Ian M Arrow Her Majesty's Senior Coroner
for the County of Devon
Plymouth, Torbay and South Devon Coroner Service

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chair, Integrated Care Commission, NHS Devon, County Hall, Topsham Road, Exeter, EX2 4QD**
1	**CORONER** I am Ian Arrow, Senior Coroner for Plymouth Torbay and South Devon
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** Inquest opened 10th March 2022 Inquest heard 5th September 2022
4	**CIRCUMSTANCES OF THE DEATH** The deceased suffered from debilitating conditions, she lived in insanitary conditions. Help was called for her on the 21st of February 2022. A safe guarding referral was made. She suffered a long lie on the night of 23rd of February. A second visit to the deceased on the 24th of February found the deceased in extremis. She had developed sepsis. She died at Torbay Hospital on 25th of February 2022.
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) On the balance of probability there was a missed opportunity to afford timely care and treatment to the deceased before she was found in extremis on the 24th of February 2022.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. Please review the protocols in Devon for dealing with individuals whose personal care and personal hygiene is inadequate due to their known personal circumstances particularly when this presents as a foreseeable risk of infection.
	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 31 October 2022. 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. I have also sent it to [redacted] who may find it useful or of interest. 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	Dated 06/09/2022 Signature