M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

4th February 2021 REF: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Practice Manager** **Long Furlong Medical Centre** **45 Loyd Close, Abingdon** **Oxon, OX14 1XR**
1	**CORONER** I am Dr Simon Fox QC Assistant Coroner for **Area of Avon**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 04/03/2020 an investigation was commenced into the death of Jerome Alexander Peat. The investigation concluded at the end of the inquest on 03/02/2021. The conclusion of the inquest was that the death was "Drug Related" and I found that Mr. Peat died from an overdose of prescribed medication, including morphine.
4	**CIRCUMSTANCES OF THE DEATH** Mr. Peat was prescribed morphine by Long Furlong Medical Centre on 4.11.19, by the Student Medical Centre in Bristol on 5.11.19 + 21.11.19 and by the out of hours doctor in Bristol on 1.12.19. He was found dead from an overdose of morphine on 12.12.19 at his student accommodation.
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. – The EMIS computer medical record on 4.11.19 failed to alert [redacted] at Long Furlong Medical Centre that Mr. Peat had already registered with the GP at the Student Medical Centre, as a result of which there was inadvertent duplication of his morphine prescription on 4.11.19 and 5.11.19 and Mr. Peat was prescribed significantly more morphine than was intended. He subsequently died from an overdose of

	prescribed morphine.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 6st April 2021. 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 Mr. Peat, [redacted] and Spire. 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. 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	08/02/2021 Signature_____ Dr Simon Fox QC, Assistant Coroner **Area of Avon**