ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] – Manager Cann House** **2. [redacted] Managing Director of Premiere Health Ltd**
1	**CORONER** I am Deborah Archer, Area Coroner for the County of Devon, Plymouth and Torbay.
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 6th July 2023 I commenced an investigation into the death of Pamela George aged 70. The investigation concluded at the end of a 1-day inquest on 22nd January 2026 the conclusion of the inquest was a narrative one namely: **Narrative** The Deceased died at Derriford hospital from acute renal failure and sepsis caused by an infection underneath the breast in circumstances where there were missed opportunities by her care home to treat her and escalate medical concerns.
4	**CIRCUMSTANCES OF THE DEATH** Pamela George was 70 years of age when she died at Derriford hospital on 30th June 2023. She was a vulnerable lady who lacked capacity and was diagnosed with a learning disability and had suffered from significant ill health in the lead up to her death in that she had been an in-patient at Derriford Hospital from 1st May – 24th May 2023 and then been discharged to Cann House where she was registered as a temporary resident because of concerns with her previous supported living accommodation. She had been in hospital because of bilateral leg swelling and general deterioration and of note she had acute kidney injury on chronic kidney injury on admission which was treated successfully. She also had a large haematoma on the right iliac fossa which was managed conservatively and she also had a breast wound that was described as cracked and open. On discharge to Cann House the discharge summary from Hospital made it clear that because of her acute kidney injury she should have post discharge monitoring blood tests every 5-7 days. This was not done and it was accepted by the home that this meant no one was monitoring Pam 's bloods from the day she left hospital until she was readmitted to Hospital by [redacted] on 29th June 2023 I was told by the home during evidence that Ms George did not have capacity, but they were unable to provide me with copies of mental capacity assessment during the inquest and accepted that her lack of capacity was not noted on the care plan. The

	Manger could not adequately explain what systems had been put in place to rectify this situation. I was further concerned that although the home's note of 27th June 2023 suggests that Miss Geroge's fall had been brought to [redacted] attention his note did not mention it. The note from the home describing the fall was not detailed enough in terms of observations or descriptions of pain and justification for not seeking further medical escalation could not be provided. [redacted] saw Miss George on 27/06/23. No concerns about infection to her breast were noted and nothing was reported about a fall. This was despite the fact that the home had described the breasts as "Red raw "on 27th June 2023. [redacted] saw Miss George at the home's request on 29th June 2023 where sepsis was suspected. She was urgently admitted to Derriford Hospital where she died shortly afterwards from 1a Acute Kidney injury and sepsis. .
	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 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. – 1. Cann House missed an opportunity to carry out regular blood tests on Miss George between 23rd May and 29th June. These blood tests may have identified the need to continue to treat acute kidney injury which if left untreated may have affected her resilience to infection. The system for ensuring that discharge summaries are actioned was not available for me to see and I was not clear if any policy on this issue existed. 2. The infection which caused her sepsis was a bacterial infection which [redacted] told me could only have been successfully treated with antibiotics. I am not satisfied that the breast infection was adequately managed at Cann House it being noted that there was no record of how the breast infection was progressing between 25th May and 27th June 2023 . 3. It is likely that Miss George's needs were too great for the care home and that the withdrawal of 1 to 1 supervision had an effect on the home's ability to care for her. I do think it likely that she was unkempt because of the inability of staff to meet her needs as well as the sepsis This does not however remove the need for close monitoring of medical conditions and appropriate escalation policies to be followed and to happen. The home has been unable to provide me with evidence that they appropriately escalated concerns to Adult Social Care which may have resulted in additional care or Miss George being removed to another provider. 4. The documentation surrounding the fall, the symptoms seen and measures taken to seek medical input were not clear. 5. There was little or no evidence that capacity had been appropriately documented with care plans remaining silent on the issue and records not analysing carefully what steps had been taken to help Miss George make decisions. 6. There was little or no evidence of policies in place generally at the home and in particular on medication, escalation and reporting of concerns .
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 4pm on 30th March 2026 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 Plymouth City Council , Livewell South West and the Care Quality Commission 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	**[DATE] 30th January 2026 [SIGNED BY CORONER]**