



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: 1 Optum (EMIS)
1	CORONER I am Alexander FRODSHAM, Assistant Coroner for the coroner area of Cheshire
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 18 March 2025 I commenced an investigation into the death of Alan MITCHELL aged 88. The investigation concluded at the end of the inquest on 03 November 2025. The conclusion of the inquest was that: Natural causes
4	CIRCUMSTANCES OF THE DEATH Alan Mitchell had a medical history which included Barrett's Oesophagus. The condition had been diagnosed in 2011 with a recommendation for lifelong management with PPI medication and continued surveillance by way of periodic gastroscopies. In 2020 Mr. Mitchell stopped ordering the PPI medication on repeat prescription from his General Practitioner. At inquest, evidence was heard that, if a prescription is not re-ordered for a period of 12 months, that medication is removed by the EMIS software and no longer appears on the list of repeat prescriptions; further, that the General Practitioner is not notified of this fact and is not prompted to authorise the change. Therefore the GP is required to re-prescribe the medication which the system has removed, and this was done twice in Mr. Mitchell's case. At a routine medication review in 2021, Mr. Mitchell told his GP that he was not experiencing symptoms which required him to take more than one tablet per month. On 8th March 2025, Mr. Mitchell was admitted to Macclesfield District General Hospital, with evidence of an upper gastro-intestinal bleed. Although a gastroscopy was planned, this was not performed as there was no evidence of active bleeding and Mr. Mitchell's underlying cardiac condition placed him at risk of a cardiac event during the procedure. On 12th March 2025, Mr. Mitchell complained of chest pain and was short of breath; an ECG revealed that he had suffered a heart attack. Mr. Mitchell became unresponsive and he died at the hospital a short time later.
5	CORONER'S CONCERNS During the course of the investigation my inquiries 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: (brief summary of matters of concern)



	Although the removal by the software of Mr. Mitchell's repeat prescription played no causative part in his sad death, the alteration to a lifelong prescription without notification (nor any choice being given to) the GP gives rise to the risk that a patient will not be provided with the medication they need. That risk is heightened when patients are elderly and/or prescribed multiple medications and/or when, as here, they do not re-order as they possess medication in reserve.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you (and/or 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 December 30, 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 [REDACTED] East Cheshire Bollington Medical Centre (Macclesfield) I have also sent it to 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. I may also send a copy of your response to any person who I believe may find it useful 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 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	Dated: 10/11/2025 [REDACTED] Alexander FRODSHAM Assistant Coroner for Cheshire