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 Mr A**
Item:	**BD/14/018.4**

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 Mr A 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 Mr A 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 of England Strategic Health Authority and examined the care afforded to Mr A. Mr A was known to AWP services from December 2006 until September 2009 when the homicide occurred.

2. Analysis and Discussion

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 North Somerset Local Delivery Unit and closely monitored by the Critical Incident Overview Group.

The report supports the findings of the Trust's own internal investigation that services could not have predicted that Mr A would have killed someone. Due legal process found Mr A culpable for his actions.

The report identifies shortcomings in the effective assessment of Mr A's mental health care and this led to an inadequate programme of treatment interventions and assistance.

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.

The Trust has accepted all of the recommendations in the report and made a concerted response which is subject to on-going monitoring.

Mr A's family have declined contact with the Trust. NHS England have made contact with the victim's family and contact with them has been initiated by AWP. Support has been provided to affected staff.

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.