of such medications and the concomitant risk of potentially fatal, (advertent or inadvertent), misuse of such medication.

There were safety provisions within the Practice's repeat prescribing policy at the time of late Mark Smith's death.

The Practice has implemented changes to strengthen the risk assessment provisions of the repeat prescribing policy as well as monitoring of same.

Summary of Actions Taken –

The following actions have been undertaken:

- **Immediate High-Risk Patient Review:** A full audit of all patients registered at Addison House Surgery, coded at risk of self-harm/suicide and on repeat medications. Identified patients have had medication/risk reviews by the pharmacists with restriction of repeat medications to seven-day periods.
- **Medication Safety Policy Enhancement:** A comprehensive review and update of our Polypharmacy and High-Risk Prescribing Policy undertaken with two core prescribing updates –
 - 1-Pharmacists to review all future correspondence received at the Surgery with identified risk of self-harm/suicide - high risk medications to be reduced to seven-day supply periods.
 - 2 -Low risk patients to remain on 6-monthly medication reviews– high risk patients to be reviewed 3 monthly or sooner if deemed necessary by clinician until the risk is de-escalated by the mental health team.

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- We have conducted an urgent review of our IT system's safety alerts. We have enhanced the triggers for alerts related to self-harm and suicide risk with high level reminders to be applied to all identified patients' records.
- Governance Oversight: This incident and the associated action plans have been escalated to the Hertfordshire and West Essex ICB (integrated care board) Patient Safety team for ongoing monitoring.

We have shared the learning from this case with our local healthcare system, including other GP practices (within our primary care network – Harlow North) and community clinicians affiliated to the Surgery (via multidisciplinary team meeting), to promote wider improvement.

We are deeply sorry for the failings in the late Mark Smith's care. We assure you that we have treated your report with the utmost seriousness and are committed to delivering sustainable change to enhance patient safety.


GP Partner
Addison House Surgery
Hamstel Road
Harlow
CM20 1DS

cc:

- The Chief Coroner
- Chair of the Local Clinical Commissioning Group/Integrated Care Board
- Care Quality Commission (CQC)

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