

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

Philippa Jane Louise Day (died 16 October 2019)

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

- 1 The Department for Work and Pensions
- 2 Capita Business Services Limited

1 CORONER

I am Mr Gordon Clow, Her Majesty's Assistant Coroner for the area of Nottingham and Nottinghamshire.

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 17 February 2020 I commenced an investigation into the death of Philippa Jane Louise DAY aged 27. The investigation concluded at the end of the inquest on 27 January 2021.

The conclusion of the inquest was a narrative conclusion:-

Despite possessing significant intelligence and ability, Philippa Day was very seriously affected by a range of complex and comorbid mental health conditions. Her primary mental health condition was Emotionally Unstable Personality Disorder which impacted on all areas of her life.

Philippa received consistent and professional support from a multi-disciplinary team of mental health professionals who worked effectively together in order to implement a range of appropriate evidence-based interventions in line with applicable national guidance.

Despite this treatment, Philippa Day led a notably dysfunctional lifestyle which, but for extensive and consistent support from her family and treating clinicians, would have likely resulted in homelessness and near-constant distress.

The support made available to Philippa Day from family and mental health clinicians led to Philippa Day experiencing stable housing, a reduction in risk, a good relationship with her son and a base from which she was able to engage in complex therapeutic interventions which, but for the event which caused her death, would have been likely to result in improvements to her mental health.

The following stressors contributed to a decision taken by Philippa, on either the 7th or 8th August 2019, to take an overdose of her prescribed insulin:-

- a) Her mental health problems and the consequent impact of these upon her family and social relationships;
- b) Her growing sense of failure as a parent at the point just before her son reached the milestone of starting school; and
- c) Philippa's fears that the therapy she was shortly due to commence in earnest would end in failure due to her perception of herself as inadequate and undeserving.

Philippa Day was eligible to receive disability benefits. The process of claiming benefits was inevitably going to be stressful for Philippa and the process of claiming Personal Independence Payments, which commenced in November 2018, began from a position of mistrust on the part of

Philippa who was predisposed by her mental health problems to wrongly imagine malign motives on the part of those administering her claim.

The administration of Philippa Day's benefits claim was characterised by multiple errors, some of which occurred repeatedly throughout the period of her claim. As a result of errors made, Philippa Day's income from benefits more than halved for a period of several months, causing her severe financial hardship. This then resulted in Philippa Day taking out high interest loans creating a financial problem that Philippa Day did not have the means to solve.

A decision was made in June 2019 to require Philippa Day to attend an assessment at an assessment centre. No assessment was in fact required in order to determine her claim and there was clear and abundant medical evidence that an assessment outside of the home would exacerbate her mental health against a background of two recent overdoses.

The requirement for her to attend this appointment created a risk of a mental health crisis resulting in an overdose. This risk was implicit in the information held in connection with the benefits claim and explicit in advice given to those processing her claim by Philippa Day's community psychiatric nurse shortly prior to Philippa's overdose. Although the error in decision making was drawn to the attention of those administering the claim on more than one occasion, it was not rectified as it should have been.

The failure to administer the claim in such a way as to avoid exacerbating Philippa Day's pre-existing mental health problems was the predominant factor, save for her severe mental illness, affecting a decision taken by Philippa Day to take an overdose of her prescribed insulin on the 7th or 8th August 2019.

The distress caused by the administration of Philippa Day's welfare benefits claim led to Philippa Day suffering acute distress and exacerbated many of her other chronic stressors.

Were it not for these problems, it is unlikely that Philippa Day would have taken an overdose of her prescribed insulin on 7th or 8th August 2019.

In doing so, it was, at the least, Philippa Day's intention to place her life at risk and to cause herself serious physical harm. It is not possible to determine on the available evidence whether or not it was her intention to thereby end her life.

The overdose resulted in Philippa Day suffering hypoglycaemic encephalopathy. She entered a coma from which she was not able to recover and despite all appropriate efforts being made by a team of clinicians over many weeks, Philippa Day's life could not be saved and she died of her injuries on 16th October 2019.

4 CIRCUMSTANCES OF THE DEATH

See box 3 above

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:

1. Call handlers as the DWP had not received, in their preparatory course prior to commencing work taking calls from claimants, specific training as to how best to interact with persons suffering from mental ill health in such a way as to avoid inadvertently exacerbating the difficulties experienced in progressing claims for benefits by such persons;
2. Records of calls handled were very brief and, at times, inaccurate. The records did not facilitate accurate decision making or enable queries to be dealt with efficiently and without inadvertently exacerbating the difficulties experienced by Philippa Day in progressing her benefits claims; and
3. The change of assessment process did not allow for a decision, which was incorrect, to be rectified

without evidence of a subsequent change of circumstances. In addition, when a change of review process was appropriate, there was no means by which upcoming appointments could be cancelled without causing prejudice to Philippa Day. A misleading letter was sent which led Philippa Day to consider that her benefits would be stopped if she did not attend the upcoming appointment.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisations 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 12 April 2021. 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:-

- Philippa Day's family
- Nottinghamshire Healthcare NHS Foundation Trust
- Nottingham University Hospitals NHS Trust

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 coroner, at the time of your response about the release or the publication of your response by the Chief Coroner.

9 Signed by:



Mr Gordon Clow, HMAc for Nottingham and Nottinghamshire

Dated: 12 February 2021