Timeline – note that this is simply an aide memoire. Unless stated, no connection is implied between the various events

* 2000
	+ ‘Minimum requirements’ (precursor to the current benefit safeguarding guidance) were introduced requiring DWP to liaise with psychiatric units and social services and to refer cases to a manager before a decision is made to withdraw benefit. These stated that ‘[w]here the claimant has a known background of mental illness there are minimum requirements that Jobcentre Plus should be adopting to ensure that we are not found to be neglectful in our duty of care towards these claimants’.
	+ Prompted by the death of a claimant in 1998 (Mr. T) as described here: <https://hansard.parliament.uk/commons/2000-03-16/debates/6c1d59d2-f269-4ec7-9332-cc8b138c08f3/MentallyIllPeople>
	+ The coroner found that neglect by the Benefits Agency was a contributing factor to Mr T’s death: [www.rightsnet.org.uk/?ACT=39&fid=3&aid=789\_LpXMW4Vbk0i1jqt9kzkK&board\_id=1](http://www.rightsnet.org.uk/?ACT=39&fid=3&aid=789_LpXMW4Vbk0i1jqt9kzkK&board_id=1)
* Mid-noughties
	+ Peer reviews introduced (Q2 <https://committees.parliament.uk/oralevidence/759/default/>)
* January 2010
	+ Stephen Carre died
* Spring 2010
	+ Reportedly, the coroner investigating the death of Stephen Carre sends a Rule 43 letter (apparently a precursor to Prevention of Future Deaths reports) to DWP
	+ DNS news story states that neither the WCA assessor nor the decision-maker who subsequently decided that he was fit for work and therefore ineligible for the new employment and support allowance, had sought information from his GP, his community psychiatric nurse or his psychiatrist <https://www.disabilitynewsservice.com/stephen-carre-scandal-dwp-finds-draft-report-that-was-never-sent-to-coroner/>
* It’s unclear when, exactly, ‘benefit safeguards’ in their current form (extra checks, home visits, and notifications to third parties – in certain circumstances) were introduced. However, the Universal Credit white paper (‘Universal Credit: welfare that works’, November 2010) commits to maintaining safeguards for vulnerable people.
* 31 December 2011
	+ ‘Ms DE’ found dead
* 24 September 2013
	+ Michael O’Sullivan died
* 13 January 2014
	+ Coroner investigating the death of Michael O’Sullivan issues a Prevention of Future Deaths report. The report states that:
		- the trigger for Mr O’Sullivan’s suicide was his assessment by a DWP doctor as being fit for work.
		- Neither the assessing Dr or the decision maker saw, or requested, any evidence from his GP, psychiatrist, or clinical psychologist
* 26 March 2014
	+ The Mental Welfare Commission Scotland, an independent organisation set up by the Scottish Parliament, releases a report into the death of ‘Ms DE’. <https://www.mwcscot.org.uk/sites/default/files/2019-06/who_benefits_final.pdf>
	+ Among other things the report criticises the WCA, the peer review process, DWP vulnerability guidance, and the lack of contact made with third parties.
	+ DWP response can be found here: [https://web.archive.org/web/20140812165310/https://www.mwcscot.org.uk/media/180947/response\_from\_dwp\_with\_mwc.pdf](https://web.archive.org/web/20140812165310/https%3A//www.mwcscot.org.uk/media/180947/response_from_dwp_with_mwc.pdf)
		- The DWP response states that vulnerability guidance was revised in 2013 and is reviewed regularly as part of an on-going process
* 17 October 2014
	+ DNS website reports on DWP’s peer review process (carried out following serious incident or death) <https://www.disabilitynewsservice.com/dwp-contradicts-its-own-position-on-benefit-related-deaths-again/>
	+ I think this is the first time that the existence of peer reviews is widely reported (despite having been mentioned in the MWC Scotland report)
	+ The story was picked up by The Guardian in December <https://www.theguardian.com/society/2014/dec/14/dwp-inquiries-benefit-claimant-suicides>
* 7 November 2014
	+ Faiza Ahmed died
* Some time in [2015](https://www.whatdotheyknow.com/request/639398/response/1531333/attach/2/WDTK%20Template%203586.pdf?cookie_passthrough=1)
	+ DWP change the name of ‘peer reviews’ to ‘internal process reviews’
	+ <https://www.disabilitynewsservice.com/dwp-secrecy-over-benefit-related-suicides/>
* 24 March 2015
	+ The Work and Pensions Select Committee release a report into ‘Benefit sanctions policy beyond the Oakley Review’ <https://old.parliament.uk/business/committees/committees-a-z/commons-select/work-and-pensions-committee/inquiries/parliament-2010/benefit-sanctions/>
	+ The submission to the committee by Disability Rights UK (dated 12 December 2014) addresses benefit safeguards (at Q.4A) <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/work-and-pensions-committee/benefit-sanctions-policy-beyond-the-oakley-review/written/16425.pdf>
	+ The committee’s report makes recommendations regarding:
		- Review of the legislative basis for sanctions, including safeguards
		- investigating deaths of benefit claimants
* 23 October 2015
	+ PFD report following Michael O’Sullivan’s inquest is reported by DNS
	+ <https://www.disabilitynewsservice.com/michael-osullivan-scandal-inquest-notes-expose-shocking-failings-of-wca-system/>
* 28 October 2015
	+ CPAG Welfare Rights Bulletin article published
	+ <https://cpag.org.uk/welfare-rights/resources/article/safeguarding-guidance-tool-practitioners>
* 9 November 2015
	+ Stephen Carre’s death is reported by DNS
	+ <https://www.disabilitynewsservice.com/wca-death-scandal-dwp-and-atos-killed-my-son/>
* 14 December 2015
	+ The government reject an amendment to the Welfare Reform and Work Bill which would have created a statutory basis for benefit safeguarding <https://publications.parliament.uk/pa/ld201516/ldhansrd/text/151214-0002.htm#15121440000458>
* December 2016
	+ UC Programme Delivery Executive took a decision for greater focus on the service and provision for vulnerable people and those with complex needs on UC and for the explicit inclusion of ‘adequate provision for vulnerable people’ in the scaling criteria for the service.
	+ Source, para 5 <http://data.parliament.uk/DepositedPapers/Files/DEP2019-0890/19-MayF-Paper5-Service_and_Provision_for_Vulnerable_Cus.pdf>
* 20 January 2016
	+ Coroner investigating the death of Faiza Ahmed issues a Prevention of Future Deaths report
* 6 February 2016
	+ Faiza Ahmed’s inquest is covered in The Guardian
	+ <https://www.theguardian.com/uk-news/2016/feb/06/faiza-ahmed-cries-for-help-missed-every-authority-simon-hattenstone>
* 19 March 2016
	+ Stephen Crabb appointed SSWP, replacing Iain Duncan Smith
* March 2016
	+ DWP set up coroners focal point, aiming to provide a single point of entry for coroner communications, including those related to suicide
* 12 May 2016
	+ FOI leads to the publication, by DWP, of redacted peer reviews
	+ <https://www.gov.uk/government/publications/dwp-foi-releases-for-may-2016>
* Summer 2016
	+ The ‘minimum requirements’ appear to have been removed from DWP guidance
* 14 July 2016
	+ Damian Green appointed SSWP
* 30 November 2016
	+ Disability Rights UK publish their submission to the NAO report into benefit sanctions.
	+ The DRUK submission includes criticisms of DWP’s monitoring of the impact of benefit sanctions on vulnerable claimants (see section of report titled ‘Sanctions and the safeguarding of vulnerable ESA claimants’ <https://www.disabilityrightsuk.org/news/2016/april/our-submission-nao-sanctions-study>)
* 2 December 2016
	+ Mhairi Black’s private member’s bill fails to progress beyond the second reading
	+ <https://researchbriefings.files.parliament.uk/documents/CBP-7813/CBP-7813.pdf>
* 21 February 2017
	+ Jodey Whiting died.
* April 2017
	+ DNS reporting (at the time and subsequently) states that DWP acknowledge that recommendations made by IPRs (previously known as peer reviews) had not been tracked by DWP between Feb 2012 and September 2015 but that improvements to processes had been identified.
	+ <https://www.disabilitynewsservice.com/letter-shows-appalling-dwp-misled-two-watchdogs-over-benefit-deaths/> & <https://www.disabilitynewsservice.com/government-admits-failing-to-record-actions-after-benefit-suicide-inquiries/>
* 18 May 2017
	+ Paper is presented to the UC Programme Board titled ‘UC – service and provision for vulnerable people and those with complex needs’. The paper acknowledges that a number of issues concerning the accessibility and responsiveness of UC in the case of vulnerable individuals and households with complex circumstances have arisen since UC went live <http://data.parliament.uk/DepositedPapers/Files/DEP2019-0890/19-MayF-Paper5-Service_and_Provision_for_Vulnerable_Cus.pdf>
	+ Since the December 2016 decision to put greater focus on this subject:
		- Adequate provision for vulnerable people has been included in the scaling criteria for the UC programme
		- Vulnerable People Steering Group established to focus on this issue
		- 5 areas were identified for improvement:
			* Early identification and recording of complex needs
			* Improving service to those without bank accounts
			* Ensuring that vulnerable claimants can make and maintain telephone claims where needed
			* New processes and guidance on appointees
			* Improving universal support delivered locally (USDL) and wider partnership working in support of vulnerable people
	+ The Programme Board confirmed they were content with the plan to deliver improvements and additions to the UC service for vulnerable people. <http://data.parliament.uk/DepositedPapers/Files/DEP2020-0644/22._H_UCPB_19.04.18_BTL01_Dec_Log.pdf>
* 24 May 2017
	+ Inquest into Jodey Whiting’s death
* 11 June 2017
	+ David Gauke appointed SSWP
* October 2017
	+ An NAO report (released in 2018 and titled ‘rolling out universal credit’) states that
		- *“the Department’s research in October 2017 shows that some staff found it difficult to support claimants because they:*
			* *lacked the time and ability to identify claimants who needed additional support;*
			* *lacked the confidence to apply processes flexibly and make appropriate adjustments; and*
			* *felt overwhelmed by the volume of claimants reporting health problems.”*
* 8 January 2018
	+ Esther McVey appointed SSWP
* 19 April 2018
	+ ‘Supporting Claimants with Complex Needs in Universal Credit Full Service –Update’ presented to UCPB <http://data.parliament.uk/DepositedPapers/Files/DEP2020-0644/20._F_UCPB_19.04.18_Paper_5_P6_Readiness.pdf>
	+ UC SRO
	+
* 20 June 2018
	+ Errol Graham’s body is discovered by bailiffs. Weighing just 4½ stone, Errol’s body was found eight months after his employment and support allowance had been stopped. He was 57 years old. His social security support was cut off in October 2017, just weeks after he failed to attend a WCA
* August 2018
	+ In August 2018 DWP began including an existing training module on supporting vulnerable customers to all new entrants joining any of its service delivery teams <https://www.judiciary.uk/wp-content/uploads/2021/02/2021-0043-Response-from-DWP-Redacted.pdf>
* 5 November 2018
	+ Government respond to SSAC report stating that ‘*We do not underestimate the challenge that managed migration represents and we are working closely with stakeholders and claimants to design the best solution. […] In doing so, our focus will be on safeguarding claimants and ensuring a smooth transition with uninterrupted support.*’
	+ Published alongside the government's response, a revised set of draft managed migration regs <https://www.rightsnet.org.uk/welfare-rights/news/item/too-much-risk-is-potentially-loaded-on-to-individuals-during-universal-cred>
* 12 November 2018
	+ CPAG send submission to the Secondary Legislation Scrutiny Committee regarding the Universal Credit (Managed Migration) Regulations 2018
	+ CPAG call for improvements to the regulations so that they guarantee that no benefit claimants will see their benefit payments stop until they have successfully claimed universal credit. CPAG go on to criticise the DWP track record on safeguarding vulnerable claimants
	+ <https://www.parliament.uk/globalassets/documents/lords-committees/Secondary-Legislation-Scrutiny-Committee/Session-2017-19/CPAG-letter-to-SLSC-on-UC-managed-migration-regulations.pdf>
* 16 November 2018
	+ Amber Rudd appointed SSWP
* 18 November 2018
	+ Roy Curtis died on or around this date
* 13 December 2018
	+ [SSAC write to SSWP regarding the draft managed migration regs](https://www.gov.uk/government/publications/universal-credit-managed-migration-regulations-2018-ssac-correspondence/ssac-response-to-dwp-universal-credit-managed-migration-regulations-2018) stating that:
		- ‘*We remain unconvinced that it is necessary to ask all claimants on legacy benefits to make a claim for Universal Credit’*
		- *‘we remain concerned by the degree to which the safeguards in the migration process depend on the Secretary of State’s discretion and administrative practice, rather than as rights that claimants can exercise’*
* 26 January 2019
	+ Alexander Boamah died
* 21 February 2019
	+ Reporting on the ICE report on Jodey Whiting’s case. See <https://www.gazettelive.co.uk/news/teesside-news/dwp-tragic-jodeys-mum-calls-15864263> and <https://www.disabilitynewsservice.com/jodey-whiting-dwp-ignored-five-safeguarding-chances-before-wca-suicide/>
	+ Roughly around this time a report by an Independent Case Examiner concluded that the DWP had made multiple significant errors in how it treated Jodey Whiting.
	+ Reportedly, the failures were that DWP failed to refer her request for a home visit to the assessor, failed to call or visit her before stopping benefit, failed to write to her GP, and failed to consider her history of mental ill health before stopping her benefit.
	+ DWP are quoted as saying that "We fully accept the Independent Case Examiner’s findings and are reviewing our procedures to ensure this doesn't happen again."
* 21 February 2019
	+ Neil Couling states ‘*The UC SRO noted that not surprisingly those who oppose UC focus on the groups that are hardest to help, but these are not typical of the majority of people using the service. Criticisms are based on the experiences of a minority of vulnerable people. A course correction will be carried out to help such claimants, but fundamentally UC is about changing the way benefits are claimed and encouraging people to come off benefits through work.*’
	+ After that comment the following action point is recorded: AP01-210219 –Look into the possibility of an alternative access route for vulnerable people to make a UC claim and provide PB with a below the line update –JP Marks
	+ This is minuted in an internal UC board paper (top of p.5) <http://data.parliament.uk/DepositedPapers/Files/DEP2021-0348/47_B_Paper1_UCPB_Minutes_210219.pdf>
* 11 March 2019
	+ Neil Couling [discloses](http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/work-and-pensions-committee/benefit-freeze/oral/97869.html) details of ‘who knows me’ to WPSC
	+ *‘What we are testing and what we are seeking to learn is the most effective way of moving people across. That will be an iterative exercise, so we are testing something that we have called Who Knows Me? That is attempting to use stakeholders and partners - because they may know the claimants better than we do - to help us ensure that they move safely from legacy benefits over on to universal credit’*
* 12 March 2019
	+ SSWP makes written statement in HoC stating that no-one will have their benefit stopped during the managed migration pilot
	+ ‘*We do not intend to stop anyone’s benefit during the pilot. In the pilot phase, our intention is to learn how to effectively assist people onto Universal Credit and to develop processes to deliver that help. This is particularly important for vulnerable and hard-to-reach claimants, who the department will help to move across to the new system.*’
* April 2019
	+ Service Excellence Directorate established, Director General is Emma Haddad
* June 2019
	+ Inquest into Errol Graham’s death
	+ DWP had followed their safeguarding procedures
	+ Coroner’s report included the following:
		- ‘[C]urrently there is no guidance for DWP staff following 'failed safeguarding visits' as occurred in this case. There is currently no requirement to seek more information before making a decision to cease benefit following failed safeguarding visits. Again I cannot say on a balance of probabilities that the cessation of Errol's ESA led directly to his death, but I do think the sudden loss of all income, and the threat of eviction that followed from it, will have caused huge distress and worry, and significant financial hardship. […] It is likely that this loss of income, and housing, were the final and devastating stressors, that had a significant effect on his mental health.’
		- ‘The safety net that should surround vulnerable people like Errol in our society had holes within it. Errol needed the GP to try harder to see him, certainly from 2015 onwards. He needed the DWP to obtain more evidence at the time his ESA was stopped, to make a more informed decision about him, particularly following the failed safeguarding visits.’
	+ However, the coroner decided not to write a regulation 28 Report to Prevent Future Deaths demanding changes to DWP’s safeguarding procedures because the DWP Chief Psychologist, David Carew, had said (in a witness statement dated 3/6/19 and confirmed in oral evidence on 7/6/19) that he was leading a review of the Defendant's safeguarding policy and procedures which was intended to be completed by Autumn 2019.
* July 2019
	+ From July 2019 we began rolling out further training, on mental health, behaviour and relationships. This enables colleagues to recognise the effect of their personal impact on people with mental health conditions, and to respond appropriately to unexpected customer behaviour and identify a claimant’s ability to proceed with a call or a face-to-face meeting. It also helps colleagues identify a claimant’s needs and signpost them to sources of help and support, where appropriate <https://www.judiciary.uk/wp-content/uploads/2021/02/2021-0043-Response-from-DWP-Redacted.pdf>
* 5 July 2019
	+ Coroner investigating Alexander Boamah’s death sends a PFD report to DWP
	+ The (undated) DWP response includes the following:
		- *In response to this a review of the DWP safeguarding policy and guidance is currently underway. The purpose of the review is to strengthen existing guidance along with ensuring liaison and co-ordination happens with other statutory and non-statutory bodies and agencies so claimants are safe and receive appropriate support safeguards.*
		- *The review team is working with teams across the Department and with reference to practice in other statutory bodies in order to create a policy that is in line with good practice. It will consider how communication channels between the Department and treating clinicians can be opened up so concerns can be raised and acted on where necessary.* ***The review is scheduled to provide a revised policy and guidance in September 2019****.*
		- [*https://www.judiciary.uk/wp-content/uploads/2019/09/2019-0232-Response-by-DWP.pdf*](https://www.judiciary.uk/wp-content/uploads/2019/09/2019-0232-Response-by-DWP.pdf)
	+ It appears that guidance may have been issued regarding large arrears payments in the 6 months prior to February 2020 <https://www.rightsnet.org.uk/forums/viewthread/9149/P135/#82129> – note that that guidance seems to be similar to that described here: <https://questions-statements.parliament.uk/written-questions/detail/2021-05-11/62>
* 21 August 2019
	+ Roy Curtis’ body is discovered, he had died on or about 18/11/2018.
	+ The circumstances surrounding his death were described, in a subsequent Safeguarding Adults Review, as follows: *In September 2018 the police were called out because an online friend had been sent a suicide note by Adult D. The reason given for ending his life was that he believed he had been assessed as ‘fit for work’ by the Department for Work and Pensions (DWP)and he feared he would no longer be able to pay his rent or afford food after his benefits were stopped and he would become homeless. He was again assessed under the Mental Health Act 1983 and admitted to the Campbell Centre as an informal patient. In October 2018 he was discharged to the care of the Acute Home Treatment Team(AHTT) and two weeks later to the care of his GP. At the time his benefits had been reinstated and it was thought that the trigger for his suicidal ideation had been mitigated. A referral was made to adult social care before his discharge as he was thought likely to require care and support. A social care assessment was not completed. Ten months later Adult D was found deceased in August 2019 by bailiffs entering the property due to non-payment of rent.*
* 27 August 2019
	+ Coroner commences investigation into death of Roy Curtis
* 4 September 2019
	+ 2019 Spending round includes a £106m package to fund the ‘Plan for DWP Excellence’, of which:
		- £36 million to ensure DWP decision-making is accurate and the application processes are straightforward and accessible, as well as improving safeguarding by creating a new independent Serious Case Panel; and
		- £23 million to fund a range of other measures, including support for vulnerable claimants and people with complex needs migrating to Universal Credit, additional outreach activities to support those who are homeless, and increasing the number of Armed Forces champions to support veterans when entering the labour market.
	+ DWP refuse to answer questions about the Serious Case Panel
		- <https://www.disabilitynewsservice.com/will-new-serious-case-panel-probe-benefit-related-deaths-dwp-stays-silent/>
		- <https://www.disabilitynewsservice.com/tomlinson-dodges-questions-over-serious-case-panel/>
* 8 September 2019
	+ Therese Coffey appointed SSWP
* 12 September 2019
	+ The [annual report](https://www.gov.uk/government/publications/dwp-complaints-annual-report-by-the-independent-case-examiner-2018-to-2019/independent-case-examiner-for-the-department-for-work-and-pensions-annual-report-1-april-2018-to-31-march-2019) of the Independent Case Examiner includes a foreword stating that ‘Many of DWP’s policies and procedures recognise this and include extra steps to try to safeguard vulnerable customers, but too often this year I have seen cases where those steps have not been followed.’
	+ The report also states that ‘[v]ery recent discussions reassure me that real action is being taken to make sure these vulnerability safeguards do work effectively and also that my concerns about meeting vulnerable customers’ needs are shared at the highest levels in DWP’. It turned out that that comment was based on un-minuted discussions with DWP
	+ The comments in the ICE annual report appear to be based on the ICE investigation into Jodey Whiting’s death (this ICO report says that the comments in the foreword to the annual report were based on an ICE report produced in February 2019 <https://www.rightsnet.org.uk/?ACT=39&fid=3&aid=2132_ngVtSFhAMElPDEeVgqRg&board_id=1>)
* 25 September 2019
	+ Frank Field MP asks a PQ about deaths by suicide among benefit claimants. DWP unable to provide an answer
* 1 October 2019
	+ Frank Field writes to NAO asking them to engage with DWP to establish what information it holds on benefit claimants who ended their lives by suicide
* Some time in October 2019
	+ Customer Experience Directorate established. According to [this letter](https://www.rightsnet.org.uk/?ACT=39&fid=3&aid=2126_CGp0W61iLMihI4cDqkht&board_id=1) it aims to bring together insight from interactions with customers to better learn from it. Director is Fiona Jones
	+ Confusingly the DWP annual report states that the CED had been set up in Summer 2019 <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/896268/dwp-annual-report-and-accounts-2019-2020.pdf> . Perhaps the confusion comes from the decision having apparently been taken in summer 2019 and the setting up of the directorate coming in Oct 19 - decision to set up the CED had been made in summer 2019: <https://www.rightsnet.org.uk/?ACT=39&fid=11&aid=2125_12KbcrbaK28Uc6SrsLuQ&board_id=1>
	+ Sits within service excellence director general group <https://www.nao.org.uk/wp-content/uploads/2020/10/Departmental-Overview-2019-20-Department-for-Work-Pensions.pdf>
* 16 October 2019
	+ Philippa Day died after having overdosed on her prescribed insulin on 7th or 8th August 2019
* 18 October 2019
	+ The NAO confirm plans to investigate information held by DWP on deaths by suicide among benefit claimants
* December 2019 (as far as I can tell)
	+ it seems, [from an ICO report](https://ico.org.uk/media/action-weve-taken/decision-notices/2021/2619540/ic-48363-c8q5.pdf) (paras.28 and 34), that the review of DWP safeguarding procedures was transferred to the new Customer Experience Directorate around this time and that this was the first time that there was a dedicated business unit responsible for this work.
* 06 January 2020
	+ The family of Jodey Whiting write to the Attorney General to request his consent to apply to the High Court for a fresh inquest into her death to examine role played by DWP
* 23 January 2020
	+ Disability News Service report on Errol Graham’s death
* 7 February 2020
	+ NAO publish report titled ‘Information held by the Department for Work & Pensions on deaths by suicide of benefit claimants’
	+ The NAO set out measures the DWP is taking to improve its processes, including the establishment of a new unit that will be responsible for -
		- improving the coroner’s focal point;
		- overseeing a newly established serious case panel; and
		- carrying out a review, focusing on strengthening the operation of Internal Process Reviews.
	+ One of the criticisms made by the NAO was that DWP do not track the recommendations made in IPRs.
		- The NAO is quoted as saying that they were unaware that DWP had committed to address this problem in 2017 when it had been criticised by the ICO for the same failing <https://www.disabilitynewsservice.com/letter-shows-appalling-dwp-misled-two-watchdogs-over-benefit-deaths/>
		- It seems, from [Therese Coffey’s letter](https://www.rightsnet.org.uk/?ACT=39&fid=3&aid=2249_nHecW5FyCTXqEkc7yIsb&board_id=1) of July 2nd 2020, that monitoring began at a regional level from 2015 (DNS reported that there had been no monitoring from 2012-14) by the DWP One Service Network (OSNs – regional staff management groups which brought together colleagues in working-age and retirement benefits). However, the OSNs had subsequently been scrapped (According to an FOI response dated 11/5/21 the OSNs were scrapped in January 2017 and were replaced by DWP Networks – these dates are confusing as in the months running up to April 2017, according to DNS reporting, DWP had told the ICO that monitoring was in place).
* 17 February 2020
	+ Coroner begins investigation into Philippa Day’s death
* 27 February 2020
	+ Leigh Day issue press release stating that the family of Errol Graham had sent a pre-action protocol letter to DWP
* 19 March 2020
	+ First meeting of DWP’s Serious Case Panel
	+ Discussion paper notes that “DWP does not have a duty of care and therefore cannot be found negligent or liable to pay compensation for this alone. The term ‘safeguarding’ itself can carry legal connotations which we should consider in terms of external interpretations of activity we undertake in this space.” <https://www.whatdotheyknow.com/request/679640/response/1693401/attach/6/Annex%20B%20Paper%202.pdf?cookie_passthrough=1>
	+ Therese Coffey has stated that ‘[t]he serious case panel review was started under my predecessor, Amber Rudd, and when I came into the Department there were some changes that I made to make sure that the panel was the Permanent Secretary with his directors general. It included the independent case examiner and also required one of our non-executive directors to chair the panel’ (Q2 <https://committees.parliament.uk/oralevidence/759/default/>)
* SSWP writes to WPSC to provide information about changes being introduced <https://www.rightsnet.org.uk/pdfs/Correspondence_with_Secretary_of_State_about_NAOs_report_on_information_held_by_DWP_on_deaths_by_suicide_of_benefit_claimants.pdf>
	+ Includes information about a new network of Senior Safeguarding Leaders
* 2 July 2020
	+ Second meeting of DWP’s Serious Case Panel
* 9 July 2020
	+ DWP centralise the complaints system <https://www.gov.uk/government/news/dwp-improves-complaints-handling>
	+ “As part of an ongoing review into complaints, we have comprehensively changed our complaints process to a centralised system effectively independent from internal departments. This is managed by a team in the Customer Experience Directorate. The aim of the single complaints management system is to ensure a high quality first response so that a) the complaint is resolved without the need for further escalation and b) DWP can gain insight into the complaints received which can then be used to improve services.” <https://committees.parliament.uk/publications/2910/documents/28102/default/>
	+ “As part of our response to the COVID-19 pandemic, we had to make changes to our complaints model to allow staff to be deployed to support processing claims and payments. From 9 July 2020, **DWP now triage complaints giving priority to vulnerable customers who may be at risk, and those with benefit payment issues**. We continue to look into all complaints as quickly as we can and, as part of the triage process used to determine lower priority, we write to those customers explaining there may be a delay in answering their complaint. We plan to review the effectiveness of the approach we have taken throughout the pandemic as part of an ongoing review into complaints handling.” <https://questions-statements.parliament.uk/written-questions/detail/2020-11-16/115726>
	+ “Our overall handling of a complaint has not changed, except that complaints are triaged depending on the issues raised and are initially prioritised as follows:Potential Suicide casesHigh profile casesVulnerable peopleOutstanding claims Payment related / severe hardshipEvictions / homelessness” <https://www.whatdotheyknow.com/request/678294/response/1685798/attach/3/FOI%2038146%20IR%2053290%20Response.pdf?cookie_passthrough=1>
* 16 July 2020
	+ Family of Errol Graham granted permission for judicial review
* 16 July 2020
	+ Universal Credit guidance on a new case conferencing process is issued to DWP staff
	+ <https://www.whatdotheyknow.com/request/704039/response/1725557/attach/3/IR%202021.00285.response...pdf?cookie_passthrough=1>
* 17 July 2020
	+ DWP respond to the PFD sent by the coroner investigating Errol Graham’s death. The coroner had, according to Debbie Abrahams MP, written to the SSWP three times over the preceding six months. Therese Coffey states that it took so long to respond ‘because of the legal cases that are under way’ (Q2 <https://committees.parliament.uk/oralevidence/759/default/>)
* 20 July 2020
	+ ESA guidance on a new case conferencing process is issued to DWP staff
* 21 July 2020
	+ PIP guidance on a new case conferencing process is issued to DWP staff
* 22 July 2020
	+ SSWP and DWP Permanent Secretary gives evidence to the Work and Pensions Select Committee.
	+ Perm Sec discloses information about the new ‘case conferencing’ process.
	+ Case conferencing means that where it is deemed a customer is a safeguarding concern the claim will not now be closed automatically after 2 ineffective home visits, payments will not cease. Instead, the case will be escalated to a manager for an additional layer of checks. In the event that safeguarding concerns remain after these extra checks are completed then DWP’s Senior Safeguarding Leaders will liaise with third party organisations(e.g. social services)
	+ Also today, an FOI response discloses DWP’s ‘spotlight on failure to participate or comply’ which shows that a case conference (meeting with team leader) has now been introduced at the point that a work coach refers a potential sanction case to a decision maker and also before the decision maker makes a decision.
	+ Therese Coffey states ‘we do not have a legal duty of aspects of what you would consider to be safeguarding’.
* August 2019
	+ since August 2019 DWP has been rolling out training and new guidance for colleagues working on PIP and ESA claims to promote a new approach to making decisions that considersa wider range of evidence that could be relevant to a claim. This new approach, known as “holistic decision making”involves decision-makers proactively contacting claimants to gather evidence, and spending more time considering all evidence available to them before making a decision <https://www.judiciary.uk/wp-content/uploads/2021/02/2021-0043-Response-from-DWP-Redacted.pdf>
* 15 September 2020
	+ Contact details for DWP’s network of Senior Safeguarding Leaders is circulated to the advice sector
* 17 September 2020
	+ Third meeting of the Serious Case Panel
* 29 September 2020
	+ The SSWP, in a letter to the WPSC, denies that DWP has a duty of care or statutory safeguarding duty.
	+ The SSWP provides a copy of the updated ESA guidance (which shows the new case conference process). The ESA guidance is more detailed than the UC or PIP guidance (which are later released through FOI)
	+ The SSWP provides a copy of the job description/key tasks for the Senior Safeguarding Leader role
* 5 October 2020
	+ DRUK write to the SSWP to express concern about her statement that DWP has no statutory responsibility for safeguarding vulnerable claimants <https://www.disabilityrightsuk.org/news/2020/october/dr-uk-letter-th%C3%A9r%C3%A8se-coffey>
* 7 October 2020
	+ Mind report calls for independent regulator of the benefit system
* 30 October 2020
	+ Foreword to the ICE annual report describes DWP’s handling of vulnerability as ‘an enduring challenge’ and states that ‘This year, following ICE systemic recommendations, we have been told of numerous changes, including: creating a vulnerable customers strategy proposal’.
* 5 November 2020
	+ Philippa Day’s death reported in The Guardian
	+ <https://www.theguardian.com/society/2020/nov/05/family-of-mentally-ill-single-mother-accuse-dwp-of-failing-to-protect-her>
	+ A recording of a phone call Philippa made to DWP, in which Philippa is distressed and tells the DWP call handler that she is starving, was later (in January) released to the press <https://www.theguardian.com/uk-news/2021/jan/28/philippa-days-family-call-for-urgent-changes-to-benefits-system> & <https://www.disabilitynewsservice.com/philippa-day-dwp-phone-agent-ignored-sobbing-claimant-who-later-took-her-own-life/>
* 21 November 2020
	+ Letter from DWP Permanent Secretary to WPSC denies that DWP has safeguarding duty in law
* 23 November 2020
	+ Safeguarding Adults Review published which examines the circumstances surrounding the death of Roy Curtis <https://www.mktogether.co.uk/wp-content/uploads/2020/11/fv_-Adult-D-Overview-report_Nov2020.pdf>
* 26 November 2020
	+ Fourth meeting of the Serious Case Panel
	+ The Panel agreed to consider a different theme in March 2021 than agreed at the last meeting in September. The new theme proposed for discussion in March 2021 was: the service provided by the department at the point where a customer tells DWP that something is going wrong.
* 02 December 2020
	+ Coroner’s investigation into the death of Roy Curtis concludes at the end of the inquest
* 03 December 2020
	+ DNS website reports on the death of Roy Curtis <https://www.disabilitynewsservice.com/roy-curtis-autistic-man-killed-himself-six-days-after-latest-fitness-for-work-demand/>
* 04 December 2020
	+ Coroner send a Prevention of Future Deaths Report to Milton Keynes Council.
	+ No PFD is sent to DWP
	+ The PFD states that Roy Curtis “*admitted to the Campbell Centre in Milton Keynes on the 13th of September 2018 after declaring his intention to take his own life. He was discharged from the Campbell Centre and then from the home treatment team without a formal multidisciplinary discharge plan. There was also, a failure to complete an adult social care assessment that resulted in a lost opportunity to assess his needs and offer him support”.*
	+ The coroner listed the matter of concern as being “*That the procedure for allocating and responding to a referral for an urgent adult social care assessment is overly bureaucratic and they are not afforded the priority within social services that they so obviously require.”*
* 21 December 2020
	+ The family of Jodey Whiting submit an application to the High Court to quash the inquest into Jodey’s death and seek a second inquest so that the role of the DWP in the events leading to her death can be considered. Permission to do so had been granted by the Attorney General in November.
* 12-13 January 2021
	+ Hearing in *Turner*, the case in which Errol Graham’s family challenges the lawfulness of the Defendant's policy on ESA and her decision in Mr Graham's case
* 26 January 2021
	+ The Group Head of Adult Services at Milton Keynes Council responded to the PFD report regarding the death of Roy Curtis
	+ The response states that the Council have improved training, monitoring, links with the acute mental health hospital ward, and processes where they fail to contact somebody.
* 27 January 2021
	+ Coroner’s investigation into the death of Philippa Day concludes at the end of the inquest
	+ Imogen Day subsequently (in May 21) said the following about her experience of her sister’s inquest (<https://docs.google.com/document/d/1xm4jbi5bB1ONy0LHLCmAV4xVNJCM47a38ued_wtLyuY/edit>):
		- “The DWP tried to release as little information to the Coroner [before Philippa’s inquest]as possible – initially their bundle was 100 pages and by the inquest it was more than 4,000.
		- “They were very hesitant to share information because they did not want the severity of the case to be known; they wanted to hide it.
		- “The DWP heavily implied I forged the suicide note.
		- “Initially, it was only supposed to be me and my dad who were due to give evidence at the inquest but my mum felt she needed to speak about her love for her daughter after what the DWP suggested.
		- “It was clear from Philippa’s CPN the DWP seemed dismissive of her experience and vast knowledge and that it was very difficult to pass information from the DWP to Capita.
* 29 January 2021
	+ The DWP Visiting Team started to collate data in relation to visits when a benefit has been suspended, or is at risk of being suspended, from 29 January 2021. <https://www.whatdotheyknow.com/request/748900/response/1782601/attach/3/Response%2030728.pdf?cookie_passthrough=1>
	+ There had been 63 referrals by 27 May 2021 <https://www.whatdotheyknow.com/request/748900/response/1799666/attach/3/Response%2035921.pdf?cookie_passthrough=1>
* 01 February 2021
	+ Amanda Reynolds replaces Emma Haddad as Director General for Service Excellence
* 03 February 2021
	+ DWP Permanent Secretary, giving evidence to the WPSC, discloses that a change has been made to PIP software to make the additional support needs of claimants more visible to DWP staff
	+ Also discloses that every disability benefits centre has a 'vulnerable customer champion' who staff can approach if they have concerns about a vulnerable claimant
	+ And discloses that DWP ‘have been talking to Capita and also Atos/IAS about how they are changing some of their processes for revisiting decisions on whether a face-to-face assessment is required’
* 12 February 2021
	+ Coroner issues Prevention of Future Deaths report, regarding the death of Philippa Day, to DWP
	+ On 27 January, HM Assistant Coroner for Nottinghamshire, Gordon Clow (“the Coroner”), concluded that the problems Philippa Day had with her application for disability benefits were “the predominant…and the only acute factor” which led her to take action that ultimately proved fatal on 8 August 2019
	+ The Coroner identified three areas of concern:
		- Mental health training for DWP call handlers. The Inquest heard that this has not to date formed part of their mandatory training programme before taking calls.
		- Record keeping at the DWP. The Coroner found that poor record keeping had contributed to poor decision making regarding Pip’s claim, without relevant factors being taken into account, and that there had been no evidence of improvements in this respect since Pip’s death.
		- The change of assessment process. This is the process by which someone can seek to change the mode of a disability assessment to be carried out by Capita (on DWP’s behalf), for example from a clinic assessment to a home assessment. (DWP explain this as follows: *We are also making sure that assessments can be paused when an appointment has already been scheduled to allow for the review of the type or location of the assessment, whether or not new evidence has been submitted.*  <https://docs.google.com/document/d/1xm4jbi5bB1ONy0LHLCmAV4xVNJCM47a38ued_wtLyuY/edit> )
* Early March 2021
	+ DWP issued internal communications to all staff working on PIP and ESA early in March 2021 to reinforce the importance of recording notes <https://www.judiciary.uk/wp-content/uploads/2021/02/2021-0043-Response-from-DWP-Redacted.pdf>
* 03 March 2021
	+ High Court dismisses the challenge in *Turner*
* 9 March 2021
	+ Will Quince and Neil Couling disclose, to the WPSC, that DWP is working on a system of claimant profiles which will enable DWP with systematically tracking and supporting vulnerable individuals and groups, and demonstrate the impact of particular interventions. They hope that this will be complete in the first half of 2021
* 25 March 2021
	+ Fifth meeting of the Serious Case Panel
	+ Difficult to tell what was discussed -
	+ However, upcoming meetings will be as follows:
		- June 2021: how we best organise ourselves to respond to customers with complex issues that need urgent resolution;
		- September 2021: how we can incentivise optimum customer service around these cases through management;
		- December 2021: the skills, capability and experience required to support customers with complex issues through to effective resolution.
	+ <https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/980002/dwp-serious-case-panel-minutes-2021-03-25.pdf>
* 24 March 2021
	+ ‘Guidance – Helping Customers Who Require Advanced Support’ is shared on DWP staff intranet on 24 March 2021
	+ It states *‘this is a living document and will continue to be developed as our services evolve and we learn from customer experience and insight continuously’*
	+ ‘Senior Safeguarding Leaders’ are renamed as ‘Advanced Customer Support Senior Leaders’
* 1 April 2021
	+ From 1 April 2021 all new entrants handling PIP and Employment Support Allowance (“ESA”; an income-maintenance benefit for people with a disability or health condition that limits their capacity to work or engage in work-related activity) will therefore undertake the mental health, behaviour and relationships training in addition to the “supporting vulnerable customers” training before they handle calls from claimants on their own. We are also arranging for existing colleagues in those roles who have not yet received the training to undertake it by 30 June 2021 <https://www.judiciary.uk/wp-content/uploads/2021/02/2021-0043-Response-from-DWP-Redacted.pdf>
* 12 April 2021
	+ DWP and Capita respond to the PFD report regarding Philippa Day <https://www.judiciary.uk/publications/philippa-day/>
	+ <https://www.rightsnet.org.uk/welfare-rights/news/item/dwp-and-capita-publish-responses-to-coroners-report-to-prevent-future-deaths-following-findings-that-their-failings-contributed-to-death-of-claimant>
	+ DWP commit to improving note-taking in PIP and ESA
	+ DWPis working with Capita and IAS, to ensure a process is put in place that allows assessments to be paused even when an appointment has already been scheduled to allow for the gathering of additional information or changing the type or location of the assessment. The new process ensures that a claimant’s assessment can be paused without affecting that claim while the reason for the pause is addressed.
* 10 May 2021
	+ Following Philippa Day’s inquest, a letter of claim has been sent to DWP and Capita which alleges breach of human rights and negligence by the DWP and Capita arising out of the events which led to Philippa’s death and seeks compensation for the wrongs Philippa and her family suffered. DWP and Capita have three months to respond before claims may be pursued in the High Court. <https://www.leighday.co.uk/latest-updates/news/2021-news/investigation-reveals-150-dwp-reviews-into-deaths-or-harm-to-benefits-claimants/>
* 10 may 2021
	+ Errol Graham’s family have submitted an application to the Court of Appeal after their judicial review challenging the lawfulness of the DWP’s safeguarding policies was unsuccessful. <https://www.leighday.co.uk/latest-updates/news/2021-news/investigation-reveals-150-dwp-reviews-into-deaths-or-harm-to-benefits-claimants/>
* 19 May 2021
	+ Justin Tomlinson tells the Work and Pensions Select Committee that he hopes the upcoming health and disability green paper will include provision for independent advocates for people going through the WCA and for other vulnerable groups. <https://www.rightsnet.org.uk/welfare-rights/news/item/promotion-of-independent-advocacy-for-claimants-will-be-a-key-theme-of-the-health-and-disability-green-paper-says-dwp-minister>
* 27 May 2021
	+ Email to OSEF states that Fiona Jones, Customer Experience Director, is leaving DWP
* 22 June 2021
	+ Jodey Whiting’s family are due to attend the High Court on 22 June to argue she should have a second inquest to consider the DWP's role in her 2017 death.
* End of June 2021
	+ DWP annual report expected to provide an update on the work of the SCP