**Note: these are not necessarily quotes, some of this is paraphrasing the original document.**

**Secretary of State’s** [**letter of 20/03/20**](https://committees.parliament.uk/download/file/?url=%2Fpublications%2F461%2Fdocuments%2F1808&slug=correspondence-with-secretary-of-state-about-naos-report-on-information-held-by-dwp-on-deaths-by-suicide-of-benefit-claimantspdf) **(published 26/03/20) in response to Stephen Timms MP’s letter of 05/03/20**

[**https://www.rightsnet.org.uk/?ACT=39&fid=3&aid=2126\_CGp0W61iLMihI4cDqkht&board\_id=1**](https://www.rightsnet.org.uk/?ACT=39&fid=3&aid=2126_CGp0W61iLMihI4cDqkht&board_id=1)

**Therese Coffey’s cover letter (p.1 of the PDF)**

1. The Service Excellence Directorate was established in response to concerns about deaths.
2. States that £36m extra funding in 2020/21 financial year for the DWP Excellence Plan to “increase investment in safeguarding, decision making and how we learn from the most complex cases”.
3. She intends to update the House on the Excellence Plan before the Summer Recess

**DWP Excellence Plan (pp.3-5 of the PDF)**

1. The Excellence Plan will include improvements to:
	1. enhancing decision making to get decisions right first time
	2. ensuring the right safeguarding processes are in place, working with other departments and agencies
	3. putting new structures in place, including the Serious Case Panel to ensure that events are learned from
2. In addition, and beyond the Excellence Plan, across the Department they have:
	1. empowered decision makers to gather all relevant evidence to make a fully informed holistic decision addressing gaps or concerns – including going back to HCPs or contacting the customer
	2. local leaders carrying out case conferencing on complex cases to try to resolve issues, often working with other agencies or local organisations
	3. work coaches tailoring support based on the customer’s circumstances and needs, signposting and referring to local support provided by expert partner organisations
	4. every jobcentre has a complex needs toolkit enabling staff to signpost to support organisations
	5. strengthened guidance to ensure that customers with complex needs, including people with mental health challenges, receive the right support
	6. mental health training for all staff with direct contact with claimants – around 30,000 staff have received this training
	7. with serious cases they have contacted families to talk about what happened in their relative’s case and to apologise for errors
	8. training events for staff by homelessness and domestic abuse organisations
3. They are also putting an emphasis on becoming more of a learning organisation:
	1. In October 2019 they set up a Customer Experience Directorate (distinct from the Service Excellence Directorate) to better learn from interactions with customers
	2. set up Serious Case Panel to discuss systemic issues arising from serious cases and make recommendations to ensure these issues stop happening
	3. Created “VOC:AL” - a learning product which appears to encourage teams to empathise with the claimants they deal with

**Responses to the specific questions raised in Stephen Timms’ letter**

1. In response to the following questions from Stephen Timms:
	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. How long do you expect this review [focused on strengthening the IPR process and the Department’s response to serious cases] to take?
	8. Will the outcome of the review, including any report, be made public?
	9. Who is conducting the review?
	10. Will the review consider whether the recommendations from IPRs could be published in a suitably anonymised form?
2. The SSWP writes that one of the first actions for the Customer Experience Directorate was to improve Internal Process Reviews. The work will consider the issues raised by Stephen Timms’ letter such as the publication of IPR material, including recommendations, and the period of time that the Department retains IPRs. As part of this work they are:
	1. clarifying the purpose of an IPR and defining when a case should be investigated – to be completed within the month (i.e. by end of April 2020)
	2. Building capacity and capability of the IPR team. They are recruiting and strengthening reporting standards
	3. Improving visibility of IPR process, this includes updating guidance in why and how to refer a case for investigation - to be completed by end of April 2020
	4. Increasing comms to coroners to raise awareness of DWP Coroners Focal Point and updating internal guidance to ensure that correspondence from coroners goes through the focal point – to be completed by the end of April 2020
	5. Establishing an organisational learning function to track recommendations for IPRs and the Serious Case Panel so the Department has a central record of recommendations and can monitor and evaluate progress
3. Goes on to state that recommendations will be brought to the attention of the ministerial team and the Serious Case Panel will ensure cross cutting departmental oversight
4. In response to the following questions
	1. 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?
	2. How regularly will you, in your capacity as Secretary of State, receive updates on progress in resolving the points raised by the NAO?
5. The Secretary of State writes that
	1. Emma Haddad, Director General for Service Excellence, and JP Marks, Director General for Work and Health Services, are responsible for ensuring that improvements are made and embedded
	2. The Serious Case Panel will be accountable for ensuring that recommendations are delivered and Emma Haddad will routinely update the Board on this
6. In response to the following questions
	1. What will the membership of that panel [i.e. the Serious Case Panel] be?
	2. Will the panel include independent members who are not DWP employees or contractors? Will the panel include anyone with medical expertise?
	3. Will the panel membership be published?
	4. What information about the panel’s work will be made public, and in what form?
	5. In particular, will its recommendations and terms of reference be made public? If not, please can you set out the reasons why?
7. The Secretary of State writes that
	1. The intent of the creation of this Panel is to ensure that the Department is not just looking at individual cases but also at themes or systemic issues with the ultimate aim, as specified in the spending review, to improve safeguarding
	2. The panel will meet quarterly to consider themes arising from IPRs, complaints, frontline feedback, reports from ICE, and coroners reports.
	3. An Independent Non-Executive Director chairs the Panel
	4. The Independent Case Examiner, Joanna Wallace, sits on the panel alongside the permanent secretary (currently Peter Schofield) and all Director Generals
	5. Over time they might invite other experts to join, such as those experienced in learning from serious cases with the police and health service
8. In response to the following question
	1. 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?
9. The Secretary of State writes that
	1. Where evidence suggests that there are systemic or cross-cutting issues relating to safeguarding that need to be addressed then the Serious Case Panel now provides a route to consider this
	2. Recruitment of the 37 Safeguarding Leaders will help to clarify DWP’s role, to support vulnerable customers, and to work collaboratively in each geographical area
10. In response to the following questions (which references this FOI response: <https://www.whatdotheyknow.com/request/peer_reviews_from_2010_onwards#incoming-1531333> stating that Peer Reviews prior to 2015-16 have been destroyed or are incomplete in line with GDPR/data retention policies)
	1. 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?
	2. What steps does the Department take to ensure that learning from reviews is not lost when these records are destroyed?
	3. 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?
11. The Secretary of State writes that
	1. She has discussed the content of the FOI with the Permanent Secretary and he will release an update clarifying the position
	2. In relation to IPRs the current position is that these are held for 6 years where they relate to suicide or self-harm. Anonymised records of recommendations are retained beyond this period – the Secretary of State notes that this is, in her view, an appropriate length of time as DWP need to act on IPRs at pace while retaining records that could be used in any future legal process

**Published by the WPSC on July 2nd**

<https://www.rightsnet.org.uk/?ACT=39&fid=3&aid=2249_nHecW5FyCTXqEkc7yIsb&board_id=1>

Please can you also let us know the following:

1. When will your review of the investigation process, as mentioned in the NAO report, be complete? Will the findings of this review be made public?

**Response**: The actions committed to within the NAO report are being taken forward as the normal work of the Customer Experience Directorate. This will not lead to the publication of a report – the SCP, the SSWP and Ministers will be updated when appropriate. Expected to conclude by the end of the year.

2. When will the Department decide whether to publish the Serious Case Panel terms of reference and recommendations, and the outcomes and recommendations from investigations? Might you set out for us the issues that need to be considered, to help the Committee to understand the time the Department is taking to think about this?

**Response**: Recommendations at the Panel may relate to government policy development so want to ensure the panel is embedded before deciding what can be published.

3. How many families has the Department contacted to discuss the most serious investigations completed, and how many apologies has the Department issued to families?

**Response**: They’ve met two families. The aim is to explain the department’s processes and actions, and for DWP leaders to hear families’ experiences first-hand. This is done on a case by case basis and at the discretion of the families.

4. It has been reported that DWP told an inquest in 2019 that it was undertaking a review of its safeguarding procedures. Did this safeguarding review happen? If so, please can you provide a summary of any key findings and actions taken as a result of the review?

**Response**: “The Department is continually looking at ways to support vulnerable claimants”. The key areas identified are:

* establishing a Customer Experience Directorate to co-ordinate and monitor policy and change
* raise awareness of learning resources – including resources on considering a range of evidence or seeking further evidence
* funding for safeguarding leaders for each district to work with LAs, police, and NHS – they will be supported by the Operational Safeguarding team within the Customer Experience Directorate.
* As part of the DWP Service Excellence Plan we will co-ordinate policy development and develop our partnerships with local safeguarding boards

5. It has also been reported that DWP and the Information Office have previously discussed DWP’s investigation procedures and that, following this, DWP launched a review of the procedures (then called Peer Reviews) in 2015 to improve accountability, responsibility, and recommendation tracking. What changes were implemented as a result of that review? What can you learn from the successes and failures of previous investigation procedure reviews to ensure that the work you are doing now will be more effective in improving these crucially important processes?

**Response:** Responsibility for tracking recommendations sat with regional staff management groups (OSNs). These groups no longer exist so we are establishing a team to do so within the Customer Experience Directorate. The Serious Case Panel will draw on the information tracked by this team.

**WPSC:** Your letter also sets out some improvements made to the guidance DWP gives to its own staff and to coroners. In particular, it explains that there have been improvements that allow Work Coaches to “tailor the support they provide to customers based on the customer’s circumstances and needs”. Might you please let us know the following:

6. What has changed to allow Work Coaches the ability to tailor the support to the needs of an individual? Can the Committee see a copy of any new guidance issued to Work Coaches to allow this increased support, and receive information on the training delivered to ensure Work Coaches are aware of and understand this guidance?

**Response:** DWP -

* have taken a number of actions to improve learning for jobcentre staff regarding customers with complex needs
* continue to updated learning resources on complex needs
* continue to provide staff with ‘complex needs toolkits’ and a District Provision Tool
* work with specialist partners e.g. Shelter and Women’s Aid have helped develop training and guidance for staff

7. You say that the Department is increasing communications with coroners, to increase awareness of the Coroner focal point. Will any new guidance be issued to coroners to set out the circumstances in which DWP wants to receive information from them? Will this include any case of death by suicide of a person DWP serves?

**Response:** letters were sent on 28/2/20 and 21/4/20 asking that all correspondence be shared via this route

Additionally, your letter sets out some of the internal mechanisms you have created to resolve the problems raised by the NAO:

8. Can you set out details of your plans for the increased capacity of the investigation team, and how staff across the Department will be made aware of the role of the investigation team and when they should be contacted?

**Response:** 20 colleagues have been identified to join the investigation team (paused due to Covid-19 pressures).

9. Thank you for setting out the current membership of the Serious Case Panel. When will a decision be made about external experts sitting on the panel and the circumstances in which this would happen? Are there any reasons why a relevant external expert couldn’t be a permanent part of the panel?

**Response:** see letter of 20th March, no plans to change this

10. You have said that investigation materials are held for six years, but that anonymised records of recommendations are held for longer than this. How long are these recommendations held for? Will you consider a review of the historic recommendations the Department holds to identify any systemic issues that have arisen previously, as well as improving procedures to ensure recommendations are recognised and acted on in the future?

**Response:** The intention is for DWP to act more quickly. No plan to undertake a review of the historic recommendations

11. You have committed to the establishment of a new organisational learning function responsible for Case Panel recommendations. Can you give the Committee any details about how this tracking will be done? What role will Ministers play in ensuring that recommendations are implemented?

**Response:** Recommendations will be tracked by the panel to ensure action is taken. The secretariat will be responsible for this tracking and updating the panel as appropriate. Escalation will be to the panel, and to SSWP and ministers as appropriate.

We appreciate that the Department currently faces significant challenges due to the COVID-19 outbreak. The following questions relate specifically to how DWP plans to ensure it supports the most vulnerable people it serves during this outbreak:

12. Many of the actions you have committed to are expected to be completed in the next month. In the light of the COVID-19 outbreak, is this timetable realistic?

**Response:** Expansion of the IPR team has been paused. The Customer Experience and Learning Team remains in place and the Serious Case Panel has gone ahead as planned

13. Your letter explains that DWP has secured £36m to improve support for the most vulnerable customers, and that some of this money will go towards ensuring correct benefit decisions are made first time and ensuring that safeguarding procedures are in place for vulnerable customers. Will £36m be enough, given the scale of the task DWP is now facing due to the COVID-19 outbreak and the likely increase in the number of vulnerable people?

**Response:** The extra funding provided the opportunity to make targeted improvements in our capabilities in areas like decision making, safeguarding, and organisational learning. Many measures have costs which are fixed or do not increase proportionate to to a changing customer base; others will be more affected by an increased number of customers.

14. You say that mental health training is being delivered to all DWP staff who have direct contact with customers. Given the COVID-19 outbreak, will this training be delivered remotely to ensure staff are able to support vulnerable people as needed? When do you expect all front line staff to have received this training?

**Response:** Coronavirus has meant that this training has been paused.

There remain some unanswered questions from my letter of 5 March 2020, which I would be grateful if you could now answer.

15. How will DWP evaluate progress against the findings from the NAO report? How regularly will progress be evaluated?

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

**Response**: The Director General for Service Excellence will update the minister as necessary.

**Oral evidence to WPSC: Therese Coffey and Peter Schofield**

22/07/20

<https://committees.parliament.uk/oralevidence/759/default/>

**TC on the serious case panel:** The 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. That is now underway. There have been two meetings of the panel in that format.

**TC on safeguarding officers**: If you think about where we have come on the journey; we now have safeguarding officers, we have 10 in place and we are recruiting another 15. This is one of the key changes that are happening in order to make sure that we have much more of a focal point involved in issues of people’s welfare.

**TC on safeguarding duty/duty of care**: It is fair to say, legally, we do not have a legal duty of aspects of what you would consider to be safeguarding. That is something that is usually held by adult or children’s social services in that essence […]

**TC on case conferences:** [W]e recognise that we are a touchpoint for many people around the country, and it may bethattheir GP was the last to see them and it may be that we were the last person to have an interaction with this person.As a consequence we have made that decision, we got the funding from Treasury so we could recruit people, so we could put more of an emphasis on that. There are things like case conferences that can be initiated so we can have that sort of discussion with the multiagency approach.

**PS on safeguarding leaders and case conferencing**: I can talk about the serious case panelthat met on 19 March, which looked specifically at safeguarding issues. That is when we took some important decisions,which included the creation of the safeguarding lead roles that the Secretary of State has just described. Those have an important role in terms of being the focus of escalation in every part of the country. We can make sure that as we case conference and look at these serious cases that come through we can address them collectively with other partners.

[…]

The point of the safeguarding leads, although this is not their only role, but the reason for setting this role up is that we were conscious that often when something goes wrong it goes wrong because someone has fallen between the cracks of different agencies as they play out in local areas. We have one set of relationships with some vulnerable people—other organisations, it could be adult social services, it could be the housing supplier, it could be the police, it could be any number of organisations—they all have different relationships and what we have not been great at is pooling the information that we have. The point of the safeguarding leads is to be a point of escalation to build those networks together.

[…]

In terms of vulnerable people, all of this comes back to the work that we were discussing at the March serious case panel around what point you would consider stopping a payment. The guidance that we have introduced now is very much that we would escalate that up through the system—we would do case conferencing. The same comes in terms of sanctions. Sanctions are a last resort, as you know, and we would only seek to do that in a situation in which—well, we would not do it unless we had been through a process of understanding the nature of the individual and why they were not working with the system and doing what we were asking them to do in terms of looking for work.

The key thing for me is you do not do it when you have the opportunity of understanding and reaching out and working with another partner organisation who might understand the needs of that individual better than we do. That is where the case conferencing and the work of safeguarding leads comes in as well.

[…]

**Q25 Chris Stephens:** Mr Schofield, there have been recent cases of people who have sadly died as a result of starvation and by suicide after their benefits were stopped. Could you, first, confirm—my colleague, Debbie Abrahams, mentioned a particular case—that the safeguarding policy was revised in autumn 2019 and could we get a copy that has been revised? What checks are made before someone’s benefits are stopped,and is there a different process for someone who has been identified as being in a vulnerable category?

**Peter Schofield:** Yes, absolutely. That was the nature of the conversation that we had in the serious case panel on 19 March. The issue here is that in the past there has been an approach where if we lose contact with a claimant, for example if they do not come forward and participate in what we term our mandatory intervention, but that might involve a work capability assessment, for example, then we would seek to contact the claimant. We would use a number of different ways of seeking to do that and if they have not been successful we would send a visiting officer out to visit them at their home. If that did not work we would try again. The system had been that if after two attempts we failed then it may well be then that the decision maker might make a decision to stop the benefits. The change now is that if we have tried all of that we would then take that back and have a case conference about the individual. Particularly, obviously, if it is someone with vulnerabilities that we know about, then we would seek to involve other organisations that might have a different way of knowing about that individual. It might be that we could involve their social landlord, it might be that we could involve local adult social services, there may be all sorts of different organisations that we could work with and bring into that case conference. Then we would seek to understand what do they know about that individual and how can we support them. If that fails that could then escalated to the safeguarding leads. In that way, basically, what we would seek to do is to provide support not removal of benefits. Now, obviously, at the end of the day, if it emerges that no one has any contact, we do not whether this person really exists, and it could it be a fictitious claim, then you would go down the route of stopping benefits. All I am saying is that the approach now is to work not just within the Department but to work with all sorts of other agencies, other organisations to make sure that we understand the vulnerability and the circumstances as best we can before we make any decision like that.

[…]

**Q28 Chair:** Okay. If there are safeguarding concerns about somebody, their benefits will not be stopped?

**Peter Schofield:** If there are safeguarding concerns then we will work with other agencies to seek to understand what is going on. The thing I am not going to preclude is that, at the end of the day, is it a fictitious claim or is it a false claims. This is all about getting the best possible evidence and information we can knowing that some people—we will know them—may worry about a contact from the Department for Work and Pensions and everything we are trying to do in terms of how we approach claimants is seeking to address that but people may worry about that. They may be more ready to receive an enquiry from their landlord or from social services or from maybe a third party, maybe a third sector charity who they are working with in whatever way. If we can identify them and find a better way in which to build an understanding about what is going on, that helps us make the decision in the most informed way we can.

**Q29 Chair:** Yes, but if through this case conference system, for example, the social landlord of the claimant says, “Yes, we are quite worried about the wellbeing of this person”, in that situation you would not stop their benefits?

**Dr Thérèse Coffey:** It is difficult to try to set blanket rules when you are dealing with individuals. What Peter has set out is the approach that has now been taken by the Department but we cannot say in every situation, every case, this X, Y or Z would definitively happen. It has to be tailored to the individual situation.

**Peter Schofield:** At the end of the day what we are obviously seeking to assess is if someone is entitled to benefits. Are they able to engage with the way that we assess the process? We are seeking to pay benefits to everyone who is entitled to be paid and to make the process as straightforward as we can. For some people that means additional support as they go along. Sometimes we are not best placed to do that but we can work with other organisations to help them through that process.

**PS on changes to guidance**: We also looked at the circumstances under which we would make a decision as to whether to continue payments when we have lost contact with a claimant. That also was discussed and led to a change in the guidance, which has been implemented. That again was discussed at the serious case panel on 19 March.

**PS on SCP, IPRs, and complaints**: t is part of an ongoing process that the Secretary of State has described in which we genuinely want to listen and learn and make sure that when we see things that have gone wrong we make changes and make sure that they do not happen again. It is part of embedding this. The serious case panel sits at the top of a process, but the internal process reviews—the system for collecting and tracking and tracing and implementing the recommendations that come from those internal process reviews—is a new process we put in place as well. It links to a new approach to complaints. All of this is part of our attempt to become a Service Excellence organisation, which is the context when the serious case panel was first announced back in September last year

**TC**: The IPR group has increased in number. There are now 12 investigators who are part of the IPR group. I believe there are 27 on the team in total and what has happened recently is that there is a more senior IPR group who will go through that at a more senior level, whereas I think in the past IPRs were locally initiated and it was of a lower scale. We have stepped that up.

Another important thing, it is not IPRs; we have changed our complaints process. I was very keen that we try to have something that was simpler and more straightforward, actually somewhat independent within the Department. I hope that reform that we have now done with the one national team in the customer experience directorate will make a good difference, moving from a two-tiered approach to just a single tier approach, and we can genuinely learn more quickly from that.

**Peter Schofield:** That is one of the changes we made that we discussed at the serious case panel on 2 July, the most recent one. Exactly as the Secretary of State has said, we used to have a two-tier process of complaints. So you made a complaint, it was dealt with by the business area where you made the complaint and then only if you were not happy with that it got escalated to a central team. It felt a bit processy and what we really want to do is have a team of dedicated experts managing complaints who just try to resolve the issue there and then. That has been brought together into a single place. It comes under the customer experience director as well. Although IPRs, which is the internal investigation in complaints, is resolving things with the claimant, they are two separate processes that come under the same director within DWP, so we are able to learn best practice as we go along.

The other thing is we have learnt from working with the independent case examiner. The independent case examiner is the next level up. If you are not happy with how your complaint is being assessed by the Department you can go to the independent case examiner. They have a great track record of investigation of concerns and how to do that in a professional way. We have learnt from some of that in how we built the IPR team that the Secretary of State has described. We are learning as well from other parts of the wider DWP family about doing complaints and investigations better than we have done before.

[…]

**Dr Thérèse Coffey:** I would say this whole relationship with our claimants, with our customers, has been really important to me since coming into the Department on how we really do step that up. This is not just life as a politician, it is like when I was in business and the interaction with customers is really important and getting feedback from that is one of the next phases I am trying to do, how we get everyday feedback more quickly back into our learnings and assessment. That is the next project, in a way but it was important to prioritise and escalate this particular phase.

**PS on senior engagement and tracking of changes**: When we set up the customer experience directorate last year we did quite a lot of work with other organisations like NHS trusts and with College of Education colleagues as well and their side of things. The main thing that we learned, which we have been putting into practice, is the importance of having a process that brings it together and a dedicated professional team that can assess the issues as they come along, and enabling us to be able to track the implementation of recommendations that have come through. We have had IPRs since 2014, 2015, but they were done in a piecemeal way. Although there was learning through the organisation we did not have a way of doing this in a systemic way across the whole organisation, and we did not have a way of bringing this to a senior enough level to make sure that this changed all across the organisation […] What we are learning therefore, and what we have learned from other organisations, is senior engagement, systemic examination of what has gone wrong, and a systemic way of tracking the implementation of recommendations.

[…]

**PS:** We have been doing IPRs for five or six years, as the Secretary of State has said, and as we have gone along a number of things have changed, probably as a result of IPRs, but we do not have a record linking changes that we have made to specific IPRs up until now. The system we have put in place over the last 12 months will do that,so we have that tracking system and are able to do that. As I say, the escalation then is up the serious case panel to embed systemic issues. There is a difference between things that need to change in specific areas of the organisation that can just happen potentially and things that are more systemic where we need to escalate it up: maybe it needs more investment—safeguarding leads require more funding, for example—and these sorts of things will go to the serious case panel.

**PS on local relationships and networks**: one of the interesting things I see as I go around the country is local relationships working well, and I have given some examples. In Newcastle, Leeds, a fantastic one in Margate, I was there that not long ago, Wiggin Hub, Leeds Social Justice Service. These are all examples of where we a part of a local network of organisations that have come together to share knowledge about systems, processes, provision but also those situations, those individuals or those families that are most at risk. What I would love to see is that sort of partnership in every community and every part of the country. That is probably the biggest area of gap at moment. I am not sure that they are everywhere but we are doing everything we can and that is part of the role of the safeguarding leaders to be part of that. We are playing our part but we want to part of local networks that bring provision together.

**TC and PS on DWP engagement with adult safeguarding reviews**:

**Q32 Neil Coyle:** It sounds a little bit like you think things are sorted, which I think will surprise many of the organisations and individuals covered. If you think the safeguarding leaders are part of the answer to preventing any further suicide or premature death, is the Department in a position that it would support adult safeguarding reviews if a suicide or a premature death occurs after you have rolled out in full the safeguarding leadership approach?

**Peter Schofield:** Some of the examples of internal process reviews have come to us because of adult safeguarding reviews. We are engaging with those, that is one of the ways that we get alerted to—

**Q33 Neil Coyle:** Sorry, I am asking if the Department would support an automatic presumption of an adult safeguarding reviewin the case of a suicide or premature death of someone known to the Department?

**Dr Thérèse Coffey:** Adult safeguarding reviews are largely undertaken by adult social services.

**Q34 Neil Coyle:** It is a multiagency approach but the Department can lead on asking for one and should be an active participant in seeking them. Are you saying you support them going forward?

**Dr Thérèse Coffey:** I think there is an element that already happens there but I expect the safeguarding leader would probably be more dedicatedto a particular area of the country.

**Letter from SSWP dated 29/09/20 – published by WPSC**

<https://committees.parliament.uk/publications/2910/documents/28102/default/>

**Preliminary comment by SSWP:** The Committee has asked a number of questions using the term ‘safeguarding’. As stated in oral evidence, DWP does not have a duty of care or statutory safeguarding duty, which is usually attributed to local authorities. The Department uses the term ‘safeguarding’ as a general reference as it interacts with other agencies who lead on safeguarding

1. Peter Schofield said that the meetings of the Serious Case Panel had led to changes in safeguarding guidance when DWP has lost contact with a claimant. Please can you provide a full copy of DWP’s safeguarding guidance, highlighting the areas that have been updated? We would also be grateful to know what proportion of front line DWP staff have been trained in the new policies.

**Response:** See Annex A. As explained in oral evidence – in cases of concern a decision to stop payment will only be made after we have tried every reasonable route, including the escalation process to Safeguarding Leads. Relevant staff have been made aware of the need to follow the updated guidance through an implementation update. While the Department does not have a duty of care or statutory safeguarding duty escalating can help to direct our claimants to the most appropriate body to meet their needs.

1. Please can you send us the guidance DWP has on suicide or self-harm prevention, and how many front line DWP staff have been trained in this area to help protect claimants? Might you also let the Committee know when this guidance was last updated?

**Response:** The six point plan is attached at Annex B and forms part of the wider ‘keeping safe’ training which all customer facing staff have to complete.

Mental health training for UC work coaches was introduced in 2017. This was complemented in 2019 by a mental health training programme for customer facing roles other than work coaches.

**WPSC:** The Committee would also like to know more about the operation of the Serious Case Panel. We were grateful for sight of the Terms of Reference and minutes, but it is not clear from the papers you have provided whether the tracking of recommendations by the Panel includes ensuring that Internal Process Review recommendations are implemented, as had previously been suggested.

1. Given that one of the key findings of the NAO’s report was that recommendations from Internal Process Reviews were not tracked to make sure that they were implemented, please can you confirm again the role the Serious Case Panel will have in this and, in the interests of transparency, ensure that the Terms of Reference are updated accordingly and that future meeting minutes provide an update on the recommendations?

**Response:** The SCP will notdirectly track the recommendations that result from individual IPRs. The panel’s remit is to consider broader systemic issues and themes. The SCP will make recommendations and track these to ensure they are implemented.

DWP are considering including an update on the SCP in the DWP annual report and accounts.

An Internal Process Review Group (IPRG) has been formed to track and monitor recommendations arising from individual IPRs.

1. Has the guidance provided to staff on Internal Process Reviews been updated since the NAO report? How has this been communicated to front line staff? Please can the Committee receive a copy of any new Internal Process Review guidance, and can you highlight the improvements that have been made?

IPR guidance has been updated for operational leaders across the Department

Individual IPR reports will be considered by the IPRG, which is chaired by the Customer Experience Director. The IPRG has been given dedicated resource to review cases, assure quality of reviews, and drive change where needed. The team is learning from best practice by collaborating with the ICE.

**WPSC:** There have been many news stories in recent years which criticise the way in which DWP has treated families of people involved in serious cases. Might you please answer the following questions about how DWP liaises with families, and how it can learn from this process:

1. Do you have any written guidance on how families of people involved in serious cases, including those where an individual has died, should be treated? Please can you provide this guidance?
2. Peter Schofield spoke about talking to families of those who have died, but said that this was “not part of a process” within DWP. Are you planning to make this part of your regular process, to make sure that you can learn from these cases? Shouldn’t all families of people who have died have the right to speak to senior DWP officials, if there is something they would like to raise in person? Aside from the ad hoc face to face meetings, how else does DWP learn from families of people involved in serious cases?

**Response to questions 5 & 6 together:**

If a deceased claimant’s family are unhappy then they can complain, ultimately to ICE and the Parliamentary and Health Service Ombudsman.

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.

Aside from the complaints process families are able to write to the DWP and senior staff will use judgment when deciding whether to offer to meet with families.

**WPSC:** You also described the safeguarding improvements DWP has made, including the appointment of ten safeguarding leads, whose role is partly to bring together organisations such as adult social services and housing suppliers to better understand the needs of an individual. You said that there was an expectation that there would be 25 safeguarding leads “fairly soon”. On safeguarding, The Committee has the following questions:

1. Please can you provide the full job description and person specification for the safeguarding leads, and let the Committee know when you expect to have 25 safeguarding leads in place?
2. You also suggested that DWP might look to appoint more safeguarding leads in the future. How did you decide that 25 was the appropriate number of safeguarding leads now? Would it be for the Serious Case Panel to discuss whether more funding is needed for safeguarding leads?

**Response to question 7 & 8 together:** 25 safeguarding leaders have now been appointed. This number was reached in consultation with area managers. The JD and key tasks are at Annex C. They are so named to provide a clear point of contact to other public bodies and agencies with a statutory responsibility for safeguarding, such as local authorities.

1. Peter Schofield said that the level of partnership between local organisations and DWP differs in different areas, and that this “probably represents the biggest gap” in how DWP safeguards people. Aside from appointing safeguarding leads, what are you doing to close this gap? What are you doing to facilitate the sharing of best practice to make sure that vulnerable people receive the same level of safeguarding, wherever they are based?

**Response**: We recognise that engaging with other public authorities (including those with statutory safeguarding responsibilities) can help us gather and share information about vulnerable claimants.

1. How was the complex needs tool, “a catalogue of local partners, local experts, local provision, which can provide support and be signposted to for anyone who is in a particular vulnerable group” put together? What proportion of DWP front line staff have received training and guidance on how to use it?

**Response:** … is not interesting

1. Peter Schofield said that DWP was looking at how arrangements vary across different benefits and seeing whether changes need to be made. Please can you let the Committee know how DWP is progressing this work, and when a decision on any potential changes would be made? What outputs do you expect there to be from this work?

**Response**: UC aims to regularise and integrate welfare support streams and has done a considerable amount to improve the cohesion and clarity of working age benefits.

The Customer Experience Directorate was established in 2019 to take a deliberately cross-cutting approach and to address recurring issues where consistency could be improved. This is why the SCP takes a thematic approach, examining issues that may have been present in a number of serious cases.

An example of this is the changes to guidance relating to safeguarding visits where a vulnerable customer has ceased to engage with the department.

1. Peter Schofield also said that it was not the role of DWP to be a safety net for people, and that it does not have the resources to fulfil this role. Whose responsibility is it, within government, to ensure that the most vulnerable people in society are safeguarded, what is the role of DWP in this, and how do you liaise with other bodies to make sure that the people DWP serves are protected?

**Response**: DWP frequently collaborates with agencies with statutory safeguarding responsibilities. We want to ensure that chances to flag concerns to these agencies are not missed.

1. The Care Act 2014 states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. How many adult safeguarding reviews has DWP been involved in since 2015, and how many has DWP requested?

**Response**: An SAB may invite DWP to participate when relevant, but DWP would not want to form part of the Board’s core statutory membership. DWP do not hold data on involvement with SARs.

1. Peter Schofield spoke about “stepping back and looking at the causes of vulnerability”, and where DWP can link with other organisations and Government Departments to look at the sorts of issues that lead to someone coming to DWP for support. Were these comments referring to a particular piece of work? If so, please can the Committee receive some information on the aims, timetable and likely outputs from this work?

**Response**: The Permanent Secretary was not referring to a specific piece of work.

1. You mentioned a “Find help” tool available on .gov, and said that it was “intended as a signpost for people looking for help on a variety of issues who might not know where to turn”. Were you talking about the coronavirus find help tool?
	1. If not, please can you let the Committee know where the tool you were discussing is located, how it can be made more accessible and better publicised, and whether DWP offers similar services for those who cannot get access to a computer and internet connection, as is the case for many of the most vulnerable people in society?
	2. If you were talking about the coronavirus tool, do you plan to produce a separate tool, not related to coronavirus, which can be maintained to help signpost people to different sources of support beyond the pandemic?

**Response**: This was referring to the Coronavirus Guidance and Support webpage on gov.uk. There are no plans to create a separate tool.

**WPSC:** In addition to the above questions, the session touched on numerous other aspects of DWP’s work. Following on from these discussions, might you please answer the following questions:

The predecessor Work and Pensions Committee recommended that DWP explore a “yellow card system” in sanctions. Such a system would mean a warning, instead of a sanction, would be issued in response to any claimant’s first sanctionable failure. In its response, DWP said that it would run a proof of concept into such a warning system in Spring 2019, with further testing then required before deciding whether to introduce it.

1. Please can you update the Committee on the results of the proof of concept for a sanction warning system, and let the Committee know what the next steps will be in evaluating and rolling out such a system?

**Response**: We have gathered internal feedback on the first proof of concept and have made a number of recommendations for subsequent proof of concepts. To proceed, we need IT functionality and operational capacity that is not currently available due to new priorities resulting from the pandemic – this will be kept under review.

1. You said that DWP has not been actively seeking to impose sanctions since they were re-imposed on 30 June. How many sanctions have you imposed since 30 June, and how does this compare to the same period last year?

**Response**: Statistics will be released as normal. Work coaches continue to ensure that all requirements are appropriate for the ‘new normal’. We don’t set out to sanction anyone and sanctions will only be applied where the claimant did not have good reason.

**WPSC:** In 2014, it was reported that the Royal National Institute of Blind People (RNIB) was threatening the Department of Work and Pensions with court action for suspending the benefits of a blind man after he missed appointments. He was only informed about the appointment through letters he was not able to read. The same report said that the RNIB had prepared 5 legal cases against the Department and was considering a further 50.

1. How many cases is DWP currently defending which involve an allegation of disability discrimination in how someone’s benefit has been processed or paid? What actions do you take to ensure that sanctions imposed are not unfairly applied to disabled people if they fail to meet requirements through no fault of their own?

**Response**: Neither DWP nor GLD holds data on this.

**WPSC:** In June, the Prime Minister spoke about an opportunities guarantee for young people. Before the Committee you mentioned a sector based work academy to “get training, work experience, and a guaranteed job interview”, as well as the Kickstarter Scheme to subsidise work placements for young people on Universal Credit who are at risk of long-term unemployment.

1. Please can you set out how the opportunities guarantee, the sector based work academy, and the Kickstarter Scheme will work together, and when you expect each of the initiatives to be in place?

**Response**: … is not interesting

**Annex C (job description for Senior Safeguarding Leader)**

The JD includes, among other things, ‘working in partnership with the Safeguarding Centre of excellence team’