Harbour Healthcare

Mission: *Together we are dedicated to enhancing the well-being of all through quality, excellence and fun*

Harbour Healthcare Ltd
The Lodge House, Dodge Hill
Heaton Norris, Stockport
Cheshire
SK4 1RD

Via Email

27th November 2025

FOC Christopher Fleming
H.M Coroners Officer – HM Coroners Service Cumbria
Fairfield, Station Road
Cockermouth
CA13 9PT

Dear Mr Fleming.

Re: Death Of Beatrice Smith, Riverside Care Home, Regulation 28 Response (Case Ref 15013096)

I refer to your letter dated 6th October 2025 in relation to the above, please find below our response and actions in relation to this matter

Harbour Healthcare
Riverside Court Care Home
Maryport
Cumbria

Regulation 28 Report to Prevent Future Deaths

Response to Coroners Concerns into the Death of Mrs Beatrice Smith who passed away on 23rd April 2025 in West Cumberland Hospital following residing at Riverside Court Care Home Maryport

Background

Harbour Healthcare is a family run car provider established in 2012.
Riverside Court Care Home was run by FSHC until it was one of a group of 19 homes as part of an acquisition to Harbour Healthcare on Friday 25th April 2025
Riverside Court is a 59 bedded Care Home with 2 communities over 2 floors offering care for individuals with nursing and residential needs and of those living with dementia and associated challenges.
Our philosophy is quite simple, and we strive to provide an excellent standard of care to our residents treating them with complete dignity and respect.

Circumstances of the Death

Mrs Smith was seen by her daughter and by an ACP from Cumbria Health on call on 17th April 2025. They both had significant concerns about Mrs Smith's condition, and the ACP made a safeguarding referral.

Coroners Conclusion

Medical Cause of Death
1a Multiple Organ Failure
1b Sepsis
1c Infected Heel Ulcer

Response

Following the inquest a Serious Untoward Incident Root Cause Analysis was completed by Harbour Healthcare Head of Safeguarding with support from Human Resources.

At the time of the incident Riverside Court was under FSHC policies and processes.
If the incident had been investigated in line with our current policy and process this could have been shared as part of the inquest but as there was no evidence, we need to accept failure in process, however we are confident our updated process would give confidence that this process would be followed for any future incidents within the company.

We have reviewed processes in the Home and coaching and support in key areas has been offered to the team along with refresher of training in Adults and Safeguarding and Wound Care.

To validate learning competency and understanding this is done through reflective practice, and discussions at Stand-Up meetings, clinical meetings, supervisions etc.

We have a Audit system in place along with an incident management system linked to a Risk Register so we have oversight as a company on key areas for monitoring and review of quality of care.

Response

As part of the internal Serious Untoward Incident RCA an action plan and lessons learned identified key areas of learning. There has been ongoing refresher training to all team members to support their understanding of Safeguarding of Residents
Aswell as the eLearning on our 'Your Hippo' Training Platform related to wounds and skin there has been, and further training attended and planned with the NHS Tissue Viability Team on wound care for all team members offering direct care.

HEAD OFFICE
The Lodge House
Dodge Hill
Heaton Norris
Stockport SK4 1RD
0161 429 0307
info@harbourhealthcare.co.uk

The Quality Team support the home with Observational Support Visits which look at the quality-of-care planning and wound management. There is ongoing themed supervisions and coaching to key team members to suppor5t ongoing development
When the nurses are completing their wound care training, they are completing reflective practice accounts to validate learning.

As a company we have implemented a Coroners Lessons Learned forum which are held via teams every month. These commenced in October and offer a presentation of a coroner's inquest relating to a home and then the associated lessons learned

The polices related to key areas have been shared with the team.

Harbour Healthcare
Mission: *Together we are dedicated to enhancing the well-being of all through quality, excellence and fun*

Actions Taken

1. A Serious Untoward Incident Root Cause Analysis was completed by the Head of Safeguarding into the events from 15th April with a focus on 17th April 2025 supported by the Human Resources Business Partner (HRBP)
2. A Review of Wounds and skin risk in the Home was completed and Audited using our Viclarity System by the Registered Manager
3. A weekly wound monitoring form is then completed and updated and shared to the Operations Director, Regional Manager, Head of Safeguarding and Director of Quality for oversight and governance.
4. All team members have undertaken the Adults with Safeguarding E Learning Module to allow for refresher in this area
5. Impact and understanding of learning is being validated through reflective discussions at stand-up meetings, support visits and supervisions.
6. Riverside Court nurses have attended a wound care update by the local NHS trust and all team members who deliver care are signed up for further training and development through them early in 2026.
7. A camera is in place now to support taking regular pictures in line with guidance
8. Observational Support Visits were commenced which focused on key areas in including wound management and triangulation of care, and the team's knowledge around safeguarding, recognising change, communication and associated actions.
9. The Registered Manager is carrying out further development and learning to the team through supervision and coaching which is being supported by the quality team for effectiveness.
10. There is a Governance Process in Place since June 2025 for all new Serious Untoward Incidents and we have a tracker monitored and reviewed by the Quality Team and Head of Safeguarding to look at detail in the RCA for lessons learned, actions, and trends in key areas
11. When completing the home add any actions to their Service Improvement Plan and share learning through their Clinical Governance Meeting
12. Shared learning and updates are reinforced through the Stand-Up Meetings each day in the Care Home along with Huddles for improvements in more effective communication.
13. Riverside Court is on the focus call group which is a process by Harbour Healthcare as part of the risk register where higher risks home due to key issues are invited to a call every fortnight with key team members to review he Service Improvement Plan, check progress and offer support if needed to meet any urgent or high risk actions.
14. Our VI clarity Audit and Monitoring System captures risk through the key care indicators report each month. This then feeds into our corporate Risk Register for allowing effective response to the homes for resident safety.
15. Harbour Healthcare have introduced a Coroners Learning Forum in October 2025 where a team's call is open to all interested individuals to share outcomes from Coroners Courts or potentially serious incidents along with any associated lessons learned for the wider organisation. The outcome of Riverside Courts inquest was cascaded to the company on Wednesday 3rd November 2025
16. These lessons learned are evidenced through the clinical governance meeting and stand-up meetings.

17. All Homes who transitioned to Harbour Healthcare in April 2025 are being transferred to Electronic Care Plans (PCS) commencing Jan 2026 to allow for continued improvements in governance and monitoring.
All of the above measures are underpinned by the following Policies and Procedures Safeguarding Adults Policy and Procedure – Reviewed 29th Oct 2025 CPN16 Wound, Bruise and Skin Conditions Policy and Procedure Reviewed 23rd Sept 25 CCN30 -Pressure Ulcer Management Policy and Procedure Reviewed 5th Nov 25 CC18 -Infection Control Policy and Procedure – Reviewed 25th June 25 CCN12 – Sepsis Awareness Policy and Procedure – Reviewed 20th Aug 25 CP11 – Person Centred Care and Support Planning Policy and Procedure – Reviewed 7th Nov 25 ABN11 – Root Cause Analysis Policy and Procedure Reviewed 16th Sept 25
Evidence Appendix (Available if required) Appendix 1 – Serious Untoward Incident Root Cause Analysis Appendix 2 – Weekly Wound Tracker Appendix 3 – Observational Visits Appendix 4 – Presentation and Lessons Learned from Forum Appendix 5 – Training Records Appendix 6 -Viclarity Audits for Wounds Appendix 7 – Viclarity Audit for KCI and Risk Monitoring Appendix 8 – Clinical Meetings/Stand up meeting templates Appendix 9 – themed supervision/coaching Appendix 10 – Associated Record of Discussions

Should you require any further information please do not hesitate to contact me.

Yours Sincerely

[redacted]
Director of Operations
Harbour Healthcare

HEAD OFFICE
The Lodge House
Dodge Hill
Heaton Norris
Stockport SK4 1RD
0161 429 0307
info@harbourhealthcare.co.uk