



Care Quality Commission
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NE1 4PA

www.cqc.org.uk

Sally Robinson
HM Assistant Coroner
Coroner's Court
The Guildhall
Alfred Gelder Street
Hull
HU1 2AA

18 August 2026

Dear HM Assistant Coroner Sally Robinson,

Prevention of future death report following inquest into the death of Susan Dale

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

We note the legal requirement upon CQC to respond to your report within 56 days, by 21 August 2026.

The registered provider of Westfield Residential Home is Westfield Residential Home Ltd. They have been registered with CQC since 7 January 2011.

The provider's location Westfield Residential Home is located at 16 Carr Lane, Willerby, Hull, HU19 6JW. 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.

Background

On 20 April 2026, [REDACTED] the registered manager of Westfield Residential Home, submitted a statutory notification to CQC informing us of the death of Susan Dale, who was using the service. The notification did not include any information about previous falls or any involvement from the coroner.

Following receipt of the Regulation 28 Report, CQC have initiated a review of this incident in line with our specific incident guidance. CQC also conducted an unannounced inspection of Westfield Residential Home on 21 July 2026. The matters of concern highlighted in the Regulation 28 Report helped to inform our inspection activity and ensure there was a particular focus on record keeping, safe management of falls and handover processes.

Matters of concern

CQC assess Registered Persons against the regulatory framework relevant to the service provided, as well as accepted best practice and relevant national policies. It is not for CQC to instruct how a Registered Provider meets the standards required, but to assess whether the relevant standards are being met as expected and take appropriate action for any identified failures. Therefore, CQC cannot speak directly to the matters of concern raised outside of our role as a regulator and our assessment of the Registered Provider during our unannounced inspection.

In respect of the matters of concern as they relate to the care provided to Susan Dale, further assessment is ongoing as part of our specific incident process in order to determine whether any relevant breaches have occurred and whether any criminal enforcement action should be considered as a result.

During our unannounced inspection, in respect of any ongoing risk posed to service users, CQC did not identify any issues relating to the matters of concern raised that would require any regulatory action.

1. The record keeping in the home appears to be inaccurate and inconsistent.

Susan Dale's care records will be reviewed as part of our specific incident process to determine whether there are any regulatory breaches in respect of record keeping, and if so, what potential impact such breaches may have had in order to determine whether criminal enforcement action should be considered.

During our recent inspection of the service last month, we reviewed record keeping in overarching general terms. Evidence available and gathered did not demonstrate poor record keeping overall, however, it is important to note that CQC's inspection methodology follows a sampling approach, and therefore this does not mean there were not some shortfalls in some records.

CQC contacted the provider, as the registered provider of Westfield Residential Home, to seek assurances regarding the actions taken in response to receiving the Regulation 28 letter, including the steps they had taken regarding inaccurate and inconsistent record keeping.

The provider advised that they have moved to a new electronic care planning system, which includes integrated accident and incident forms. They stated this system supports staff to record accidents and incidents more clearly and consistently.

- 2. The falls policy of the home states that there are number of scenarios to consider before lifting a resident for the floor and states that the resident should not be moved until clinical assistance arrive. One such situation is if head, neck, back or hip injury is suspected. The incident log on advanced care cloud states there was a head injury, yet Mrs Dale was moved and no clinician saw her until she worsened and an ambulance was called. Inaccuracies in reporting can lead to missed opportunities to provide care and inaccurate time recording of incidents can lead to the accurate appraisal of the developing clinic picture being made more difficult which in turn would lead to a delay in medical assistance being sought. This could lead to resident safety being compromised and deaths occurring.**

The management of Susan Dale's fall will be assessed in line with CQC's specific incident guidance.

In relation to our recent inspection of the service last month, we reviewed falls management as part of our assessment of whether the service was providing safe care and treatment to all who use the service. Evidence available and gathered in respect of this identified no concerns with the management of falls.

CQC contacted the provider, as the registered provider of Westfield Residential Home, to seek assurances regarding the actions taken in response to receiving the Regulation 28 letter, including the measures implemented to prevent a similar incident from occurring in the future.

The provider advised that a staff meeting had been held to discuss the lessons learned. They stated that during the meeting, staff were introduced to the Falls and Accident Guidance that had been developed to provide a clear procedure for responding to accidents or incidents. The provider also confirmed that the falls policy and associated procedures were discussed with staff.

- 3. The senior care worker who came on shift later that day said she did not receive any hand over from the staff going off shift. This is a concern as observations need to be carried out when someone has fallen and banged their head and a handover would detail such incidents and whether there are any concerns with residents.**

The management of Susan Dale's fall will be assessed in line with CQC's specific incident guidance.

In relation to our recent inspection of the service last month, we reviewed handover processes as part of our assessment of whether the service was providing safe care and treatment to all who use the service. Evidence available and gathered in relation to handover processes between staff did not identify any concerns.

CQC contacted the provider, as the registered provider of Westfield Residential Home, to seek assurances regarding the actions taken in response to receiving the Regulation 28 letter, including the measures implemented to ensure effective communication and handover of information between shifts.

The provider advised that the new electronic care planning system also has an inbuilt handover function, which staff are able to read and verbally discuss at the beginning of each shift. A file for senior carers has also been implemented and is being updated as an ongoing resource. They informed us this contains master copies of relevant documents and guidance tools to support senior carers in their role.

The provider also advised that 24/7 on-call support is available to staff, who are aware that they can seek advice at any time, day or night. They advised a further senior carers' meeting has been planned for September, to continue to embed knowledge and good practice.

Thank you for drawing our attention to this matter and sharing this important information with us.

Please do not hesitate to contact us via our customer contact centre on 03000 61 61 61 if you have any further queries.

If you do contact us, please quote CQC reference [REDACTED]

Yours sincerely,

[REDACTED]

[REDACTED]

Deputy Director of Adult Social Care
Care Quality Commission
North East Area,
North Region,