19 April 2024
Sent via email

Dear HH Goldstone KC

I write in response to your Report to Prevent Future Deaths (hereafter "PDF") dated 16 February 2024 concerning the death of Sobhia Tabasim Khan on 28 May 2017. In advance of responding to the specific concerns raised in your Report, on behalf of Cygnet Health Care, I would like to express my deep condolences to Ms Khan's family and loved ones.

To reassure you and Ms Khan's family that the concerns raised in your PFD have been listened to and reflected upon, the following steps have been taken:
1. The PFD action plan was reviewed at Clinical Governance meetings on 22 March 2024. It is listed to be an agenda item every month until September 2024 and provided that all actions are embedded at that point, it will be closed.

2. The action plan has been shared with the Senior Management Team for, and the Multi-Disciplinary Team (MDT) and all staff involved in Mr Mustafa's care at, Cygnet Hospital Derby.

3. The action plan is included in Cygnet Derby Overarching Local Action Plan (OLAP) and reviewed bi-monthly by the General Manager, Hospital Manager, and Clinical Manager to ensure completion and embedding of the actions.

4. The action plan was discussed and agreed at Medical Advisory Committee (MAC) (8 March 2024).

5. To ensure 'Ward to Board' learning and dissemination a presentation on learning points and actions from the PFD has been, and will be presented, at the following meetings: Regional Governance for East and West Midlands Managers (13 March 2024) and Secure Services steering group (30 April 2024), Regional Governance Medical Leads (9 July 2024).

6. The action plan will also be disseminated to NHS IMPACT Contract meeting for Commissioner scrutiny and openness of process (23 May 2024).

Cygnet Health Care responds to your PFD concerns as follows:

<u>Concern 1:</u> Clinicians should be provided with full reports when considering discharge: ***Those recommending discharge were not provided with the full Spousal Assault Risk Assessment, but only a summary. Given [redacted] risk profile, and the catastrophic consequences that were liable to result from him being pre-emptively discharged, and that discharge was being recommended without recourse to the Tribunal, it was essential that the s.117 meeting was informed by detailed reports which, had they been properly considered, would have indicated a need for circumspection.***

Response:

1. Spousal Assault Risk Assessment (SARA) document are provided in full in professionals CPA meeting/s.117 meeting report packs. There document will be sent as a full document to the Ministry of Justice when applying for section 17 leave permissions from the MOJ. It will be indicated on the Request for Discharge that it is available for the MoJ to view (as the request for discharge form does not allow for attachments).

2. A yearly service audit to be conducted by the psychology team at Cygnet Derby, to have as its focus in 2024, the delivery and evidence base of service users' understanding and implementation of skills taught in sex offender, violent offender, and arson treatments.

<u>Concern 2:</u> Over-reliance on self-reporting: ***It was recognised that Mustafa was narcissistic and manipulative but he was nonetheless relied upon to provide updates as to his mental health, his travel plans and the reasons for them, and – critically - whether or not he was in a relationship. Mustafa's risk arose primarily in the context of relationships and he was not somebody that could be relied upon to disclose them. On the contrary, he had shown himself willing and adept at concealing them. This underlined why his self-reporting could not be relied upon and this was something that should have featured in his management throughout, and flagged at the point of discharge.***

Response:

The MDT may be vulnerable to manipulation by service users and team 'splitting' can occur which can lead to poor decision making on risk factors and discharges.

1. The manipulation measurement tool, currently used for females, to be added as an addendum to the HCR-20 (a Secure Services Standard Risk Assessment tool for baseline risk assessment) and used for males going forward.

2. Potential Manipulation and Measurement tool to reviewed at CPA/s.117 meetings

To be completed by audit on 31 May 2024.

3. A second opinion of a medical specialist, such as a neuropsychiatry specialist, to be sought in cases of high risk, or where the need for a speciality outside the remit of the MDT is identified.

The need to consider the need for a second opinion will be added to the CPA checklist along with the relevant actions indicated if the need for a second opinion is identified. This will be monitored via MHAA audit.

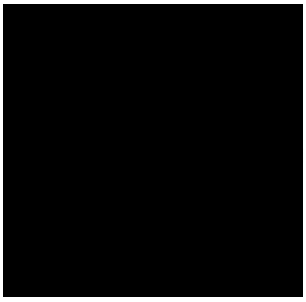
Concern 3: Record-keeping: ***This was a thread that ran through the case and applied both to the clinical notes but also the notes of meetings, such as MAPPA, which are necessarily a summary but which did not always include sufficient information to enable those reviewing them to understand what had been discussed and what actions taken. In terms of clinical records, whilst basic, mundane matters such as his sleeping habits and appetite were recorded, much of what mattered was not. The paucity of records and the poverty of their quality meant that Dr Kumar was not aware of the history of manipulation and the other factors which indicated an ample need for reassessment. In terms of the SOTP, whereas there was a conflict of evidence as to why the group programme was not available at Cygnet hospital, the keeping of proper records would have ensured that there was a ready answer if needed. The discharge meetings were poorly recorded, with the spousal assault risk assessment not having featured at all. There were repeated instances of witnesses not being able to remember, understandably, what had happened with respect to certain events. There was no excuse for professional witnesses to be put in this embarrassing position. The MoJ are reliant on what they are told in writing, but given that there is a culture of poor record-keeping, until and unless that record-keeping is improved to an acceptable level, they have to be more pro-active and more prepared to question things.***

1. All staff complete a report writing and record keeping developmental Skill workbook as part of their Cygnet induction.

2. Cygnet audits on triangulation of records completed 3 monthly to ensure cross referencing of information in different streams of records.

3. Section 117 and transfer of care meetings are monitored and audited at Cygnet Derby to ensure up to date reports or addendums are submitted, and detailed minutes recorded, the main focus being on MoJ , MAPPA, and high profile service user discharges.

Kind regards



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Executive Director of Nursing
Cygnet