Written evidence from Anne-Marie & Declan O'Sullivan (SVC0077)

Submission to the Work and Pensions Committee inquiry into safeguarding vulnerable claimants

1. We make our response in memory of and in protection of our much-loved father Michael O'Sullivan who died on the 24th of September 2013 and in loving memory of Nick Dilworth, a benefits welfare expert, who worked tirelessly on our case for many years.

2. Whenever we write, speak or think about our father, we are reminded of the father we miss so much and know we will never see again. In that regard, we feel it is appropriate for us to make comment on the admirable objectives set out by the Committee to evaluate the DWP's approach to safeguarding vulnerable claimants.

3. This is about people and we very much hope that you remember this when considering the responses you will hopefully have before you in helping you.

4. The facts relating to the death of our father are now well known to the Department for Work and Pensions and the Independent Case Examiner. Our case currently sits with the Parliamentary and Health Service Ombudsman.

5. It has taken us 11 years to get this in front of the PHSO due to the inordinate time it has taken the DWP and ICE to respond to our concerns and voluminous rounds of complaint. We have the names of over 100 DWP officials tasked with responding to us. In stark contrast, we are not supported by a team of lawyers or barristers.

6. We take this opportunity to express our continued deep concerns over the danger of repeating mistakes from the past by failing to consider the truly harrowing impact benefit reforms have on people, like our father, if government does not get the assessment of sick and disabled people right when considering how best to reform what is clearly a very broken system.

7. The failings of our father's (second) Work Capability assessment were all too clearly pointed out by His Majesty's Senior Coroner ME Hassell who upheld the following narrative verdict in the St Pancras Coroner's Court in January 2014. The Senior Coroner in the narrative verdict concluded (excerpt)

> ***"The anxiety and depression were long term problems but the intense anxiety that triggered his suicide, was caused by his recent assessment by the Department for Work and Pensions (benefits agency) as being fit for work, and his view of the likely consequence of that."***

The verdict followed what we can only describe as the most traumatic day of our lives. This was on the 24th of September 2013 when our mother discovered, upon looking through a letterbox, that our father was there lifeless. As a family we all remember that day vividly and will never forget the realisation that our father had taken his life by hanging himself. Waiting for the emergency services seemed to take an eternity but ever since then time has very much stood still for us all.

8. The Coroner's verdict is a clear indication that finding people fit for work is not always conducive to better health; in our father's case it was exactly the opposite. The fit for work finding reached by the Department for Work and Pensions was causative of our father's death; that is the unpalatable cold hard fact.

9. No regard of importance was placed on contacting our father's general practitioner and nor did the Department for Work and Pensions seek to question why they themselves had declared our father unfit for work since 2000, after which they assessed him again in 2002, in 2006, in 2007 and again in 2009.

10. Despite such a stern warning from the Coroner, the DWP never made any contact with us, the bereaved family, but senior lawyers from the DWP's legal team requested a copy of the full audio recording from the inquest, before requesting extra time to respond. We found it strange that the DWP failed to offer us an apology or any expression of condolence.

11. We're a normal family, not campaigners and we do not seek public attention. When we made the decision to make a formal complaint to the Prime Minister, this was initially done on a naive assumption that the DWP didn't fully appreciate the severe harm their Work Capability assessment process had caused to our precious father and that they might even welcome all the meticulous work we had prepared in showing them their wrongs. We did this in the hope they would take responsibility for their failings and to prevent future deaths from occurring.

12. As a family, we have spent an unconscionable amount of time deliberating the DWP's position on duty of care. In July 2020, the then Secretary of State, Dr Therese Coffey, told a Work and Pensions Committee that the DWP do not have a legal duty as "this is really something that is usually held by adult or children social services."

13. Dr Coffey later clarified in a letter to the Committee that the DWP does not have a "statutory" duty of care.

14. In the case of our father, we firmly believe the DWP did have a legal duty of care and we are resolute in our opinion that had they executed their duty correctly he would still be alive today.

15. Earlier guidance in the form of ESA for Benefit Delivery Centres (02 Customer Contact 03 Customers with Additional Needs) shows a clear recognition to have been in place on the duty of care; we refer:

    20. "Where 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."

16. At a meeting with a Service Excellence Director General and other senior DWP officials in January 2020, we were left astounded that the officials could not tell us what their position on duty of care is or was in 2012/2013.

17. The senior officials and Service Excellence Director General did not know what an any time review was.

18. At this face-to-face meeting we distinctly drew attention to Peer Review no 6 carried out from the DWP OPD Business Management Team, released by the DWP following application to the Information Commissioner's Office. The relevant excerpt from peer review 6 is this:

    "We recommend that a review is undertaken of DWP's ongoing Duty of Care in relation to the

identification and support of claimants required to participate in the IBR Process, who as a result of a [REDACTED] may be vulnerable and have different or additional support needs

When defined, the Duty of Care should be brought to the attention of all colleagues including those from Atos who are involved in the IBR Process, and that their responsibilities for the identification and support of claimants with a [REDACTED] are written into role descriptions and included as specific process steps"

19. So when Dr Coffey clarified in her letter to the Committee that the DWP does not have a "statutory" duty of care, she was right to make that correction, as she saw that the DWP could not absolve itself of any duty, due to the transferable nature that the concept of duty of care is.

20. Our argument is that with no clear and defined duty of care, the DWP wrongly considered themselves to be above responsibility for their own actions and omissions. We say the fact that the DWP failed to take account of the significant worsening in our father's condition was a negligent and foreseeable indication that he was suicidal and adversely reactive to work related activity. It was this that was the catalyst that led to such a severe and rapid deterioration in his mental state such that he was increasingly and unnecessarily more predisposed to taking his life and eventually did.

21. All other statements we have received from the DWP and the Independent Case Examiner surrounding duty of care have been inconsistent and contradicted by other definitions, all lacking any real clarity. We would argue because there is no statutory duty of care, this is why the DWP finds it so difficult to communicate their position, especially to painfully bereaved families.

22. One might also ask why do the DWP, when responding to this point, need to involve an army of officials from its litigation team, including senior lawyers and barristers, if there is simply no duty of care?

23. Did a duty of care exist in 2012/2013 that has since been removed, for example when vulnerable claimants started to take their own lives? In our experience when dealing with the DWP we would say they don't follow their own guidelines and even legislation.

24. It was under the Work Capability assessment regime that our father was first assessed, in 2012. On the first occasion, the assessment was conducted by a healthcare professional, a trainee physiotherapist with no formal psychiatric training, who declared my father fit for work in a 12-minute assessment.

25. Clear evidence of the dangers of declaring people like our father, a man who had suffered serious mental health problems for years, including clinical depression, agoraphobia and social anxiety, became obvious when he was subjected to work related activity after being sent on a course by the Jobcentre having been found fit for work. Five days into that course our father was driven to taking a serious overdose.

26. He was once again placed on Employment and Support Allowance when he had only recently been refused it. His GP issued a six-month sick note/fit note following this serious overdose attempt; one that he would tell his doctors was an attempt to end his life.

27. No one seemed to talk to anyone in the DWP because nothing seemed to be noted of the fact our father was back on the sick, on grounds of his condition *significantly worsening*.

28. The six-month sick note/fit note issued following this overdose attempt was mistakenly recorded by the DWP as three months. The DWP has been unable to tell me why this was entered

incorrectly despite me asking them this question for many years.

29. Four months into that sick note/fit note, our father was called for a second WCA. He was subsequently seen again by a healthcare professional with no formal psychiatric qualification, and one who didn't follow up on my father's medical history nor question the fact that he was now back under the care of the Community Mental Health team (following the significant overdose attempt), or explore his suicidal ideation that was clearly well documented on his second ESA50 questionnaire.

30. The ATOS doctor, a former orthopaedic surgeon, did not request any further medical evidence, but nor did the DWP's decision maker.

31. Our father was once again declared fit for work following this second flawed assessment, one which would later be deemed by the General Medical Council to *"fall below the standard expected of a reasonably competent Disability Analyst".*

32. During the inquest, Dr 'S' confirmed to the Coroner that he did not ask our father any questions relating to his mental ill health but had marked the 'no' boxes as though he had asked my father these questions and my father had responded 'no' to these questions. He told the Coroner, while under oath, that he falsely completed the form because our father "looked okay".

33. In concluding their investigation into Dr S's fitness to practice, the General Medical Council found;

    "A number of systemic issues were clearly at play in this tragic case. Analysts employed by ATOS had no formal psychiatric training and were not required to utilise the depression score in assessing mentally disabled claimants. Following the conversion of Incapacity Benefit to ESA, the DWP put immense pressure on ATOS disability analysts to deem claimants fit for work when they previously would have qualified for benefits. The criteria to be applied during workplace capability assessments were altered, making it much more difficult for points to be awarded. These were matters outside of Dr S's control."

34. We have always believed this was systemic failure fuelled by a thirst to find unwell people fit for work, it was all about subscribing to the scrounger narrative and yet our father was anything but a scrounger, he was a deeply anxious man who simply could not cope with all the DWP chose to throw at him.

35. At the age of 60 and with a complex medical history as profoundly serious as our fathers was, he was bombarded with demands to find work. The one job offer, which did come to fruition, was notified to him on a Friday in September 2013. He was told where to report to on the following Monday with no guidance, risk assessment, support or any help for a four-week placement. Our father was totally underprepared for what he was being expected to do, he'd lived for 13 years being told he was unable to work; for the best part of those he was told this by the DWP's assessment process.

36. Monday came but our father didn't turn up at the 7.30 am start time. He was telephoned by people trying to find out where he was on 13 occasions within 3 hours.

37. Our father never heard the phone, as we believe he was already dead. It would be unbearable to think he was still alive as the work placement chased his whereabouts and it crucifies us to think that he might have been hounded to his death. This is something that has overwhelmed us for many years. Navigating this grief has been all consuming and changed the natural direction of our lives.

38. Following our father's inquest in January 2014, His Majesty's Coroner issued the DWP a Prevention of Future Deaths report which was then forwarded by the DWP, internally, to many people including the then Minister of State for Disabled People Mike Penning, members of the DWP legal team, the DWP press team and others.

39. The response that eventually followed to the Coroner made no mention of any Internal Peer Review process, which is astonishing given it is meant to be a continuous improvement tool.

    "Where it is alleged that DWP's actions may have had a severe negative impact on a claimant, DWP conducts a review of its claim handling and interactions in the individual's case."

40. There has been further inconsistency surrounding a peer review into our father's death. On 28 October 2015, in response to a PMQ, former Prime Minister David Cameron told Parliament that he had seen a 'report' but could not disclose the contents of it due to sensitive information contained within it. We have never been provided a copy of this 'report' despite asking for it. The DWP say Lord Cameron got it wrong because he wasn't looking at a peer review.

41. We have been told no peer review was ever carried out, which naturally makes us ask what was Lord Cameron looking at?

42. In 2017, when asked by the Prime Minister Theresa May, to respond to our serious complaint, DWP Minister Penny Mordaunt told us that all of our father's records had been prematurely destroyed. Despite a clear (DWP) policy on retaining documents in cases of suicide for six years.

43. In 2018, another former DWP Minister, Amber Rudd, authorised disclosure of hundreds of documents relating to our father and our subsequent complaint which contradicts entirely what Penny Mordaunt had told us in 2017, as the documents still exist in 2018. They could not have been prematurely destroyed if they were still available.

44. The Prevention of Future Deaths report had been forwarded by email, internally, to numerous people at the DWP including their lawyers and barristers. It is difficult to believe that not one of the official's were aware of their own document retention policy or know to retain and to obviously mark safe these records, especially giving the Coroner's damning verdict and the very fact they since the complaint landed on their desks the DWP has feared us bringing a legal action against them.

45. In the spring of 2014, a call for evidence was announced by Dr Paul Litchfield who was carrying out the fifth and final review of the Work Capability assessment. This was published in the autumn of 2014, but made no reference to our father's case or the Coroner's Prevention of Future Deaths report, nor any mention of the Coroner's report following the tragic death of Stephen Carre, by suicide, in 2010.

46. There was sadly and chillingly another tragic DWP related death the day after our father's death on 25th September 2013, this being the untimely death of Tim Salter, also very sadly by suicide. The Guardian reported on 3 December 2015 that a 'secretive' peer review had been carried out in Tim Salter's case which begs the question why no peer review was carried out in our father's case, and why, despite the lengths we have gone to show the DWP the copious mistakes they made leading up to, and since our father's death, why they have still chosen not to carry out one. As I have said we have spent close to 11 years unravelling the enormous catalogue of failings the DWP made.

47. In November 2020, we finally secured an any time review of our father's benefit claim on the grounds of 'official error'. The DWP concluded they were satisfied that following his second Work

Capability assessment in March 2013, he "***had a significant exacerbation of an already longstanding mental health condition that had affected him for some years***" and as a result both 'fit for work' decisions were overturned.

48. The DWP confirmed in the any time review that "*there was a clearly documented risk to his mental and physical wellbeing if he (our father) were found not to have Limited Capability for Work and Limited Capability for Work Related Activity".*

49. The any time review concluded ***"There is a clear correlation as recorded by Mr O'Sullivan's GP between the work related activity that resulted from this decision and the deterioration in his mental health'.*** This evidence was provided by my father's GP posthumously because the DWP had not followed their own policy, and therefore had not requested an ESA113 as it should have or any further medical evidence at all.

50. Even though the DWP have no statutory duty of care, in our father's case, we say they did have a duty of care, which they assumed from his treating doctors who did have the original duty of care.

51. The DWP recognise the significant deterioration following his first flawed WCA and his treating doctors believed the best way to safeguard him from any further harm whilst he underwent treatment was to sign him off from engaging in any work related activity.

52. Despite being under these sick notes/fit notes the DWP overruled the doctors to find our father fit for work. We say, with this action they assumed the duty of care from his doctors.

53. It was only in the any time review that the DWP were able to retrospectively foresee the risks of finding our father fit for work and the implications that it would have for his mental and physical wellbeing.

54. This confirmed what we, his family, had suspected all along; he was not fit for work. He had always been too unwell to cope with the demands of life which most of us just take for granted.

55. The any time review did not mention any mental health flag or 'marker' and despite copious requests down through the years to the DWP and ICE, we have never been provided with any evidence to suggest our father was marked as a vulnerable person with mental ill health. We have repeatedly asked how this was recorded and requested auditable reference as to when it was first recorded. Our requests remain outstanding.

56. I would argue that the DWP cannot take appropriate safeguarding of our most vulnerable in society if they have not been identified as vulnerable or with a long-standing and well-documented mental health history.

57. The conclusion of the any time review brings an even greater sadness with it because it reconfirms everything we already knew.

58. In December 2021 Dr Litchfield confirmed to the Work and Pensions Committee that he believed he had not been passed copies of DWP reviews into benefit-linked deaths, or the two reports sent to the DWP by Coroner's aimed at <u>preventing</u> future deaths and if they had been, the result of his report would have led to him making further recommendations to improve the assessment.

59. I would urge the Committee to now consider conducting a sixth review with all the available evidence being considered this time, if not an independent inquiry.

60. Each suicide is estimated to cost £1.7m (Department of Health and Social Care, 2017). Most of this cost – around 70% - is the emotional impact on families and on society. The national cost of suicide is almost £10 billion a year.

61. We now enter the eleventh year since our father's passing. For many years we have been asking the DWP to accept the link between their (now admitted) maladministration and the Coroner's verdict. It appears plainly obvious to everyone, including their own ESA/WCA litigation team, who was tasked with responding to our first round of complaint on behalf of Prime Minister Theresa May in 2017 and one who asked their legal colleagues;

"Can you clarify for me why we're not accepting responsibility for his death? Is it just that we're accepting responsibility for making an error? If so, what's the relationship between that error and his death?"

62. If the DWP cannot accept responsibility in this tragic case, we would ask the Committee how can we ever be satisfied that they have learned from their failings? This has always been about preventing harm and preventing future deaths but to learn from your wrongs, the DWP must take responsibility, surely? Is it not of paramount importance that Ministers give accurate and truthful information to Parliament, correcting any error at the earliest opportunity?

63. The DWP's efforts have simply concentrated on trying to make this case 'go away' by using delaying tactics to try and wear us down and insult us. This has wasted 11 precious years and opportunities to put matters right and then furthermore deliberately via the Independent Case Examiner (ICE), in not answering our questions despite being given more than one opportunity to do so. This has further exacerbated an already difficult bereavement, prevented a natural course of grieving and blocked us from moving forward with our lives.

64. Following our father's funeral, we set out to find out what went so tragically wrong leading up to that fateful Monday in September 2013. We have now completed what feels like a 100,000-piece puzzle. In doing so, we have eliminated any grounds of uncertainty.

65. The essence of our evidence is that the DWP had a duty of care towards our father (in 2012/2013) but failed to adhere to it. This is because their position seems to change when it suited them; only a statutory duty will remove any such ambiguity within the department.

66. We have persevered all these years in search of the truth about what happened and what went so tragically wrong in the hope of preventing this from happening to anyone else or to any other family.

67. I have found that the DWP cannot adhere to their own rules and would rather obfuscate their failings rather than face up to their own shortcomings. For a government department, we have been shocked to find the level of understanding of their own rules and policies to be woefully poor. We have found that there is no consistency with their decision-making processes, which risks precious lives and the wellbeing of their vulnerable service users.

68. The DWP will no doubt say to this Committee that they have learnt lessons in order to improve how they deal with their vulnerable clients, but they haven't been able to say what they have specifically learnt from our father's case or exactly what failings they have addressed. We would

argue that the DWP are unable to improve anything when they haven't faced or defined their own past failings.

69. Based on all the above we believe the Department cannot be trusted to act appropriately with vulnerable people voluntarily and to impose a statutory duty of care is the only way to best protect the lives of our most vulnerable in society.

70. We respectfully ask the Committee to remember this is about people and the human cost of life and in our specific case the ripple effect of suicide and its cost.

71. We are eternally grateful to our MP, Sir Keir Starmer KC, and his senior caseworker Richard Banham, for their unwavering support all these years. Keir and Richard have patiently navigated the complexities of this case with the upmost decency, compassion and sensitivity; they are the finest examples to us all.

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