Department for Work & Pensions

THE RT HON THERESE COFFEY MP
Secretary of State for Work & Pensions

The Rt Hon Stephen Timms MP,
Chair, Work & Pensions Committee
House of Commons

20th March 2020

Dear Stephen,

Thank you for your letter of 5 March about the NAO's report on information held by the Department on deaths by suicide of benefit claimants. The Department takes this seriously. It is why, last year (and before my time as Secretary of State), the Department established a new Service Excellence Directorate. We successfully secured new Government funds for the DWP Excellence Plan, which will increase investment in safeguarding, decision making and how we learn from the most complex cases. This £36 million extra funding is for the 2020/21 financial year.

I want the Department to be able to look back at how it has served claimants, including those with the most complex cases, to learn lessons and improve processes. Information about the specific improvements the Department has already put in place, along with answers to the Committee's questions about the NAO's report, Internal Process Reviews and the Serious Case Panel are attached. I also intend to update the House on the Excellence Plan before the Summer Recess.

While Government is rightly focussed currently on the Covid-19 challenge and DWP's focus at the moment is on frontline services to those in need of a safety net, we had already started work by redirecting some resources as it is very important that the Department is a listening and learning organisation to help us serve our customers better in a systemic way. We will of course continue this work at pace as soon as the current situation allows.

Yours sincerely,

Therese

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DWP Excellence Plan

In the Spending Round, the Department secured £36 million for improving how we support our most vulnerable customers. This includes improvements to a number of important areas; from enhancing our decision making, so we get more decisions right first time, to ensuring we have the right safeguarding processes in place, working with other departments and agencies. It is allowing us to put new structures in place, including the Serious Case Panel to ensure that we learn from events. In addition, and beyond the Excellence Plan, across the Department we have already acted to improve how we respond to those with complex lives, including:

- We have empowered our decision makers to gather all relevant evidence to make a fully informed holistic decision addressing any gaps or concerns identified in their assessment, by any appropriate means available to them. This includes going back to Health Care Providers if they want more information from the assessment before they make a decision, as well as contacting the customer to check for any additional information about their health condition.
- Local leaders carry out case conferencing on complex cases to try to resolve issues in the best interests of the customer, often working with other agencies or local organisations.
- Work coaches tailor the support they provide to customers based on the customer's circumstances and needs, signposting and referring to local support provided by expert partner organisations.
- Every jobcentre has a complex needs toolkit containing links to local support for a range of complex needs and circumstances so that staff can signpost customers to specialist organisations best able to support them.
- We have strengthened the guidance for colleagues to ensure customers with complex needs, including those with mental health challenges, receive the right support.
- We have introduced mental health training, designed by experts, for all staff who have direct contact with customers, whether face to face or by telephone, so they are better equipped to identify mental health issues or vulnerability and take appropriate action to support customers. To date around 30,000 colleagues have received this training.
- With serious cases, we have contacted families and met them to talk about what happened in their relative's case, answer their questions and apologise if we made errors.
- We have held training events for Jobcentre Plus staff, developed by working with a number of leading homelessness and domestic abuse organisations and co-delivered with Women's Aid. These events equipped work coaches to deliver better support to customers who are experiencing homelessness or domestic abuse, and to function as a point of contact for local specialist organisations.

We are also putting an emphasis on becoming much more of a learning organisation:

- In October 2019 we set up a Customer Experience Directorate with a dedicated Director, with the aim of bringing together the wealth of insight we have from our interactions with customers to better learn from it;
- We have set up the Serious Case Panel charged with discussing systemic issues arising from serious cases and making recommendations to ensure these issues stop happening; and
- We have created "VOC:AL" – Voice of the Customer Active Learning – which is a product that teams use to talk about real examples of customer cases. They are asked to put themselves in the customer's shoes and talk about what we could have done differently in that case.

NAO report on information held by the Department for Work and Pensions on deaths by suicide of benefit claimants

Turning to the specific points you raise in your letter.

Questions 1-6 & 12-14

You asked about the main changes the department has made as a result of the 69 investigations referred to in the NAO's report. This relates to Internal Process Review investigations which can be triggered for a number of reasons, including cases in which we have been informed that a claimant may have committed suicide. Internal Process Reviews bring officials together from across the Department to look at specific complex cases. They check whether processes were followed, investigate any mistakes that may have been made and identify whether there are lessons to learn and actions to take in response to ensure not just that our processes work efficiently but that they also help us to safeguard vulnerable people as best we can.

IPRs were initially established before 2009 as what were called Peer Reviews. Prior to 2012 they were conducted by local business areas, and date back to 2009. While they are often tragic cases which we can learn from, the fact we have undertaken an IPR does not necessarily mean that the department was culpable in that death.

As the NAO note sets out, historically, the department has not consistently tracked these recommendations centrally, instead recommendations were made to local business leaders to be taken forward. One of the first actions for the Customer Experience Directorate was to improve Internal Process Reviews. The review mentioned in the NAO briefing note is being led by a team within Emma Haddad's area, the Customer Experience and Learning team. This work will also consider the issues you raise, such as publication of IPR material, including recommendations, and the period of time the Department retains IPRs. This work began before the NAO's report, as this is one of our key priorities. As part of this work we are:

- Clarifying the purpose of an IPR, including defining when a case should be investigated – drawing on best practice from HMRC, the NHS and others across government. We hope to have this in place in the next month.
- Building the capacity and capability of the IPR team to conduct high quality investigations and reports. Recruitment has already begun and will be continuing in the coming months. We are also strengthening reporting standards by learning from the Independent Case Examiner and external bodies.
- Improving the visibility of the IPR process with all colleagues through internal communications, including updating guidance outlining why and how to refer a case for investigation. We expect this to be completed by the end of April and the communications work will continue on a regular basis after this period.
- Increasing communications to coroners to raise their awareness of our Departmental Coroners' Focal Point and updating internal guidance so that correspondence from coroners can get to the focal point. Again we expect this to be completed in April.
- Establishing an organisational learning function to rigorously track recommendations for both IPRs and the Serious Case Panel so we have a central record of recommendations and monitoring of progress against their delivery. This will allow us to evaluate our progress in these critical areas.

In the past, the recommendations have not, as a matter of course, been subject to Ministerial attention. As part of the DWP Excellence Plan I want to assure you that we are improving the tracking of recommendations and the visibility at the most senior levels in the department, including my Ministerial team. The IPR process has previously made recommendations at an operational level with local senior leaders. The creation of the Serious Case Panel, looking at systemic issues arising from complex cases and other sources such as ICE reports, will help to ensure greater cross-cutting departmental oversight of recommendations.

Questions 7 and 8
Both Emma Haddad, Director General for Service Excellence, and JP Marks, DG for Work and Health Services, are responsible for ensuring improvements are made and embedded in our delivery areas. That said, the whole of the Executive Team and my Ministerial team (and I) have a role to play here: Learning lessons and acting on them might be about changing our policies, developing new digital tools or coaching our staff, and, as such, creating a learning culture spans the whole Department.

The Serious Case Panel will be accountable for ensuring that recommendations are delivered and I have asked Emma Haddad to update the Board on this routinely, in order to ensure we make progress on the most critical areas, including the work referenced in the NAO note.

Questions 9, 10 and 11a
You asked a number of questions about the Serious Case Panel. The intent behind the creation of this Panel is to ensure we are not just looking at individual cases but also looking at themes or systemic issues with the ultimate aim, as specified in the Spending Review, to improve safeguarding. The panel will meet quarterly to consider

themes arising from a range of sources including Internal Process Reviews, complaints, frontline feedback and reports from the Independent Case Examiner. There are already independent investigations into any situation involving the death of a claimant in unexplained circumstances, namely that of an inquest of a coroner. Any conclusions they reach can be considered by the Panel.

One of our independent Non-Executive Directors chairs the Panel. Joanna Wallace, the Independent Case Examiner, sits on the panel, alongside the Permanent Secretary and all Directors General. Over time we might invite other experts to join the Panel, for example those experienced in learning from serious cases in the health service or the police.

Question 15
Where our evidence suggests that there are systemic or cross-cutting issues relating to our role in safeguarding that need to be addressed, the Serious Case Panel now provides a route to consider these at the most senior level and take forwards recommendations to address these issues.

Recruitment is under way to recruit 37 Safeguarding Leaders across the country to act for DWP for all service lines and provide active participation on multi-agency boards to ensure all stakeholders are clear on DWP's role and accountabilities, how we can support vulnerable customers, and to look for opportunities to create a collaborative approach across each geographical area.

Questions 16 and 17
You asked specifically about how long DWP keeps records of reviews, and how we capture learning. Your letter also makes reference to a recently released Freedom of Information request on this matter. I have discussed the Department's response to that Freedom of Information request with the Permanent Secretary and have asked him to release an update which clarifies the position.

DWP's Information Management Policy sets out at a high level how we process, store and dispose of all types of information. It is partly necessitated by the General Data Protection Regulation's (GDPR) Storage Limitation and Transparency Principles but also as part of the good record keeping practice demanded of all departments by The National Archive which is the lead authority for Information Management in government. Neither the GDPR or The National Archive specify time periods for storing personal data. Rather they require us to consider the business justification for holding information and to set out time periods accordingly. To achieve this, the Information Management Policy is accompanied by Retention Schedules which set out how long customer information relating to the Department's key products and services should be kept.

In relation to IPRs, the current position is that these are held for 6 years where they relate to suicide or self-harm, in line with the Department's Information Management Policy. Anonymised records of recommendations are retained beyond this period. I think this is an appropriate length of time as we need to act on IPRs at pace while correctly retaining records that could be used in any future legal process.

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From the Chair

Rt Hon Dr Thérèse Coffey MP
Secretary of State
Department of Work and Pensions

5 March 2020

Dear Thérèse,

I met Peter Schofield, Permanent Secretary, on 13 February to discuss the recent National Audit Office report *Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants*, as well as other matters.

The report exposes significant weaknesses in how the DWP learns lessons from some of the most tragic cases it sees—when the people it serves die by suicide. In the light of the gravity of the NAO's findings, the Committee has asked me to write to you to seek further information about how the Department plans to respond.

We were particularly concerned by the following matters highlighted by the NAO's report:

- The DWP has investigated 69 deaths by suicide in the last 6 years. The NAO concluded that it is "highly unlikely" that this represents the number of cases that the Department could have investigated in that period.

- The DWP does not have robust records of contact by coroners. Some contacts from coroners may not have resulted in an investigation being initiated.

- DWP staff have not always had clear guidance on when an investigation should be initiated, and not all staff are aware of the guidance that does exist.

- The DWP does not track the findings and recommendations from its own investigations. As a result, it "does not know whether the suggested improvements are implemented".

- The DWP does not seek to identify trends or themes in the outcomes of investigations. As a result, the NAO concluded that "systemic issues which might be brought to light through these reviews could be missed".

It is shocking that DWP does not have suitable processes in place to identify these tragic cases. Even where it does try to learn lessons, the Department has no system in place to check to see whether recommendations from its own investigations have been put in place, or whether there are any trends or systemic issues that could be identified. It is therefore entirely possible that recommendations made after people have died have not

been implemented, and that DWP is missing opportunities to prevent deaths of the people it serves as a result. This cannot be allowed to continue.

I am pleased that the initial response to the report, including the commitments made by DWP in the report itself, suggests that DWP is taking the NAO's findings seriously. We would, however, be grateful for further information about your plans, and in particular for answers to the following questions:

1. **What are the main procedural changes the Department has made as a result of its investigation of the 69 deaths by suicide since 2014-15?**

2. **What information have Ministers received about the outcomes of those investigations and the recommendations arising from them?**

3. **What specific actions has the DWP already taken in response to the NAO's report?**

4. **What actions does the DWP still plan to undertake in response to the NAO's report?**

5. **How long will it take for the remaining actions to be implemented?**

6. **How will DWP evaluate progress in this area? How regularly will progress be evaluated?**

7. **Which Director General is ultimately responsible for ensuring that DWP resolves the above issues, and that DWP learns all lessons it should from these tragic cases?**

8. **How regularly will you, in your capacity as Secretary of State, receive updates on progress in resolving the points raised by the NAO?**

The NAO reports that a new 'serious case panel' has been established in the Department, to consider the most serious systemic issues raised by investigations and to make recommendations to the Department.

9. **Can you describe in detail what the role of the serious case panel will be, and how it will fulfil this role?**

10. **What will the membership of that panel be?**
    a. **Will the panel include independent members who are not DWP employees or contractors? Will the panel include anyone with medical expertise?**
    b. **Will the panel membership be published?**

11. **What information about the panel's work will be made public, and in what form?**

a. **In particular, will its recommendations and terms of reference be made public? If not, please can you set out the reasons why?**

The NAO also reports that the Department will be carrying out a review, which will focus on strengthening the investigation (Internal Process Review, or IPR) process and the Department's response to serious cases, including suicides.

12. **How long do you expect this review to take? Will the outcome of the review, including any report, be made public?**

13. **Who is conducting the review?**

14. **Will the review consider whether the recommendations from IPRs could be published in a suitably anonymised form?**

15. **As part of its learning, will the Department also review its safeguarding procedures and how staff are made aware of them, in the light of reports of failures to follow safeguarding procedures in some cases?**

We would also be grateful for clarification of how long DWP keeps the records of reviews it has conducted (until October 2015, these were called peer reviews). Will Quince, Minister for Welfare Delivery, told the House on 4 July 2019 that:

> "The Department holds the original commission and final report for all peer reviews of disability benefit claimants' deaths up to 2015. All these documents are kept for **six years** from the date of the final report."[1]

On 21 February 2020, however, a response from the Department to a Freedom of Information (FOI) request seeking access to peer reviews from 2010 onwards explained that:

> "Records prior to 2015–16 have been destroyed or are incomplete in line with GDPR/data retention policies."

The same FOI response also says that "personal data kept for any purpose should not be kept for longer than necessary", citing the Data Protection Act 2018 and GDPR as the reason for the Department's data retention policies.

16. **How long are the initial commissions and final reports retained from the date investigations are concluded? Why did the Department choose this length of time?**

[1] HC Deb, 4 July 2019, col 1353. Emphasis ours.

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17. **What steps does the Department take to ensure that learning from reviews is not lost when these records are destroyed?**
    a. **Does the Department take any steps to retain redacted records of historic investigations, and their recommendations, without unnecessarily holding personal data? If not, please can you explain why not?**

We would be grateful for a reply by **18 March**. The Committee will then want to examine your response carefully and consider what further work we wish to do on this subject.

Yours sincerely,

Rt Hon Stephen Timms MP

Chair, Work and Pensions Committee