From Helen Whately MP
Minister of State for Social Care

39 Victoria Street
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[redacted]

Department of Health & Social Care

[redacted]

Mr. Graeme Irvine
East London Coroner's Court
Queens Road
Walthamstow
London
E17 8QP

[redacted]

16 May 2024

Dear Mr Irvine,

Thank you for your Regulation 28 report to prevent future deaths dated 31/08/23 about the death of Donna Rose Lydia Levy. I am replying as Minister with responsibility for adult social care and safeguarding.

Firstly, I would like to say how saddened I was to read of the circumstances of Ms. Levy's death and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the significant delay in responding.

The report raises concerns about the level of care provided by community services, including no formal referral being made to mental health services. You also raise concerns that the North East London Foundation Trust responsible for community care did not undertake a Serious Investigation Review.

The Department wants to see a focused and effective safeguarding system, where harm or risk of harm is identified, acted upon effectively and ultimately prevented.

In preparing this response, Departmental officials have made enquiries with NHS England and the Care Quality Commission.

I understand the Trust responded to your report on 09/11/23 with actions it will take to improve patient safety and quality of care. These include: increasing nursing capacity; holding weekly multidisciplinary Complex Case discussion meetings; updating the risk escalation process; devising standardised operating procedure relating to how district nurses conduct their daily handovers; providing relevant training for health and social care staff; making the completion of mental capacity assessments in complex cases mandatory; undertaking risk assessments to identify anxiety and depression scores; increasing frequency of high risk cases reviews; ensuring incident reports incorporate concerns across integrated services; and introducing a new Patient Safety Incident Response Framework.

In addition, CQC reviewed the incident in line with their specific incident guidance and assessed that it does not meet the threshold for CQC to consider using its criminal

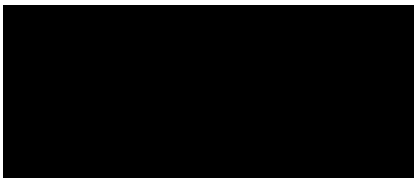
enforcement powers. However, they are keeping the incident under review with the Trust and will be asking for an update on their action plan in relation to this incident at their next engagement meeting.

Local authorities have a statutory duty to investigate safeguarding concerns under the Care Act 2014. A new duty on the CQC to assess local authorities' delivery of their adult social care duties under Part 1 of the Care Act 2014 came into effect on 1 April 2023. Linked to this new duty is a power for the Secretary of State to intervene where, following assessment under the new duty, it is considered that a local authority is failing to meet their duties. The Department are awaiting CQC's findings from five pilot assessments that took place between July and early September 2023 and their proposed assessment framework.

Furthermore, on 12 June 2023 the Safe Care at Home Review was published. This is a joint review led by the Home Office and DHSC into the protections and support for adults abused, or at risk of abuse, in their own home by people providing their care. This includes those who are unable to make safe decisions in their own best interests and the review considers the balance between choice and safety when dealing with someone who self-neglects. The Home Office and DHSC are making progress on implementing recommendations made by the review.

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

Yours,



HELEN WHATELY