Your reference
Our reference [redacted]
Date 24 January 2021

City of
Stoke-on-Trent

Margaret J Jones
Assistant Coroner
Stoke-on-Trent & N Staffs Coroner's Court
HM Coroner's Court & Chamber
Stoke Town Hall
Kingsway
Stoke-on-Trent
ST4 1HH

Adult Social Care, Health Integration and Wellbeing
Civic Centre, Glebe Street
Stoke-on-Trent
ST4 4HH

24th January 2021

Dear Mrs Jones,

Thank you for sending me a copy of your Section 28 Report dated 27th November 2020, following an inquest into the death of Geoffrey Peter Banks (GB) which concluded on 24th November 2020. The conclusion of the inquest was that the deceased died from a heart attack and that a self-administered overdose of medication 8 days earlier contributed to his death. It was not possible to determine whether the overdose had been accidental or deliberate

The first matter of concern was stated as:

> *The deceased resided at Oak Priory and was the tenant of a privately rented flat in a scheme from a housing provider. He was on a care package provided by Comfort Call under a contract from Stoke on Trent Council. He received visits four times per day principally to administer medication. The medicine was kept in a locked kitchen cupboard in his flat. He had been identified as not being able to manage his own medication. The tenant was easily able to pull open the cupboard door and the barrel of the lock fell out. He overdosed on medication. There appears to be no system of safe storage in place where a resident has been identified as needing supervision with medication.*

The Coroner's report was received by me on 4th December 2020. Since that date I have undertaken the following actions:

- The report and concerns were shared and discussed with both Comfort Call, the Care Provider, and Your Housing Group, the landlord of the Extra Care Housing Scheme, at the Council's monthly contract management meeting on 22nd December 2020.

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- We agreed that GB resided at Oak Priory, an Extra Care Housing Scheme commissioned by Stoke on Trent Council, and received four calls a day from Comfort Call, the Care Provider on site, principally to administer medication.

- It was confirmed that the medication cupboards conformed with the specification set out in the contract that the City Council has with the provider

- The medication was kept in a locked cupboard in the kitchen which GB had forced open. Whilst it had been identified that GB was not able to manage his own medication and might forget to take his medication, there were no indicators that GB was at risk of deliberate or accidental overdose.

- Co-codamol is not a controlled drug and therefore did not require additional secure measures.

At that meeting on 22nd December 2020, we discussed and agreed the following actions:

Action	Who is responsible	T Target Completion Date
Specification of lockable cupboards in contracts of all Extra Care Housing Schemes to be reviewed	**Stoke on Trent City Council**	**28/02/21**
All lockable cupboards in PFI Extra Care Housing Schemes to be inspected to check on general state of repair – If the inspection identifies any faults then these should be urgently rectified/repaired	**Your Housing Group**	**28/02/21**
Reviews to be undertaken of care plans for all tenants in receipt of care who are unable to manage their own medication. • Review risk of deliberate/accidental overdose • Consider installation of more secure storage where required	**Stoke on Trent City Council/ Comfort Call** **Your Housing Group**	**28/02/201** **28/02/201**
Communication to be sent to all home care and extra care providers requesting that medication storage is reviewed for those customers that are unable to manage their own medication.	**Stoke on Trent City Council**	**31/01/2021**

In summary this will ensure that, if a resident is identified as needing support with medication for any reason, a full review will be undertaken to decide whether or not the existing storage arrangements for medication are satisfactory or need enhancing. I believe that this satisfies your first concern as set out in the Section 28 notification.

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The second matter of concern was stated as:

> *The apparent investigation into the incident was perfunctory and carried out by an untrained member of staff.*

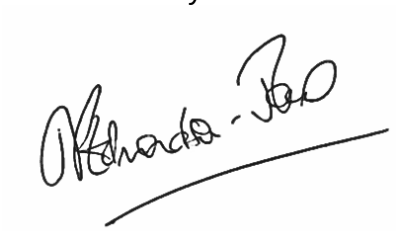
We have conducted a review into our records and we are clear that, in relation to any assessment and review undertaken by the Stoke-on-Trent City Council these were all undertaken by a trained and qualified social worker. The notes on the case file and the assessment and support plan for GB was completed by a qualified social worker and while no specific risk assessment in relation to medication had been undertaken a range of assessments were in place and had been done by a suitably qualified member of staff. Any internal review of a death that raised any concerns would be undertaken or overseen by the Principal Social Worker or Assistant Director (Adult Social Care).

In summary, I am confident that all appropriate assessments and reviews that were done by the City Council were undertaken by a qualified social worker. I believe that this should satisfy your second concern as set out in the Section 28 notification.

I hope that I have been able to reassure you that we have carefully reviewed our processes and contracts and are confident that the measures we have put in place will reduce the risk of a similar situation happening in the future.

Please let me know if I can help you any further.

Yours sincerely



[redacted]
Director of Adult Social Care, Health Integration and Wellbeing
Email [redacted]
Contact number [redacted]

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