




**REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
KEVIN CONRAD GALE**

THIS REPORT IS BEING SENT TO:

**DEPARTMENT FOR WORK AND PENSIONS (for the attention of the Rt Hon Mel Stride
MP, Secretary of State for Work and Pensions)**

1	<p>CORONER</p> <p>I am Miss Kirsty Gomersal Area Coroner for County of Cumbria</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013:</p> <p>https://www.legislation.gov.uk/ukpga/2009/25/contents</p> <p>http://www.legislation.gov.uk/uksi/2013/1629/contents</p>
3	<p>INVESTIGATION and INQUEST</p> <p>Mr Kevin Conrad GALE died on 4 March 2022 at his home address.</p> <p>An inquest into Mr Gale's death was opened on 22 March 2022 and his inquest was heard before me on 2 November 2023.</p> <p>The medical cause of Mr Gale's death was:</p> <p>1a Hanging</p> <p>The determination was:</p> <p>Mr Kevin Conrad Gale died on 4 March 2022 at his home address, 8 Langton Court, Penrith as the result of deliberate self-suspension [REDACTED]. Mr Gale had a long history of low mood and anxiety. He was engaging with mental health services and had been diagnosed with severe depression and anxiety. Mr Gale was taking his medication but was still struggling to manage anxiety. Although Mr Gale denied suicidal intent, on the evidence and on the balance of probabilities, Mr Gale intended to take his life.</p> <p>The conclusion of the inquest was:</p> <p>Suicide</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Gale was detained under Section 2 Mental Health Act in November 2021 and was discharged from that section on 4 January 2022. Mr Gale was diagnosed with severe</p>

	<p>depression and anxiety. Mr Gale was seen regularly by mental health professionals and was in frequent contact with mental health services. Those services were provided by Cumbria, Northumberland Tyne & Wear NHS Foundation Trust (“the Trust”). Mr Gale was compliant with his medication and engaged with services. He was well supported by his family and friends.</p> <p>Mr Gale’s anxiety continued during his engagement with mental health services. Evidence was heard about what caused Mr Gale’s anxiety. One ongoing feature was his application for Universal Credit.</p> <p>On 2 March 2023, 2 days before his death, Mr Gale was seen by an Associate Specialist Psychiatrist, who gave evidence at the inquest. The Psychiatrist considered Mr Gale’s anxiety was exacerbated by his application for Universal Credit. During Mr Gale’s appointment, the Psychiatrist called the benefits office for help but the call was not answered before the end of the consultation. Mr Gale was expecting a call from a DWP representative the next day (3 March).</p> <p>On 3 March 2022 at approximately 11:00 am, Mr Gale spoke to the duty Registered Mental Health Nurse. He remained very anxious and his main concern was the application for Universal Credit.</p> <p>During their evidence, the Associate Specialist Psychiatrist expressed concerns about the experience of mental health service users with DWP. These concerns were not just specific to Mr Gale.</p> <p>Evidence was also given by the Trust’s Group Nurse Director (a Registered Mental Health Nurse) who considered that the issues identified by the Psychiatrist were national. The Director considered it important to address these issues as they were debilitating for service users.</p> <p>The Director advised that the Trust’s Crisis Team had started a food bank 3 years ago to support service users. The Director was also aware that the DWP had been invited to the Cumbria Suicide Prevention Group.</p> <p>I stress that I did not make a causal link between Mr Gale’s death and his anxiety about his Universal Credit application. DWP was not an Interested Person in Mr Gale’s inquest and did not give evidence as the concerns raised did not come to light until the hearing.</p>
5	<p><u>CORONER’S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows:</p> <p>Current DWP procedures may not be practical for those with mental health illness and can exacerbate symptoms. I heard evidence that:</p> <ol style="list-style-type: none"> 1. The number of and length of DWP forms required to be completed can be overwhelming for someone with a mental health illness. This is perpetuated if the applicant cannot get help to complete the paperwork. 2. There are long telephone queues to speak to a DWP advisor. 3. Having to travel long distances for appointments can be detrimental for those with a mental health illness.
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe the</p>

	<p>DEPARTMENT FOR WORK AND PENSIONS For the attention of the Rt Hon Mel Stride MP Secretary of State for Work and Pensions Caxton House Tothill Street London SW1H 9NA</p> <p>has the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 2 January 2024.</p> <p>I, the Coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>Mr Gale's family. Cumbria, Northumberland Tyne & Wear NHS Foundation Trust</p> <p>I have also sent copies to:</p> <p>Lakes Medical Group (Mr Gale's GP surgery)</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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 coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.</p>
9	<p>Dated this 6 day of November 2023</p> <p></p> <p>Miss Kirsty J Gomersal HM Area Coroner County of Cumbria</p>