[redacted]

Rebecca Sutton
Assistant Coroner, County Durham and Darlington

12 September 2025

Dear Rebecca,

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS – Patricia Heaviside

We have reviewed the above report relating to the sad death of Patricia Heaviside and have responded below to the coroner's matters concerns as outlined in section 5 of the report.

(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.

It is important to clarify that Durham County Council was not directly informed of the recommendations made by the County Durham and Darlington NHS Foundation Trust (CDDFT) Community Falls Service. In accordance with standard protocol, such recommendations are communicated solely to the care home, which retains full responsibility for reviewing, actioning, and implementing the advised measures.

The responsibility for ensuring that appropriate falls prevention equipment is sourced and put in place lies with care home management. Care Homes within County Durham are expected to act upon external clinical guidance and advice to ensure that any necessary interventions are completed in a timely and effective manner. The absence of equipment at the time of the incident reflects a failure in the care home's duty to follow through on the recommendations provided by CDDFT.

Durham County Council's Strategic Commissioning Team and Practice Improvement Team commenced monitoring visits within the care home in September 2024, with a total of 22 onsite monitoring visits taking place from that date until the care home closed on the 1 August 2025. During this period, Durham County Council's formal Planning Meeting process was invoked and subsequently escalated to the Executive Strategy Meeting process to address ongoing issues. It should be noted that there have been multiple changes in care home management during the last 12 months and this lack of continuity

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has had a detrimental impact on the quality of care provided, as key information was not consistently recorded or effectively handed over between managers and care staff, resulting in missed actions and compromised management and owner oversight.

Planning and Executive Strategy Meetings in relation to Howlish Hall included representation from the Care Quality Commission and other relevant partners.

In July 2025, following intensive oversight as described above, Howlish Hall issued notice to the Council that the care home would close. Durham County Council arranged for a dedicated team of officers to manage the transition and closure process with the service and all residents were re-assessed and moved to alternative care home provision within 7 days.

(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.

In order to clarify the events and actions taken by Mrs Heaviside's allocated social worker, a summary is provided below:

On 27 September 2024, the allocated social worker visited Howlish Hall to discuss the safeguarding concerns raised. During the visit, care home staff informed the social worker that a falls detector was available on site and assured that it would be placed next to the client's beds. The social worker documented his intention to undertake an unannounced follow-up visit to confirm that the equipment had been appropriately installed. Sadly, Mrs Heaviside experienced the significant fall on 4 October 2024 before this follow-up visit could be carried out.

A further unannounced visit was conducted by the social worker on 22 October 2024, following Mrs Heaviside returning to the home on 11 October. During this visit, the Deputy Manager stated that she had not been made aware of the requirement to install the falls equipment, as the relevant messages had not been passed onto her. When challenged on the continued delay, the social worker was informed that care staff 'did not have access to the care home's finances' and requested that the social worker submit the equipment request in writing. The social worker advised that this was unacceptable and insisted that the equipment be ordered immediately.

On 31 October 2024, the social worker returned to the care home to complete Care Act and Mental Capacity Assessments. During this visit, it was identified the falls equipment had still not been put in place for Mrs Heaviside. Care staff once again claimed that previous instructions had not been communicated. The social worker remained on site until they received assurances from the Howlish Hall Care Home Manager, that equipment was going to be ordered imminently.

A final visit was undertaken on 1 November 2024, during which the social worker records that the equipment issues were now resolved.

This highlights repeated failures in both communication and internal accountability within the care home, which contributed to unacceptable delays in implementing essential safety measures, despite clear and ongoing intervention by the allocated social worker.

The Council has an established information sharing protocol to ensure that any concerns or issues relating to providers' contractual obligations are appropriately communicated to

the commissioning team by social work staff. All staff will be reminded of the importance of adhering to this process.

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

We have reviewed this matter and can confirm that we are unable to identify any Council records indicating that the recommendations made by the CDDFT Community Falls Service on 16 August 2023, and again during June 2024, were shared with either Durham County Council or the family by CDDFT Community Falls Team or the Care Home.

Following enquiries with the CDDFT Community Falls Team, they have advised that it is not routine practice to share such information more widely. In light of this, the Council will be working with our CDDFT Community Falls Teams to explore how this process can be strengthened. The Council's aim would be to establish a process whereby any recommendations made by CDDFT Community Falls Team are communicated appropriately and in a timely manner to relevant parties, including families and social services.

Additionally, the Council has been informed by the CDDFT Community Falls Team that their records from August 2023 note: *"no more falls have been reported and the care setting has put all measures in place."* This record suggests that, at that time, the care home had reported to CDDFT they had taken steps to address the concerns raised.

(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".

Council records reflect similar observations or comments made by care staff concerning the financial implications of purchasing the equipment. Furthermore, during a safeguarding enquiry dated the 13 September 2024, documentation includes a reference to a comment made by care home staff to a member of the CDDFT's Community Therapy Team, indicating that Howlish Hall was 'financially struggling to provide'.

It is important to note that Durham County Council had not received any formal notification from the Care Home owner regarding financial difficulties, despite our expectations on Provider transparency on sustainability issues being communicated to the market on a number of occasions. This is regularly reiterated at provider forums etc. The Council strongly encourages Providers who may be experiencing financial pressures to engage with us directly, so that constructive dialogue is initiated and, where necessary, appropriate action taken.

(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.

In addition to the areas highlighted in the response to point 4 above, we are not aware of [redacted] advising that he would not specifically provide resources for falls prevention equipment. During monitoring visits, Council officers noted that falls prevention equipment was installed and operational in several resident bedrooms.

However, financial sustainability and cash flow of the home was discussed with [redacted] during a meeting held on 6 March 2025. In this meeting, [redacted] was asked how the Care Home Manager can access funds to source essential items given he spends prolonged periods of time out of the country. [redacted] advised that arrangements had been made to enable the care home manager to have access to cash and a credit card and it is documented that [redacted] would speak to the current care home manager to emphasise that if any finances were required it was acceptable to request them. However, despite this assurance in March 2025, these measures were not put in place until June 2025.

(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.

Care home providers are contractually required to maintain polices and protocols relating to the Deprivation of Liberty Safeguards (DoLS) including mental capacity. In addition, all staff must receive appropriate training in mental capacity to ensure compliance and uphold best practice.

In January 2025, Durham County Council worked with the newly appointed manager at Howlish Hall to ensure that all necessary DoLS applications were submitted and any expired authorisations were promptly renewed.

DoLS considerations have been applied to all residents who have transitioned to a new care home placement as part of the care home closure work for Howlish Hall.

Deprivation of Liberty Safeguards is a regular agenda item and discussion point at our Care Home Strategic Provider Forum meetings, and we will continue to reinforce its importance in upcoming forum sessions. To strengthen oversight, commissioning and safeguarding teams will work with the DoLS team to explore ways of identifying care homes that currently have no active DoLS authorisations in place or where renewals may be overdue. This will help us highlight potential gaps and ensure timely action is taken to proactively address any issues with the care home.

I hope this response clarifies the input of the Council and wider context relating to Howlish Hall and would like to thank you for sharing the report with us. We will work to complete the actions set out above for DCC.

Yours faithfully

[redacted]

[redacted]
Deputy Director of Local Delivery / Head of Integrated Commissioning