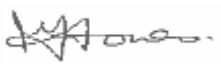
HM Coroner's Court & Chamber
Stoke Town Hall, Kingsway, Stoke-on-Trent, ST4 1HH
Email: coroners@stoke.gov.uk

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Comfort Call, City and County Healthcare Group Ltd. Registered Office, Caparo House, 101-103 Baker Street, London, W1U 6LN** **2. Stoke on Trent City Council, Adult Safeguarding Civic Centre, Glebe Street, Stoke-on-Trent, ST4 1HH**
1	**CORONER** I am Margaret J Jones, an Assistant Coroner for **Stoke-on-Trent & North Staffordshire Coroner's Court**
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 23/01/2020 I commenced an investigation into the death of Geoffrey Peter Banks, aged 64. The investigation concluded at the end of the inquest on 24th November 2020. The cause of death was :- 1a.Acute myocardial infarction. 1b. Coronary artery thrombosis with atheroma. 2. Co-codamol; diabetes mellitus type 2. The conclusion of the inquest was :- The deceased died from a heart attack. 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.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was 64 years of age and had a medical history which included heart attack, coronary artery by-pass grafting, pacemaker, stroke, diabetes and dementia which had worsened recently. He lived in assisted accommodation and was visited 4 times per day by carers, principally to assist him with his medication which was kept in a locked kitchen cupboard in his flat. Carers visited at around 07.00 hours on the 1st January 2020 and found that he had pulled open the locked medicine cupboard and had taken 44 co-codamol tablets. He was admitted to the Royal Stoke University hospital where he was treated for pulmonary oedema and mixed overdose. A blood test done on admission showed a paracetamol level at 91mg/l. There was no real evidence of liver damage but there was clear indication of heart failure consistent with his coronary condition. He had clinically improved from the overdose and he did not need any further treatment for that. On the 8th January 2020 he became unresponsive as he was being helped into a chair. Resuscitation attempts were unsuccessful and he was certified dead at 08.20 hours. Post mortem examination found the cause of death to be an acute heart attack. The co-codamol overdose added some strain onto his already weak heart

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. – (1) 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 visit 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 being in need of supervision with medication. (2)The apparent investigation into the incident was perfunctory and carried out by an untrained member of staff.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Comfort Care and Stoke on Trent City Council and/or 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 **Monday 25th January 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 [redacted]. I am also under a duty to send the Chief Coroner a copy of your response and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	27/11/2020 Signature  **Stoke-on-Trent & North Staffordshire Coroner's Court**