IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Ramona Doreen Harbott
A Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Barchester Health Care Limited [redacted] Interim Chief Executive, Care Quality Commission [redacted]
2	**CORONER** Ms Susan Ridge, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
4	**INQUEST** An inquest into Mrs Harbott's death was opened on 14 Mach 2025. The inquest was resumed on 13 November 2025 and concluded on 8 December 2025. The medical cause of Mrs Harbott's death was: 1a. Sepsis 1b. Pneumonia 2. Deep Sacral Sore With respect to where, when and how Mrs Harbott came by her death a narrative conclusion was recorded in Box 4 of the Record of Inquest as follows:

	Ramona Doreen Harbott was a frail elderly lady who suffered with dementia. She had a diagnosis of diabetes mellitus and very limited mobility. She was admitted to the Windmill Manor Care Home on 27 December 2024. At the time of admission, she was assessed as at high risk of developing pressure sores. Within the first week of her stay in the care home Mrs Harbott was largely bedbound and remained so throughout her stay. She was not regularly repositioned until sixteen days later on 13 January 2025 once it was noticed that she had developed redness to the sacral area. On 20 January 2025, the care home recorded that she had developed what they assessed as a category 2 sacral sore. On 24 January 2025 Mrs Harbott was taken to East Surrey Hospital following advice from her General Practitioner after the care home staff had noticed that she was drowsy, less responsive and deteriorating. On admission to East Surrey Hospital she had high infection markers, a cough, and fever. Mrs Harbott was also found on admission to hospital to have a significant unstageable necrotic sacral pressure sore. Although actively treated for both the sacral sore and her infection, Mrs Harbott continued to deteriorate and died in East Surrey Hospital on 19 February 2025. She died from sepsis having contracted pneumonia. The serious sacral sore which was well established by the time she was admitted to hospital more than minimally contributing to Mrs Harbott's death as it contributed to her overall deterioration and lack of physiological resilience.

5	**CIRCUMSTANCES OF THE DEATH** Mrs Harbott was discharged from hospital to Windmill Manor Care Home, Oxted on 27 December 2024 because of her increasing care needs. At this stage she was largely immobile and assessed at high risk of pressure sores. Mrs Harbott developed a sacral sore whilst in the care home which by the time she was taken to East Surrey Hospital on 24 January 2025 had become an unstageable necrotic ulcer. She also had a serious pressure sore to her right heel which was not identified by the care home until 23 January 2025 and an undocumented deep tissue injury to her other foot. Mrs Harbott's pressure sores were treated (requiring debridement on the ward on several occasions) and contained once she was admitted to East Surrey Hospital. But as the court heard, the damage had already been done before she arrived in hospital. The evidence showed that both the sacral sore and the sore to the right heel were well established and significant before her admission to hospital in January 2025.
6	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are: a. The evidence heard by the court indicated that though the care home had policies and guidance for the prevention and management of bed sores that was not followed by on-site care or nursing staff. Although at high risk of pressure sores Mrs Harbott was not regularly repositioned until she had developed a sacral sore. Her skin condition was not monitored and recorded to the extent that though the sore was apparently being treated, it had become an unstageable necrotic wound by the time she was taken to hospital. The serious pressure sore on the right heel was not documented until it was seen on 23 January 2025 although it was likely well established for at least a week. b. The coroner acknowledges that Barchester Health Care have since this death and the inquest hearing in November 2025 commenced an action

	plan of improvements including greater regional management oversight however the coroner remains concerned that the matters identified at the inquest regarding issues surrounding early and appropriate assessment of risk, use of preventative measures, skin monitoring, pressure sore treatment and record keeping are the subject of ongoing improvement which has yet to be completed and audited.
7	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths, and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mrs Harbott's family

10	**Signed:** **Susan Ridge** **H.M Assistant Coroner for Surrey** **Dated 19 December 2025**