



Department
of Health &
Social Care

[REDACTED]
Minister of State for Social Care

39 Victoria Street
London
SW1H 0EU

[REDACTED]

Mrs Charlotte Keighley
HM Assistant Coroner for West Yorkshire Western Coroner Area
Cheshire Coroner's Court,
Museum Street,
Cheshire,
WA1 1JX

[REDACTED]

15 September 2026

Dear Charlotte,

Thank you for the Regulation 28 report of 11th July 2026, sent to the Department of Health and Social Care (DHSC), about the death of Mr John Bryan Wetton. I am replying as the Minister with responsibility for adult social care.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Wetton's death; I offer my sincere condolences to his family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

The Prevention of Future Deaths (PFD) report raises concerns over:

1. The accuracy and reliability of incident recording at Alexander House;
2. Incomplete documentation in respect of the care provided to residents at Alexander House.
3. Honesty and integrity of staff working at Alexander House.
4. The absence of appropriate and robust training for the Registered Manager at Alexander House in respect of safeguarding investigations to ensure thorough and complete investigation and transparency of investigation.
5. The absence of any form of independent monitoring within the home to provide independent oversight of any events occurring within communal areas.
6. The absence of any form of professional regulatory body (over and above the CQC) to ensure that staff tasked with caring for vulnerable elderly individuals are suitably qualified and consistently deliver safe, high-quality and effective care to provide oversight and accountability of those individuals.

I note your overriding concern about the lack of clarity around the events leading to Mr Wetton's injuries, and the extent to which there may have been some degree of neglect in the actions of those providing him with care and support. My department recognises the importance of safe, person-centred care and the important role of local authorities in ensuring that individuals are supported to live safely. Providers of regulated adult social care services are responsible for ensuring that people receive safe care and treatment. This requires them to prepare care plans which identify relevant lifestyle risks and set out how these will be managed.

My departmental officials have been in contact with the Calderdale Safeguarding Adults Board (SAB) chair, who advised that a safeguarding referral had originally been made upon Mr Wetton's admission to hospital and a s.42 Enquiry was undertaken. At that time, it was not believed that Mr Wetton had been subject to neglect or abuse and consequently the case was not referred to the SAB for consideration of a Safeguarding Adult Review (SAR).

However, in light of the coroner's concerns, the SAB chair has asked that the case be referred so they can determine whether it meets the criteria for a SAR. This process could take up to 6 months, and my officials have asked the SAB Chair to share any updates on this with both my department and you.

You may also wish to note that in response to Baroness Casey's recommendation to improve national oversight of safeguarding, my department is strengthening national leadership, accountability and coordination across the adult safeguarding system. Through the new National Adult Safeguarding Board and the urgent review of statutory duties and powers, the Government is taking practical steps to ensure risks are identified earlier, oversight is more consistent, and adults at risk of abuse or neglect are better protected.

I will now respond to each of your specific concerns.

1. The Department recognises the importance of accurate incident recording in care settings. In this case, the safeguarding enquiry considered the incident form, staff statements, care plans and a root cause analysis reviewed by senior staff.
2. I agree that clear and complete documentation is essential for safe care and effective oversight of that care. The registered manager confirmed that relevant records were reviewed, including the falls care plan, risk assessment, incident form and family correspondence. Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires providers to have effective governance, including assurance and auditing systems or processes.
3. The Department agrees that openness and honesty are fundamental to safe and effective care. Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires registered providers to act in an open and transparent way with people receiving care and treatment.

Honesty and integrity are embedded across Learning and Development Support Scheme (LDSS) funded learning, including the Adult Social Care Certificate, safeguarding and mental capacity training, governance and regulation modules, and leadership and management programmes. These courses promote professional standards, accountability, person-centred care and effective decision-making across adult social care.

The Care Certificate sets out expected knowledge, skills and behaviours for health and social care roles. While not mandatory, the Care Quality Commission (CQC) expects care workers to receive a robust induction, for which the Care Certificate provides a recognised guide. The standards were refreshed in March 2025 to reflect sector developments and align with the Level 2 Adult Social Care Certificate, launched in June 2024 and eligible for LDSS funding.

4. DHSC recognises the importance of equipping adult social care staff, particularly Registered Managers, with the skills needed to deliver safe, high-quality, personalised care. The Adult Social Care Learning and Development Support Scheme, established in 2024, enables employers to claim funding for eligible staff to complete relevant training and qualifications. Continued funding of up to £10m has been confirmed for 2026/27.

The scheme supports courses in governance, safeguarding, business skills, CQC assessment preparation, and Level 5 diplomas in leading and managing adult social care. We strongly encourage employers to ensure staff make full use of this offer, including Skills for Care training on preparing for CQC inspection where appropriate. In addition, Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires providers to ensure they deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to meet the regulatory requirements placed upon them.

5. My department notes the concern about independent oversight of events in communal areas. While regulations do not prescribe a specific monitoring model, providers must have effective governance, assurance and auditing systems to assess and improve the safety and quality of care, as described in Regulation 17 above.
6. The Government recognises the importance of ensuring that people who draw on care and support receive safe services. Although social care does not have a professional regulatory body, local authorities have a statutory duty under the Care Act 2014 to ensure commissioned services are safe, effective and of high quality. Regulated providers also play a key role in safeguarding adults, and health and care employers must assure themselves that their staff have the necessary skills, competence and suitability. Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires providers to ensure that care and treatment is provided in a safe way for service users.

The Care Quality Commission (CQC) monitor, inspect and regulate adult social care services to make sure they meet fundamental standards of quality and safety. Where concerns on quality or safety are identified, CQC uses its regulatory and enforcement powers available and will take action to ensure the safety of people drawing on care and support.

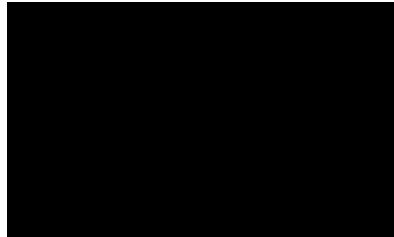
This includes using requirement notices to highlight areas of poor care that need improvement, placing adult social care providers into special measures to closely supervise the quality of care or, in cases of significant concern, taking actions which could lead to removing a provider's registration, issuing fines or taking criminal action. All of these are designed to ensure providers act quickly to improve the quality of care they are delivering.

As part of the Prime Ministers renewed focus on adult social care, he has agreed to expedite the timelines for the Independent Commission into adult social care, chaired by

Baroness [REDACTED] The Commission will now produce its final report by summer 2027 and, supplemented by the Prime Minister's own cross-party talks, has been tasked with building public and political consensus that is so essential in ensuring that reforms stand the test of time.

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

Yours sincerely,



MINISTER OF STATE FOR SOCIAL CARE AND MENTAL HEALTH