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Rebecca Sutton
HM Assistant Coroner
Fourth Floor
Civic Centre
North Terrace
Crook
County Durham
DL15 9ES

Our reference: [redacted]
Your reference: [redacted]

27 August 2025

Dear HM Assistant Coroner Rebecca Sutton,

Prevention of future death report following inquest into the death of Patricia Heaviside

Thank you for sending the Care Quality Commission (CQC) a copy of the prevention of future deaths report issued following the sad death of Patricia Heaviside.

We note the legal requirement upon CQC to respond to your report within 56 days, by 5 September 2025.

The registered provider of Howlish Hall Residential Care Home (referred to as Howlish Hall hereafter) is Williams & Spenceley Limited. They have been registered with CQC since 1 October 2010.

The provider's location, Howlish Hall is located at Coundon, Bishop Auckland, County Durham, DL14 8ED. The provider is registered for the following regulated activity: accommodation for persons who require nursing or personal care. The provider is not permitted to provide nursing care at this location.

On 2 July 2025 CQC began an inspection of Howlish Hall following concerns we had received about the service relating to the environment, staff training, fire safety, the departure of the registered manager and ongoing concerns from the local authority

about a lack of sustained improvements within the service. The inspection continued on 3, 9 and 11 July 2025 and found significant shortfalls at the service and identified several breaches of fundamental standards. We took urgent enforcement action in the form of imposing conditions, to ensure the immediate safety of residents until suitable alternative accommodation could be found. Due to the significant and widespread issues found during the inspection, we also issued a Notice of Proposal to cancel the provider's registration.

On 24 July 2025 CQC met with representatives from Durham County Council and [redacted] (provider) at Howlish Hall. During this meeting [redacted] indicated his intention to serve the local authority with a 3 month notice period and stated his intention was to close the home as quickly as possible, before CQC cancelled his registration. We worked closely with local authority colleagues, and all residents were moved to other care facilities by the end of the day on Friday 1 August 2025.

Background

On 9 October 2024 [redacted] (the registered manager of Howlish Hall at the time) submitted a notification of serious injury to CQC regarding Mrs Heaviside's fall at the service on 4 October 2024. The notification did not contain any information regarding concerns about the care provided, so CQC closed this with no further action.

In light of the Regulation 28 report received from yourself, we are gathering further information and reviewing this incident in line with our Specific Incidents guidance.

Matters of concern

1. **Despite recommendations for falls prevention equipment being made by the Community Falls Service in August 2023, no falls prevention equipment was put in place by the time of the Deceased's fall in October 2024.**

Had CQC been aware of this we could have taken action to contact the provider, but no such concern was shared with CQC.

2. **Despite the social worker expressing concern about the lack of falls prevention equipment on 27 September 2024, no falls equipment was put in place prior to the Deceased's fall on 4 October 2024.**

CQC was not aware of the social worker's concern in this regard. CQC would expect a social worker to complete a safeguarding referral to the local authority's safeguarding team in such circumstances. CQC is unaware whether a safeguarding referral was completed in this case as safeguarding referrals are not always routinely shared with CQC by local authorities.

3. **Information about the Community Falls Service recommendations was not passed on to the family, or to social services.**

CQC would usually expect the care home management team or staff to update the family and the person's social worker about such recommendations from external

health professionals. We were not aware at the time that this information had not been passed on.

4. **On 5 August 2024 (following a fall, but before the more significant fall on 4 October 2024), the Deceased's family were told by the Deputy Manager of Howlish Hall that the owner of Howlish Hall "probably wouldn't want to pay for a sensor mat".**

CQC did not hear the evidence at the inquest, but we accept the findings of the inquest. CQC would expect providers to supply sensor mats if it was appropriate for the individual's assessed needs. This is an issue that the Provider would be best placed to answer.

5. **I received evidence that, subsequent to the Deceased's death, there had been a reluctance on the part of [redacted] (who was believed to be the owner of Howlish Hall Care Home) to provide adequate resources for falls prevention equipment.**

When CQC and local authority representatives met with [redacted] at Howlish Hall on 24 July 2025 he stated this was untrue, sensor mats were inexpensive and there was always a supply of several sensor mats in the home at any given time. However, we accept the findings of the inquest.

CQC expects care providers to follow the NICE guidelines on falls management (https://www.nice.org.uk/guidance/ng249/chapter/Recommendations#interventions-to-reduce-the-risk-of-falls). We expect providers to take a multi-factorial approach to falls management which includes measures such as conducting medication reviews, encouraging the person to remain physically active and removing hazards from the environment. Whilst sensor mats are useful as an early warning system that alerts care staff to potential falls or movements to enable swift responses to prevent injuries, they do not physically prevent a person having a fall.

During the inspection on 2, 3, 9 and 11 July 2025 and subsequent concerns shared with us by Durham County Council, we had significant concerns in relation to falls management at the service. As stated above, we took urgent action to impose conditions on the provider's registration. One of the conditions included a requirement for the provider to take steps to safeguard people from the risk of falls, including confirmation that appropriate equipment was in situ and service users care plans reflected the level of support and equipment they required to reduce the risks associated with falls.

6. **Despite it being recognised that the Deceased lacked mental capacity to make decisions about where she lived and was unable to keep herself safe, it appears that the home did not make any application for a DoLS assessment for the Deceased. Indeed, I received evidence that when a new home manager was appointed at Howlish Hall in January 2025 none of the residents were subject to a DoLS, despite a large number of the residents lacking mental capacity.**

We were not aware of concerns regarding a lack of application for a DoLS assessment for the Deceased, as this was not reported to CQC. Neither were we aware that a large number of residents who lacked mental capacity were not subject to a DoLs. Had we been aware of these concerns we would have taken action at the time.

When we inspected the home in July 2025 we found several breaches of fundamental standards, including a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (need for consent). We found evidence the provider did not have an effective process in place to monitor DoLS applications, or any conditions imposed.

Further Queries

Should you have any further queries please contact our National Customer Service Centre using the details below:

Telephone: 03000 616161 or email: enquiries@cqc.org.uk

If your query is regarding this letter, please quote the CQC reference [redacted]

Yours sincerely,

[redacted]
Deputy Director of Operations
Network North, CQC