From Helen Whately
Minister of State for Social Care

39 Victoria Street
London
SW1H 0EU

[redacted]

Department of Health & Social Care

[redacted]

Alison Mutch
Senior Coroner for the Coroner Area of
Greater Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

[redacted]

12 June 2024

Dear Ms Mutch,

Thank you for your letter of 14 September 2022 to the then Secretary of State for Health and Social Care at the time Thérèse Coffey, about the death of Diane Austin-Martin. I am replying as Minister with responsibility for social care.

Firstly, I would like to say how saddened I was to read of the circumstances of Ms Austin-Martin's death, and I offer my sincere condolences to her family. I am grateful to you for bringing these matters to my attention.

Your first concern referred to the lack of a mechanism to ensure that Social Services were aware of her move despite her vulnerability having been identified whilst she resided in Northern Ireland. Having made enquiries to the Department of Health Northern Ireland (NI), we can advise that there are general duties about making necessary services available under the HPSS (NI) Order 1972 and the Chronically Sick and Disabled Persons (NI) Act 1978. There is also the NI policy 'Adult Safeguarding: Prevention and Protection in Partnership: 2015'. Paragraph 14.2 of this policy references information sharing for safeguarding purposes.

The use of these pieces of legislation would depend on an individual assessment of need. NI officials have advised that it would be good practice to offer support and guidance to someone moving and make referrals in accordance with an assessment of need at this point.

In relation to the second and third concerns you raised, adult safeguarding is particularly relevant. Given that it is good practice for a local authority's Safeguarding Adults Board (SAB) to work with coroners, you may wish to write to the local SAB for further information about this case, including whether the SAB has considered a Safeguarding Adults Review (SAR).

Adult safeguarding is relevant because local authorities have a duty, under the Care Act 2014, to make enquiries when they suspect that an adult with care and support needs is a) at risk of abuse or neglect and b) unable to protect themselves as a result of those needs. You were concerned that there is no mechanism to ensure that domiciliary care is of a sufficient and appropriate quality, in contrast to regulation of care homes. While it is correct that CQC does not inspect unregulated home care settings, local authority adult safeguarding duties do provide a mechanism by which to investigate private home care arrangements if the quality of care puts the cared-for person at risk of harm.

According to the care and support statutory guidance, safeguarding adults with care and support needs is everyone's business and multi-agency working is vital. Local authorities must co-operate with such other agencies or bodies as it considers appropriate in the exercise of its adult safeguarding functions, including primary and secondary healthcare services. This is described in section 6(7) of the Care Act 2014[1], and those partners must also co-operate with the local authority in the exercise of their functions relevant to care and support including those to protect adults. This means that, if a local authority conducts a safeguarding enquiry and finds that action must be taken to protect the adult in question, local partners must cooperate and lead on that action when required.

In addition, the Care Act 2014 requires each local authority to set up a Safeguarding Adults Board (SAB). SABs are required to carry out a Safeguarding Adult Review (SAR) of a case involving an adult in its area with needs for care and support in circumstances where an adult has died, and the SAB knows or suspects the death resulted from abuse or neglect (whether or not they knew this at the time of death).

Your fourth and final concern noted that Ms Austin Martin dropped out of sight of agencies. NHS England has noted that there are robust processes in place across the Stockport GP population around the management of newly registered patients. The expectation is that following registration, an initial appointment will be offered to the patient which would include an assessment of medical needs, the prescribing of medications, and a plan agreed for how care will be managed moving forward and when any regular medications will be reviewed. The GP Practice where this patient was registered, have confirmed that Ms Austin-Martin was seen at a face-to-face consultation on 6th November 2019 shortly after registering on 30th October. She was identified to have Multiple Sclerosis (MS) and asthma requiring ongoing management with medications, that were duly prescribed and a follow up with local MS service (a referral was created to this effect) had been arranged. She was advised to book in for an asthma review with the practice nurse alongside being offered (but declined) a seasonal influenza vaccination. As far as the practice were aware, appropriate follow up and referral had been initiated following her initial consultation to address her long-term conditions and medication requirements.

NHS England has confirmed that this is within the level of expectation of when a new patient registers with a GP in Stockport and on this occasion all appropriate steps appear to have been taken to complete her initial registration assessment and to

[1] https://www.legislation.gov.uk/ukpga/2014/23/section/6/enacted

address her long-term conditions and medication requirements with appropriate follow up planned.

NHS England have advised they are seeking further clarity on why the annual reviews for Multiple Sclerosis did not take place.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

HELEN WHATELY