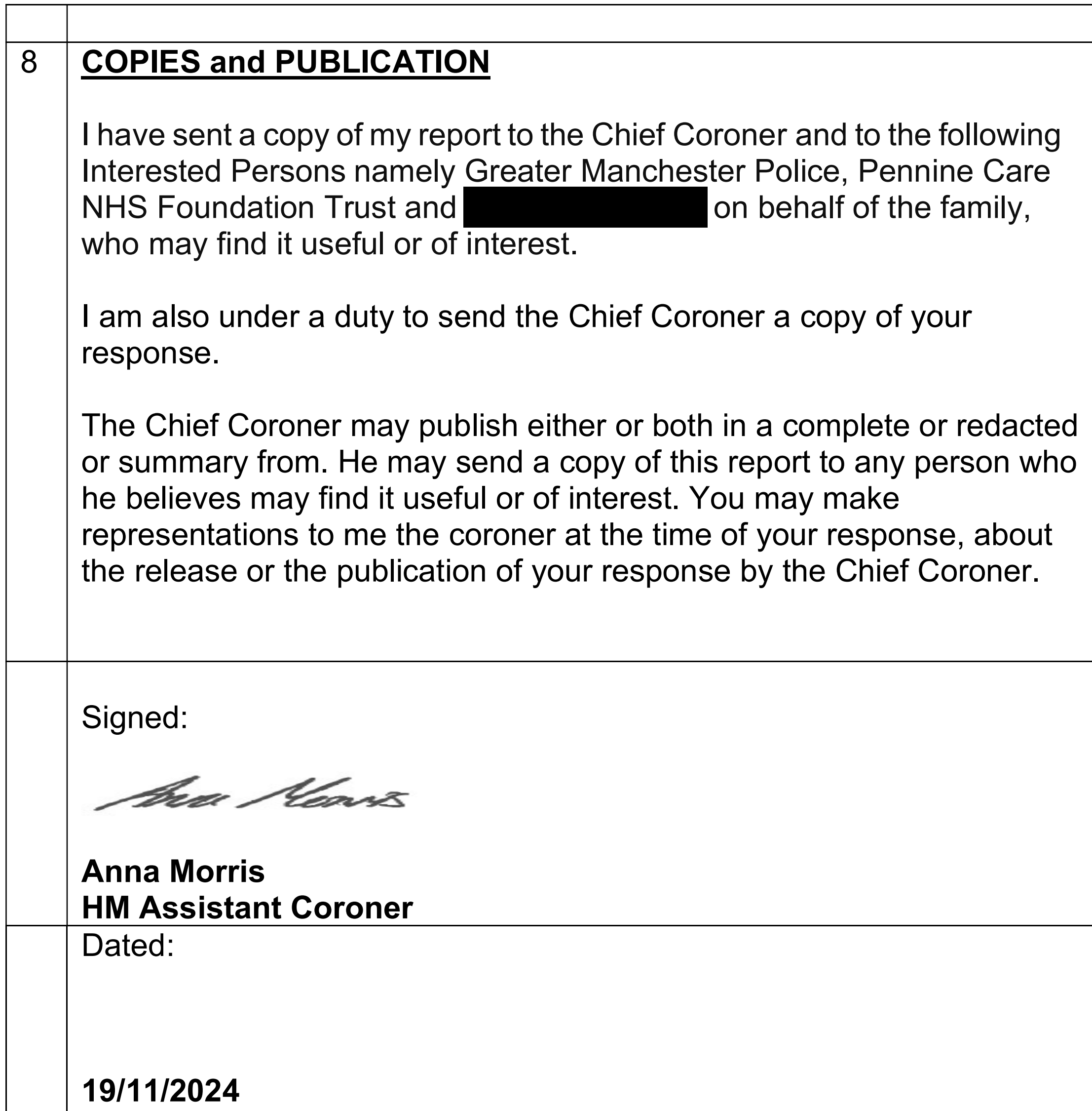
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Department for Work and Pensions
1	**CORONER** I am Anna Morris KC, Assistant Coroner for the Coroner Area of Greater Manchester South.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 23rd February 2024, I commenced an investigation into the death of Richard William Brookes, known to his family as Rick. I heard an inquest touching on Rick's death at Stockport Coroner's Court on the 14th November 2024.
4	**CIRCUMSTANCES OF THE DEATH** At the Inquest on the 14th November 2024, I returned a conclusion of suicide. In respect of the circumstances of the death I found that on the 25th January 2024, the deceased accessed the railway by the [redacted]. He intentionally stepped in the path of an approaching train and was struck, causing catastrophic and fatal injuries. In the days prior to his death, the deceased had been experiencing a crisis period in his mental health. He had been diagnosed with possible paranoid schizophrenia in 2011 and was taking anti-psychotic medication. In the days prior to his death he had been expressing paranoid thoughts to his family and was anxious and distressed. His deliberate actions combined with his expressions to his family prior to his death that he thought something would happen that day, led me to conclude that it is likely that he intended to end his own life.

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. During the inquest, I heard that Rick was a vulnerable adult. He had a diagnosis of possible paranoid schizophrenia and was taking anti-psychotic medication. Rick was receiving support from the DWP. I heard from [redacted] from the DWP that he was in receipt of ESA and DLA until 2016 when his DLA was transferred to PIP. At this point, this should have triggered an additional payment the Severe Disability Payment on his ESA. This didn't happen and DWP accepted in evidence that this was an error. There was then a delay in rectifying that error. In November 2023 the missed SDP calculation was identified and steps were taken to rectify it. By November 2023 the DWP stated in evidence that they owed Rick over £37,000 in arrears. [redacted] told the inquest that the DWP Guidance for Making Large Payments states that in the case of vulnerable individuals, which Rick had been identified as being, should be dealt with by the CEAST team. [redacted] said that the process should have been that Rick was spoken to by an agent who would assess how best to make the repayment in light of any known vulnerabilities he had. However, there is no qualitative record of that conversations beyond a drop down menu on the Severe Disability Journey Management System and "Phone Call Made" being selected as "Yes". There is no record of the content of that conversation. On the evidence, I found it is likely that a call did take place. However without the notes, it is not possible to evaluate what was said, how long the call took and what steps were put in place to ensure that Rick understood the information within the call. Without any notes of the call, it is also not possible to assess what Rick was asked about his state of mind, any vulnerabilities he was experiencing and his ability to safely manage the receipt of large payments of money. The first DWP large payment was made on the 8th December 2023 of £5,000, which was paid directly into Rick's bank account. Prior to this date, Rick had been receiving benefits to the amount of under £300 per week plus a monthly stipend of money from his family of around £300. This was therefore a significant increase in his income.

	It was clear to me from the evidence from Rick's sister that he became paranoid about the source of that money, indicating to me that any call from the DWP wasn't understood fully, or that it fed into a period of delusional thinking. The text messages he sent to his sister in the days prior to his death indicate that he didn't know where the money was coming from. The **MATTERS OF CONCERN** are as follows. – 1. This was a large payment of money to a vulnerable adult who was then required to self-manage that money. In these situations, it is important that there are robust systems in place for ensuring that the requisite assessments and checks are made of an individual to ensure that large payments can be made in a way that does not increase any vulnerability. 2. I heard evidence from that the DWP systems that are currently in place are hybrid of electronic and clerical systems and that payments can be initiated without there being a full note on the system of the content of the call with the individual. 3. I am therefore concerned that there is no way that an agent, quality assessor or team leader can properly evaluate whether any agreement made between the DWP and an individual regarding repayment has fully considered all the relevant factors regarding their vulnerabilities before a large payment is made. 4. I am also concerned that the DWP currently has no ability to effectively audit its large payments caseload to ascertain whether the failure in record keeping evident in the present case has occurred in other cases.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 14th January 2025. 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 namely Greater Manchester Police, Pennine Care NHS Foundation Trust and on behalf of the family, who may find it useful or of interest. 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 from. 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.
	Signed: **Anna Morris** **HM Assistant Coroner**
	Dated: **19/11/2024**