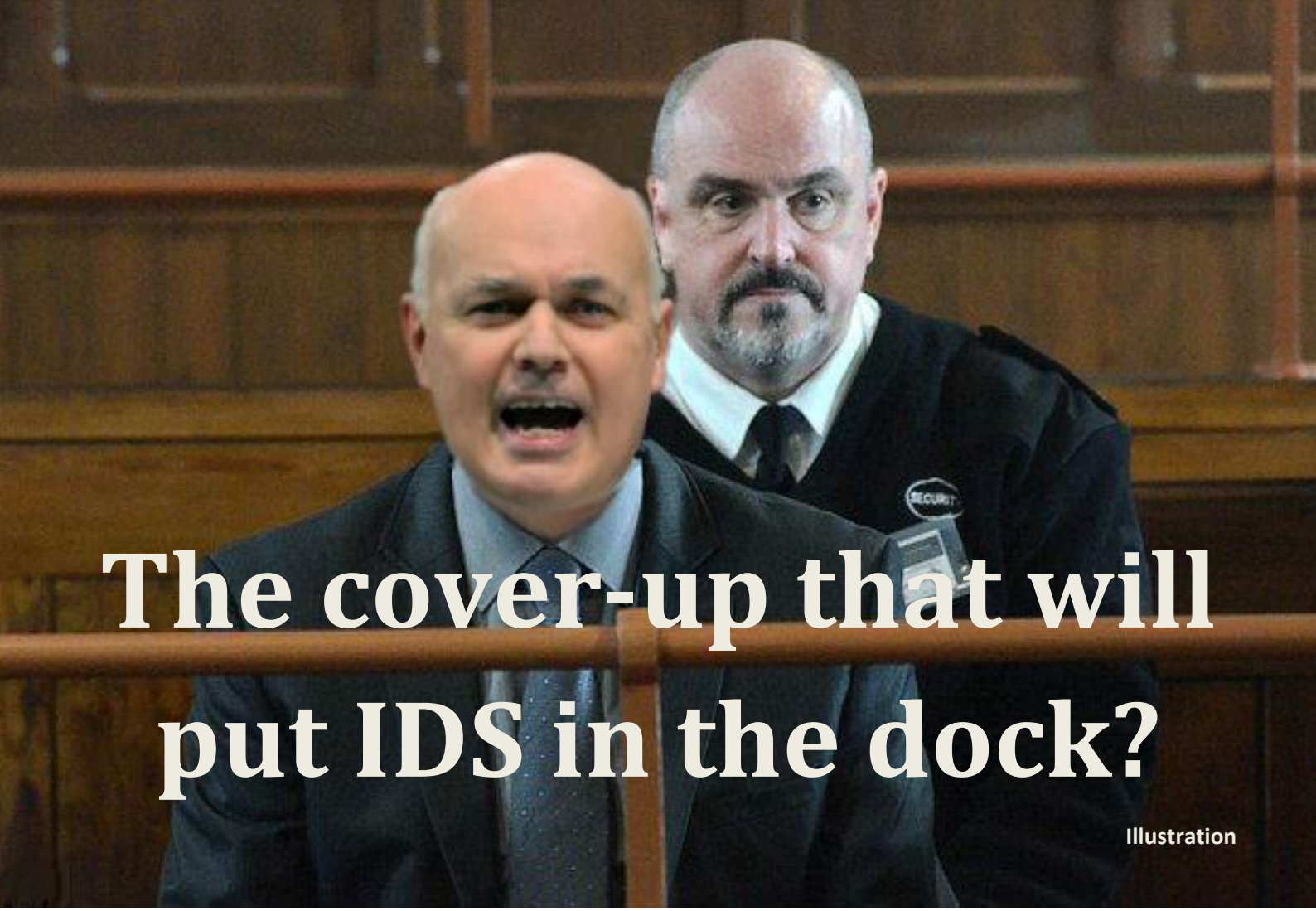

The cover-up that will put IDS in the dock?

Illustration

News from http://www.benefitsandwork.co.uk/

The DWP finally released very heavily redacted versions of the 49 peer reviews into claimant deaths in May 2016.

In fact, some of the documents have been so heavily redacted that there is literally nothing left other than headings and standard text. Every word of substance, including details of lessons learned and recommendations for the future has been redacted.

Yet, the documents still reveal a great deal.

Most of the reports appear to be about claimants being forced off incapacity benefit (IB) and onto employment and support allowance (ESA).

In at least six of the 29 reports that contain any detail, there was a failure to even identify claimants as vulnerable, let alone offer them additional support

In other cases, even where a claimant has been identified as vulnerable, guidance was not followed and they did not receive the support they should have.

Perhaps worst of all, the reports show that the six point plan for claimants at risk of suicide was not being followed and in some cases had not even been drawn up by local offices.

The inescapable conclusion is that the DWP was putting targets before lives in the rush to push claimants off IB and onto ESA.

For those who want to research this issue in more detail, we've published a 16 page collection of extracts from the reports.

IDS COVER UP

Linked to the 49 peer reviews is a possible DWP cover up of their failure to act on an undertaking they gave a coroner in 2014, in relation to preventing future claimant deaths.

If this proves to be the case, it could see Iain Duncan Smith standing in the dock of a criminal court in Scotland.

In 2014 the DWP gave an undertaking to a coroner that they would *"issue a reminder to staff about the guidance related to suicidal ideation that has been described in this report."* This was a reference to the six point plan mentioned above.

For the last 7 months Benefits and Work, and more recently the Information Commissioner's Office, have been trying to get the DWP to prove that they actually issued that reminder. So far without success.

Meanwhile, in Scotland, IDS has been reported to the police for wilful neglect of duty by a public official for allegedly failing to act on a different coroner's report in 2010.

If it turns out that a second coroner's report was also effectively ignored, IDS could finally find himself having to account for at least some of the claimant deaths that occurred on his watch.

It's a trial that an awful lot of claimants would dearly love to see.

Is this the cover-up that will put IDS in the dock?

The DWP may be trying to cover up their failure to act on an undertaking they gave a coroner in 2014 in relation to preventing future claimant deaths. If this proves to be the case, it could see Iain Duncan Smith standing in the dock of a criminal court in Scotland.

Coroner's report
Michael O'Sullivan committed suicide in September 2013. He had been suffering from anxiety and depression for a number of years and had previously been in receipt of incapacity benefit. He applied for employment and support allowance (ESA).
Following the inquest into his death in January 2014, the coroner issued a Regulation 28 report which is designed to prevent future deaths occurring in similar circumstances.

In the report the coroner stated that:

"I found that the trigger for Mr O 'Sullivan's suicide was his recent assessment by a DWP doctor as being fit for work."
In their response the DWP told the coroner that they would *"issue a reminder to staff about the guidance related to suicidal ideation that has been described in this report."* This was a reference to the DWP's six point plan for supporting claimants who had talked to DWP staff about thoughts of committing suicide

Fobbed off
In October 2015 we made a freedom of information request to the DWP for copies of the reminders that were sent out and details of which agencies they had been sent to.

Initially, the DWP fobbed us off with a response that said *"We regularly review and remind staff of current guidance as well as any changes. A copy of the latest guidance issued to healthcare professionals in February 2015 can be found here"* and referred us to a scheduled update of a wide ranging handbook that was published over a year after the Coroner contacted the Department.
We responded by requesting a copy of the precise document that the DWP issued specifically in order to fulfil the undertaking they gave to the Coroner's court.

The DWP then pretended that they thought we hadn't got their original email and resent it some weeks later.

At that point we referred the matter to the information commissioner's office (ICO).

In March of this year they confirmed that they were taking up the case and were contacting the DWP.

Now, seven months after we made our initial request, the ICO tell us that they are still waiting for a response from the DWP.

Regular reminders
Yet in the letter that they released along with the 49 peer reviews last week the DWP claim that
"With direct relevance to self -harm, DWP has a national 'Six Point Plan' which offers a clear process outlining what staff should do in these circumstances. Regular reminders are sent out – most recently in April this year – reiterating to offices the importance of having plans in place and reviewing them regularly."

If regular reminders are sent out, why are the DWP finding it so hard to give details to us or the ICO?

If, on the other hand, the first reminder that was sent out was the one that went out in April 2016, then the DWP and the secretary of state at the time, IDS, have some serious explaining to do.

Because at least four deaths since 2012 are connected with the DWP's failure to follow the six point plan.

And, in Scotland, **IDS has been reported to the police for wilful neglect of duty by a public** official for failing to act on a coroner's report in 2010.

If it turns out that in 2014 the DWP did almost exactly the same thing in relation to an issue that has been shown by the department to be implicated in the deaths of at least four claimants, then IDS might yet find himself standing in the dock.

Why claimants died - the 49 peer reviews

The DWP finally released very heavily redacted versions of the 49 peer reviews into claimant deaths last week. They show that the DWP repeatedly failed to act on warnings that vulnerable claimants were not being identified or supported. They also show that the six point plan for claimants at risk of suicide was not being followed. The inescapable conclusion is that the DWP was putting targets before lives in the rush to push claimants off incapacity benefit (IB) and onto employment and support allowance (ESA).

Avoiding scrutiny

The DWP have worked hard to avoid being scrutinised over their treatment of vulnerable claimants.

Initially they denied that the review documents even existed. Then they refused to release them.

Even when forced to do so, many of the documents have been so heavily redacted that there is literally nothing left other than headings and standard text. Every word of substance, including details of lessons learned and recommendations for the future has been redacted.

In other cases, the peer reviewer explains that virtually all the evidence had been destroyed by the DWP during regular purges before the investigation even began.

One reviewer points out that telephone calls between the DWP and claimants undergoing the IB to ESA transfer process were not being routinely recorded, unlike other calls, making it much harder to learn what had happened.

It is an enormous tribute to the courageous tenacity of campaigning journalist John Pring, founder of the Disability News Service, that even the limited information we now possess ever came to light.

Failure to identify which claimants are vulnerable

In total, there are just 29 reports out of 49 that provide information about what went wrong and what lessons can be learnt.

It is clear that the vast majority of the documents relate to people claiming ESA and, in particular, IB claimants being forcibly reassessed for ESA.

The biggest lesson is that over and over again, in at least six of the 29 reports, there was a failure to identify vulnerable claimants.

In case 1 the reviewer points out that the ESA50 is not read by DWP staff until after Atos issue a report, so staff don't even consider if a claimant should be treated as vulnerable until after they have had a medical, by which time it may be too late.

In case 6 the reviewer warns that no particular member of staff is responsible for checking if a claimant is vulnerable and there is no way of flagging vulnerability on DWP software to alert other members of staff.

"The problem of identification and ongoing awareness of a claimant's vulnerability is exacerbated for example by the absence of IT functionality to "flag" a claimant as such, and we also need to consider whether or not there is sufficient awareness of whose job it is to consider vulnerability and at what stage(s) of the process it should be considered."

The reviewer questions whether staff are too rushed and expected to meet too many targets to be concerned about vulnerability:

"we need to ask whether or not in the context of a fast moving environment of high volumes and anticipated levels of performance, the current process requires, encourages and supports colleagues to independently and systematically consider claimant vulnerability."

The reviewer in case 6 urges the DWP to accept its duty of care in relation to vulnerable claimants being transferred from IB to ESA and to make identifying and supporting vulnerable claimants part of specific job descriptions.

There is no evidence that this ever happened.

In case 15 the reviewer urges the DWP to wholly ‘relaunch’ information about the importance of identifying and supporting vulnerable claimants:

“Consideration is given to a re-launch to staff of the importance of identifying vulnerable claimants and taking their needs into account throughout the whole process via updated bulletins, Comms discussions and any other practical means.”

A similar request is made in case 27, where the reviewer recommends that:

“The guidance links and awareness of Dealing with Vulnerable Customer's instructions and supporting products to be more visible within the Journey, and reminders given across all Operational arms at regular intervals to remain high on staffs radar.”

Failure to support vulnerable claimants
In other cases, even where a claimant has been identified as vulnerable, guidance was not followed and they did not receive the support they should have.

In case 38, the reviewer says that even where a claimant is identified as vulnerable, there is no clear guidance about what actions should be taken:

“The Vulnerable Customer Guidance identifies personal factors that can make a customer vulnerable. The IB Reassessment guidance also states that vulnerable customers will be identified during the customer journey. The guidance however is not specific enough about the actions staff should take, once a claimant has been identified as vulnerable. Minimum actions that need to be taken by staff need to be agreed across the full IB Reassessment process.”

In case 26 the reviewer accuses the DWP of neglecting their duties:

“It is clear that we had several opportunities to identify and address the errors made over the duration of this claim. but we neglected to do so”

Further comments make it clear that this was another case involving a vulnerable claimant:

“Management teams in both BC and JC have been made aware of the case and the issues that were identified from it, and processes in both have been revised to ensure it does not happen again, to, make sure we provide adequate support for vulnerable customers.”

Even with heavy redactions it’s also clear that case 46 involved failure to properly support a vulnerable claimant, as the recommendations include:

“That the guidance for handling vulnerable customers is reviewed and that staff are reminded of the correct process[REDACTED]
“That we empower staff to use some discretion in cases involving vulnerable people, instead of doing everything 'by the book’ [REDACTED]”

Failure to follow guidance about suicide
In 2011 the DWP introduced a six point plan for dealing with claimants who threatened self-harm or suicide. Yet on at least four occasions claimants died after DWP staff failed to follow their own six point plan.

In case 10 it seems that the six point plan has not even been properly adapted to include local information about support services. The reviewer recommends:

“The six point plan to be developed locally with information available to JCP staff re signposting for support agencies and made available on the intranet page.

“Awareness to be raised with all staff who deal with customers of the action to be taken if customers make suicide/self harm declarations.”

In Case 14 the reviewer reflects suggests that senior staff should deal with claimants who have spoken of suicide:

"Once customer first indicates suicidal ideation, the case needs to be considered by a more senior officer to decide on whether or not it merits extra care. I believe this may now be in updated guidance."
They also highlight the lack of empathy of staff:

"Calls into [REDACTED] Contact Centres were poor demonstrating a lack of empathy, summing up, follow up, proactivity and setting realistic expectations. I would suggest that staff are regularly reminded WHY progress chasing calls need to be noted in detail i.e. to 'tell the story for the next Agent."

In case 17 the reviewer refers to failure to follow the six point plan being a recurring theme:

"Remind staff about the Six Point Plan. This will be referred to the Customer Journey for consideration of further action to embed the Six Point Plan as it is a recurring theme."

Exactly the same words are used in document 31, raising the possibility that the same peer reviewer kept encountering the same issue.

Failure to contact GP
The failure to contact the claimant's GP or other health professional is of particular concern, because it was the very problem highlighted by the coroner in the case of Stephen Carre to which the DWP apparently never responded. It was highlighted again by the coroner in relation to the death of Michael O'Sullivan

In case 6, the reviewer explains that vulnerable claimants may *"be inclined to provide less information than they could about their condition in the ESA50"*.

Yet where a claimant is considered vulnerable there is *"no specific requirement to consult with the GP in order to ensure that the ESA50 has been completed as comprehensively as possible".*

One of the recommendations made in case 38 is that:

"Contact to be made with a claimant's GP where they have been identified as vulnerable and there is often a delay in obtaining medical evidence for an appeal. Permission to contact the GP can be obtained at the point that the customer is identified as vulnerable or an appropriate third party can be asked to assist the customer to obtain this information."

Delays cost lives
Delays in processing claims and appeals, delays in carrying out face-to-face assessments and delays in making payments are all identified as failings in relation to claimants who died.

The overwhelming anxiety suffered by some claimants left waiting months for the result of a medical or to have their appeal heard may well have proved ultimately unbearable for some.

Case 12 appears to relate to an unreasonably long wait for an assessment:

"The Customer Journey teams are aware of the issue about delays, but Centre for Health and Disability (CHDA) is working to collect evidence and resolve backlogs. They are looking at possible fast tracking for certain face to face appointments."
The recommendations in case 16 relate to delays in getting appeals heard:

"The need to improve the length of time for the Customer Journey from IB reassessment to appeal, [REDACTED].
"Consider an earlier intervention in the process, by Jobcentre Plus to support the customer."

In case 42 the reviewer recommends that some appeals should be fast-tracked:

“Use this case as part of customer service awareness discussions with staff to illustrate when a more a pragmatic (common sense) approach may be required in prioritising the handling of appeals (rather than in strict date order) — sites need_ to apply a more common sense approach to proactively manage cases[REDACTED] aiming to conclude outstanding actions much quicker. [REDACTED]”

Other errors
There were other very basic errors which contributed to the deaths of claimants.

For example, in case 30 the decision maker failed to look at whether regulations 29 and 35, the safety net regulations, applied. In addition, no extra check was made even though the claimant had a severe mental health condition and had been in the support group but was suddenly found to be capable of work.

In case 7 it appears that an overpayment was incorrectly calculated and in case 39 the overpayment was not dealt with correctly. In both cases the failures may have cost claimants their lives.

In case 11 it appears that a vulnerable claimant had their benefit sanctioned and that the suspension was not reviewed within a reasonable time.

DWP denial
The DWP have repeatedly argued that the causes of suicide are complex and it is misleading and irresponsible to claim that any suicide is a result of a benefits problem.

The truth is, of course, very different.

Suicide is undoubtedly a complex issue.

But, if you take a person who has a severe mental health condition and subject them to extreme mental distress, it is entirely foreseeable that they may attempt to harm themselves as a result.

The IB to ESA transfer process was just such a source of mental distress. The DWP knew that it was costing lives, but they considered it was a price worth paying.

For claimants and activists who want to research these issues further, we have extracted what we think is the most important text from each of the documents, along with details of what we think are the main issues involved. You can download the document in .pdf format.

You can download the DWP documents from here or from our backup below in case UK Government accidentally removes them.

Peer reviews of handling of benefit claims

Ref: 4551/IR566

Peer reviews of handling of benefit claims: redacted copies

Ref: 4551/IR566

Case 1, Case 2, Case 3, Case 4, Case 5, Case 6, Case 7, Case 8, Case 9, Case 10, Case 11, Case 12, Case 13, Case 14, Case 15, Case 16, Case 17, Case 18, Case 19, Case 20, Case 21, Case 22, Case 23, Case 24, Case 25, Case 26, Case 27, Case 28, Case 29, Case 30, Case 31, Case 32, Case 33, Case 34, Case 35, Case 36, Case 37, Case 38, Case 39, Case 40, Case 41, Case 42, Case 43, Case 44, Case 45, Case 46, Case 47, Case 48, Case 49