REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department for Work & Pensions**
1	**CORONER** I am Miss Fiona Butler, His Majesty's Assistant Coroner for the coroner area of Rutland and North Leicestershire.
2	**CORONER'S LEGAL POWERS** 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.
3	**INVESTIGATION and INQUEST** On 28 June 2023 I commenced an investigation into the death of Nazerine Frances Anderson aged 52. The investigation concluded at the end of the inquest on 12 February 2024. The conclusion of the inquest was that: Nazerine Frances Anderson ('Naz') had a medical history of anxiety and depression which had been managed with medication in primary services until October 2022. Naz was referred to secondary mental health services in November 2022 after a decline in her mental health. Following a voluntary admission to the Bradgate Unit in December of 2022, Naz was diagnosed with Adjustment Disorder the trigger for this having been notification that she was facing a performance review by the Department for Work Pensions ('DWP'). Naz was discharged from the Bradgate Unit in January 2023 and was managed in the community by the Crisis Resolution & Home Treatment team. Naz's mental health presentation fluctuated and the DWP review continued to preoccupy Naz's thoughts. The review concluded in May 2023 and between 03 May and 11 May 2023 Naz received 3 different letters setting out different sums of money owed to the DWP. These were sent directly to Naz despite the DWP being in receipt of correspondence from Naz's daughter asking for all correspondence to be sent through Naz's daughter, because continued correspondence would be of serious detriment to her mental health. On 17 May 2023, Naz took an overdose [redacted]. She was subsequently admitted to the Leicester Royal Infirmary Emergency Department and transferred to the liver transplant unit at the Queen Elizabeth Hospital in Birmingham. Unfortunately, Naz was not a candidate for liver transplant and developed complications as a result of the irreversible damage caused to her liver. Naz was transferred to the Melton Community Hospital on 17th June 2023, for palliative care and passed away at 19.30 hours on the 19th June 2023 with her family present. Naz did not intend to die as a result of taking the paracetamol overdose, but sadly developed complications as a result of the damage caused to her liver, which were irreversible.

4	**CIRCUMSTANCES OF THE DEATH** Nazerine Frances Anderson (Naz) had a history of anxiety and depression stretching back over 20 years. She had no active symptoms of these conditions until 2021 and until November 2022 her symptoms had been managed in primary care services with medication. Naz's referral into secondary mental health services in November 2022 followed notification by the DWP that she would have her universal credit reviewed, by the Performance Review Team. Naz's mental health deteriorated necessitating a period of informal admission to the Bradgate Unit on the 5th December 2022 and she was diagnosed with Adjustment Disorder, an excessive reaction to stress that involves negative thoughts, strong emotions and changes in a person's behaviour. I heard evidence from a Consultant Psychiatrist that the trigger stressor for this was the DWP performance review, suggested overpayment and potential debt. It took 6 months for the DWP review to be completed. During which time there: a. were at least 6 missed opportunities to use an additional support tab on Naz's DWP profile to record the details of her vulnerability and alert other DWP personnel. b. was a failure to pass vital information between the performance review team and universal credit case handling team of the need to correspond with Naz's daughter, because corresponding with Naz was of serous detriment to her mental health. Naz's mental health was managed throughout this time by the secondary heath teams, and for the majority by the Crisis Resolution & Home Treatment team. The Crisis team were responsive throughout this time to Naz's fluctuating symptoms and needs. In the 4 weeks prior to the paracetomol overdose, despite a request for all correspondence to be directed through her daughter, Naz received 6 communications from the DWP, 2 telephone calls requiring detailed information of Naz, a journal log she didn't understand and 3 separate letters which had a cumulative increase of the amount Naz owed of 75%. 6 days after receiving the last piece of correspondence from the DWP Naz took an overdose [redacted]. Those mental health professionals who had worked with Naz throughout 7 months in which her mental health had deteriorated gave evidence to me that the recurrent and predominant cause of Naz's increased anxiety was the DWP performance review. I find of the basis of the evidence I have heard and read that this was the case.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. Despite the DWP case workers and call handlers having the availability of an additional support tab on a profile of a customer on the DWP computer system; there were 6 missed opportunities to use this facility to record vital information about Naz's vulnerability; despite Naz being tearful and distressed on the telephone on more than one occasion and advising the DWP of information surrounding her mental health and her inability to cope. This meant there was no alert to DWP staff of Naz's vulnerability and consequently no adjustment to how communication was made with Naz. The trigger for mental health decline and Adjustment Disorder continued.

	2. The failure to act upon a simple request for the DWP to direct communication through Naz's daughter. This was a simple request and had been renewed by Naz during telephone calls and journal entries to the DWP. The request which had been made in writing by Naz's daughter sat in another DWP computer system for a period of 4 months but even when uploaded to the main DWP computer system was not acted upon. In addition to the active requests of Naz and her daughter being overlooked, DWP staff did not proactively consider the need for communication to be directed to someone else to safeguard Naz, given her obvious vulnerability. 3. I heard evidence from the DWP of plans to introduce a number of changes. What I did not hear was evidence about how DWP operatives were going to be trained, upskilled and refreshed in their knowledge (given the toolkit already available to them) to ensure the issues identified at 1 and 2 above aren't repeated with other vulnerable individuals.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 April 09, 2024. 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 Chief Coroner and to the following Interested Persons: **1. The Family of Mrs Anderson** **2. Leicestershire Partnership NHS Trust** **3. Leicestershire County Council** I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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.
9	 **Miss F BUTLER** **His Majesty's Assistant Coroner for Rutland and North Leicestershire** **Dated: 13/02/2024**