



National Audit Office

Report

by the Comptroller
and Auditor General

Department for Work & Pensions

Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants

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Report by the Comptroller and Auditor General

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Gareth Davies
Comptroller and Auditor General
National Audit Office

5 February 2020

We produced this briefing for Parliament in response to correspondence from The Rt Hon Frank Field, who wrote to us in September 2019 while he was an MP and Chair of the Work and Pensions Committee.

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This report can be found on the National Audit Office website at www.nao.org.uk

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What this briefing is about

1 On 25 September 2019, the Rt Hon Frank Field MP (Mr Field) tabled a Parliamentary Question relating to benefits claimants who end their lives by suicide. His question was:

“How many inquests relating to benefits claimants who have ended their life by suicide her Department (Department for Work & Pensions) has submitted evidence to since 2013; and in how many inquests it was ruled that the policies of her Department were partly responsible for the deceased person’s state of mind.”

2 The Department for Work & Pensions (the Department) responded on 30 September 2019 that:

“Unfortunately, the information requested is not held centrally and is therefore unavailable without incurring a disproportionate cost.”

3 On 1 October 2019, Mr Field wrote to the Comptroller and Auditor General (C&AG) raising concerns about the Department’s response. His letter to the C&AG raised two substantive issues:

- whether the National Audit Office (NAO) could put together a list of inquests relating to suicide of benefit claimants to which the Department has submitted evidence since 2013, and of the number of inquests in which it was ruled that the Department was partly responsible for the deceased’s mental state; and
- the way the Department responded to the specific Parliamentary Question.

4 The C&AG, in his response to Mr Field of 18 October 2019:

- noted that ministers and their departments are expected to respond to Parliamentary Questions within the agreed Parliamentary deadlines, which vary depending on the type of question. There are several exemptions for responding to Parliamentary Questions, including a disproportionate cost threshold if questions are costly to answer. Details of this were set out within the response; and
- proposed that the NAO engage with the Department to establish what information it holds on benefit claimants who ended their lives by suicide, how that information is produced, and how it is stored, accessed and used.

5 Mr Field also raised an additional Parliamentary Question on 21 October 2019, asking that the Secretary of State place in the House of Commons Library a copy of the note setting out the justification for the response and the full costs of answering the initial Parliamentary Question. He received the following answer on 24 October 2019:

“There is no requirement for a coroner to inform the Department of the outcome of an inquest unless it specifically relates to the Department, for example Reg. 28 Prevention of Future Deaths report. There was no corporate memory for Coroners’ cases prior to the Coroners’ Focal Point being set up in 2016. Despite the existence of the Focal Point, we know that Coroners interact with areas of the Department without liaising with the Focal Point nor Legal Services.

When submitting evidence to Inquests, the Department would not necessarily know the inquest related to a suicide as cause is not established at that point.

There is no requirement for Coroners to advise the Department of findings of suicide. Communication from Coroners can enter the Department at multiple points. There is therefore no robust central record of these contacts. To establish that we are certain we have all information to answer such questions would require a broad spectrum query to be sent out to the business. Answering the question would require us to contact the multiple possible entry points through which a Coroner can contact the Department. Conduct a thorough search. Collate the information and provide the answer within the limited time allowed by a named-day question. This is not possible within the costs laid out in Parliamentary guidance.

The Department takes the welfare of vulnerable clients seriously and where the Department is made aware of a suicide of a customer a review is undertaken. This process is being updated and strengthened to further improve how we identify, review and learn from serious cases, including those involving suicide.”

6 This briefing sets out the findings from our enquiries with the Department on the information it holds on benefit claimants who ended their lives by suicide, in response to the correspondence we received from Mr Field. We sought only to find what information the Department holds on the matter and did not undertake a full investigation of the topic, engage with any other government or stakeholder bodies, or conclude on the Department’s performance. Given the issues with the Department’s information, set out below, we concluded it would not be feasible to compile a list of all inquests relating to death by suicide of benefits claimants from the Department’s data. We have cleared the facts set out in this briefing with the Department.

- 7 In compiling the information set out in this briefing, we:
- received a written submission from the Department responding to our queries on the topic;
 - viewed examples of documentation the Department holds on the topic, including guidance on relevant procedures and a small number of reports into individual cases, to confirm the procedures described to us;
 - spoke to officials responsible for managing those processes within the Department; and
 - reviewed information online such as previous Freedom of Information responses and media reports.

Findings

Information the Department receives on deaths by suicide of benefit claimants

8 The Department has received nine contacts from coroners via its official coroner focal point relating to suicide since March 2016. The Department established the coroner focal point in March 2016, aiming to provide a single point of entry for coroner communications, including those related to suicide cases. The Department has recorded 19 contacts from coroners via this route since 2016-17, of which nine were related to suicide. The Department told us that before this point there were multiple routes by which coroners might contact it, including locally, but that there is no single or complete record of such contact. It also told us that it is aware that coroners do not always contact the Department via the focal point, so the quantity of this contact is unknown (**Figure 1**).

Figure 1

Information held by the Department for Work & Pensions on contacts from coroners and about suicide of benefits claimants

Contacts via DWP's coroner focal point since March 2016	Contact from coroners outside of the coroners' focal point	Departmental Internal Process Reviews (IPRs) since 2014-15	Prevention of Future Death (PFD) reports since 2013
19 (of which nine related to suicide)	Unknown	69 related to suicide	Four (of which two related to suicide)

Notes

- 1 The Department established the coroner focal point in March 2016, aiming to provide a single point of entry for coroner communications, including those related to suicide.
- 2 The Department commissions IPRs in response to a range of circumstances or events, including suicides.
- 3 PFD reports arise when a coroner has been investigating a person's death, and something revealed by the investigation gives rise to a concern that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future.

Source: National Audit Office analysis of Department for Work & Pensions information

9 The Department has received four Prevention of Future Death (PFD) reports from coroners since 2013, of which two were related to suicide. These reports arise when a coroner has been investigating a person's death, and something revealed by the investigation gives rise to a concern that circumstances creating a risk of further deaths will occur, or will continue to exist, in the future. The coroner has a duty under the Coroners and Justice Act 2009 to report the matter to a person or organisation who the coroner believes may have power to act. When the Department receives these, it is given 56 days to either respond to the report setting out actions to be taken or explain why no action is proposed. The Department told us that it is aware of having received four such reports from coroners since 2013, of which two related to deaths by suicide and two related to other causes of death among benefit claimants.

10 The Department has investigated 69 suicides of benefit claimants since 2014-15. The Department commissions Internal Process Reviews (IPRs) in response to a range of circumstances or events, including suicides of claimants. The IPR process involves the production of a factual report and sequence of events, followed by an internal panel of relevant subject experts, gathered to make recommendations at either a local or national level. The Department becomes aware of cases which may lead to IPRs via coroners, claimants' families, the media, doctors and the police. Of the 69 suicide-related IPRs the Department has completed since 2014-15:

- 21 were completed between 1 April 2019 and 13 November 2019, compared with 13 in the whole of the 2018-19 financial year, and two in the 2017-18 financial year;
- only nine cases arose as a result of communication from coroners. More were instigated as a result of communication from the claimants' family or from the Department's review of media reporting (19 cases each). The Department told us that it has recently begun to more actively monitor intelligence about deaths by suicide from the media. The Department also becomes aware of cases from MPs, assessment or work programme providers, doctors and the police; and
- the Department does not have a robust record of cases investigated before 2014-15.

11 It is highly unlikely that the 69 cases the Department has investigated represents the number of cases it could have investigated in the past six years:

- The Department does not have a robust record of all contact from coroners. Prior to 2016, when the Department established its coroner focal point, there was no single, clear route for coroners to contact the Department. The Department also acknowledges that coroners still do not always use this route and that many will have contacted the Department through other routes, such as: job centres; service centres; or through other correspondence with the Department. This means that some contacts may not have resulted in an internal review being initiated.

- The Department's guidance has not always been clear about when a case should be investigated. The Department accepts that not all its staff are aware of the IPR guidance. We also found that the Department's guidance does not necessarily reflect the full scope of issues that could trigger an IPR. The Department's internal IPR guidance states that an IPR is mandatory where information is received that a claimant has attempted suicide or died by suicide, and it is alleged Department activity may have contributed to this. The Department told us that an IPR should be completed when it becomes aware of any suicide of a benefit claimant, regardless of whether there are allegations of Department activity contributing to the claimant's suicide.
- The Department has only recently taken a more proactive approach to conducting IPRs into suicides of benefits claimants. As noted above, the Department has already investigated more cases this financial year than in previous years. This is partly a result of investigating more cases where information received from the media was the trigger.

How the Department uses information from Internal Process Reviews

12 The Department describes the IPR as a 'continuous improvement tool'. It told us that the objectives of the IPR process are to scrutinise Departmental processes and, if appropriate, identify recommendations for changes to the customer journey. The recommendations contained in IPR reports are the main mechanism through which the Department would share any lessons from individual cases and seek to make improvement. Each report can include a number of recommendations. National recommendations should be passed on to teams responsible for managing claimants' experiences ('customer journey' teams) of the relevant service or benefit, while local recommendations will be handled by the area director.

13 While the Department's guidance states that the focal point should be notified of the outcome of the recommendations, the Department told us that there is no tracking or monitoring of the status of these recommendations. As a result, the Department does not know whether the suggested improvements are implemented. The IPR reports themselves are held in a shared folder, with access restricted to the team handling IPRs. Additionally, the Department does not categorise IPR outputs to identify larger trends or themes from within the outputs, and so systemic issues which might be brought to light through these reviews could be missed.

How the Department is trying to improve its processes

14 The Department told us that it is committed to improving the way it learns lessons from its customers' experiences and that it considers this a key priority. It has established a new unit, which aims to: improve the Department's approaches to identifying, investigating and learning lessons from customers' experiences; and to ensure lessons are fed back into improvement processes. It told us the unit will be responsible for a number of activities that relate to the issues raised within this note:

- **Improving the coroner's focal point.** The Department told us that following liaison with the Chief Coroner's Office, it is writing to all coroners to ensure they are aware of the Department's coroner focal point and in which circumstances they should report a death to the Department. The Department also intends to improve its internal guidance to ensure that its staff are aware of the coroner focal point and can direct any enquiries accordingly.
- **A new serious case panel,** which has been established within the Department. The panel's role is to consider the most serious systemic issues which have been identified from IPRs and cases from the Department's Independent Case Examiner. The panel will make recommendations to the Department and help to assign accountability at the most senior levels in the organisation for ensuring sustainable improvements are implemented. In doing so, the Department aims to focus on learning how to avoid similar issues in the future.
- **Carrying out a review, focusing on strengthening the IPR process** and the Department's response to serious cases, including suicides, which will focus on:
 - **identifying cases:** clarifying the circumstances in which the Department should carry out an IPR. This will include improving its internal guidance and communication to ensure staff are aware of and understand the processes for reporting a suicide;
 - **maximising learning:** strengthening the analysis of IPR reports and recommendations to ensure that the Department is aware of any systemic themes and issues, and is able to act to put in place effective corresponding improvements; and
 - **prevention:** developing a centralised team to coordinate all improvement activity including monitoring the occurrence of issues and delivery of improvements to reduce the risk of issues occurring again. The team will provide a centralised point to support local and regional customer case reviews to identify and act on systemic issues.

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