Dear Mr Pegg

Regulation 28: Report to prevent future deaths in relation to Shahida Khan

I am responding to the Regulation 28 Report issued on 24 April 2024 following the inquest into the death of Shahida Khan ('Ms. Khan') on 17 December 2022. The inquest concluded on 23 April 2024.

Voyage Care ('Voyage') deeply regrets the death of Ms. Khan and the distress this has caused her family. Our staff at the care home were also very saddened by her passing.

The concerns raised by you at paragraph 5 of your PFD report are as follows:

1) All of the deceased's medications were administered by care home staff. The medications were kept secure in a locked medicine chest in an office.
2) The deceased was administered with toxic and fatal quantities of valproic acid, lamotrigine and paracetamol. It cannot be ascertained how this happened.
3) In the absence of an explanation there is a risk of a further recurrence where those in the care of the staff are administered toxic and fatal quantities of medications.

Your concerns touch upon medication storage, medication audit and medication administering competencies. I can confirm that Voyage has established policies and procedures in place to deal with medication storage, medication audit and medication administering competencies, and these were in place at the time of Ms. Khan's death. Extracts of these have already been provided to you. The policies and procedures are robust and are subject to audit. Staff are trained in all of the areas referred to both on induction and annually.

Until 19th April 2024 Voyage was unaware of the confirmed Medical Cause of Death for Ms. Khan. The investigations into Ms Khan's death undertaken by Voyage immediately following Ms. Khan's death were carried out without knowledge of the postmortem or toxicology findings.

In order to address your specific concerns and those matters which came to light at the inquest on 23 April 2024, specifically regarding medication levels found on postmortem, Voyage conducted a further investigation specifically focused on medication storage, medication audit and medication administering competencies at the care home where Ms Khan resided. This investigated confirmed:

I. Ms. Khan's medication was stored in a locked cabinet and in accordance with our policies and procedures.
II. Medication audits for the care home were completed by the former Registered Manager on 1st December 2022 (for the month of November 2022) and 29th December 2022 (for the month of December 2022). The medication audits completed confirm that the care home was compliant in all areas and there were no discrepancies in the medication stock count in either month.
III. Ms Khan's medications were administered by support staff and when she went home to stay with her family, medications were provided to them to administer in accordance with her prescriptions.

In addition, having received copies of the postmortem and toxicology reports on 19th April 2024, we instructed an independent Consultant in Chemical Pathology and Forensic Toxicology to review the evidence following our internal investigation. Regrettably, the independent Toxicologist's investigation and our own medication investigation did not determine the origin of any overdose. In the circumstances we have referred the matter to the Police. Whilst medication

is usually given to the People we Support by staff, the investigation by the Police will no doubt have to consider the possible involvement of third parties, for example other visitors to the service. We have confirmed to your office that the matter has been referred to the Police and, in those circumstances, I would respectfully request that this response should not be published until the Police have completed their investigation, to avoid any risk of compromising this. Until the Police complete their investigation it is difficult to comment further, and we will be advised by them as regards next steps including any steps which should be taken to address matters of concern at paragraph 5 of the PFD Report. In liaison with them, we will also take the steps necessary and appropriate, to manage staff, which may include suspension pending the conclusion of investigations.

As previously stated, we have found no evidence of misadministration by our staff, having completed rigorous medication counts as part of our investigation. We have, however, taken a number of further steps to reduce the risk, insofar as is possible, of a Person We Support being administered toxic and fatal quantities of medications. These include:

- We have reviewed the care of all residents at the home and their care plans, including, where relevant, protocols for the administration of rescue medication.
- We have reviewed the medication training in the home and are in the process of renewing medication training for all staff at the home.
- We have commissioned an independent pharmacist to review our policies, procedures, training content and audits. Whilst not as a direct result of this sad circumstance, it is relevant to our response as a reflective and responsible provider.
- A further related action is the planned implementation of an electronic Medication Administration System across the organisation. This is part of a larger programme of work designed to provide more comprehensive oversight of the delivery of care to residents, including the administration of medication.

We will be keeping matters under close review and implementing all and any changes that appear to be necessary as a result of the Police investigation. We understand that the coroner's office is also in direct contact with the Police regarding this matter.

Thank you for raising your concerns. I hope that the content of this letter provides sufficient assurance that we have taken appropriate action following the death of Ms. Khan and in response to information as it has become available to us. We continue to work to improve the service we provide to the People we Support.

Yours sincerely,

Chief Operating Officer (previously Interim Chief Executive Officer)
Voyage Care