The Grove Surgery

Farthing Grove
Netherfield
Milton Keynes
Buckinghamshire
MK6 4NG

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02/09/2026

**FAO HM Assistant Coroner, Dr Sean Cummings**
**Milton Keynes Coroner's Court**
**Civic Offices, 1 Saxon Gate East, Milton Keynes MK9 3EJ**

[redacted]

Dear Sir

**Re: Inquest touching upon the death of Alison Rose Thomas - response to the Report to Prevent Future Deaths issued under Regulation 28 of the Coroners (Investigations) Regulations 2013 on behalf of the Grove Surgery**

I am writing in my capacity as a GP Partner at the Grove Surgery (Farthing Close, Netherfield, Milton Keynes, Buckinghamshire, MK6 4NG) ("**the Practice**") in response to the Prevention of Future Deaths ("**PFD**") Report issued by you on 8 July 2026 following the inquest touching upon the death of Ms Thomas.

I would like to take this opportunity to express my sincere condolences to Mrs Thomas' family and friends.

The Practice has taken the concerns expressed in the PFD report extremely seriously. The actions either already taken or planned to be taken in response to the learning from this inquest are summarised below.

GP Partners at the Practice will be responsible for the oversight of the delivery of these actions through monthly clinical meetings. Quarterly and annual audits will also be completed.

I hope that this letter provides assurance that, as a Practice, we are committed to learning from this inquest to improve the care of patients at the Practice and to mitigate any risk of future deaths.

Coroner's concerns and the Practice's responses

***Concern 1****: At the date of Alison Rose Thomas' death, the practice operated a Medicines Management Policy, but that policy contained no provision addressing the safe prescribing, review, monitoring, or quantity-control of long-term combined benzodiazepine, opioid, or gabapentinoid medication. This is so despite these classes of medicine being the specific subject of extensive national guidance, including NICE Guideline NG215 (Medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults, April 2022), NICE Guideline NG193 (Chronic pain, 2021), and*

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*Successive MHRA Drug Safety Updates addressing the risk of fatal respiratory depression from opioids and gabapentinoids and their combination, and the dependence and addiction risks of opioids. I heard that a policy of this nature is now being developed, but that the work remains at a very early stage and that no such policy was in place at the date of the inquest some seven months after death. There is accordingly a continuing and unremedied risk that other patients receiving long-term opioid, gabapentinoid, or benzodiazepine treatment are being prescribed for without the safeguards that national guidance requires.*

We have developed a comprehensive Medicines Management and Safe Prescribing Policy, which is **appended** to this response.

The policy has been implemented on 19 August 2026 and will be reviewed annually. The policy was discussed at the clinical meetings on 15 July 2026 and 19 August 2026. The policy is available within the shared drive of the practice which is accessible to all staff. Staff have been informed of this new development. Audits will be conducted annually led by the Practice Prescribing Lead and supported by the practice pharmacist. There will also be a quarterly meeting to discuss controlled drugs which will be implemented in October 2026. This is in addition to discussions which are normally undertaken concerning any medication queries in the monthly clinical meetings.

The policy has been developed with reference to the CQC Regulations, NICE guidance, the British National Formulary (BNF), the MHRA Drug Safety Updates and alerts, NHS England guidance, local ICB formulary and prescribing guidelines, local controlled-drug arrangements, professional regulatory standards, shared-care protocols and national patient safety alerts. The policy will be updated when significant changes occur in the local or national guidance.

The Practice Prescribing Lead will be responsible for overseeing implementation of the policy, coordinating prescribing audits and identifying trends, reviewing high-risk prescribing, monitoring controlled-drug prescribing, disseminating guidance, liaising with relevant medicines-optimisation teams, reviewing MHRA alerts and escalating significant prescribing risks. The lead will work closely with the Practice Pharmacist when necessary.

The policy (at page 15, paragraphs 23 and 24) specifies that before prescribing high-risk medication, such as benzodiazepine, gabapentin or pregabalin, the prescriber should assess risks, with the following factors in mind:

- indication;
- expected benefit;
- renal function;
- age/frailty;

- respiratory risk;
- concurrent CNS depressants;
- opioid use;
- substance-misuse history where clinically relevant;
- potential for dependence and withdrawal.

The policy (at page 15, paragraph 25) specifically addresses the combined prescribing of opioid, benzodiazepine and gabapentinoid medication. Where all three classes are prescribed concurrently, the policy requires that the patient undergoes a documented medication review (unless there already is a clearly documented specialist-led rationale) and for the patient to have concurrent review arrangements in place. Even when a patient is taking one or two of these medications, a review must occur prior to any new prescription being issued. In addition (as per paragraph 21, page 14), patients on long-term opioid therapy must also undergo regular reviews, every 3 months and this also applies to patients on long-term benzodiazapine treatment (as per paragraph 23). Patients who take any of these classes of drugs are identified by the Practice and reviewed as a priority to ensure the current regimen is appropriate. The Practice will consider implementing the following measures:

- structured medication review; (every 3 months)
- dose reduction;
- deprescribing;
- specialist advice;
- psychological support;
- physiotherapy/MSK interventions;
- pain-management services;
- substance-use services;
- social prescribing;
- other locally commissioned interventions.

As such, the policy now addresses both the immediate and long-term risks of prescribing.

***Concern 2****: Alison Thomas' codeine was deliberately restricted to weekly prescribing because of a known risk of abuse and self-harm. Despite that restriction, she was able to obtain approximately a month's supply of codeine, together with gabapentin, oxycodone and oral morphine (Oramorph), on the strength of an unverified assertion that she was to travel to France for a month over the holiday period. The evidence disclosed an inadequate system by which such a request – for a quantity of medication markedly greater than usual, made by a patient who was subject to a deliberate dispensing restriction imposed for her own safety –*

*was risk-assessed or verified before the medication was released. A safeguard that can be set aside for an unverified account of foreign travel, with no countervailing check, affords limited protection to a patient at known risk.*

We have developed a policy for patients requesting medications earlier than expected especially in relation to travel 'Policy For Requests For Medication To Cover Travel And Periods Abroad'; this is **appended** to the response.

This policy was revised on 19/08/2026 and will be reviewed annually.

The policy deals with prescription of both routine and high-risk medication, specifying that the high-risk medication requires enhanced scrutiny. The policy also addresses the issue of patients who have an existing prescribing restriction; the default position is that the restriction stays in place until a clinician is satisfied that there is a clinical reason to alter it. The policy specifies that travel alone is not a sufficient reason to alter the restriction. The policy also deals with verification of travel, noting that verification may be necessary if it is proportionate to the risk that the particular medication poses.

In addition, where a patient is subject to a weekly prescribing regime, the policy makes it clear that a higher request should be treated as an exception request and that the clinician should undertake a risk assessment, consider verification of the reason for a higher quantity, document their rationale and what safeguards have been put in place. The clinician has to consider whether removing the weekly prescription restriction would undermine the original safety plan. This was discussed in the clinical meeting of staff. The policy is easily accessible to all staff via the shared drive where all practice policies are kept. Staff have been made aware of the location of this policy.

***Concern 3:*** *At the time of Alison Thomas' death the practice had no policy governing how requests for larger-than-usual quantities of medication for travel purposes from patients known to misuse prescription medication and to have taken overdoses in the past. I was told that this deficiency has since been rectified. I have not, however, been provided with the replacement policy or with evidence of its implementation, and I am not yet in a position to be satisfied that the remedial measure is in place and operating affectively.*

A policy (referred to above and **appended**) was developed and has been implemented since 16/07/2026. It will be audited annually.

It is hoped that our comments in relation to Concern 2 address this issue.

***Concern 4****: Alison Thomas was in possession of three opioid medicines (codeine, oxycodone and oral morphine) together with a gabapentinoid (gabapentin) and also high dose temazepam,*

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*a benzodiazepine, in circumstances where she also had chronic obstructive pulmonary disease, an extensive mental-health history, and documented history of prescription-medication misuse and overdose. There was a vague history of chronic pain and I was told that as she described the individual analgesics being insufficient, new ones were added. These are the features that national guidance identifies as substantially increasing the risk of fatal respiratory depression from the combined use of central nervous system depressants, and compromised respiratory function is expressly recognised by the MHRA as a heightened-risk factor. The evidence disclosed no mechanism – whether at the point of prescribing, dispensing or medication review – by which the concurrent supply of multiple such medicines to a patient presenting this risk profile would be identified and reviewed. The existing policy was inadequate and 10 years old. There is a risk that future deaths could occur if patients with this combination of medication and risk factors are not systematically identified and reviewed.*

As referred to in our response to Concern 1, we have developed, and I **attach**, our Medicines Management and Safe Prescribing Policy which now covers concurrent prescribing, especially in cases where there are multiple high-risk medications prescribed.

In addition, the policy specifically deals with opioid and benzodiazepines management, dictating that long-term therapy should be reviewed regularly every 3 months, depending on clinical indication. The review should encompass issues such as indication, dose escalation, dependence, withdrawal, sedation and concurrent medicines.

Throughout the policy, the prescribers are reminded to consider the risk of respiratory depression and that the MHRA safety advice must be followed.

Appendices

1. Medicines Management and Safe Prescribing Policy
2. Policy for requests for medication to cover travel and periods abroad

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**On behalf of the Partners at the Grove Surgery**