Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

enabling and empowering people to reach their potential and live fulfilling lives

Summary Report – Trust Board Meeting (Part 1)	**Date: 30 January 2013**
Report Title: Receipt of Homicide Reports	
Agenda Item: 09	**Enclosures: none**
Sponsor: NCAS Director	**Presenter: NCAS Director**
Report Author: Head of Risk and Compliance	
Report discussed previously at:	*EMT/Board Committee/TWMG/other*

Purpose of the Report and Action required		
The purpose of the report is to receive 3 published homicide inquiry reports.	Approval	
	Discussion	X
	Information	

Executive Summary of Key Issues
Board members will be aware of the detail of the homicides inquiries launched regarding the care afforded Mr X, Mr Y and Mr Z. The Board is now asked to formally consider the published homicide reports. There are no causative failings identified in any of the reports, however, they usefully provide further opportunities for learning and are a key driver for quality improvement.

Which Strategic Objective does this paper address	
A sustainable value for money business	*Yes*
Excellent service user access and experience	*Yes*
Excellent partnership working with other organisations	*Yes*
Effective engagement and improvement in staff satisfaction	*Yes*

Link to Fit for the Future Implementation Plan	
Specify objective number	26

Corporate Impact Assessment	
Quality and Safety implications	*The publications highlight quality and safety issues.*

Recommendations to other committees
In-depth scrutiny to the reports and their action plans has been given by the Critical Incident Overview Group.

Recommendation/Decision
The Board is recommended to **note** the report.

Receipt of Homicide Reports

1. Purpose of the Report

The purpose of the report is to ask the Trust Board to receive and consider the 3 independent homicide inquiry reports published by NHS South West on 9 January 2013. These reports can be found on the Trust's Intranet site or at this link to the SHA website: http://www.southofengland.nhs.uk/about-us/publications-and-reports/swsha-publications-and-reports/.

2. Analysis and Discussion

2.1. The homicide inquiry reports into the care afforded to Mr X, Mr Y and Mr Z were received by the Patient Safety and Care Standards Committee of NHS South West on 9 January 2012. HASCAS, the company commissioned to lead the investigations presented each of the cases to the committee. The Trust was represented by the Chief Executive, the Medical Director and the Head of Risk and Compliance. The widow of one of the victims also attended with other family members.

2.2. Trust Board members are already familiar with the details of each of the cases from the Trust's internal investigations, other briefings and through its close scrutiny of action taken to respond to the inquiry findings.

2.3. Whilst it is pleasing that there are no causative failings identified in these reports, the recommendations are helpful and will further contribute to the quality improvement work already underway.

2.4. Key themes arising from the inquiries include:

2.4.1. Carer involvement

2.4.2. Public protection and safeguarding

2.4.3. Supervision and training

2.4.4. CPA and risk assessment

2.4.5. Dual Diagnosis

2.5. Board members will be aware that practice in relation to these themes has changed significantly since these homicides (for example they pre-date the establishment of the safeguarding team), but more importantly will be aware that work streams exist to drive quality improvements in each of these areas, supported amongst other things by audit activity, surveys and balanced scorecard monitoring.

2.6. The Critical Incident Overview Group continues to take a lead role in scrutinising action plan implementation internally, and the Care Quality Review Meeting led by the Lead Commissioner and supported by the Strategic Health Authority provides an external

scrutiny role. Excellent progress, led by Clinical Directors, has been made in addressing the actions arising from these inquiries and the Board can be assured that robust ongoing monitoring mechanisms are in place based on detailed thematic analysis of homicide findings.

3. Conclusion

3.1. The Trust Board are asked to consider the inquiry reports and recommendations.