Regulation 28: Prevention of Future Deaths report

Michael Brendan O'SULLIVAN (died 24.09.13)

THIS REPORT IS BEING SENT TO:

The Department for Work and Pensions Caxton House Tothill Street London SW1H 9NA

1 CORONER

I am: Coroner ME Hassell

Senior Coroner Inner North London

St Pancras Coroner's Court

Camley Street London N1C 4PP

2 | CORONER'S LEGAL POWERS

I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.

3 INVESTIGATION and INQUEST

On 2 October 2013, I commenced an investigation into the death of Michael O'Sullivan, aged 60 years. The investigation concluded at the end of the inquest on 7 January 2014. The conclusion of the inquest was that Mr O'Sullivan took his own life by hanging, whilst suffering anxiety and depression. I made a narrative determination, which I attach.

4 | CIRCUMSTANCES OF THE DEATH

I found that the trigger for Mr O'Sullivan's suicide was his recent assessment by a DWP doctor as being fit for work.

5 | CORONER'S CONCERNS

During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion, there is a risk that future deaths will occur

unless action is taken. In the circumstances, it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows.

The DWP assessing doctor (who saw Mr O'Sullivan for a 90 minute consultation) did not take into account the views of any of Mr O'Sullivan's treating doctors, saying that the ultimate decision maker would do that.

However, the ultimate decision maker (who is not, I understand, medically qualified) did not request and so did not see any reports or letters from Mr O'Sullivan's general practitioner (who had assessed him as being unfit for work), his psychiatrist or his clinical psychologist.

6 ACTION SHOULD BE TAKEN

In my opinion, action should be taken to prevent future deaths and I believe that you and Jobcentre Plus have the power to take such action.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 11 March 2014. I, the coroner, may extend the period.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8 COPIES and PUBLICATION

I have sent a copy of my report to the following.

- HHJ Peter Thornton QC, the Chief Coroner of England & Wales
- Michael O'Sullivan's general practitioner

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.

9	DATE	SIGNED BY SENIOR CORONER
	13.01.14	