REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Chief Executive Officer, Harbour Healthcare Ltd., Lodge House, Dodge Hill, Stockport, SK4 1RD

CORONER

I am Chris Morris, Area Coroner for Manchester South.

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

INVESTIGATION and INQUEST

On 28th June 2024, I opened an inquest into the death of Peter Good who died on 9th January 2024 at Stepping Hill Hospital, Stockport, aged 64 years. The investigation concluded with the inquest which I heard on 17th December 2024.

A post mortem examination undertaken by a consultant forensic pathologist on the Home Office Register determined Mr Good died as a consequence of:

1) a) Pneumonia;

1) b) Cerebral infarction, Parkinson's disease and skin ulceration.

At the end of the inquest, I recorded a narrative conclusion to the effect that Mr Good died as a consequence of complications arising from a previous cerebral infarction, Parkinson's disease and skin ulceration which had significantly deteriorated whilst at the nursing home from which he was admitted to hospital for the final time.

CIRCUMSTANCES OF THE DEATH

Mr Good was a resident at Hilltop Hall Nursing Home who was nursed in bed as a result of complex care needs particularly arising from a previous cerebral infarction. On 26th December 2023, Mr Good was admitted to Stepping Hill Hospital, Stockport with a blocked gastrostomy tube.

On admission, Mr Good was noted to be in poor condition exhibiting what clinical staff perceived as signs of prolonged neglect, leading to a safeguarding alert being raised.

Despite treatment with antibiotics, Mr Good deteriorated further whilst in hospital and died on 9th January 2024.

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 court heard evidence that a safeguarding alert was raised by nursing staff at Stepping Hill Hospital shortly after admission on the basis that Mr Good appeared to them very dirty and unkempt with some of his wounds looking and smelling infected. It was further suggested that on admission, Mr Good was noted to exhibit poor oral hygiene, with calculus-covered teeth which the hospital safeguarding nurse regarded as indicative of prolonged neglect.

Whilst the Nursing Home's Deputy Manager gave evidence to the effect that she did not recognise this description of Mr Good, she accepted she had last provided care to him several weeks prior to his admission to hospital.

I am concerned in the light of this description that Harbour Healthcare as the owner and operator of Hilltop Hall has not instigated its own investigation into the way which Mr Good was cared for, with a view to considering any ongoing risk of harm to other residents and whether any learning can be derived for staff and managers of the home.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **27th February 2025**. 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.

COPIES and PUBLICATION

I have sent a copy of my report to Mr Good's daughter.

I have also sent a copy to the Care Quality Commission, Stockport NHS Foundation Trust, Greater Manchester ICB and Stockport Metropolitan Borough Council 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. She 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.

Dated: **2nd January 2025**

Signature: Chris Morris HM Area Coroner, Manchester South.