**Premiere Health Ltd**
**Providers of Cann House Care Home**

**25th March 2026**

**HM Coroner Deborah Archer**
**Area Coroner for the County of Devon, Plymouth and Torbay**

**Dear HM Coroner,**

**Re: Regulation 28 Report to Prevent Future Deaths**
**Inquest touching the death of Pamela George (Deceased)**

Premiere Health Ltd acknowledges receipt of the Regulation 28 Report issued following the inquest into the death of Pamela George, concluded on 22 January 2026.

Firstly, we wish to express our sincere condolences to Ms George's family following their loss.

Premiere Health Ltd and Cann House Care Home have carefully considered the matters identified in your report. While the organisation notes the narrative conclusion reached by the Court, we take the concerns raised seriously and have undertaken a comprehensive review of relevant policies, governance arrangements and operational practices at Cann House Care Home.

Set out below is the organisation's response to each matter of concern.

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**1. Systems for Actioning Hospital Discharge Summaries and Post-Discharge Blood Tests**

The Coroner raised concerns regarding the absence of regular blood testing following Ms George's discharge and the lack of a clear system for ensuring discharge summaries were properly actioned.

Following the inquest, the following actions have been implemented:

- All staff responsible for admissions have received one-to-one supervision regarding Ms George's case, ensuring learning is embedded.
- Information has been disseminated to all junior staff for awareness training, emphasising the importance of correctly processing admission and discharge documentation.
- All hospital discharge summaries are now scanned directly into residents' care plans upon receipt.
- The organisation has enforced its formal Hospital Discharge and Clinical Follow-Up Procedure, which includes:

- Senior staff review of all discharge documentation within 24 hours.
- Use of a Clinical Action Log to record and allocate required actions (e.g., blood tests, follow-ups).
- Mandatory confirmation with GP surgeries within 48 hours regarding follow-up requirements.
- Management oversight and audit of all discharged-related actions.

These measures ensure transparency, accountability, and documented completion of all post-discharge clinical tasks.

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**2. Monitoring and Management of Infection**

The Coroner noted insufficient documentation regarding the progression of the resident's breast infection between 25 May and 27 June 2023.

The service has taken the following steps:

- Staff have received feedback on the importance of record keeping, particularly where care is refused.
- All staff will undertake refresher training on record keeping, including expectations for documenting infection progression.
- The Care Manager now conducts daily checks on notes for residents who may be declining personal care or presenting clinical concerns.
    - In the Care Manager's absence, this is undertaken by the Team Leader.
- Registered Nurses are required to take action on concerns escalated to them and update care plans accordingly.
- Wound and Infection Monitoring Chart including documenting photographs is being used effectively to ensure clear, regular and structured documentation.
- A consolidated clinical escalation protocol is being implemented, requiring early medical review where symptoms do not improve.
- Staff training in infection recognition, wound documentation, sepsis awareness and escalation has been reinforced.

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**3. Escalation of Increasing Care Needs to Adult Social Care**

The Coroner identified concerns regarding whether Ms George's needs exceeded those the home could safely meet, and whether appropriate escalation to Adult Social Care occurred.

Actions taken include:

- Cann House Care Home has reviewed its acceptance criteria and will no longer accept residents requiring 1:1 support, recognising the significance of the challenges faced in Ms George's case and wider systemic issues around funding.

- All staff have been reminded of the importance of documenting and communicating concerns to Social Workers and Adult Social Care, both at admission and throughout residency.
- A requirement is in place for multidisciplinary reviews where needs increase significantly.
- A documented escalation procedure now mandates notification to the placing authority where needs may exceed home capability.
- All escalation discussions and communications with commissioning bodies are now formally recorded.

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**4. Documentation of Falls and Escalation for Medical Review**

The Coroner noted concerns regarding the clarity of documentation surrounding Ms George's fall and post-incident clinical observations.

In response:

- All staff have been reminded of the established incident procedure.
- A new system has been implemented whereby a manager reviews all incident forms immediately following any incident to ensure detail, completeness and clinical appropriateness.
- A strengthened Falls Management and Post-Incident Observation Procedures in place, including:
    - Comprehensive documentation of the fall circumstances.
    - Required physical observations and pain assessments.
    - Neurological observations where clinically indicated.
    - Clear documentation of clinical reasoning regarding escalation to medical professionals.
- Mandatory post-fall observation charts are now used for unwitnessed or potentially injurious falls.
- All care staff have received refresher training in incident reporting and falls management.

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**5. Documentation of Mental Capacity**

The Coroner identified that capacity assessments were not clearly documented.

Actions implemented:

- All trained staff are completing further mental capacity and MCA training, delivered in-house or via Plymouth City Council.
- A formal Mental Capacity Assessment Procedure is now in place requiring:

- Clear documentation where there is reason to believe a resident lacks capacity regarding a specific decision.
- Recording of assessment outcomes in the care plan.
- Documentation of best-interest processes where required.

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**6. Policies and Governance Arrangements**

The Coroner observed concern regarding the availability and sufficiency of policies, particularly in areas such as medication, escalation and reporting concerns.

Actions taken:

- A full review and consolidation of all operational policies has been completed.
- Updated policies now in place cover:
  - medication management
  - infection control
  - incident reporting
  - clinical escalation
  - safeguarding
  - reporting concerns
  - hospital discharge management
- Policies are now centrally stored within a digital governance system, accessible to all staff.
- Regular audits are undertaken to ensure compliance.

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**Governance Oversight and Monitoring**

To ensure sustained improvement, Premier Health Ltd has strengthened governance oversight through:

- Routine clinical audits
- Management supervision and competency checks
- Monitoring of incident trends
- Senior management oversight visits

These measures support continuous quality improvement and ensure the actions implemented remain effective and embedded.

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**Conclusion**

Premiere Health Ltd acknowledges the matters raised within the Regulation 28 report and has undertaken a detailed review of the systems and processes in place at Cann House Care Home.

The actions outlined above are intended to strengthen clinical oversight, documentation, escalation and governance across the home.

We trust that this response assists the Court. Should the Coroner require any further information regarding the actions described above, Premier Health Ltd would be pleased to provide clarification.

**Yours sincerely**

Registered Manager

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