Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

'You matter, we care'

Trust Board Meeting (Part 1)	Date: 30th April 2014

Title:	**Briefing on the Independent Investigation Report regarding Ms X**
Item:	**BD/14/018.1**

Executive Director lead and presenter	**Director of Nursing and Quality**
Report author(s)	**Head of Patient Safety Systems**

History:	*Critical Incident Overview Group*

This report is for:	
Decision	
Discussion	X
To Note	

The following impacts have been identified and assessed in relation to this report:	
Equality	
Quality	
Privacy	

Executive Summary of key issues
The purpose of this report is to share the findings of the independent investigation report regarding Ms X and the Trust response.

This report addresses these Strategic Priorities:	
We will deliver the best care	X
We will support and develop our staff	X
We will continually improve what we do	X

We will use our resources wisely	
We will be future focussed	

1. Overview

The report of the independent investigation into the care and treatment of Ms X was published by NHS England on Monday 14 April 2014, as one of two legacy cases it inherited relating to the Trust.

The independent investigation had been commissioned by NHS South West and examined the care afforded to Ms X. Ms X was known to AWP services from May 2009 until October 2010 when the homicide occurred.

2. Analysis and Discussion

Ms X received a custodial sentence for her part in the homicide committed by her boyfriend.

Board members have previously been briefed on the details of this very serious incident from the Trust's own internal investigation and the follow up work. The response to this homicide has been led by Bristol Local Delivery Unit and closely monitored by the Critical Incident Overview Group.

The report concludes that the homicide was due to a combination of events which could not have been predicted or prevented and found no causal factors. It praises the quality of the internal investigation conducted by the Trust.

The report makes a number of service issues for the Trust to address. The Trust has accepted and responded to all of the recommendations made in the report and quality improvements are subject to on-going monitoring.

The executive summary of the report is available as Appendix 1 to this paper and the Trust response to the findings is provided as Appendix 2. The full report has been published on the Trust website.

Ms X has declined contact with the Trust, but contact has been initiated with her family. The Trust was prevented from making contact with the victim's family and they did not engage with the independent investigation.

Support has been provided to affected staff, who can hopefully take some comfort from the many positive comments made about the quality of their service provision.

As a result of this publication, the Trust's thematic work relating to learning from homicides will be refreshed and a report prepared for consideration by the Quality and Standards Committee.

3. Conclusion

The Trust Board is asked to consider and comment as it wishes on the report and Trust response.