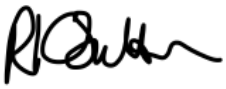
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], as Sole Director and 75%+ shareholder of Williams and Spenceley Ltd (the company that owns Howlish Hall Care Home), 29 Finkle Street, Bishop Auckland, DL14 7PL** **2. Manager of Howlish Hall Care Home ([redacted])** **3. CQC ([redacted])** **4. Head of the AHS Practice Improvement Team, Durham County Council**
1	**CORONER** I am Rebecca Sutton, assistant coroner, for the coroner area of County Durham and Darlington.
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 30 December 2024 an investigation was commenced into the death of Patricia Heaviside, 85. The investigation concluded at the end of the inquest on 9 July 2025. The conclusion of the inquest was that the Deceased died on 26 December 2024 as a consequence of a fall that occurred on 4 October 2024 at Howlish Hall Care Home.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased had been a resident of Howlish Hall Care Home since February 2023. During her time at Howlish Hall the Deceased suffered a number of falls. In or about August 2023 the home manager received advice from the Community Falls Service, who recommended that a sensor box be placed in the Deceased's bedroom and that the Deceased should use hip protectors, which could be purchased by the Deceased's family. The home did not follow these recommendations and did not inform the family of the option to purchase hip protectors. Following the family reporting concerns to social services, a social worker attended at the home on 27 September 2024. The home staff assured the social worker that they had a sensor mat that they would place next to the Deceased's bed, but this was not done. On 4 October 2024 the Deceased suffered an unwitnessed fall in her room and sustained a fractured left hip. She underwent surgery to fix the fracture on 6 October 2024. She was discharged back to the home on 11 October 2024. Due to ongoing family concerns the Deceased was moved to a different care home on 3 December 2024. Her condition deteriorated and she died as a consequence of the hip fracture on 26 December 2024.

5	**CORONER'S CONCERNS** 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. – [BRIEF SUMMARY OF 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 (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. (3) Information about the Community Falls Service recommendations was not passed on to the family, or to social services. (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". (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. (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.
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 5 September 2025. 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, [redacted] and [redacted]. 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. He may send a copy of this report to any person who he believes 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	 **Rebecca Sutton HMAC County Durham and Darlington** **10.07.25**