Miss K J Gomersal LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

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2 October 2025

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

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

1) CORONER

I am Robert Cohen, HM Assistant Coroner for Cumbria

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

On 1 May 2025 I commenced an investigation into the death of Beatrice SMITH. The investigation concluded at the end of the inquest . The conclusion of the inquest was a narrative in the following terms:

Beatrice Smith was 88 years old. On 22nd September 2024 Mrs Smith was admitted to the Cumberland Infirmary, Carlisle, following a fall and long lie. Mrs Smith had a serious ulcer on her left leg. Whilst in hospital there was a period of one month during which Mrs Smith's ulcer was not seen or treated by Tissue Viability Nurses. Following their involvement, Mrs Smith's condition began to improve, but she had developed further ulcers including to her right heel. Mrs Smith was discharged to Riverside Court Care Home on 13th February 2025. Whilst resident there Mrs Smith's condition deteriorated seriously and the ulcer on her right heel became badly infected. Mrs Smith's condition noticeably worsened from 15th April onwards. Despite this, Riverside Court did not seek specialist attention for her and the ulcer was not always properly dressed. Mrs Smith developed sepsis. She was admitted to the West Cumberland Hospital, Whitehaven on 23rd April 2025. She died there at 17:01 on that day.

Neglect, being the failure to seek specialist care and wound management for Mrs Smith following her deterioration on 15th April 2025, contributed to her death.

I concluded that the medical cause of Mrs Smith's death was:

1a Multiple Organ Failure

1b Sepsis

1c Infected Heel Ulcer

II Diabetes Mellitus, Dementia, Frailty

4) 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. The ACP's note (which she wrote at the time) was as follows:

"sat in chair on arrival. evident leaking haemaserous fluid from the right foot/ankle this was leaking underneath her sensor mat with noted blood clots on the floor from the exudate....I was very shocked at how Beatrice was sat with her leg wound pooling out in her room under her sensor mat. Daughter has raised concerns that this was how it was when she arrived yesterday".

The Manager of Riverside Court attended the inquest and gave evidence. I asked her how Mrs Smith had been allowed to develop such a poor condition. She responded that she had attempted to find this out but had not been able to. She confirmed that she would have expected staff to conduct rounds and that they should have addressed Mrs Smith's deteriorating condition. She was not able to tell me why this had not occurred.

I understand that Harbour Healthcare Limited is now the owner of Riverside Court.

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) A safeguarding referral was made in respect of Mrs Smith's condition at the time. Despite this, and despite Mrs Smith's death, no effective internal investigation appears to have been conducted. I am concerned that the absence of such an investigation means that opportunities for learning are likely to be overlooked. In turn this risks residents being exposed to repeated practices that are inadequate. This is a risk to those residents.

2) I asked the Manager of Riverside Court whether any additional training or guidance had been provided to staff in the light of this incident and Mrs Smith's death. She replied that it had not. Given my concerns that Mrs Smith's condition was not well managed I am concerned that the absence of such training and guidance risks a repeat of these events.

6) ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you, the CEO of Harbour Healthcare Limited, 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 28th November 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.

8) COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the each of the Interested Persons in the inquest. I have also sent it to 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.

2 October 2025

Signature 

Robert Cohen HM Assistant Coroner for