REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **GP Partner, Addison House Surgery, Hamstel Road, Harlow Essex, CM20 1DS** [redacted]
1	**CORONER** I am Sean Horstead, area coroner, for the coroner area of Essex
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 14th March 2024 I commenced an investigation into the death of **Mark Alan SMITH**, aged 50 years'. The investigation concluded at the end of the inquest on the 5th August 2025. The conclusion of the inquest was a Narrative Conclusion In the following terms: *Mark Alan Smith took his own life, but the evidence does not establish to the required standard of proof his intent at that the time he consumed the fatal quantities of prescription medication and alcohol.* *The admitted failure of his GP Practice to review, adequately or at all, the clear risk involved in the continued prescribing of unnecessarily excessive quantities of sedative prescription medication in the context of Mr Smith's extensive background of addiction and mental health issues, including anxiety and depression and a previous history of overdoses of prescribed medication, probably contributed more than minimally to the death.*
4	**CIRCUMSTANCES OF THE DEATH** Mark Alan Smith was found deceased on 5th March 2024 at his home address, 23 Church End, Harlow, Essex. He died following the ingestion of large quantities of prescription medication including Mirtazapine and Pregabalin

	together with a very significant quantity of alcohol. Crews from the East of England Ambulance Service Trust (EEAST) attended Mr Smith's home for around two and a half hours from around 04.00 hours on the 4th March (following concerns raised by family members that he had taken an overdose of prescription drugs). An EEAST crew reattended for around twenty minutes on the afternoon of the same day after Essex Police contacted EEAST following a call from Mr Smith's mother that he was threatening to take his own life. On neither occasion was Mr Smith taken to Hospital. The last contact with family members was between 18.00 and 19.00 hours on the 4th March. Mr Smith was found deceased the following morning by his son.
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. – 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 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. 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 19.11.2025. 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: *The Family of the deceased*. I have also sent it to the *Hertfordshire and West Essex Integrated Care Board*, The Forum, Marlowes, Hemel Hempstead, Hertfordshire, HP1 1DN who may find it useful or of interest. 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. She 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	**24.09.2025** **HM Area Coroner for Essex Sean Horstead**