

Strictly Private and Confidential

Mr Graeme Hughes HM Senior Coroner The Old Courthouse Courthouse Street Pontypridd CF37 1JW

3rd January 2023

Dear Graeme Hughes (HM Senior Coroner)

Re: Prevention of Future Death report following inquest into the death of Susan Jane Perry.

Further to your letter dated 29th November 2022 concerning the Regulation 28 Report to prevent Future Deaths and your requirement for me to respond to your concerns in relation to:

(1) I received evidence from her support workers that service user's medications were kept in locked cupboards on the ground floor. However, the keys to the same were kept either in an unlocked drawer nearby, or in a pot on an adjacent, or nearby work surface. I sought clarification upon this and evidence to determine if this arrangement was still in place today. Whilst I did not receive any evidence per se on this matter, the indication I received from counsel for MIRUS Wales did not satisfy me, that arrangements for access to this cupboard had been altered or revised since Susan Perry's death on 23.10.20.

(2) My concern is simply that these arrangements give rise to a risk that a service user could access medication (their own, or other service users) from the locked cupboards by opening the same using nearby keys, defeating the purpose of securing the medication. Deliberate, or inadvertent administration of such medication could well lead to the death of that individual.

(3) I believe that MIRUS Wales operate several similar supported accommodation concerns across South Wales, and I received no evidence to satisfy me that practices & procedures were in place across these concerns to address this risk of self-harm.

Actions taken to prevent further incidents from occurring

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Registered Address: mirus Wales, Unit 5, Cleeve House, Lambourne Crescent, Llanishen, Cardiff. CF14 5GP Tel: 029 20236216, Email: admin@mirus-wales.org.uk , Website: www.mirus-wales.org.uk Registered Charity



• **mirus** has reviewed its medication policy, procedures, and practice in relation to the handling of keys. (Action completed 5th December 2022)

Within the policy we have reworded the expectations of 'key holders'

"Where the requirement is for medication to be in locked storage, as identified by the Medication risk assessment; arrangements must be in place for keys to be kept on the nominated medication key holder's person at all times".

• We have instructed managers to conduct an observation of practice to all staff who have responsibility to administer medication by the end of December 2022.

• The content of the medication training for staff and managers has been updated to strengthen the additional measures for handling of keys to ensure safe storage and prevent unauthorised access to medication. (Action taken 5th December 2022)

• Additional quality assurance measures will follow to ensure that the above actions have been implemented. (Action by end of February 2023)

The above measures will be subject to full scrutiny at our leadership meetings and at the next full Board of Trustee meeting in March 2023.

The incident was previously reported to the Charity Commission, and we have since provided them with a further update and shared your findings with them.

Trustees have been fully briefed on the incident and the outcome of the coroner's inquest on 12th December 2022 a full Board of Trustee meeting.

We have notified Care Inspectorate Wales (CIW) at the time of Susan Jane Perry's death and have provided updates of the incident and the outcome of the inquest to them. (See attached serious incident form and updates).

In addition to this, we have notified Cardiff Social Services commissioning authority of the incident and the outcome of the inquest. (See attached serious incident form and updates).

Should you require any further evidence of the actions taken please let me know as soon as possible.

Yours sincerely

Chief Executive Officer

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