Department for Work & Pensions

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Rt Hon Sir Stephen Timms MP
Chair, Work and Pensions Select Committee
House of Commons
London SW1A 0AA

14 March 2024

Dear Sir Stephen,

Re: Safeguarding vulnerable claimants' inquiry – closed session follow-up

Thank you to all Committee members for their time on 28 February. Whilst it was a short session, I do hope Committee members found the information shared helpful in understanding how the department is developing as a learning organisation.

I am writing to you to respond to points raised by Committee members during the session, providing further clarity.

Publishing complaints data by service line

The Committee asked why the department does not publish complaints data by service line. The total number of complaints received will be published in this year's Annual Report and Accounts. This will cover the number of complaints, for the previous year, for the following business areas; Retirement Services, Universal Credit, Working Age Benefits, Disability Services, Child Maintenance and Counter Fraud Compliance and Debt. The department also intends to place complaints data into the public domain on 21 March.

To aid further understanding and transparency, **Annex A** also provides the Committee with a step-by-step process map of DWP's complaints journey, from the point a customer initially raises dissatisfaction through to escalating the complaint to the Independent Case Examiner (ICE) and Parliamentary and Health Service Ombudsman (PHSO). Committee members may also be interested in reviewing The Independent Case Examiner's annual report on complaints, covering the period 1 April 2022 to 31 March 2023, as referenced in the 28 February session.

Prevention of Future Deaths reports

The Committee also asked the department how many prevention of future deaths (PFD) reports have been issued since the National Audit Office (NAO)'s report in February 2020. Five prevention of future deaths reports have been issued to the department since 2020, one of which relates to suicide. The department takes all concerns raised by a coroner very seriously, reviewing these in detail and responding to every PFD report received, taking recommendations forward on occasions where there is learning for the department.

We also conduct an Internal Process Review (IPR) on every case where we are an 'interested person' in an inquest and/or if a PFD report is issued by a coroner. We conduct an in-depth investigation of our interactions with the claimant and share information on improvement activities across DWP services.

In 2016 we implemented a single point-of-contact for coroners to liaise directly with the department, to ensure correspondence is not delayed and actioned promptly. Following the NAO's report in February 2020 the department wrote to coroners again instructing that all coroner's correspondence be sent via this coroners' focal point.

Internal Process Reviews and IPR criteria

I understand that the Committee raised concerns that, since the publication of NAO's February 2020 report, the criteria of when a case will undergo an IPR has narrowed.

It is a mischaracterisation to say that the department's IPR criteria has been narrowed, and arguably, it has actually been broadened. I urge the Committee to consider the full NAO report, particularly the section '*How the department is trying to improve its processes'* which states how the department committed to clarifying the circumstances in which an IPR is carried out:

- **Carrying out a review, focusing on strengthening the IPR process** and the Department's response to serious cases, including suicides, which will focus on:
  - **identifying cases**: clarifying the circumstances in which the Department should carry out an IPR. This will include improving its internal guidance and communication to ensure staff are aware of and understand the processes for reporting a suicide;

Figure 1 - extract from NAO 2020 report - 'How the department is trying to improve its processes'

The department has done exactly that, providing clarity by establishing new IPR criteria in 2021 which was agreed by the then Secretary of State. Focussing on an earlier section in the report in isolation of the later commitments is both misleading and unhelpful.

We have previously shared the current IPR criteria with the committee in correspondence from the Permanent Secretary to the Chair on 29 January, but for full transparency, where a case is referred for an IPR, the criteria for it to be accepted are:

There is a suggestion or allegation that the Department's actions or omissions may have negatively contributed to the customer's circumstances, AND a customer has suffered serious harm, has died (including by suicide), or where we have reason to believe there has been an attempted suicide,

OR

The Department is asked to participate in a Safeguarding Adults Review (SAR), a Significant Case Review (SCR, Scotland only), a Domestic Homicide Review (DHR), or is named as an Interested Person at an Inquest. In these circumstances, an IPR will be conducted regardless of whether there is an allegation against the Department.

Whilst the department would not carry out an IPR unless there was an allegation or suggestion that the department's actions or omissions may have negatively contributed to the customer's circumstances, you will note that the changes to the IPR criteria ensures it is now inclusive of circumstances where a customer has died (including by suicide), attempted to take their own life, or suffered serious harm. This is to ensure the department focusses on the cases where it plausibly has the most to learn.

For clarity, coroners have a statutory responsibility to investigate a death which is reported to them in specific circumstances, including where the cause of death may be violent, unnatural or of unknown causes. This may lead to an inquest. If a coroner's investigations give rise to a concern that future deaths could occur and it is considered that action should be taken to reduce the risk of death, that coroner will be under a duty to make a prevention of future deaths report. Where such a report is issued to DWP, the department will formally respond in full to all the points raised by the coroner in the PFD report. This is the appropriate channel by which the DWP should become involved in the circumstances of a customer's death, since the determination of why an individual has died (and any necessary investigation of surrounding circumstances) falls squarely to medics or HM Coroner.

To further support the Committee's understanding of IPRs, we have provided a step-by-step guide on the journey that a case will take through the IPR process once a referral is received (**Annex B**). To help aid the Committee's understanding of how key findings from IPRs translate into learning and, ultimately, improvements, we have provided a redacted copy of an IPR (**Annex C**) which provides an explanation of the information and recommendations that are captured within an IPR.[1]

The Committee also asked for clarification of the process the department has in place when family members request to see an IPR report. Presently, the process is to consider each request on a case-by-case basis, however, the department is considering a framework to support these requests from family members. There are several legal considerations that the department seeks to understand before we can provide further detail, but we are keen to keep the Committee informed around this ongoing work.

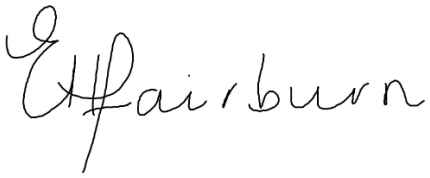
During the session, officials also explained the Serious Case Panel's purpose in considering issues and themes arising from serious cases and other insight, for example, from complaints. Since 2021, the department has published updates on the changes the Panel oversees, and further to the correspondence from the Permanent Secretary to the Chair on 28 February, I would like to again direct Committee members to DWP's Annual Report and Accounts 2022-23 which details the long-term improvement activities the Panel is overseeing. It is a priority of the department to ensure the work of the Serious Case Panel remains in the public domain and the department is very open to exploring further channels to increase transparency.

As you are aware, due to time constraints DWP officials were not able to fully provide further information to aid the Committee's learning in the session on 28 February. I would like to offer Committee members a further informal session with officials prior to the DWP oral evidence session on 26 March to continue building their knowledge and confidence, particularly to walk them through an IPR and talk them through the multiple routes in which the department implements lessons learnt from the work of IPRs and the Serious Case Panel.

[1] Annex C has been removed from this document.

We hope you will find this reply helpful and we welcome the Committee reaching out for further information or to arrange a follow up session where officials can provide more detail on these important topics.

Yours sincerely,



Elizabeth Fairburn
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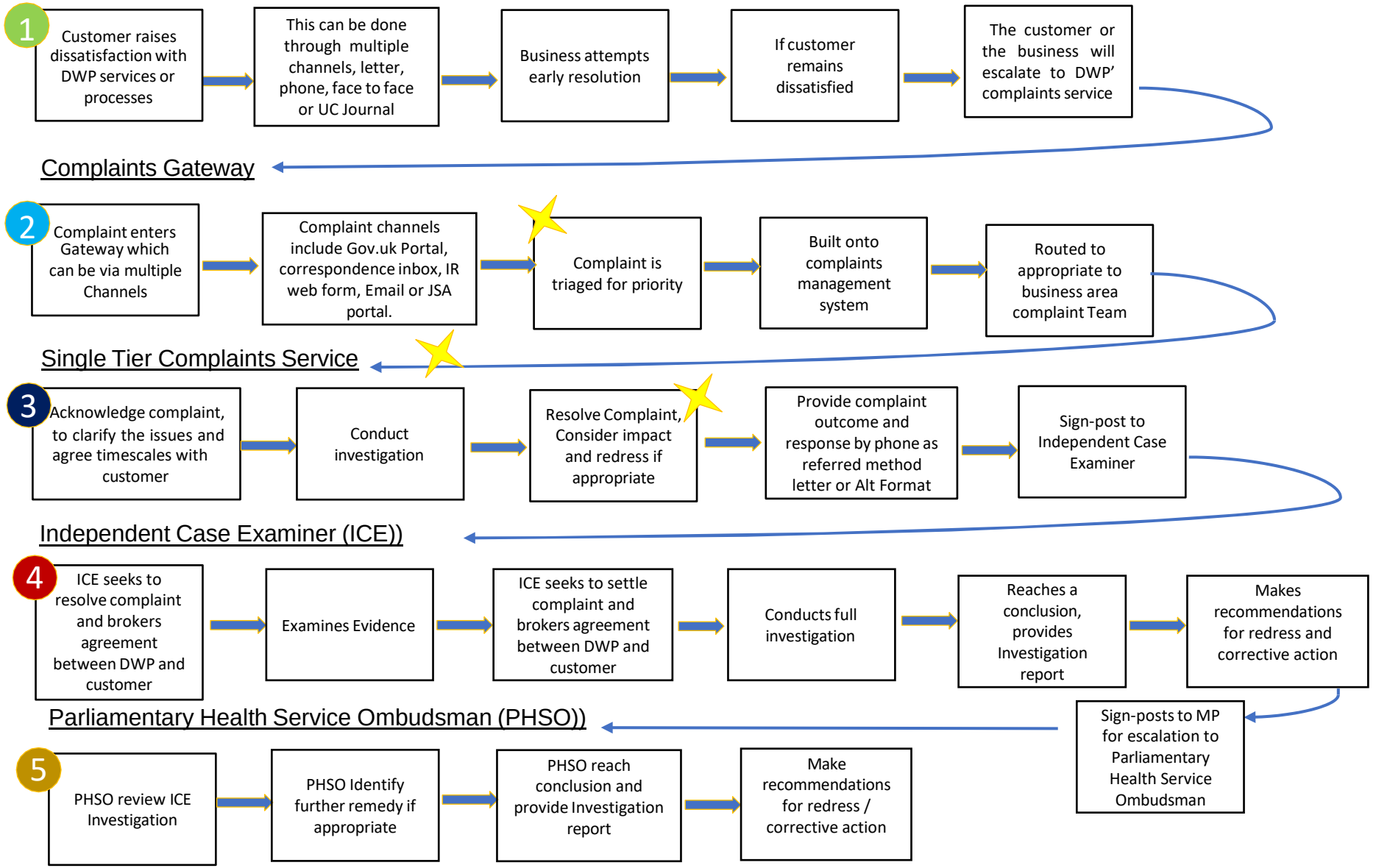
Annex A: DWP Complaints journey



Annex B: Internal Process Review Process

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IPR referral received

Triage
Referral triaged against the criteria by team leader

Criteria not met
Team leader refers case back to product line for local action inc. signposting ACSSL and other support teams

Consider any learning or insight to capture to feed into existing governance routes

Criteria Met
Case allocated to an IPR Investigator

Investigate
Evidence gathered and reviewed by an Investigator. Factfinding discussions with relevant stakeholders completed and a draft report compiled

Quality Assurance
Draft report is peer reviewed then quality assured by team leader

Sign off
Draft report is discussed with IPR senior leaders in weekly case conferences. Report and key findings are signed off.

SCS oversight
IPR reports shared with Deputy Director monthly to discuss findings and provide an overview of IPR themes

Learning into Action
Service Line specific stakeholder review meetings chaired by a senior leader. IPRs are discussed and next steps and ownership agreed.

Wider Learning
IPRs shared monthly with IPRG members with a summary of key findings and learning themes

Governance
Themes from IPRs provide a key source of evidence for Serious Case Panel and other governance routes to improve the vulnerable customer journey.

Improvement activity is monitored through existing governance routes and via stakeholder engagement including evaluation

[Annex C Redacted]

[Annex C Redacted]