GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
THE OLD COURTHOUSE
COURTHOUSE STREET
PONTYPRIDD
CF37 1JW

[redacted]

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive, MIRUS Wales**
1	**CORONER** I am **Graeme Hughes Senior Coroner**, for the coroner area of South Wales Central.
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.
3	**INVESTIGATION and INQUEST** On 2 November 2020 I commenced an investigation into the death of Susan Jane PERRY . The investigation concluded at the end of the inquest on 24.11.22 . The conclusion of the inquest was:- The deceased died due to the indivisible contribution of COVID-19 infection and elevated levels of her prescription medication. In combination, these have likely led to central nervous system depression and her death. Her Cause of Death was found to be: - **1a Mixed (Prescription) Drug Toxicity with Covid 19 Infection**

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	1b **1c** **II**
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Susan Parry had a chronic complex mental ill health condition. In order to manage the same, she had required long-term care and support. At the time of her death, she was receiving the same at 21 Rockwood Avenue Llandaff. From around the 17th of October 2020, both her mental and physical health deteriorated. Posthumously, she was found to be infected with the COVID-19 virus. To manage her mental ill health, she was prescribed a range of medication which was slightly altered on the 20th of October 2020. During the week, she became more lethargic, remaining in her room. On the morning of the 23rd of October 2020, she was found deceased there by her support workers. Post-mortem examination, supported by toxicological analysis found that she had died due to a combination of mixed prescribed drug toxicity and COVID-19 infection. The Inquest focused upon: - a. How she came to have such elevated levels of her prescription medication in her post-mortem blood samples and the contribution that may have had to her death. Whilst the precise causation of the same was not established on the evidence, it was found that neither she, nor her support workers had administered an overdose(s) of her medication deliberately, or accidentally. It was found, on a balance of probabilities, that the elevated levels were more likely to have their causation in post-mortem re-distribution and/or the instability of the medication for the purposes of toxicological testing. .
5	**<u>CORONER'S CONCERNS</u>** During 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. (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 the

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	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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 23rd January 2023 unless 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 family who may find it useful or of interest. Also to Care inspectorate Wales & Welsh Government. 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	28 November 2022 **SIGNED:**  Graeme Hughes Senior Coroner for South Wales Central Coroner Area

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