REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Sean CUMMINGS, Assistant Coroner, for the Coroner area of Milton Keynes.
2.	**DATE OF REPORT** 08 July 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. The Grove Surgery You are under a duty to respond to this report within 56 days of the date of this report, namely by September 02, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6.	**SUMMARY OF CORONER'S CONCERN**
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** On 30 December 2025 I commenced an investigation into the death of Alison Rose THOMAS aged 58. The investigation concluded at the end of the inquest on 07 July 2026. The conclusion of the inquest was a narrative one: Alison Rose Thomas was discovered deceased at her home address on the 29th December 2025. She had taken a large amount of different prescribed and over the counter medication. I am unable to reach a conclusion of suicide as there is insufficient evidence before me to determine that or to reasonably infer it.
9.	**CIRCUMSTANCES OF DEATH** Alison Rose Thomas was discovered deceased at her home address on the 29th December 2025. She had taken a large amount of different medications. She had secured a large amount of her regularly prescribed medication including codeine [redacted] tablets which was normally prescribed on a weekly basis, gabapentin, oxycodone and oramorph from her GP. She had done this claiming she was travelling to France for a month over the holiday period. It was accepted that the reason for the codeine restriction was because of known risk of abuse and potential self-harm. She had also acquired diphenhydramine which is available to purchase from pharmacies. She was known to abuse prescription medications and had taken overdoses in the past. She had an extensive mental health history. She had chronic obstructive pulmonary disease. There was a Medicines Management Policy at the Grove Practice GP surgery but there were no policies in place at the time to describe the management of long term benzodiazepine, opiate/opioid or gabapentinoids and the policy in place does not address the issue. At the time of Inquest there are still no policies addressing this. I was told this was being addressed but it transpired this was at a very early stage. There were no policies in place in December 2025 to address the issue of patients who are known to misuse prescription medications requesting larger than usual amounts. I was told that had been rectified although I have not seen that.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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) 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 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.

(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.

(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 medicines were to be identified, assessed, or authorised. The deceased was known to the practice 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 effectively.

(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, a benzodiazepine, in circumstances where she also had chronic obstructive pulmonary disease, an extensive mental-health history, and a 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.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. 1. [redacted] (Son of Deceased) I also may send a copy of the report to any other person who I believe may find it useful or of interest. 1. Chief Executive NHS Central East Integrated Care Board Gemini House, Bartholomew's Walk Cambridgeshire Business Park, Angel Drove Ely, Cambridgeshire CB7 4EA and 2. Chair of Council Royal College of General Practitioners 30 Euston Square London NW1 2FB I can confirm I have sent the report to: 1. The Grove Surgery 2. Callum Thomas 3. Chief Executive Integrated Care Board 4. Chair of Council, Royal College of General Practitioners I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

12.	**SIGNATURE**  **Sean CUMMINGS** **Assistant Coroner for Milton Keynes**