REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of State for Health and Social Care
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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
3	INVESTIGATION and INQUEST On 23rd March 2021 I commenced an investigation into the death of Diane Austin-Martin. The investigation concluded on the 29th July 2022 and the conclusion was one of **Narrative: Died from natural causes contributed to by neglect.** The medical cause of death was **1a) General debility from multiple sclerosis exacerbated by urinary tract infection, pressure ulcerations and low body mass index**
4	CIRCUMSTANCES OF THE DEATH Diane Margaret Austin-Martin was a vulnerable adult with significant health issues including multiple sclerosis. She had significant care needs. She moved to Stockport. The Social Services team in Northern Ireland who had been working with her did not notify Stockport Metropolitan Borough Council of the move or seek to make robust enquiries to ensure the private care in Stockport would be appropriate. She was therefore not visible to Stockport Social Services. A claim was made and accepted by the Department for Work and Pensions for care support for her. Regular payments commenced. There was no evidence of any quality assurance in relation to the care provided. She was seen once by the GP. An attempt to refer to secondary care was unsuccessful and she was never seen or assessed by Multiple Sclerosis Services. Her carers were the people she lived with. The level of care was wholly inadequate to meet her needs. On 22nd March 2021 when police attended the address she was found to have multiple pressure ulcers and be severely underweight. She was found in filthy, squalid living conditions.

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are as follows. – 1. The inquest heard evidence that there was no clear mechanism to ensure that Social Services were aware of her move despite her vulnerability having being identified whilst she resided in Northern Ireland. As a consequence Social Services were unsighted as to her being resident in Stockport; 2. DWP were aware of her presence and payments were made recognising her needs but there was no mechanism to ensure that the care provided was of an appropriate quality; 3. The inquest heard that where a private care arrangement exists as in this case there is no mechanism to ensure that the care is of a sufficient and appropriate quality in contrast to a resident of a care home; 4. After her initial claim for payment and her initial GP visit she dropped out of sight of agencies until she was found.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 9th November 2022. 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 namely [redacted] on behalf of the Family, who may find it useful or of interest. 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	**Alison Mutch** **HM Senior Coroner**  **14.09.22**