IN THE MATTER OF

THE LAMPARD INQUIRY
RULE 9 (3) RESPONSE

SECOND WITNESS STATEMENT OF CHRISTIAN JOSEPH YOUNG

I, **Christian Joseph Young,** of Cygnet Health Care Ltd, Nepicar House, London Road, Writham Heath, Sevenoaks TN15 7RS will state as follows:

INTRODUCTION

1. I am the General Counsel (UK) of Cygnet Health Care Ltd ('Cygnet'). I am one of the solicitors with responsibility for and day to day conduct of this matter and am duly authorised to make this statement on behalf of Cygnet.

2. I make this statement following a request for evidence pursuant to Rule 9 of the Inquiry Rules 2006 by the Lampard Inquiry team, by letter dated 21 January 2025. The Inquiry Team require Cygnet to produce information concerning findings of neglect and/or Prevention of Future Death (PFD) Reports, Responses and related records of inquest in respect of deaths falling within the Inquiry's scope. I refer to my witness statement dated 14 August 2024 for details of those who died whilst receiving NHS funded mental health inpatient care at Cygnet or at sites acquired by Cygnet, within the Inquiry's scope.

3. The facts and matters set out in this statement are within my own knowledge unless otherwise stated, and I believe them to be true. Where I refer to information supplied by others, the source of the information is identified; facts and matters derived from other sources are true to the best of my knowledge and belief.

SEARCH UNDERTAKEN

4. Following the Inquiry's initial request for details of inpatient deaths within the Inquiry's scope, a search of all archived, physical and electronic files, including all files from companies acquired by Cygnet within the 24 year timeframe, identified 8 deaths. None of the deaths occurred at sites which were under Cygnet's ownership at the time. I refer to my statement dated 14 August 2024 for further details. We have searched through the records relating to the deaths of the 8 patients identified to respond to this further request for information. We have also liaised with various colleagues in numerous departments

who may be able to assist with the provision of information requested, including our governance and digital services teams.

REQUEST FOR EVIDENCE PURSUANT TO RULE 9 OF THE INQUIRY RULES 2006, RULE 9(3):

Request for information concerning findings of neglect and/or prevention of future death (PFD) reports, responses and related records of inquest ("ROI") in respect of deaths falling within the Inquiry's scope

5. I have not dealt with each of the questions asked by the Inquiry. This is because they are predicated on Cygnet having received a PFD Report during the period of time being examined by the Inquiry. Following the searches which have been by other staff within Cygnet who have assisted me in attempting to comply with this Rule 9 request, I can confirm that there have been no PFD reports identified during the relevant period, within the scope of the Inquiry.

6. In addition and following searches of our archive files, we have found no documentation in relation to any PFD reports or ROI. As indicated previously, all 8 deaths identified occurred at sites which were not owned by Cygnet at the time and accordingly, Cygnet is reliant on what information was recorded and retained by the site at the time, and then transferred to Cygnet when the relevant site was acquired.

7. Currently Cygnet follows the PFD process map, this is attached at Exhibit CY1.

8. On receipt of a PFD report, whether by the in-house legal team (directly or via an external advocate) or the CEO's office, it is disseminated to the CEO, in-house legal team, site specific manager, regional manager, operations director, medical, nursing and governance directors, patient safety team, safeguarding, health and safety and estates. The director of nursing takes the lead on responding to the PFD Report and works with the group clinical director to draft the initial response. The deadline for the response is diarised and the person best placed to respond is supported to draft the response. The PFD is added to the in-house legal team's PFD spreadsheet and discussed at the Complex Case Panel (a weekly meeting).

9. Where required, meetings will be held with the legal team, external advocate and senior managers at site, to discuss the PFD and the concerns raised by the coroner. The draft response and any additional or updated action plan is reviewed by the in-house legal team before being approved by the CEO, signed and filed. Findings and learning are shared with the local unit, wider operations, medical and nursing directorate and next of kin as

appropriate. Learning is shared widely via bulletins, learning videos and the lessons learnt group. If the circumstances allow our Group Investigations Manager will often meet with the family of the deceased to speak with them about the incident and our internal report.

10. A log and copy of all PFD reports and responses is kept by the in-house legal team and if a review date is required in respect of any outstanding actions, this is diarised. Any PFDs issued are discussed quarterly at the Learning from Deaths group, Safety Response Group, Lessons Learnt and Mortality Groups and at Executive Board level.

11. If the PFD relates to a concern wider than the site in question, learning is disseminated to all staff via the Lesson's Learned Bulletin, email updates from the Regional Directors and also a regular briefing at Executive Board level. Where it is felt that there is a need for more in depth, wider or ongoing training or awareness, a campaign on that particular topic is run. Examples of this over the past two years include a topic on diabetes and a year long campaign on choking awareness (neither of which emanated from a PFD concerning an Essex site). I attach at Exhibit CY2 a copy of our lessons learnt flowchart, available to all staff on Cygnet's intranet. This flowchart details how lessons learnt are included on meeting agendas locally (staff/governance/handover and other forums) then escalated and shared as necessary.

12. Specifically in respect of PFD reports, at our quarterly Learning from Deaths group, the Chief Regulatory Counsel gives a presentation on all mental health related PFD reports published on the Chief Coroner's website. This provides an opportunity for Cygnet to gain insight into, and learn from incidents wider than within our own organisation. The Inquiry should note that our Chief Regulatory Counsel is also an Assistant Coroner.

13. There is also a national learning forum co-chaired with Cygnet which invites nursing leads and safety leads to discuss and share learning from various threads including PFD learning.

STATEMENT OF TRUTH

I believe the content of this statement to be true.

Signed

[I/S] 

CHRISTIAN JOSEPH YOUNG

Dated: 20 March 2025