Avon and Wiltshire NHS
Mental Health Partnership NHS Trust

'You matter, we care'

Trust Board Meeting (Part 1)	Date: 25th June 2014

Title:	**Report & Trust Response to the Independent Inquiry into the care of MC**
Item:	**BD/14/079**

Executive Director lead and presenter	**Medical Director**
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	None identified
Quality	None identified
Privacy	None Identified

Executive Summary of key issues

The purpose of this report is to share the findings of the independent investigation report regarding Mr MC and the Trust response. Themes arising include:

- *Risk assessment*
- *Multi-disciplinary working*
- *Multi-agency working*
- *Use of Clinical Tools*
- *Information Sharing*
- *Mental Health Act*
- *Discharge Planning*
- *Incident Management*

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	X
We will be future focussed	X

1. Overview

The report of the independent investigation into the care and treatment of Mr MC was published by NHS England on Monday 16 June 2014.

The independent investigation had been commissioned by NHS England in June 2013 to examine the care afforded to Mr MC. Mr MC had been involved with mental health services since his teenage years and first engaged with AWP's services in 1994.

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 Secure Services and closely monitored by the Critical Incident Overview Group.

The report supports the findings of the Trust's own internal investigation, and asserts that the tragic event was neither predictable (in the nature and seriousness of the event) nor preventable. The report identifies some shortcomings, particularly in relation to risk assessment and multi-disciplinary working and makes 13 recommendations, which the Trust has welcomed and fully accepted.

The report is available as Appendix 1 to this paper and the Trust response to the findings is provided as Appendix 2.

Mr MC's family have declined contact with the Trust and did not wish to engage with either the internal or independent inquiry.

The Trust has had considerable contact with the victim's family. Mr GN's family have actively engaged with the Trust from the outset and have very generously given their feedback on the investigations, as well as describing how the tragedy and the resultant efforts at support and assistance affected them. Their homicide case worker will be attending the Board meeting to provide direct feedback to the Trust Board on these issues.

3. Conclusion

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