Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** a) The Ministry of Justice b) Cygnet Health Care c) Derbyshire Constabulary d) Derbyshire NHS Foundation Trust e) Derby City Council
1	**CORONER** I am HH Clement Goldstone KC, Assistant Coroner sitting in the Coroners' areas of Derbyshire.
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 28 May 2017 an investigation was commenced into the death of Sobhia Tabasim Khan, aged 37. The investigation concluded at the end of the inquest on 16 February 2024. The conclusion of the inquest was unlawful killing. I found that there were numerous failures by the various state agencies involved with Sobhia, including one that was causative of her death, namely the failure of Derbyshire Police to act on information received indicating that Sobhia's killer was in a relationship with a woman in Bradford and was planning to marry her in February 2017.
4	**CIRCUMSTANCES OF THE DEATH** Sobhia formed a relationship with a man named [redacted] who was subject to conditional discharged from a s.37 hospital order with s.41 restrictions following violent and sexual offences against his former wife. His discharge conditions included that he should notify the authorities of any developing relationships. He failed to notify the authorities that he had

	begun a relationship with Sobhia, and after the relationship had been ongoing for around a year he persuaded her to move from Bradford to Derby. Within little more than 5 weeks of her doing so he brutally murdered her. He ran a defence of diminished responsibility but was convicted of her murder. At the time of the murder [redacted] was being supervised by numerous agencies: the police, social services, the community mental health team, MAPPA, and the Ministry of Justice. That he was nonetheless able to form a relationship with Sobhia in secret, and to murder her, was surprising and concerning. This formed the focus on my inquest.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: a. **Scrutiny of s.41 MHA 1983 cases by the Mental Health Tribunal**. In this case [redacted] was discharged by the Ministry of Justice (MoJ) following the receipt of reports from Cygnet Hospital which were inadequate and misrepresented the progress he had made and the risk that he posed. Nonetheless there were indicators which should have led the MoJ to question whether this case should have been referred to a Mental Health Tribunal, such as [redacted] minimising his culpability for his previous offending. The offences against his former wife were of the utmost gravity, particularly in the context of his behaviour during the marriage that she later disclosed. This indicated a risk of such a level as to make it not only desirable but essential that discharge was not contemplated until there had been close and careful scrutiny by those with expertise in forensic risk assessment. The MoJ Guidance on restricted patients says that "the vast majority" of discharge decisions are made by the Tribunal. In a patient with [redacted] risk profile it is difficult to envisage circumstances whereby that should have been displaced. b. **Ensuring that s.41 restricted patients are supervised under a forensic pathway**. In this case no such pathway even existed in the locality. This meant that Mustafa's supervision was inadequate having regard to the risk that he posed. Such orders are imposed to protect the public from the risk of serious harm. Even where it has been adjudged that any previous offending would not have happened but for a mental disorder, there is still the need for a forensic approach. The risk component must not be overlooked as it was here. Forensic pathways must be available across the country. c. **Police power to arrest where there is a reason to believe a person is at risk of death/serious injury.** Whilst I was critical of the failure of the police to take measures that were reasonably available to them to investigate the intelligence that had been received that [redacted] was in a relationship, the one power that was not available to them was to arrest him. This leaves a significant gap in the powers that are available to the police to protect individuals who are at risk of death/serious injury. Although I cannot say whether the threshold would have been met in Sobhia's case, such a power could in future cases ensure that it is understood that where an individual poses a significant risk of causing serious harm in relationships, and there is evidence that he is concealing a relationship, he can be arrested. d. **Ministry of Justice power to recall where a patient poses a significant risk to the public.** The MoJ will not generally recall dangerous individuals unless there is a decline in their mental health presentation notwithstanding the fact that s.41 MHA 1983, to which [redacted] was subject, is designed to protect the public from serious harm. Whilst there is the possibility of the judge imposing a hybrid order, and that was not considered appropriate in this case, it did not mean that [redacted] risk only existed in the context of a decline in his mental health. If an individual subject to a s.41 restriction order poses a significant risk to the public then the public can only be

protected if he can be recalled to hospital where further assessment can be undertaken. If it then transpires that, as likely was the case here, the mental health component had previously been exaggerated, this would at the very least allow for a discharge plan to then be prepared which takes account of this and ensures that there is adequate focus on managing the risk. One way of achieving this would be a power to arrest being attached to the patient's discharge conditions, enforceable where there is a significant risk of serious harm.

e. **Travel overseas for s.41 restricted patients.** [redacted] was permitted to travel to and from Pakistan freely and to return seemingly as and when he saw fit. Whilst he was outside the jurisdiction there was no way of checking on him, including in terms of his mental health, but also his risk. There were concerns, for example, that he may have been arranging a forced marriage for his niece. He could have entered into a relationship, for all the authorities knew. It also allowed him an opportunity to push and test the boundaries. He was permitted to travel out of the jurisdiction as he pleased, sometimes returning late, sometimes early. By contrast, had he been on licence after serving a custodial sentence, he would in all probability have been prevented from travelling outside the jurisdiction, at least in the early stages. Whilst I acknowledge that there are qualitative differences between a prison sentence and a hospital order, it remains legitimate if not necessary to ensure that those who have recently discharged from a s.41 order are carefully monitored, in the jurisdiction, at least for the first 12 months. This is beneficial not only in terms of monitoring mental health, but also risk.

f. **Clinicians should be provided with full reports when considering discharge.** This was a particular concern in relation to the fact that 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.

g. **Over-reliance on self-reporting**. This was a theme that ran throughout the inquest and the various agencies involved. This was a case that required a forensic approach throughout, both in hospital and in the community. It was recognised that [redacted] 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. [redacted] 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.

h. **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 [redacted] 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. i. **Familiarisation of professionals with cultural issues**. In this case there appears to have been a reluctance to make enquiries with the Mosque and the Islamic Meat Centre, and to be aware of how the family dynamics are impacted by cultural issues. Although it was intended that a family tree would be completed, and this should have been done pre-discharge, [redacted] was able to some extent to throw a curtain around his family and thereby prevent those working with him from understanding the lengths they were prepared to go to protect him. It was noted that him becoming the Head of the family after his father's death was significant, but the wider consequences were not properly considered.
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 12 April 2024. I, the coroner, may extend the period if there are good reasons for doing so.. 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 1. [redacted] (Sobhia's brother) 2. Ministry of Justice 3. Derbyshire Police 4. Derbyshire NHS Foundation Trust 5. Derby City Council 6. Cygnet Health Care I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated:** **16 February 2024** **Signed:** **HH Clement Goldstone KC**