Lentulus Properties

T/A ,Bamford Grange Care Home
239 Adswood Road, Shaw Heath, Stockport,
Greater Manchester. SK3 8PA

[redacted]

Alison Mutch
Senior Coroner for Manchester South

[redacted]

11 December 2025

Dear Ms Mutch,

Inquest Touching the Death of Richard Charles Worswick

Thank you for your Regulation 28 report of 7 November 2025 following the Inquest into the death of Richard Charles Worswick. I am responding on behalf of both Lentulus Properties Ltd t/a Bamford Grange (hereinafter "the Home") and the overall care provider, Springcare Limited.

I know that you will share a copy of this response with Mr. Worswick's family, and I would like to take this opportunity to express my condolences for their loss.

Concerns Raised

In your Regulation 28 report you raised the following concerns with regards to the Home:

"The inquest heard evidence that when he was discharged to the care home from the acute hospital the care home felt that they did not understand what was required regarding wound care because the care plan regarding wound care was not clear… As a consequence of this, there was a lack of clarity regarding wound management."

and

"The home did not have a clear escalation policy for actions to be taken when a resident arrived, and their staff were unclear how they were being asked to manage a wound by the hospital. In addition, the documentation surrounding concerns and attempts to escalate was limited."

A concern was also raised in respect of Stepping Hill Hospital's system for communicating and recording relevant patient information on discharge.

Response

At the outset I would like to reassure you that we have reflected seriously upon the contents of your Report, both within the Home and across the broader service, and

that we welcome the opportunity to identify learnings as well the opportunity to both improve the quality of our care provision and strengthen the existing policies and procedures moving forward.

I would further like to reassure you that both the Home and Springcare in general have always maintained a comprehensive policy pertaining to re-admissions to the home from hospital. This policy requires that any changes to a treatment plan for wounds are put in place without delay and that any resident who appears unwell should be monitored closely using the relevant approved scoring systems such as NEWS 2 / RESTORE 2.

The policy also requires that where no information is received from the discharging hospital, persistent efforts should be made to contact the hospital and obtain details of the relevant treatment plan(s) with these efforts being clearly documented and recorded in the care notes. Unfortunately, that policy was not followed or adhered to in relation to Mr. Worswick's discharge on 2 May 2025.

I can confirm that at no time has the Home ever been provided with a Ward Summary/Transfer of Care document as referenced by Stepping Hill during the course of the Inquest in connection with the discharge of any resident. The Home has only ever been provided with a hospital discharge summary which, on this occasion did not provide any details for the treatment of Mr Worswick's spinal abscess.

The senior carer on duty at the time did initially twice attempt to contact the hospital for details of the wound care plan but was unsuccessful. Unfortunately these attempts were not documented in the care records and consequently not followed up by other members of staff. There was a delay in referring Mr. Worswick to the TVN.

As a result of the Inquest findings and I can confirm that the following action has been taken to ensure proper adherence to the existing policies and procedures going forwards particularly with regard to the re-admission of residents to the Home from hospital and arrangements for monitoring of wound care and clinical observations:

- Staff issued with refresher guidance as to the requirements of the existing policy and importance of following the same.
- All calls to hospital/community teams are to be documented including if unsuccessful, and staff must also document what mitigation is put in place in the event of a missing treatment plan.
- All hospital calls for admission/discharge planning to be recorded on the electronic record system Nourish including details of date and time of call, who was spoken to, and any follow up needed.
- Referrals to TVN or other community teams to be made within 24 hours of identified need and to contain all relevant information including photographs and current treatment plan.

In addition to reinforcing the above, the following additional action has been taken to improve the care provision going forwards:

- A review of all currently unstageable pressure ulcers in the Home and

implementation of enhanced observations to identify softer signs of deterioration or flag where more urgent escalation is needed.
- Implementation of a sepsis risk assessment for all residents with chronic wounds.
- Regular and routine checks and audit of entries on Nourish by Home Manager and Deputy to ensure wound care is being delivered as per prescribed treatment plan.

Springcare Limited also continues to carry out a monthly review of deaths and hospital admissions/re-admissions to identify any themes or trends which may need to be addressed.

Thank you again for bringing your concerns to my attention. I trust that this response provides assurance that appropriate action is being taken to address those concerns.

Yours sincerely,

[redacted]

[redacted]
Operations Manager
Springcare Limited