

Tip of the Iceberg?

Deaths and Serious Harm in the Benefits System

July 2021

Trigger warning: self-harm, suicide and death.

This report discusses self-harm and death relating to suicide, which the reader may find upsetting. **At the end of this report, you will find links to sources of advice and information, as well as where you can find crisis support organisations.**

Rethink
Mental
Illness.

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Foreword

From Brian Dow, Deputy Chief Executive of Rethink Mental Illness and Co-chair of the National Suicide Prevention Alliance.

“When Clive received the first erroneous letter from the Department for Work and Pensions saying that he was being investigated for fraud, and a few months later, a further letter making the same erroneous accusation, his mental health spiralled downhill. He lost all belief in himself and was unable to take any comfort from his friends or family. It became impossible to reason with him or reassure him, and thereafter he felt that it would be better for everyone if he died.”

- Clive's sister, Trudi.

As the Deputy Chief Executive of a mental health charity and co-chair of the National Suicide Prevention Alliance, it never gets easier to hear about the hardship and pain endured by the families and loved ones of those who have been failed so badly by the very system that is meant to support them.

The benefits system is designed to be a safety net for people across the country who find themselves unable to work or in need of financial support. It is one of the cornerstones of our society and exists for all of us when we might need it. Many people supported by benefits live with a mental health condition. Almost half of adults receiving an out of work benefit have a common mental health disorder

and many live with severe mental illness, including 7.3% identified as having psychosis, compared with 0.2% of people not on benefits. People on Employment and Support Allowance (ESA) are particularly affected, with one in eight screening positive for bipolar disorder and almost half have made a suicide attempt at some point¹.

It follows that the mental health impact of the Department for Work and Pension's (DWP) policies and processes should be at the forefront of everything the department does. However, our research has found that many people like Clive and his family are being let down to an unimaginable degree. **The DWP's processes and actions have been found**

to negatively impact people's wellbeing, causing severe anxiety and distress, creating financial hardship, worsening existing mental health conditions, and in very tragic cases, leading to death.

The causes of these deaths, particularly suicides, are complex. There is no single reason why a person may choose to end their own life, with a range of factors playing a role. However, suicide is not inevitable - it is preventable - and the DWP can play a vital, unique role in suicide prevention. This includes improving its practices and more importantly, understanding and responding to the systemic drivers behind tragic cases of death, self-harm and mental health crises.

¹ NHS (2016) Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2014.

As well as suicide and self-harm, we know that there are also cases of vulnerable people, including those living with severe mental illness, who have experienced extreme financial hardship after having their benefits stopped.

No one's life should be at risk because they cannot afford food or other essentials.

Our research has found that these issues occur across the benefits system. If they could be solved by small incremental changes, identified and delivered internally by the department, then we expect them to have been fixed by now. Instead, **new data shows that the number of cases being investigated is rising, with 124 internal investigations of deaths or serious harm conducted in the last two years – almost triple the rate from 2012 to 2019.**

Let us not mince our words. **There is strong evidence to suggest that a government department has played a part in the deaths of over a hundred people.**

Our concern is not simply that a system which is supposed to protect people has failed, though that would be bad enough. It is that the process for investigating those failings is not fit for purpose. It is a situation that has continued for years, and which puts people at grave risk every day.

In any other public service, the tragic deaths of so many people would have triggered an urgent public investigation and outcry. But the current process is shrouded in secrecy, with little to no public accountability.

For there to be confidence in the benefits system, we need to see concrete evidence that the DWP is learning from these heart-breaking cases and implementing change. This government has made strong commitments to suicide prevention, and we believe that the DWP has a moral and a legal duty to play its full part.

The DWP must give families the answers they deserve, restore faith in the system and prevent further tragedies. We urgently need a full public inquiry and a new body to investigate any future cases of death and serious harm. When our benefits safety net is found to be putting those it supports at risk, it is in everyone's interest to be open about what has gone wrong and what must change to improve it.

Without urgent action, we will be forced to draw the conclusion that the DWP is complicit in failing to tackle these serious and ongoing problems.

On behalf of Rethink Mental Illness, I would like to thank all the families who have been campaigning on this issue and who have contributed to this report. We will endeavour to continue to work with you to fight for a more equitable system built on understanding, compassion and empathy.

Executive Summary and Key Findings

This report sets out Rethink Mental Illness's preliminary findings about deaths and serious harm linked to the benefits system. **We cover six key areas of the benefits process that can cause severe distress for people - from applying for benefits and the assessment process to the struggles endured by people living on benefits.**

Our research found many examples where the DWP has failed to support people and reveals serious problems with the system for identifying and investigating cases and for learning lessons.

Although there have only been a small number of Prevention of Future Deaths (PFD)² reports in which the DWP has been compelled to recognise mistakes publicly, there is evidence linking the DWP to the deaths of hundreds of people, including many who lived with a mental illness. Our research raises concerns that there may be many more people who have experienced serious harm or death because of the actions or omissions of the DWP.

The first section of this report shows how there are numerous stages in an individual's journey throughout the benefits system that have been associated with serious harm or death for people living with mental illness. The second section examines the way that deaths and serious harm are currently investigated. According to the DWP, Internal Process Reviews (IPRs) are a continuous improvement tool used to scrutinise DWP processes and if appropriate, identify recommendations for change. Although the DWP has undertaken hundreds of IPRs, the conclusions and lessons of these reviews are not routinely published and therefore the public cannot determine the extent to which the DWP makes changes to prevent future harm.

Our four key findings:

- 1. Recent data covering the last two years shows that the DWP conducted 124 Internal Process Reviews into death or serious harm³.** This represents an almost three-fold increase (176% rise) of IPRs compared to the period of February 2012 to July 2019. We do not currently know how far this reflects increased levels of harm or how far it shows that serious cases were previously not being investigated.
- 2. There is a wide range of issues across the benefits system that have resulted in deaths,** as well as causing self-harm and mental health crises.
- 3. Benefit deaths and serious harm reported in the media or investigated internally by the DWP may be the tip of the iceberg,** with gaps in the way that cases are identified. There is also evidence linking DWP processes to widespread mental health harm including death by suicide.
- 4. The DWP's current process for investigating cases of death or serious harm are not independent.** They lack external oversight and it is unclear whether they have recommended, far less delivered, systemic policy or culture change within the DWP.

² Prevention of Future Deaths reports (PFDs) are issued by coroners at inquests where there are matters for concern, which if left unaddressed, they believe could result in more people dying in the same way. PFDs are sent to the organisation which is responsible for the product, service or procedure that needs to change.

³ The Minister for Disabled People provided this data in response to a Written Question submitted by the Shadow Secretary for Work and Pensions. [The response was published on 28 June 2021.](#)



Our recommendations:

We call on the government to:

- 1. Establish a full public inquiry into benefit related deaths and cases of serious harm**
 - 2. Set up an independent body to investigate future cases of death or serious harm in the benefits system.**
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How serious harm happens in the benefits system

Public scrutiny of the scale and nature of deaths or serious harm linked to the benefits system has been difficult as so little information has been published by the DWP.

We have therefore drawn evidence from three sources in order to examine the stages in an individual's journey through the benefits system that appear to have resulted in death or serious harm.

First, we have reviewed the handful of cases where Prevention of Future Deaths reports (PFDs) or other legal proceedings mean there is detailed evidence in the public domain. Second, we have reviewed and analysed a public database compiled by the BBC Shared Data Unit of media stories relating to cases that have been publicly reported.⁴ Third, we reviewed independent evidence from charities and academics that examines the link between DWP actions and emotional and financial distress for claimants. Finally, we have spoken directly to some individuals who have been affected, some of whom were able to share further evidence with us.

Together, these sources show a system in which poor decision making and administrative errors are compounded by processes and communications that seem harsh and uncaring.

⁴ BBC Shared Data Unit (2021). [Spreadsheet: People's deaths allegedly related to DWP activity](#).

Applying for benefits

Our research suggests that many people face psychological distress at the point of making a claim and being assessed for benefits. Both living with a disability and needing support from benefits are heavily stigmatised and the process of applying for benefits often makes people feel worthless, guilty or on trial for asking for support.⁵

Claiming Universal Credit

Evidence suggests that many people find the initial application process for benefits confusing, demeaning, impersonal, and a source of anxiety and fear.⁶ A recent report by the Money and Mental Health Policy Institute highlighted that people with mental illness are more likely to find the application process difficult, particularly if they are going through a mental health crisis.⁷

For Kelly, who has a diagnosis of Borderline Personality Disorder, applying for Universal Credit (UC) was a major source of stress and anxiety, leading to thoughts of suicide:

“It took such a toll on me. It exacerbated my Borderline Personality Disorder, causing me severe mood swings and made me feel incredibly worried and angry. At one point I was hysterically crying so much that I threw up. There have been times during the whole process where it has been so bad that it has caused me to have suicidal thoughts.”⁸

The inquest into the death of Mark William Jacka identified a connection with the initial benefit application process. Mr Jacka died by suicide the day after he had visited a Jobcentre to apply for benefit support having struggled to compete his application due to his dyslexia. His partner said that his confusion and stress caused by the benefit application process was a catalyst for his death. Coroner Peter Brunton recorded a verdict of suicide, and stated that **“he was not well, but was stressed about completing forms promptly. He had no money and had to borrow from his girlfriend. He was only 26 years old and his girlfriend was expecting his child.”⁹**

- 5 Z2K (2020). [Blunt, Bureaucratic and Broken – How the Universal Credit system is failing people in vulnerable situations](#); Pybus, K. Wickham, S, Page, G, et al (2021) [“How do I make something out of nothing?”: Universal Credit, precarity & mental health.](#)
- 6 Barr B, Taylor-Robinson D, Stuckler D, et al (2016). [‘First, do no harm’: are disability assessments associated with adverse trends in mental health? A longitudinal ecological study](#)
- 7 Money and Mental Health Policy Institute (2021). [Set Up To Fail: Making it Easier to Get Help With Universal Credit.](#)
- 8 Blog by Kelly on Rethink Mental Illness website <https://www.rethink.org/news-and-stories/blogs/2020/03/stop-benefit-deaths-campaign-kellys-story>
- 9 Robson, S. (2015). [Jobless dad-to-be hanged himself over stress of applying for benefits](#)

Claiming PIP or ESA

Many people severely affected by mental illness, as well as those with other disabilities, apply for Employment and Support Allowance (ESA) to meet their living costs and Personal Independence Payment (PIP) to support them with extra costs associated with their condition.¹⁰

An inquiry by the Work and Pensions Select Committee into both PIP and ESA found that the application process to receive this support can be a significant source of confusion and distress.¹¹ The experience of being wrongly found fit for work or ineligible for PIP can be very distressing, as well as causing severe financial hardship, and has been linked with a number of deaths.¹²

Assessments

The Work Capability Assessment (WCA), which assesses the extent of the disabilities of people applying for ESA, has been found to be a major source of distress for many claimants¹³ and has been linked with many deaths by suicide, particularly with regard to reassessments.

A study comparing trends in reassessments in each local authority in England between 2010 and 2013, found that WCA reassessments were associated with an additional 590 suicides, 279,000 additional cases of self-reported mental health problems, and the prescribing of an additional 725 anti-depressant prescriptions.¹⁴

The coroner's PFD report for Michael O'Sullivan found that the trigger for his suicide was his recent reassessment by a DWP assessor which found him 'fit for work'. The PFD report highlighted as a major area of concern that the DWP assessing doctor did not take into account the views of Mr O'Sullivan's general practitioner (who had assessed him as being unfit for work), his psychiatrist or his clinical psychologist.¹⁵

Kevin Dooley who had been on ESA for many years was also found 'fit for work' after a reassessment. Mr Dooley suffered from depression, anxiety and significant health problems. The decision by the DWP to find him 'fit for work' was very distressing for Mr Dooley and ultimately led to his death by suicide.¹⁶

10 Department for Work and Pensions (2017), [Personal Independence Payment: official statistics](#), ESA data via [DWP Stat-Xplore](#)

11 Work and Pensions Committee (2018). [PIP and ESA assessments](#), page 15.

12 E.g. Stephen Carre took his own life after being found ineligible for ESA. Benefits and Work (2015). [Another WCA coroners 'Risk of future death' warning uncovered.](#)

13 Z2K (2020). [Blunt, Bureaucratic and Broken – How the Universal Credit system is failing people in vulnerable situations](#), page 17.

14 Barr B, Taylor-Robinson D, Stuckler D, et al (2016). ['First, do no harm': are disability assessments associated with adverse trends in mental health? A longitudinal ecological study.](#)

15 Hassell, ME. (2014). [Regulation 28: Prevention of Future Deaths - report Michael Brendan O'SULLIVAN.](#)

16 Clare, H. (2019). [Chronically ill Leeds dad took own life after DWP stopped his benefits, inquest hears.](#)

Appointments

Although paper-based, telephone and video appointments are available for people claiming ESA and PIP, claimants do not make the final decision on how they are assessed. If the DWP decides that an individual does not have a 'good reason' not to attend an arranged face-to-face assessment, their claim can be closed.

Decisions around assessments have been associated with several cases of deaths and serious harm. The requirement to attend a face-to-face appointment was a key factor in the deaths of Errol Graham, Jodey Whiting and Philippa Day. For Mr Graham and Ms Whiting, missing their face-to-face appointment resulted in immediate large cuts to their payments and led to significant financial hardship.

Mr Graham's benefits had been stopped even though he had a severe mental illness that had led to him being detained under the Mental Health Act just weeks before he was required to attend an appointment. He tragically starved to death in 2018.

Ms Whiting took her own life in 2017 after her benefit payments were stopped because she had missed her WCA appointment.

Ms Day died by suicide after being asked to attend a face-to-face appointment, as the result of an administrative error, when it should have been undertaken at her home.¹⁷

¹⁷ Clow, G. (2021). [Regulation 28 - Prevention of Future Deaths - report Philippa DAY.](#)



Struggling on benefits

Our analysis shows that even when benefit claims had been accepted, people faced risks of errors by the DWP and the threat of benefit sanctions. This is in addition to the risks associated with applying or being reassessed for benefits. These problems are experienced as a double threat: the direct risk of a cut to benefits that could lead to destitution and the psychological danger created by the possibility - or reality - of facing a major reduction in benefits.

Administrative errors

Our research has found many examples of DWP administrative errors that have had devastating consequences for people living with mental illness.

The coroner's PFD report into the death of Philippa Day stated the administration of her claim was **"characterised by multiple errors, some of which occurred repeatedly throughout the period of her claim."** The PFD report states **"the distress caused by the administration of Philippa Day's welfare benefits claim led to Philippa Day suffering acute distress and exacerbated many of her other chronic stressors. Were it not for these problems, it is unlikely that Philippa Day would have taken an overdose".**¹⁸

The tragic case of Clive Johnson is another example of how an administrative error can cause significant distress, resulting in death by suicide. Mr Johnson

had severe physical health problems and as a result needed support from the benefits system. Mr Johnson was cared for by his sister Trudi, who helped him with everyday tasks like shopping and cooking when he was unable to do it for himself.

Mr Johnson was twice falsely accused of benefit fraud by the DWP within a six month period. These accusations were later classed as "administrative errors" by the DWP. These errors caused a major deterioration in his mental health and were ultimately a key factor in his suicide.

In her personal statement to the coroner's inquest following Mr Johnson's death, his sister Trudi said: **"I believe the main trigger for Clive's state of mind was the erroneous letter from the DWP dated 23 June 2016. At this point Clive's anxiety levels increased and he became extremely depressed and suffered from insomnia. He began to feel like he didn't deserve anything and**

was worthless and found fault with himself constantly."¹⁹

It is not only the frequency of administrative errors in benefit claims that is concerning but also the way in which the DWP responds to these errors. In the cases we reviewed, when an error is made by the DWP, the onus has often been on the benefit claimant to rectify that error, yet the process to do so has not been simple. The letter to Mr Johnson sent by the DWP about alleged fraud provided no reference to support services in case he found the content distressing. Furthermore, the letter provided no direct phone number or process to contest the claim.

This is extremely problematic when a claimant is facing complex issues in their life including mental illness, physical illness or financial distress, particularly as these issues can all be a significant risk factor for suicide.²⁰

¹⁸ Clow, G. (2021). [Regulation 28 - Prevention of Future Deaths - report Philippa DAY.](#)

¹⁹ Statement from a family member of Clive Johnson to Coronial Inquest (2017)

²⁰ Money and Mental Health Policy Institute (2018). [A Silent Killer – Breaking the link between financial difficulty and suicide](#), page 13.

Impact of sanctions on claimants

The impact of the conditionality and sanctions regime on the wellbeing of claimants has long been a matter of concern.²¹

The suspension of someone's only source of income can be physically and psychologically damaging. Sanctions create a great deal of fear in claimants, with the possibility of being sanctioned enough to worsen an individual's mental health.

Last year, Rethink Mental Illness surveyed people severely affected by mental illness about their experiences of sanctions. Our findings showed that, regardless of whether or not someone had received a sanction, the threat of receiving one meant that 83% of respondents said that thoughts about sanctions or conditionality had a negative or very negative impact on their mental health.²²

Katie lives with an eating disorder and anxiety. When she was claiming Job Seekers Allowance (JSA), she was sanctioned for moving closer to her family, which she needed to do for her mental health. She told Rethink Mental Illness about the impact of being sanctioned for six months:

“This plunged me into huge financial difficulty forcing me to choose between spending the little money I had on rent or food. I chose to spend it on my rent because I didn't want to become homeless, but as a result, my eating disorder got much worse.”²³

Katie's story is one illustration of how sanctions can have multiple detrimental impacts on a person's life, including mental health and access to safe housing.

Although there has been an overall reduction in the use of sanctions in recent years, the rates remained substantial at around 20,000 per month for UC before the Covid-19 pandemic. Rethink Mental Illness therefore welcomed the government's decision to suspend new sanctions for three months from March 2020 in response to the pandemic.

Despite this encouraging change of approach, the use of sanctions is increasing again.²⁴ Given the evidence of the harm that can be done by sanctions and the threat of sanctions, the DWP now have a rare opportunity to end the use of sanctions on disabled people for good.

21 E.g. Williams, E. (2020). [Punitive welfare reform and claimant mental health: The impact of benefit sanctions on anxiety and depression.](#)

22 Rethink Mental Illness (2020). Unpublished survey of 158 people severely affected by mental illness about their experiences of welfare conditionality

23 Read Katie's story [here](#).

24 Department for Work and Pensions (2021). [Benefit sanctions statistics to January 2021 \(experimental\).](#)

Justice, transparency and learning lessons

This report has so far covered the different stages in an individual's journey through the benefits system and the points at which serious harm can be caused. This section will look at what happens once someone comes to serious harm: what we know about the steps the DWP take to identify, investigate and learn from individual cases, and the gaps we have identified where they must do more to improve the system.

It shows that the current system for investigating deaths and serious harm is piecemeal, opaque, and inadequate.

Inquests and Prevention of Future Deaths reports

An inquest is conducted in cases of death which appear unnatural or suspicious and as a judicial process, it can be confusing and extremely distressing. Their purpose is not to determine culpability or appropriate blame, but to establish causal or contributory factors to the death.

Coroners are funded by local authorities, not by central government. This means there is no national oversight of the performance and consistency of coroners, which in turn could mean that the extent to which the DWP's actions are recorded as a factor in a death is dependent on the local area.²⁵ Of the 69 suicides investigated by the DWP that were highlighted by the National Audit Office (NAO) in 2020, only nine were raised with the DWP by coroners.²⁶

Brian Sycamore took his own life after running out of money to pay for his electricity. He left a suicide note "sarcastically thanking Universal Credit bosses"²⁷. The coroner did not refer to UC as a contributing factor to his death, despite the evidence of the note indicating that benefits played a significant role in Mr Sycamore's suicide.

One way in which the DWP has been held accountable for its failings in some cases is through PFD reports. These reports are issued by coroners at inquests where there are matters for concern and which, if left unaddressed, could result in more people dying in the same way. PFDs are sent to the organisation which is responsible for the product, service or procedure that needs to change. The body to whom the PFD has been sent must respond to explain what action they will take to address the concern, or to explain why they

will not address the concern.

PFDs have been sent to the DWP in a number of cases²⁸, and their responses are illuminating insofar as they say what changes have been committed to. However, there is no official public follow-up²⁹, meaning there is no process to confirm whether they made the promised changes. In other cases, such as the case of Errol Graham, a PFD report was avoided on the basis of commitments given by the DWP to the coroner.³⁰

This suggests that the PFDs sent to the DWP represent just the tip of the iceberg of cases where the DWP's actions and procedures contributed to someone's death. This is one of the reasons that we are calling for a new independent body to investigate cases of death or serious harm linked to the DWP.

25 Justice Select Committee (2021). [Bereaved people are not yet at the heart of the coroner service.](#)

26 National Audit Office (2020). [Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants.](#)

27 Allen, G. (2019). [Tragic tenant left suicide note sarcastically 'thanking' Universal Credit bosses.](#)

28 National Audit Office (2020). [Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants.](#)

29 Justice Select Committee (2021). [Bereaved people are not yet at the heart of the coroner service.](#)

30 Pring, J. (2020). [The death of Errol Graham: Man starved to death after DWP wrongly stopped his benefits.](#)

DWP Internal Process Reviews into deaths and serious harm

The DWP has an internal process for reviewing individual cases or death or serious harm. These are known as Internal Process Reviews (IPR) and prior to 2015 were known as Peer Reviews.

According to the DWP, IPRs serve as a way in which its processes can be improved through scrutiny and the adoption of recommendations for changes to the claimant's journey through the benefits system.³¹ Up until recently policy was considered "outside scope"³², which limited IPRs' ability to identify systemic problems or achieve systemic change. The DWP now claims to look "holistically" at all interactions between the department and a claimant when conducting an IPR³³, but we do not know whether this change in approach has led to policy recommendations being made or implemented.

IPRs take place in cases formally raised with the DWP, or where a case has been identified by the DWP internally. There are two IPR panels: one which conducts the IPRs, and a separate dedicated group which tracks the learnings from these IPRs and "feeds into the wider organisation".³⁴ These groups are distinct from the Serious Case Panel (see page 20), although the precise nature and extent of collaboration between these groups is unclear.

Historically, recommendations from IPRs have not been tracked centrally, although the DWP has committed to "establishing an organisational learning function to rigorously track recommendations".³⁵ The DWP does not routinely publish conclusions or lessons of its IPRs. Therefore, the public cannot determine how effective the process is, nor the extent to which the DWP accepts their policies or actions as a factor in the death or serious harm of claimants.

Where limited information on IPR recommendations has been released in response to freedom of information (FOI) requests, it suggests that recommendations have largely been limited to reminding staff to follow existing processes and guidance, rather than considering more far-reaching change to processes.³⁶

³¹ Department for Work and Pensions (2020), in a Freedom of Information request response: [IPR procedures](#).

³² See previous footnote.

³³ Department for Work and Pensions (2021), in an unpublished response to an FOI request from the Child Poverty Action Group. This FOI was made possible by a challenge by John Pring of Disability News Service at the First Tier Information Rights Tribunal in 2016 to a DWP decision that no IPR details would be released.

³⁴ Baroness Scott of Bybrook (2021). [Disability Benefits Claimants. Transcript of House of Lords debate](#).

³⁵ Secretary of State for Work and Pensions (2020), in [a letter to the Chair of the Work and Pensions Select Committee](#).

³⁶ Recommendations from redacted IPR documents released to Child Poverty Action Group under the Freedom of Information Act. The documents date to a time when policy recommendations were considered outside scope for IPR recommendations

Increase in Internal Process Reviews

New data shows that **over the last two years (between the end of July 2019 and June 2021)**, the DWP set up **124 Internal Process Reviews** linked to death or serious harm.



IPRs started:

97 IPRs have been started in cases where there was a **death**

27 IPRs have been started in cases of **serious harm** aside from death

124 IPRs started in total



IPRs completed:

54 IPRs have been completed in cases where there was a **death**

8 IPRs have been completed in cases of **serious harm** aside from death

62 IPRs completed in total³⁷

There has been a 176% rise in IPRs in the last two years, compared to the period 2012-2019

³⁷ The Minister for Disabled People provided this data in response to a Written Question submitted by the Shadow Secretary for Work and Pensions. [The response was published on 28 June 2021.](#)

Data covering the period **February 2012 and July 2019** shows that during this time the DWP set up at least 144 IPRs.³⁸

This means that since February 2012, the DWP has investigated 268 cases of death and serious harm of people claiming benefits. Comparing the data for the last two years with the data from 2012 to July 2019 reveals an almost a three-fold increase (176% rise) in the rate at which IPRs are being conducted.

As the DWP has released no analysis of these figures, it is not possible to know how far this increase represents the fact that cases which were previously being missed are now being addressed, or whether it reveals an increase in deaths and serious harm.

It is important to note that there are many more IPRs for cases of death than for other types of serious harm. Given that there are many more cases of self-harm and attempted suicide than completed suicides, we would reasonably expect to see much higher numbers of IPRs into serious harm aside from death than into deaths. As this is not the case, it implies that a substantial number of cases

that meet the threshold for a “serious harm” IPR are not being investigated.

We also know that suicide and suicide attempts are, sadly, especially prevalent among people claiming benefits. Two thirds of people on unemployment benefits report having thoughts of taking their own lives, almost half attempt suicide and a third have self-harmed.³⁹ Conducting an IPR is required in cases of suicide or attempted suicide where it is alleged that the DWP’s actions have played a role.

Additionally, the National Audit Office says that it was told by the DWP 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”.⁴⁰ A simple comparison between the number of IPRs investigating a death (around 50 per year) with the overall number of deaths by suicide (over 6,500⁴¹, of which people claiming benefits will be a significant minority) shows that this is not happening.

Therefore, we strongly suspect that these increasing numbers of IPRs represent the tip of the iceberg regarding the extent of serious harm. It appears that the DWP either has no adequate method for identifying cases that meet the threshold for an IPR or is not following its own rules on when they should be conducted. It may be that the DWP is simply unaware of the majority of cases of serious harm related to its actions which do not involve a death. If this is the case, it indicates that the IPR system is not fit for purpose.

38 BBC Shared Data Unit (2021). [Benefit deaths](#).

39 Zero Suicide Alliance (2014). [Unemployment Benefit Recipients](#).

40 National Audit Office (2020). [Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants](#).

41 Office for National Statistics, [Suicides in the UK 2018](#)

Serious Case Panel

In 2020, the DWP set up the Serious Case Panel (SCP). This body exists to examine themes that emerge from cases where there have been problems. The terms of reference are publicly available, as are the minutes. As Baroness Sherlock noted in the Lords, the minutes “are so brief and redacted as to be pretty much entirely unrevealing”.⁴² Therefore, in practice, we currently know almost nothing about the SCP’s actions. Crucially, we do not know how many cases (or how many IPRs) would have to share common elements for them to result in a “theme” being discussed at the SCP.

While we acknowledge that the SCP is still a relatively new body, we know very little about what the panelists have achieved so far, or what they intend to achieve in the future.

Independent Case Examiner

The DWP works with an Independent Case Examiner (ICE). The ICE reviews complaints made by the DWP’s service users once they have had a final answer from the DWP - it is a last resort mechanism.⁴³ The ICE’s office also supports “service improvements by providing constructive comment and meaningful recommendations”.⁴⁴ The persistence over a number of years of many of the issues outlined in this report suggests that either the DWP does not listen to the ICE’s recommendations, or the recommendations themselves do not go far enough.

In the year 2019 - 2020, of 67 ICE investigation reports issued concerning disability benefits, only around a fifth (19%) were fully upheld, with almost half (45%) partially upheld, and more than a third (36%) not upheld at all.⁴⁵ Moreover, the ICE focuses on cases of maladministration, rather than cases of harm⁴⁶ meaning that these figures do not come anywhere close to representing the true extent of serious harm that people experience following contact with the DWP. As a result, we recommend a stronger mechanism for people to have their cases investigated to sit alongside the ICE.

Rethink Mental Illness is calling for the introduction of a new independent, national body, which would have the power to investigate cases of death or serious harm that result from the policies or actions of the DWP. People should be able to go directly to this body, without going through the coronial system. When DWP errors are established, this body should be able to publicly hold the DWP to account for implementing any changes that have been identified.

42 Baroness Sherlock (2021). [Disability Benefits Claimants. Transcript of House of Lords debate.](#)

43 Independent Case Examiner (2020). [How to bring a complaint to the Independent Case Examiner.](#)

44 Independent Case Examiner (2020). [Annual Report 1 April 2019 - 31 March 2020.](#)

45 Independent Case Examiner (2020) [Annual Report 1 April 2019 – 31 March 2020](#)

46 Independent Case Examiner (2020). [How to bring a complaint to the Independent Case Examiner.](#)

Data and systemic issues

A running thread throughout this report has been the lack of systematic data collection, publication and analysis around benefit related deaths and serious harm, the causes, and the actions required to prevent future tragedies.

This lack of data means the true scale of the issues around death and serious harm outlined in this report remains hidden. The locally delivered system of coronial inquests has been inconsistent in identifying cases in which the DWP has played a role. Where a link has been identified, only a small number of cases have led to Prevention of Future Deaths reports. In turn, the DWP has stated that it does not think there is a “business need” to collect data on the deaths of people on benefits.⁴⁷ We disagree, and believe that such data could play a powerful role in helping the DWP to reduce instances of death and serious harm, especially in relation to mental illness.

Without a transparent and independent approach to data collection, it is impossible to know how many deaths and cases of serious harm have been caused by the DWP.

Crucially, it is also impossible to know how many are likely to be saved by the actions that have been taken by the DWP, or to what extent there needs to be systemic changes that address issues such as national policy and organisational culture. It is for this reason that we are calling for a full public inquiry into benefit related deaths and serious harm.

⁴⁷ Department for Work and Pensions (2018), in a Freedom of Information request response: [ESA support group suicide](#).

Restoring faith in the benefits system

There is a wealth of evidence demonstrating that while the support provided by the DWP can be lifesaving and plays a vital role in supporting millions of people, a substantial number of deaths and serious harm are associated with the DWP's actions and omissions, particularly in relation to people severely affected by mental illness.

We know that the DWP has taken a number of steps to improve its procedures and correct mistakes. However, this report shows that the number of cases being investigated is increasing and that these cases relate to failings across many aspects of the benefits system. The persistence of cases over a number of years shows that the DWP's current processes for learning from failings is insufficient to prevent serious harm.

The limited DWP data that has been published suggests that the department has an incomplete picture of the scale or nature of benefit related deaths and serious harm, with the publication of data and lessons learnt appearing piecemeal and inadequate.

The number of cases investigated has almost tripled in recent years, but it is unclear how far this relates to a change in the number of cases or changes to when an investigation is undertaken.

We also have little confidence whether, even now, the DWP is investigating all those cases that should be investigated according to its own policies.

It is hard to reconcile the possibility that three times as many deaths are investigated as serious harms when, for example, it is well known that there are far more suicide attempts than completed suicides. Likewise, the number of deaths being investigated by the DWP suggest that it is investigating only a small proportion of claimant deaths by suicide, despite saying that these deaths meet the threshold for an IPR.

It is for these reasons that we are calling for an independent public inquiry into benefits related deaths and other serious harms. We believe that this is the only way to truly establish the full facts of these cases, and only by publicly establishing them can the DWP make the systemic improvements needed to stop benefits deaths once and for all. Looking to the future, the establishment of an independent body to investigate new cases of

death and serious harm would give individuals and families a trusted process to investigate cases and make sure that lessons are learned. Such a body could work well alongside – or be part of – any wider regulator of the DWP, as has been recommended by Mind⁴⁸

There is a real opportunity for the DWP to play a full role in the work that the government is already doing on suicide prevention, including through its National Suicide Prevention Strategy, the NHS Long-Term Plan and the Cross Government Suicide Prevention Plan released in 2019⁴⁹. Yet this recent Suicide Prevention Plan does not currently list the DWP as a delivery partner.

The impact of each individual case is devastating. We believe that the DWP would agree that those left behind deserve to understand what has happened to their loved ones, and that it is in everyone's best interest to create and maintain a system that is supportive, safe and compassionate.

⁴⁸ Mind (2020) [People, not Tick Boxes](#)

⁴⁹ UK Parliament (2021). [Research Briefing: Suicide Prevention – Strategy and Policy](#). House of Commons Library.



Please see below for sources of advice and information, as well as where you can find a list of crisis support organisations.

- Relating to suicide: **rethink.org/suicidalthoughts**
- Relating to self-harm: **rethink.org/self-harm**
- **If you are currently in a crisis or know someone who is**, please visit our crisis support pages to find out which organisations can provide the most appropriate support depending on your circumstances: **rethink.org/helpnow**
- **Advice on benefits:** visit our Mental Health & Money Advice service for practical support if you are experiencing issues with welfare benefits. You can find out what financial help is available and how to make a claim or appeal: **mentalhealthandmoneyadvice.org/en/welfare-benefits**

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**Leading the way to a better quality
of life for everyone severely affected
by mental illness**

For further information
on Rethink Mental Illness
Telephone 0300 5000 927
Email info@rethink.org

rethink.org