Ministry of Justice

Rt Hon Edward Argar MP
Minister of State for Justice

His Honour Clement Goldstone KC

16th April 2024

Dear Mr Goldstone,

RESPONSE TO REGULATION 28: PREVENTION OF FUTURE DEATHS REPORT

Thank you for your Regulation 28: Prevention of future Deaths (PFD) report dated 16 February 2024 following the inquest into the death of Sobhia Tabasim Khan who died on 28 May 2017 at 68 Peartree Crescent, Derby.

I anticipate that you will share a copy of this response with Ms Khan's family so I shall take this opportunity to offer my sincerest condolences to them all including Ms Khan's brother, who was present at the inquest and I have been told showed great fortitude throughout. The pain and anguish of losing a family member in such terrible circumstances must be an immense burden and I understand why Ms Khan's family may have many questions about how it was able to happen, especially given Ataul Mustafa's previous offending, and why they will be interested in what the authorities will do to try to prevent any similar tragedies happening.

Following evidence heard at the inquest you have identified a number of concerns, some of which are relevant to the Ministry of Justice, namely, the scrutiny of restricted patients by the Mental Health Tribunal, the Secretary of State's use of recall powers, travel overseas for section 41 restricted patients and supervision under a forensic pathway.

The Mental Health Casework Section (MHCS) in HMPPS exercises the Secretary of State's statutory powers under the Mental Health Act 1983 (MHA 1983), whilst the day to day supervision of conditionally discharged patients is the responsibility of the care team in the community.

A common theme during the inquest and in the areas of concern in the PFD report was that the Ministry of Justice was not furnished with a complete picture of presentation whilst detained in hospital or discharged into the community. was discharged into the community in 2015 by MHCS on behalf of the Secretary of State and he murdered Ms Khan in May 2017. Since this tragic event, a number of improvements have been made to the way the MHCS and care teams interact.

In March 2022 MHCS updated application forms for community leave and discharge applications requiring increased detail around MAPPA engagement and victims with the aim of improving the quality and completeness of the information submitted to the MHCS.

In July 2023 MHCS published guidance for those supervising conditionally discharged patients in the community[1]. The guidance aims to support the supervision and reporting requirements for discharged

[1] https://assets.publishing.service.gov.uk/media/64b016148bc29f000d2ccd15/Guidance-_Conditionally_Discharged_patients_-_supervision_and_reporting_Final.pdf

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patients, it covers all aspects of a patient's discharge into the community. At the same time, the reporting tool that is used to keep the Secretary of State updated with regards to a restricted patient's progress in the community was also refreshed and improved.

One of your concerns centred on the fact that [redacted] was allowed to travel to Pakistan soon after his discharge into the community. Under the MHA 1983, there is no statutory bar to overseas travel for conditionally discharged patients and no mechanism for the Secretary of State to impose a blanket ban on all overseas travel. However, guidance published in July 2023 underlines the following expectations:

'(T)he primary contact with the patient should be face to face'; and

'(W)here a patient has left the country for more than a short holiday, the Secretary of State does not consider effective supervision possible and consideration will be given to recalling the patient for an urgent assessment at the point of their return to the United Kingdom. It would not be acceptable for telephone contact or supervision to be continued on the basis that the patient is in the community whilst they remain outside the jurisdiction of the 1983 Act…'

Also among your concerns was the fact that [redacted] had an overall lack of forensic input, namely the lack of a forensic psychiatric evaluation in advance of the request for discharge compounded by there being no community forensic supervision. Although it is not within the legislative powers of the Ministry of Justice to ensure that restricted patients are supervised under a forensic pathway, MHCS continues to work with partner agencies in support of delivering a comprehensive approach to supervision of discharged patients. The Government's White Paper *Reforming the Mental Health Act* (January 2021) set out aspirations to strengthen and further develop the role of the social supervisor. Health Education England commissioned a project to develop a Social Supervision Quality Framework, training materials and tools for social supervisors and their line managers aligned with the MHCS guidance, which my department published in 2023. Further products from this joint work will be launched later in 2024.

The Framework and resources will better support social supervisors and clinical supervisors who must submit regular progress reports to the MHCS for previously detained patients who remain liable for recall to hospital from the community as part of their conditional discharge. You may also wish to note the recently published DHSC guidance, *Discharge from mental health inpatient settings*[2], it aims to share best practice in relation to how NHS bodies and local authorities can work closely together to support the discharge process and ensure the right support in the community. It includes a section on forensic mental health forensic inpatient settings covering restrictedpatients.

You suggested it would have been more appropriate for the discharge decision to have been put before a Tribunal instead of it being taken by the MHCS on behalf of the Secretary fo State. Parliament entrusted to the Secretary of State a power to discharge restricted patients, and unlike the Tribunal, which must reach a decision on discharge entirely on the statutory criteria in section 73 of the Act, the Secretary of State has a broad discretion to order discharge where deemed safe to do so. The MHA 1983 has been subject to intense public scrutiny since 2017, when the then Prime Minister, Theresa May, commissioned an Independent Review of the Act. In response, the Government published a White Paper and public consultation in 2021. The Draft Mental Health Bill (MH Bill) was published in June 2022 and made subject to Pre-Legislative Scrutiny. Given this high level of independent scrutiny of the legislative provisions, I do not consider the discharge process requires any changes.

When considering recall, MHCS guidance[3] is clear that '(T)here is no need for the patient's mental health to have necessarily deteriorated in order to justify recall.' MHCS can and do recall restricted patients where there is an increased risk to others in order to protect the public. My officials regularly updats guidance for those working with restricted patients including the publication of guidance on s42 discharge in March 2022 and shall consider whether any changes to the recall guidance are necessary.

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[2] Discharge from mental health inpatient settings - GOV.UK (www.gov.uk)
[3] Recall of conditionally discharged restricted patients - GOV.UK (www.gov.uk)

In 2024, MHCS introduced a new system in order to identify cases where domestic violence has taken place, whether as part of the index offence or in the patient's history. Once identified, the issue of domesic violence will be highlighted to decision makers at all stages of a patient's movement through the hospital system and prompt them to to ask further, specific questions around domestic violence to ensure that this aspect of the risk is properly considered and mitigated.

Record-keeping 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. The National MAPPA Team in the Ministry of Justice has sought to improve the quality of MAPPA meetings and the recording of decisions. Specifically, in May 2022 updated Statutory Guidance was published on the conduct and recording of MAPPA meetings, including attendance, a clear focus on decisions relating to risk assessment and management, and that actions are clearly recorded and followed up. The Guidance is supported by a revised minutes template and an aide-memoire for MAPPA Chairs. Furthermore, in April 2023 The National MAPPA Team published learning resources for MAPPA Chairs and administrators with the aim of building confidence in ensuring that meetings are focused on risk and that that all agencies are clear about their contribution to risk management planning and are accountable for agreed actions.

I am confident that the above changes and updated guidance documents, designed to ensure that MHCS are furnished with all relevant information in order to discharge responsibilities under the MHA 1983, and that professionals supervising patients in the community continue to use their profession curiosity has led to an improved overall system. MHCS continue to identify opportunities to enhance our guidance and share knowledge with stakeholders.

Thank you for bringing these concerns to my attention. I trust that this response provides assurance that action has been and is being taken to address the matters you have raised.

RT HON EDWARD ARGAR MP