REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Secretary of State for Work and Pensions**
1	**CORONER** I am Alison Mutch, senior coroner, for the coroner area of Manchester South
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 27th May 2025 I commenced an investigation into the death of Tamara Jade Logan. The investigation concluded at the end of the inquest on 9th January 2026. The conclusion of the inquest was suicide. **The medical cause of death was: 1a) Hypoxic Brain injury 1b) Hanging.**
4	**CIRCUMSTANCES OF THE DEATH** Tamara Jade Logan was a vulnerable person with a history of self-harm and suicidal ideation. She had previously been assessed as being eligible for PIP by the Department of Work and Pensions with the enhanced daily living allowance and the standard rate of mobility allowance. Her file held by Department of Work and Pensions indicated previous self-harm and suicidal ideation. In 2025 her entitlement to PIP was reassessed and the enhanced daily living allowance was removed from her. She was notified by letter. The decision to remove the enhanced payment has been accepted as an incorrect determination. The method used for communication of the decision was also not appropriate given her known vulnerabilities. Upon receipt of the letter from Department of Work and Pensions Tamara Jade Logan's mental health deteriorated further. On 18th May 2025 she was found suspended [redacted] and

	taken to Tameside General Hospital where she died on 20th May 2025. On the balance of probabilities, the incorrect decision to withdraw her enhanced daily living allowance and the method of communication of the decision significantly contributed to her declining mental health and her actions on 18th May 2025 which led to her death on 20th May 2025
5	**CORONER'S CONCERNS** During the inquest the evidence 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. – 1.It was accepted that the assessment of her entitlement to benefits had been incorrectly determined despite it having been checked before the final decision was made. The impact of that on her was very significant. The evidence before the inquest was that the person carrying out the initial assessment carried out the assessment correctly and that the checking process had not picked up on the errors. The purpose of the check was to avoid these errors being made and it was unclear why it had not picked up the incorrect approach 2. It was clear from the evidence that her vulnerabilities were recognised by the Department of Work and Pensions and their paperwork was flagged to that effect. Despite that a standard letter was sent with no attempt to reduce the risk that receipt of the letter would cause.
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 **19th March 2026**. 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 the family of Ms Logan 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 form. They may send a copy of this report to any person who they believe 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	**Alison Mutch OBE** **HM Senior Coroner**  **22/01/2026**