Ministry of Justice

The Right Honourable
Robert Buckland QC MP
Lord Chancellor & Secretary of State for Justice

Ms M Hassell, Senior Coroner
Inner North London St Pancras Coroner's Court
Camley Street
London
N1C 4PP

[redacted]

27 July 2021

Dear Ms Hassell,

RESPONSE TO REGULATION 28: PREVENTION OF FUTURE DEATHS REPORT

Thank you for your Regulation 28: Prevention of Future Deaths report dated 4 June 2021 following the inquest into the death of Angela Rosemary Best who died on 15 December 2016 at [redacted] Dartmouth Park Hill, London.

I met members of Ms Best's family in my role as Solicitor General when I referred the case to the Court of Appeal under the Unduly Lenient Sentence Scheme and personally appeared to present the case there. At that time they were going through excruciating pain and were desperate for justice to be done. I can understand why they may still have many questions about how it was able to happen, especially given [redacted] previous homicide convictions. The pain and heartache of losing Angela will never leave them and I understand why they may be interested in what the authorities will do to try to prevent any similar tragedies happening. I wish all her family the very best and I hope they are able to find some peace.

Following evidence heard at the inquest you have raised concerns, namely the unreliability built into the system that relied upon self-reporting from a known killer who had a vested interest in withholding relevant information.

The Mental Health Casework Section (MHCS) in HMPPS exercises the Secretary of State's statutory powers under the Mental Health Act 1983, and whilst the day to day supervision of conditionally discharged patients is the responsibility of the care team in the community, I recognise that there are improvements we can make to the way MHCS and care teams work together. In response to the concerns you have raised, MHCS have identified a number of actions they propose to take forward:

Review of Conditions of Discharge and Associated MHCS Guidance: Mr Johnson had a condition *'to notify his/her supervising team (his Responsible Clinician and Social Supervisor) of any close relationship he/she was having or was developing'.* Conditional discharge reports routinely provided updates on Mr Johnson's relationship status, based on his own self reporting. Officials will review the MHCS condition applied to relationships, to explore whether additional or amended conditions may assist. This will be subject to informal consultation with stakeholders (such as the Forensic Faculty of the Royal College of Psychiatrists). MHCS guidance on managing discharged patients will be revised to promote and support the sort of professional curiosity and challenge that is acknowledged practice in fields of probation supervision, social work, domestic violence, safeguarding and adult social care. We will encourage a

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more investigative approach, being vigilant and inquisitive in seeking out information from a wide range of sources to inform ongoing assessment. MHCS receives regular reports on conditionally discharged patients, this is a statutory requirement. MHCS will revise the template for conditional discharge reports alongside the guidance thereby facilitating the sharing of information between supervision care teams and MHCS, setting the expectation that reliance on self-reporting is not sufficient.

MHCS will also work with partner agencies in support of delivering this different 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; including a consultation question asking stakeholders how best to achieve this. The consultation has now closed and responses are being considered. MHCS will continue to work with DHSC to deliver on this ambition and the proposals on qualifications and training requirements.

Discharge applications and associated guidance: MHCS has not formally published discharge guidance before now; officials are in the process of drafting it and it will, in due course, be published on gov.uk. I can confirm the current drafting contains information on MAPPA and the responsibilities of responsible clinicians in this regard.

Communications to care teams of discharged patients in the community: in response to the recommendations of the Domestic Homicide Review into the death of Angela Best, MoJ took a number of follow up actions. These included identifying patients that met criteria similar to that of the case of [redacted], namely they were discharged prior to 2003 (so may not have been automatically MAPPA-eligible), and had the same condition (to notify their care team of any developing relationship). At that time a small number cases were identified and MHCS wrote to the clinicians responsible for their care seeking reassurance that MAPPA management had been considered. Officials have subsequently identified a further 250 cases, without the specific condition, but whom were also discharged prior to 2003, and are in the process of writing to those supervising teams to ensure they are aware of their own responsibilities in respect of MAPPA.

Hospital Orders and MHCS Issued Warrants: For new patients in receipt of hospital orders from the Crown Court, there is now clear wording on the Court Order aimed at responsible clinicians, highlighting their statutory responsibility to identify and refer patients for MAPPA management. We are working to see similar changes implemented for orders issued via the Magistrates court. MHCS will also review the warrants they issue in prison transfers to incorporate similar changes.

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

Yours sincerely

Robert Buckland

RT HON ROBERT BUCKLAND QC MP