TERMS OF REFERENCE FOR THE INDEPENDENT INVESTIGATION INTO THE CARE AND TREATMENT OF MR A

BACKGROUND

Under Department of Health Guidance HSG (94)27 (amended in 2005), SHAs are required to undertake an independent investigation 'when a homicide has been committed by a person who is or has been under the care, i.e. subject to a regular or enhanced care programme approach, or specialist mental health services in the six months prior to the event'.

On the 11 September 2008 Mr A and a group of other inmates attacked the Deceased in his cell (the 'Offence'). The Deceased subsequently died from an underlying heart condition brought on by the attack. Mr A and 2 others were found guilty of manslaughter. Mr A had been seen on 3 occasions by the HMP Peterborough In-Reach Team (the 'Team'), a service provided by Cambridge and Peterborough NHS Foundation Trust (the 'Trust').

AIM OF THE INVESTIGATION

To provide an independent report into the care and treatment provided to Mr A from his first contact with the Team up to the time of the offence.

This investigation is commissioned in accordance with the Department of Health guidance and follows the National Patient Safety Agency Good Practice Guidance for Independent Investigations.

Stage 1

Following the review of clinical notes and other documentary evidence:

- Review the Trust's Internal Investigation (SI Ref Number: 146/2008 V.8) and assess the adequacy of its findings, recommendations and action plan.
- Review the progress that the Trust has made in implementing the action plan

Stage 2

- Review the care, treatment and services provided by the Team, from the service user's first contact with the Team to the time of the Offence.
- Compile a comprehensive chronology of events leading up to the homicide.
- Review the appropriateness of the treatment, care and supervision of the mental health service user by the Team in the light of any identified health needs, identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including specifically the risk of the service user harming himself or

others during the period between first referral to the Team and the date of the Offence.

- Examine the effectiveness of the service user's care plan including the involvement of the service user.
- Review and assess compliance with local policies, national guidance and relevant statutory obligations applicable to the Team.
- Consider if this incident was either predictable or preventable.
- Provide a written report to the SHA that includes measurable, relevant to the current clinical environment and sustainable recommendations with a view to preventing a recurrence.

Method of working

- The panel will examine all appropriate documentation which in its view relates to the care of Mr A by the Team and seek evidence from those involved in his care, in order to properly carry out its investigation.

- The panel will agree appropriate communication arrangements with family members and give an opportunity to the families to contribute to the investigation, as the panel feels necessary.

- The panel will conduct its work in private.

Output and reporting arrangements

- The panel will provide a written report including recommendations specific to the care and treatment of Mr A to NHS East of England, the Trust and the commissioning Primary Care Trust

- The SHA will make the findings and the recommendations of the investigation public.