

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Bamford Grange Care Home 2) Stockport NHS Foundation Trust
1	CORONER I am Alison Mutch, senior coroner, for the coroner area of Manchester South
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 4th June 2025 I commenced an investigation into the death of Richard Charles WORSWICK. The investigation concluded at the end of the inquest on 16th October 2025. The conclusion of the inquest was Narrative: Died of the complications of a spinal wound when the significant deterioration in the wound was not recognised until he became seriously unwell on the 17th May 2025. The medical cause of death was: 1a) Sepsis 1b) Infected spinal wound; and I) Parkinson's Disease, Frailty.
4	CIRCUMSTANCES OF THE DEATH Richard Charles Worswick had multiple health conditions including Parkinson's Disease. He had become increasingly frail and had to move to Bamford Grange on a nursing care placement because of his poor health and complex needs. He developed an abscess in his spinal area because of his underlying poor health and immobility. A wound care plan was put in place for this wound whilst he was in Stepping Hill Hospital. He was discharged back to Bamford Grange on 2nd May 2025. It is unclear what information was communicated by Stepping Hill Hospital to Bamford Grange around wound management. His wound was noted to be deteriorating, and advice was sought from Tissue Viability Nurse

	team. It was not felt that the wound was infected at that time. On 17th May 2025 at about 05:30am he was noted to have become unwell. His observations were taken. Observations had not been taken the previous day. The observations identified that he was seriously unwell, and an ambulance was called. He was taken to Stepping Hill Hospital where the wound on his spine was found to be severely infected and to have led to him developing sepsis. Despite treatment he deteriorated and died at Stepping Hill Hospital on 19th May 2025.
5	<u>CORONER'S CONCERNS</u> 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. – The inquest heard evidence that when he was discharged to the care home from the acute hospital that 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 .The Trust did not have a copy of what information had been provided. As a consequence of this, there was a lack of clarity regarding wound management. The Trust did not the inquest was told have a clear procedure that ensured that there was a clear, effective and documented communication system in relation to care plans that included wound management. 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.
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 2nd January 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 namely the family of Mr Worswick, 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. They may send a copy of this report to any person who they believe 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	<u>Alison Mutch OBE</u> <u>HM Senior Coroner</u>  <u>07/11/2025</u>