LOCAL NEWS PARTNERSHIPS

Benefit deaths

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What's the story?

Government officials have carried out over 150 reviews after people claiming benefits died or came to serious harm since 2012, the BBC can reveal.

The Department for Work & Pensions(DWP) carries out these internal reviews when:

- There is a "suggestion or allegation" its actions had a negative impact
- Cases where the DWP thinks it can learn about its process and a claimant has suffered serious harm or died, (including by suicide or where it believes there has been an attempted suicide)
- or when it is named as an interested party at an inquest or the DWP is asked to participate in a Safeguarding Adults Board

That information comes from two sources.

The DWP carried out "60 peer reviews" between February 2012 and November 2014, according to FOI responses to the Disability News Service. The DWP later corrected its figures saying these were into 49 deaths and 11 other serious incidents.

And in July 2019, Justin Tomlinson MP, then Minister for Disabled People, Health and Work said there have been 84 deaths which were subject to Internal Process Reviews (which replaced peer reviews) by the DWP since 2015. He said at the time "an additional six had been received and would have an IPR conducted shortly".

The BBC has also seen copies of IPRs which began after July 2019, which suggests fatal mistakes continued to be made.

Separately, the BBC Shared Data Unit has created a dataset of Press reports naming 82 individuals to have died after some alleged DWP activity such as termination of benefits over the same time period (out of 106 the SDU found overall since 2008). Mental health vulnerabilities were a contributing factor in 35 of those people's deaths.

Many of these individuals took their own lives, or were discovered after having starved to death. Others died within days of being found fit to work, according to the government's Work Capability Assessment (WCA) process to see if they were entitled to sickness or out-of-work benefits.

Since 2013, the deaths of four individuals have prompted Coroners to issue Prevention of Future Death reports to the DWP:

Michael O'Sullivan: https://www.judiciary.uk/publications/michael-osullivan/

Faiza Ahmed: https://www.judiciary.uk/publications/faiza-ahmed/

Alexander Boamah: https://www.judiciary.uk/publications/alexander-boamah/

Philippa Day: https://www.judiciary.uk/wp-content/uploads/2021/02/Phillipa-Day-2021-0043.pdf

The death of Stephen Carré in 2010 had also prompted Bedfordshire Coroner Tom Osborne to send a Rule 43 letter - the earlier incarnation of what is now a PFD report - to the DWP: https://www.disabilitynewsservice.com/dwp-the-case-for-the-prosecution/

The death of Roy Curtis was similar to many of the deaths we've identified in other Press reports but the Coroner issued a PFD to Milton Keynes council: https://www.judiciary.uk/wp-content/uploads/2021/01/Roy-Curtis-2020-0272_Redacted.pdf

We also know from the draft interim IPRG report for Philippa Day which the Coroner allowed into the public domain during her inquest that her death was not referred for IPR until 21 July 2020 - after the time period for the aforementioned 150 internally-reviewed deaths - so her death evidenced that significant fatal errors continued to be made by the DWP after these 150 internal reviews.

Secretary of State for Work and Pensions Thérèse Coffey maintains the DWP "does not have a duty of care or statutory safeguarding duty."

But human rights specialist Tessa Gregory, partner at Leigh Day solicitors who brought the judicial review against the DWP's safeguarding policy applying to the case of Errol Graham, said there was a "dissonance" between the DWP's legal stance and its role in some instances providing the sole income for vulnerable people.

Ken Butler, welfare rights adviser at the charity Disability Rights UK, said people had their benefits cut and suffered "fear and anxiety" due to "poor and inaccurate medical assessments" carried out on behalf of the DWP by the private contractors Capita, the Independent Assessment Services (formerly called Atos) and Maximus.

Labour's Debbie Abrahams MP, who previously read out the names of 29 individuals to have died during a Commons debate, told the BBC there should be an independent inquiry into the scale and number of deaths allegedly linked to DWP activity.

She said: "These deaths have definitely not received the attention they should have. I believe that the ones that you have collated are just the tip of the iceberg. There's too often an assumption that these deaths are from natural causes. That there has been such a lack of openness and transparency to enable us to properly examine reports on all deaths is a disgrace. Unfortunately I don't have any confidence in the Internal Review Process.

"There needs to be an independent inquiry investigating why these deaths are happening and the scale of the deaths needs to be properly understood.

"Then there needs to be an independent body set up to investigate any future deaths. It needs to be taken out of the hands of the DWP."

The Equality and Human Rights Commission has meanwhile backtracked on assurances it previously gave to Ms Abrahams it would conduct an inquiry into the WCA process and Personal Independence Payment (PIP) for disabled claimants. As yet it has also ruled out reviewing deaths allegedly linked to some DWP activity such as termination of benefits or following DWP sanctions, which Ms Abrahams said was "very disappointing".

It comes after a inquest concluded in January that authorities who dealt with a benefits claim from single mother **Philippa Day**, who took a fatal overdose after her payments were cut, made 28 errors in managing her case.

The family of mentally-ill **Errol Graham** submitted an application for permission to appeal to the Court of Appeal in April after losing a judicial review against the DWP's safeguarding policy. Mr Graham was found starved to death when bailiffs broke into his Nottingham flat to evict him. His benefits had been terminated when he missed WCA appointments.

Solicitors acting for the family had argued at a High Court hearing in January the DWP's guidance was unlawful and breached his human rights. Leigh Day solicitors said that guidance failed to impose a duty of care on decision-makers to investigate when mentally-ill claimants did not engage with the benefits system, and instead placed an unfair burden on vulnerable claimants to prove that they had good cause when they did not attend meetings with DWP officials.

Ruling the DWP guidance was lawful and that officials had acted reasonably in Mr Graham's case, Mr Justice Bourne said neither the law nor DWP policy at the time "mandated any further

specific steps to be taken in that situation”.

When his body was found, Mr Graham weighed four-and-a-half stone (30kg) and his family said he had used pliers to pull out his teeth.

The family of **Jodey Whiting**, who took her own life after her benefits were stopped, are due to attend the High Court on 22 June to argue she should have a second inquest to consider the DWP's role in her 2017 death.

Ms Whiting's mother, Joy Dove, of Norton, Stockton-on-Tees, was granted permission to request a new inquest by the office of the Attorney General following her submission that the original hearing into her daughter's death was insufficient.

New evidence she submitted included the results of an independent inquiry, which concluded mistakes were made by the DWP.

Methodology

We made email requests to every Coroner's office in England and Wales asking for copies of all of the Prevention of Future Death (PFD) reports or Rule 43 letters their Coroner or office had sent to the Department for Work & Pensions(DWP) over the past decade and scoured the Chief Coroner's website for all PFDs where the DWP was a recipient.

Separately, we made four requests under the Freedom of Information Act(FOI) to the DWP itself: one successful for copies of minutes from the DWP's Serious Case Panel and three requests for data on the numbers of benefits claimants' deaths recorded by the DWP, which were all refused on the grounds of cost.

A further separate FOI response from Northern Ireland's Department for Communities received the response: "The Department is not aware of any benefit-related deaths in Northern Ireland nor is it aware of any coroner's reports that have explicitly stated a benefit decision that has had a causal impact on the death of a claimant." In Scotland, we also analysed the most recent 100 Sheriffs' determinations in Fatal Accident Inquiries but none mentioned the DWP.

We meanwhile created our own dataset of Press reports naming individuals to have died after some alleged DWP activity such as termination of benefits - we found 104 examples of individuals since 2008 (as well as Press reports of the death of Cecilia Burns from Strabane, County Tyrone, Northern Ireland) - 82 of those individuals died in Great Britain over the same time period as we were able to establish the DWP carried out 150 internal reviews.

Interview quotes:

Debbie Abrahams, Labour MP for Oldham East and Saddleworth, who previously read out the names of 29 individuals to have died during a Commons debate (https://www.theyworkforyou.com/whall/?id=2019-04-24c.325.1) said:

“These deaths have definitely not received the attention they should have – as I said I believe that the ones that you have collated are just the tip of the iceberg. There’s too often an assumption that these deaths are from natural causes. That there has been such a lack of openness and transparency to enable us to properly examine reports on all deaths is a disgrace. Unfortunately I don’t have any confidence in the Internal Review Process.

“There needs to be an independent inquiry investigating why these deaths are happening – I’ve given you my views – and the scale of the deaths needs to be properly understood.

“Then there needs to be an independent body set up to investigate any future deaths (we’re not going to stop all of them).

“It needs to be taken out of the hands of the DWP.

“I think there are 4 key issues with the social security system that have developed over the last 10 years or so:

1. The value of in and out of work cash transfers for working age people has been significantly eroded, particularly affecting children and disabled people. Since 2010, some £34bn per annum has been taken out, making out of work support the lowest in the OECD. This has driven poverty increases, and associated with this poverty - debt and immediate adverse impacts on mental health. This includes people with no previous mental health diagnosis. The cuts have therefore exacerbated mental health risk.

2. Specific social security policies, e.g. WCA, sanctions, Universal Credit, have added to mental health vulnerability, existing and acquired, as evidenced in https://jech.bmj.com/content/70/4/339 Key policies have therefore exacerbated mental health risk/vulnerability.

3. On top of this, there is the added effect of the culture of the system and how this is perceived. I mentioned the qualitative studies which described how claimants felt dehumanised and saw their sense of self-worth eroded. The culture with the DWP and its service delivery model has exacerbated MH risk/vulnerability.

4. One of the Government's key objectives has been to cut welfare spending and their target has been working age people.

On The Work Capability Assessment (WCA) reviews by Harrington and Litchfield, both said they weren't given the Internal Review reports that the DWP does after a death. So no, I don't think they [the reviews] were effective. Tomlinson's letter in response to my enquiry was that they hadn't requested them and although they looked for them they think they'd been destroyed as a part of a new document storage policy. I kid you not. I still have the letter. Given that 70% are overturned on appeal and the cases I've had locally and heard about, this is a key policy to change.

"On Covid, I know that nearly all DWP staff including those who don't normally deal with claimants were transferred to deal with processing new UC claimants.

"No, I don't think they [the DWP] are set up to identify and provide appropriate support for vulnerable claimants. We discussed their response to the WPSC report on UC and our concerns that there are no consistent approaches for identifying vulnerable claimants or co-ordinating with other local agencies. The Government rejected our recommendations on this.

A spokesperson for the Equality and Human Rights Commission said:

SDU question: Debbie Abrahams MP said she had been given an assurance the EHRC would begin an inquiry into The Work Capability Assessment (WCA) and Personal Independence Payment (PIP) in 2020 but it had been delayed by the Covid-19 pandemic. Does the EHRC still plan to take on that inquiry?

Like other organisations, our work plans have had to change significantly to respond to the context and challenges of the coronavirus pandemic. We are currently finalising our plans for the year ahead and considering how best to use all of our powers as a strategic regulator to address the barriers facing disabled claimants in the benefits system.

We are currently reassessing what the most pressing issues that impact on equality and human rights are for disabled people, and considering how best to use our powers to address them. It is therefore too early to say whether an inquiry is the best route for us to take and, if so, what its focus should be.

We have already undertaken several pieces of work related to social security decision-making, including our recent intervention in the High Court case regarding Errol Graham. This case raised important questions about the lawfulness and potential impact of the DWP's policy for withdrawing an individual's Employment Support Allowance. We provided submissions in relation to the DWP's duties when withdrawing benefits, as well as the applicable regulations and human rights law. Separately, we are actively monitoring a legally binding agreement we reached with the DWP to improve the accessibility of DWP communications, and have provided advice to the joint JUSTICE and Administrative Council Working Party, which is expected to publish recommendations to improve the benefits decision-making system for claimants later this year.

Our immediate response to the pandemic included using our compliance and legal powers to address the barriers disabled people face accessing food and essentials, as well as access to justice in criminal matters and the use of remote hearings. We are also looking at a significant new strand of work focused on the rights of older and disabled people in relation to social care, which will consider the impact the pandemic has had.

SDU question: If the EHRC did still plan to take on that inquiry, what potential sanctions or recommendations can result from an EHRC inquiry please and when might that work begin?

In all of our inquiries we seek to make recommendations that lead to change and improvement in policy, practice, legislation and/or regulation, and organisations are required to take account of such recommendations. However it is too early to say whether an inquiry on this issue will be the best route, and it would not be appropriate to speculate on any potential recommendations we would make.

SDU question: Why did the EHRC limit its terms of reference for its planned inquiry to The Work Capability Assessment (WCA) and Personal Independence Payment (PIP) please?

We are a strategic regulator and when considering this area we concluded that focusing on the wider issue of decision-making processes regarding WCA and PIP would allow us to address the systemic barriers disabled claimants in the benefits system face when accessing this support. However, the landscape has changed considerably in the past year, we and others have undertaken relevant work in this area and it is too early to say whether an inquiry would be the best approach on this issue.

The JUSTICE and Administrative Justice Council Working Party is expected to publish recommendations to improve the benefits decision-making system for claimants later this year. We have contributed to this work and will consider its recommendations.

SDU question: Why would the EHRC not also consider investigating benefits-related deaths of claimants and conditionality and sanctions?

We are a strategic regulator and when considering this area we concluded that focusing on the wider issue of decision-making processes would allow us to address the systemic barriers disabled claimants in the benefits system face when accessing this support. . However, the landscape has changed considerably in the past year, we and others have undertaken relevant work in this area and it is too early to say whether an inquiry would be the best approach on this issue.

SDU question: Has the EHRC ruled out carrying out an inquiry into benefits-related deaths of claimants and conditionality and sanctions? Or does it plan to look into those issues separately? If so, how and when?

Like other organisations, our work plans have had to change significantly to respond to the context and challenges of the coronavirus pandemic. We are currently finalising our plans for the year ahead and considering how best to use all of our powers as a strategic regulator to address the barriers facing disabled claimants in the benefits system.

We will continue to scrutinise the issue, engaging with stakeholders and seeking out relevant legal cases regarding decision making that we can intervene in.

Daphne Hall, the vice chair of the National Association of Welfare Rights Advisers and rightsnet Editor, said:

SDU question: Do you have a view on whether there might be something to look into further for the DWP here based on my research, or whether or not some of these deaths illustrate anything wider you personally have seen, or which other welfare rights advisors have told you, with regards the accuracy of work capability assessments (WCA) or of the sensitivity of call handling? Do either of those DWP processes need review or do any others? Do you believe previous reviews of work capability assessments have been robust and thorough in their remit, the evidence on which they were based and in their findings?

“I think the general feeling among advisers is that the DWP need to do a lot more to look into where they are going wrong and to take positive action to sort things - this has been an issue for such a long time now - can't remember if I've previously directed you to this discussion thread https://www.rightsnet.org.uk/forums/viewthread/8346 - currently had more than 115,000 views which gives you an idea of much of an issue it is. It's a long time since we've had any reviews of the WCA - the last one was in November 2014 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/380027/wca-fifth-independent-review.pdf. I think it's pretty well accepted among advisers that the current WCA is not fit for purpose - it's something that the government is supposed to be looking at as part of its Health Transformation Programme but this has been very delayed - https://questions-statements.parliament.uk/written-statements/detail/2020-07-09/HCWS353.

“I think the whole WCA process is extremely daunting for claimants particularly if they don't have any support. For those that are vulnerable, it can easily push them over the edge as your research shows. There seems to be a real reluctance to use evidence from people that know the claimant. It will be interesting to see statistics that come out from the period of the pandemic. Obviously there haven't been face to face assessments and I know that some claimants have preferred this.”

SDU question: Does the number of these deaths over this period of time surprise you?

“It horrifies me but sadly it doesn't surprise me - I've worked in welfare rights for a long time and the treatment and disrespect shown to claimants can be shocking to say the least (not to say that this is always so, and I think work coaches in jobcentres in particular have got loads better in recent years)”

SDU question: Does the DWP’s safeguarding policy/approach need any kind of review? Do the circumstances leading up to some of these individuals’ deaths illustrate just that the department has no legal statutory duty of care to people? Is that the right interpretation of its legal position RE a duty of care? Is it ethical for that to continue or should that change, in your view?

“Thérèse Coffey is adamant that the Department has no statutory responsibility for safeguarding - https://committees.parliament.uk/publications/2910/documents/28102/default/ - if the Secretary of State won't accept that it's not a good starting point! I'm not a lawyer but if that is the case then I think it should be changed.

SDU question: Do you believe the DWP is able to cater for the potential different needs of vulnerable “customers” in its words or people who are suffering with their mental health? Do you believe the DWP’s proposed additional support marker for vulnerable claimants and its proposed vulnerable customer champion for every disability benefits centre is sufficient in response to the inquest conclusions and Prevention of Future Death report issued by the Coroner investigating the circumstances of the death of Philippa Day? https://committees.parliament.uk/oralevidence/1630/pdf/

“I think the safeguarding 'watermark' is a good idea. However, I'm currently in conversation with the DWP trying to establish how a claimant ensures that all the relevant information goes on that 'watermark'. I haven't been able to get clarification other than general comments like 'tell them in a phone call' or 'put it in the journal'. It is all too clear that that method has not been working! It's all very well having a marker but not much good if the information on it isn't kept up-to-date or put on in the first place. I've yet to be given an explanation of how that will happen.”

SDU question: Do you believe the number of deaths of this nature and the circumstances of these individuals' deaths over the period of time covered by this research so far, has received the scrutiny it merited or that the DWP should be questioned further?

"No - as I said previously DWP have been very slow to move on this and very secretive. It will be interesting to see how the court action that is planned on behalf of Errol Graham and Philippa Day progresses."

SDU question: The DWP has had an internal review process throughout the period I initially highlighted. Does 150 internal reviews over that period surprise you? Do you have confidence in the review process and that DWP is learning lessons from those internal reviews, bearing in mind the number of them?

"No - there doesn't seem to have been progress - while I appreciate that not all the information relating to the internal reviews can be put in the public domain, it would be helpful if the DWP was transparent about what is going wrong and what it plans to do about it.

"It's difficult to form a view of the internal review process because we know so little about it. The fact that things haven't changed leads me to think it's not working."

Ken Butler, welfare rights adviser at the pan-disability charity Disability Rights UK, said:

"I am surprised at the number of tragic deaths your research has uncovered.

"I do think a major cause is the fear and anxiety caused by requests to attend PIP and ESA medical assessments. And the impact of being subject to inaccurate fit for work decisions leading to a loss of benefit/work conditionality. Similarly the financial impact of losing PIP.

"At the heart of both are the poor and inaccurate medical assessments carried out by Atos, Capita and Maximus.

"We did write to the Secretary of State for Work and Pensions but have received no reply – https://www.disabilityrightsuk.org/news/2020/october/dr-uk-letter-th%C3%A9r%C3%A8se-coffey

"Even if it is legally correct that the DWP does not have a statutory duty of care, surely it would be better for it to operate on the basis that it does?

“Are the circumstances leading up to Philippa Day’s death an example of an organisation operating on the basis that it does not have a statutory duty of care?”

Tessa Gregory, partner at Leigh Day solicitors, and human rights specialist who brought the judicial review against the Department for Work and Pensions’s safeguarding policy applying to the case of Errol Graham, said:

“The DWP’s safeguarding systems need overhauling. The DWP needs to better consider how it can use the information it has available to it to properly evaluate the vulnerability of some claimants and assess how such claimants’ mental health difficulties can impact on their ability to navigate and engage with DWP processes. There seems to be a real issue with the DWP failing to make reasonable adjustments for claimants who due to their mental health issues struggle with responding to official letters or participating in assessments.

“The Secretary of State for Work and Pensions has recently made plain that she does not consider she owes a duty of care to benefit claimants yet it is her department that is responsible for providing the sole source of income to some of the most vulnerable people in society. When DWP decision making goes wrong it can, as we have seen in far too many cases have devastating and sometimes fatal consequences, so it is vital that decisions are taken with full regard to a person’s disability. The case for reform is clear as we desperately need a benefits system which serves to support, rather than endanger, the lives of vulnerable individuals.”

Imogen Day, whose sister Philippa took a fatal overdose after authorities who dealt with her benefits claim made 28 errors in managing her case, said:

“We were incredibly close. In her eulogy at her funeral I described her as my soulmate.

“I spoke to her [Philippa] almost daily about it [her benefit claim].

“She talked about how it disempowered her and made her feel inhuman.

“She told her Community Psychiatric Nurse(CPN) she felt like a National Insurance Number. She used that word - that she felt ‘dehumanised’.

“An organisation called Framework in Nottingham helped her with her forms and I attended that appointment with her.

“She felt that the process was discriminatory against disabled people with forms that are so hard to fill in and which require so much evidence.

“Her CPN called [the DWP] several times saying how much distress she was in.

“It [Philippa’s death] was like watching a car crash in slow motion...we helped her emotionally, financially and practically and we could see the tragedy in front of us but couldn't do anything more to stop it."

On being told that between February 2012 and July 2019 the DWP had carried out at least 150 internally reviews, she said:

“I think there will be many more that will be unrecorded.

“I am not surprised. I wouldn’t have confidence in the internal review process.

“The DWP tried to release as little information to the Coroner [before Philippa’s inquest]as possible – initially their bundle was 100 pages and by the inquest it was more than 4,000.

“They were very hesitant to share information because they did not want the severity of the case to be known; they wanted to hide it.

“The DWP heavily implied I forged the suicide note.

“Initially, it was only supposed to be me and my dad who were due to give evidence at the inquest but my mum felt she needed to speak about her love for her daughter after what the DWP suggested.

“It was clear from Philippa’s CPN the DWP seemed dismissive of her experience and vast knowledge and that it was very difficult to pass information from the DWP to Capita.

“I don’t think the DWP understands disability, vulnerabilities or chronic illnesses.

“It’s not a person-centred or a person-led approach, it’s very administrative and it’s clear they haven’t consulted disabled people or disabled activists and it’s clear the DWP is getting worse.”

Asked what - if anything - should happen next, Miss Day said: “There needs to be a complete overhaul of the DWP. The process [for benefit claims] needs to change and so do the people involved.

“There’s a culture of a lack of empathy from the call handlers to the civil servants and everything needs to change; you can’t teach people how to feel.”

The family of Errol Graham, who starved to death while seriously mentally ill after his benefits were stopped, have submitted an application for permission to appeal to the Court of Appeal in April, after losing a high court case against the Department for Work and Pensions (DWP). Alison Turner, fiancée of Mr Graham’s son, said:

“With a lot of it, claimants have some form of mental disablement. It seems to be a big problem the DWP can’t handle. There’s a lot of ignorance around mental health.

“The DWP won’t accept that some people are born this way. I dread the system as it stands..

“The DWP doesn’t know the first thing about how to talk to them; all they require is the simplest adjustment, to go one step further and when people are not engaging with them, there will be somebody who can speak for them: a relative or their GP who could speak for them.

“It wouldn’t cost the DWP anything to pick up the phone. That’s all it would take to help them speak when they can’t speak for themselves. It’s like we’re asking too much but it’s disgusting. The DWP says there’s data protection issues but claimants have given their consent for the DWP to access their medical records so there’s absolutely no excuse for it. They can’t be bothered to go the next step.”

“I set out with the mission to make sure the DWP recognises it cannot come out with some of the things it comes out with. With Covid-19, more people are going to experience mental health issues. More and more people are going to rely on the DWP for help and it’s a death trap for people with mental health.

“I wouldn’t trust them with my cat. It’s not a lack of education, it’s ignorance.

On why her family is seeking to appeal the judicial review hearing which found the DWP acted lawfully in its safeguarding of Errol, Ms Turner said: “We are trying to make sure the DWP has a duty to make reasonable adjustments, further enquiries for people who can’t engage with the process due to mental disablement. We’re not asking the DWP to change the system for nine million people, we’re asking them to change it for the number of people who would be disadvantaged because of mental disablement. We’re trying to make sure they recognise that duty is theirs and everyone should be able to have equal treatment.”

“At the moment they put the responsibility on the DWP decision maker but as a department they should form a policy that gives equal treatment to everyone that should be enforceable. They should make sure they comply with their own policy. It’s life and death as far as I’m concerned.

“I want to make sure this doesn’t happen to anyone else. It’s got to stop. They are not just damaging one person, there’s a ripple effect on families.”

On being told that between February 2012 and July 2019 the DWP had carried out 150 internal reviews, Ms Turner said: “I would think there’s way more than 150 - the DWP get away with it. The Internal Process Reviews (IPRs - one form of internal review) are not made available to family members automatically; I think that should be an automatic entitlement to all family members. I think it’s important that families can see lessons are being learned. The DWP leave too many gaps in policy and people like Errol fall through them. They see people like Errol as too much hard work but they are still people. It was almost a year after Errol died before his IPR, it wasn’t done immediately. It’s disgusting to think how long it took and how many people were at risk in that time [before it concluded].”

Asked whether extra mental health training for all DWP call handlers would help, Ms Turner said: “It would go a long way if the DWP gave everyone mental health training. The amount of times the DWP has backtracked you cannot count though. The recommendation for mental health training was in the IPR for Errol and he died in 2018. I will believe it when I see it from the DWP.

“It’s one thing training people though but they have to audit staff are using that training too. My understanding is the DWP told the inquest into Philippa Day’s death they have already started rolling out mental health training. But if assessors have not had mental health training, they are not equipped to assess people and check what benefits they are claiming are in line with their conditions. Who are they to question that?”

The family of Jodey Whiting, who took her own life after her benefits were stopped, are due to attend the High Court on 22 June to argue she should have a second inquest to consider the DWP's role in her February 2017 death.

Ms Whiting's mother, Joy Dove, of Norton, Stockton-on-Tees, won permission to request this new inquest after lawyers submitted evidence the first was insufficient, including an independent inquiry's conclusions that mistakes were made by the DWP.

“Jodey had been poorly for years; she had back operations, she had bipolar – she had a lot of medical problems: she was on 23 tablets a day including two types of morphine.

“In 2016 she had been in hospital with pneumonia and they found she had a cyst on the brain and while they were deciding what to do next she was told she could go home to convalesce.

“While she was at home, a letter came from a decision maker saying she was fit to work. They hadn’t seen her face and decided that. It was unbelievable.”

Ms Whiting, from Stockton, took her own life on 21 February 2017 after her ESA, housing benefit and council tax benefit payments were stopped.

The payments were halted after the mother of nine failed to attend a work capability assessment (WCA), but Ms Whiting had requested a home visit for the WCA due to her poor health which was refused.

Ms Dove asked at the JobCentre if Ms Whiting could have a hardship loan but was denied.

“When I told her I could see the disappointment in her face. The last thing she said to me was ‘I love you mam, I’m going to have a sleep’

“She left a letter to each and every one of us saying she couldn’t go on with life.”

The family received a letter endorsing the decision Ms Whiting's benefits should be stopped and saying she was fit to work while she was in a mortuary ahead of her burial, her mother said.

“I phoned up the DWP and said my daughter had died, that she had committed suicide and that first person who took my phone call had to tell all the other departments involved in Jodey’s case.

“Two days later, Jodey was laid in the undertakers, she hadn’t even been buried after her post-mortem and a letter was sent out by the second decision maker saying I have looked at your appeal and I stand by the first decision, you are fit to work.

“How fit could she be to work lying dead in the undertakers? It was just ridiculous.”

Ms Dove said after his mother's death, one of her twins Cory Bell was "just a lost soul" and died at the age of 19 from a drug overdose in May last year.

"We've had that second death in the family and I blame the DWP too," Ms Dove said. “He was close to his mam.”

On why the family has sought a second inquest for Ms Whiting, Ms Dove said: “I wrote a letter to the first Coroner how the DWP affected Jodey and how she couldn’t cope.

“The first Coroner said it wasn’t in their remit to bring it [the DWP’s role] all in but to me, they pushed her.

“The people who hurt me most are the decision makers because they never saw my daughter’s face and everything was took off her.

“She loved her kids to bits and they’ve all suffered really bad, losing their mam. It’ll never be the same. It changes your life.

“I hope we can have a proper day in court to get it all out there.”

Following the Coroner’s conclusions in the inquest of Philippa Day, the DWP said it would give all of its call handlers training in mental health, behaviour and relationships and supporting vulnerable people. Ms Dove said she had been told by the DWP representatives in person in 2018 they would be working with the mental health charity MIND to improve their call handling.

“You can’t believe a word they [the DWP] say. They need to get the system properly together instead of different departments not knowing what the other ones are doing,” Ms Dove said.

“There’s lots more people died since Jodey after we’ve been told they’re going to supposedly change the system.”

Asked if the DWP is able to help people with mental health issues, Ms Dove said: “I don’t think so, we need proof of somebody out there who they have helped.”

A Department for Work & Pensions(DWP) spokesperson said:

“We support millions of people a year and our priority is they get the benefits to which they are entitled promptly and receive a supportive and compassionate service.

“In the vast majority of cases this happens but when, sadly, there is a tragic case we take it very seriously.

“In those circumstances it’s absolutely right we carry out an internal review to check if the correct processes were followed and identify any lessons learned to inform future policy and service.”

Additional information for editors:

- Internal Process Reviews are not designed to identify or apportion blame. The Coroner has responsibility for concluding the cause of death. IPRs look at whether processes were followed correctly and what learning we can derive from this. They, alongside the Serious Case Panel, demonstrate the Department’s commitment to learning from serious cases.

- IPRs will be conducted in all cases where:

o there is a suggestion or allegation that the Department’s actions or omissions may have negatively contributed to the customer’s circumstances, or cases in which the department may be able to learn about the operation of its processes, AND a customer has suffered serious harm, has died (including by suicide), or where we have reason to believe there has been an attempted suicide.

o the Department is asked to participate in a Safeguarding Adults Board, or is named as an Interested Party at an Inquest, an IPR will be conducted - regardless of whether there is an allegation against the Department.

ADDITIONAL BRIEFING FOR EDITORS:

Medical assessments/WCAs

RESPONSE:

- Our Disability Assessors are all trained and qualified health professionals (for example nurses, physiotherapists, paramedics or occupational therapists) with significant experience. Healthcare Professionals who conduct PIP and WCA assessments receive comprehensive training from our providers and are required to demonstrate that they can produce high quality reports before DWP approves them to carry out assessments. They are subject to stringent

ongoing quality monitoring, as part of which DWP carries out an audit of a statistically significant proportion of provider reports.

- Assessments help us ensure people get the support to which they are entitled. Decisions are made using all the information that's available to us at the time, including from a person's GP or medical specialist. If someone disagrees with that decision, then they have the right to ask for a review.

Safeguarding processes

RESPONSE:

- While the Department does not have a statutory safeguarding duty, we engage with, and where appropriate can help direct our claimants to agencies - including the police, local authorities and social services - who have a duty of care and can provide appropriate support.

On safeguarding leader roles and network:

- Our Advanced Customer Support Senior Leaders were previously known as Senior Safeguarding Leaders, reflecting their interactions with representatives from other organisations which do have a statutory safeguarding duty. However, we found this title confused rather than clarified our bridging role, and the new title better reflects DWP's statutory position on safeguarding. Advanced Customer Support Senior Leaders allow us to better engage with organisations which have a duty of care and can provide appropriate support.

The number of deaths linked to DWP activity

RESPONSE:

- The Department established the Serious Case Panel in late 2019 to consider thematic issues identified from serious cases, across the spectrum of the Department's work.

- The Panel is chaired by a Non-Executive Director and includes independent membership.

RESPONSE:

- Our condolences are with Ms Whiting's family. It would not be appropriate for us to comment further, as this is now a matter for the High Court.

Vulnerable people

RESPONSE:

- Our sincere condolences remain with Miss Day's family. While we know nothing we say will alter the family's loss, we take the Coroner's concerns seriously and are working hard to address them.

- We have significantly improved the service we provide to people with mental health conditions. This includes mandatory mental health training for all new Personal Independent Payment and Employment Support Allowance telephony staff before they handle calls from claimants on their own.

- We are also making sure that assessments can be paused when an appointment has already been scheduled to allow for the review of the type or location of the assessment, whether or not new evidence has been submitted.

On training for staff:

- We provide mental health training for all staff who have direct contact with customers (including via telephone) to equip them to identify customers' mental health issues or vulnerability, and take appropriate action to support them.

- Comprehensive guidance is available for work coaches and case managers on how to support claimants who indicate they are at risk of suicide or self-harm. This guidance applies to all methods of communication, including the online journal. When a risk of suicide or self-harm is identified, staff follow a six-point plan, which helps them take the right action at the right time, and ensures the customer receives the support that they need.

Data collection and retention

RESPONSE:

- These timescales apply to information that identifies individual customers. Anonymised recommendations are retained beyond these timeframes in line with business needs, to ensure that learning from cases is progressed and tracked. This anonymised data enables us to identify patterns and themes across cases over time

- We also direct the journalist to our personal information charter - https://www.gov.uk/government/organisations/department-for-work-pensions/about/personal-information-charter#data-protection-principles

Culture of the DWP

RESPONSE:

In relation to Philippa Day matters, please refer to the previous statement.

- We do not have targets for sanctions referrals or sanctions decisions. Allegations of targets have been investigated previously and no culture of sanction targets within the organisation has been found.

- We don't want to sanction anyone and no one is sanctioned unless they fail to meet their agreed claimant commitment without good reason.

BBC dataset:

https://docs.google.com/spreadsheets/d/12or_c9cUspul4lWM1Tiv45tEuWSjyOzf/edit#gid=1323456278