Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO: [redacted], interim CEO Voyage Care** **1 Cloverdale**
1	**CORONER** I am Jason PEGG, HM Area Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 05 January 2023 I commenced an investigation into the death of Shahida KHAN aged 46. The investigation concluded at the end of the inquest on 23 April 2024. The conclusion of the inquest was that: The deceased died on 17th December 2022 at Cloverdale Care Home, [redacted]. The deceased was given by another substantial quantities of prescribed [redacted] and [redacted] together with a substantial quantity of [redacted] which caused toxicity in consequence of which the deceased suffered respiratory depression. The deceased had a history of epilepsy. The substantial quantity of [redacted] caused the deceased to suffer three seizures immediately prior to her death which contributed to the death. How the deceased came to be given substantial quantities of [redacted], [redacted] and [redacted] cannot be ascertained.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died on 17th December 2022 at Cloverdale Care Home, [redacted]. The deceased was given by another substantial quantities of prescribed [redacted] and [redacted] together with a substantial quantity of [redacted] which caused toxicity in consequence of which the deceased suffered respiratory depression. The deceased had a history of epilepsy. The substantial quantity of [redacted] caused the deceased to suffer three seizures immediately prior to her death which contributed to the death. How the deceased came to be given substantial quantities of [redacted], [redacted] and [redacted] cannot be ascertained.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 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 [redacted], [redacted] and [redacted]. 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (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 June 18, 2024. 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 have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any 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 by the Chief Coroner.
9	**Dated: 24/04/2024**  **Jason PEGG** **HM Area Coroner for** **Hampshire, Portsmouth and Southampton**