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PUBLICATION OF INDEPENDENT INVESTIGATION REPORT INTO THE CARE AND TREATMENT OF MR S

22 September 2017

Findings are published today of an independent investigation into the circumstances surrounding the care and treatment of Mr S.

Sincerest sympathies are offered to all the people who have been affected by this tragic event. We speak of four victims in this incident, Rachael, her unborn child and Auden who were tragically killed and Mr S, who was receiving mental health treatment and who took his own life.

A Coroners Inquest convened in 2013 concluded that the deaths of Rachael and Auden were unlawful killings. It was held that Rachael and Auden were killed by Mr S in their home, following which Mr S then committed suicide. Mr S had contact with mental health services provided by Derbyshire Healthcare NHS Foundation Trust.

Dr David Levy, Medical Director at NHS England – Midlands and East, said: “We would like to offer our sincere sympathies to the people who have been affected by this tragic incident.

“Thankfully, events such as this are rare. However, when they do occur, we work closely with the relevant organisations to ensure that lessons are learned and improvements put in place to make any changes necessary to ensure patient and public safety.”

The independent investigation was commissioned by NHS England following the completion of an internal investigation undertaken by Derbyshire Healthcare NHS Foundation Trust into the events leading up to the death of Rachel and her two-year-old son, Auden, and the publication of the Serious Case Review into the death of Auden.

The aim of this investigation is not to investigate the circumstances of the offence, but to enable the providers of care, and the whole of the NHS, to learn lessons and make improvements for the benefit of future patients, their carers and the public. We commission these reports so that the NHS is open and transparent with the families involved and the wider public about what took place and what the NHS is doing to fix it.

The investigation team’s view is that the incident was neither predictable nor preventable.

In conducting their investigation, the team found that Mr S received appropriate treatment for depression, which was compliant with NICE guidelines and a reasonable and proper approach was taken in treating his personality disorder. He received immediate crisis response when it

was required which the Trust are commended for.

However, the investigation also found there were missed opportunities. One of the systemic missed opportunities in the treatment of Mr S was the lack of formal involvement of Rachael and Mr S's sister in the management and approach to his care. When Mr S's mental health deteriorated formal involvement from Rachael and Mr S's sister was crucial as they would have provided valuable information and insights into his mental state which would have warranted exploration.

The report concludes that there are areas where additional learning can be unlocked for the NHS as a result of these tragic events and has made three recommendations:

1. Ensuring formal adherence to the Care Programme Approach (to make information sharing between professionals as efficient as possible)
2. Working with carers (and family members where applicable)
3. Improving liaison with families after adverse events.

A copy of the full independent investigation report is available on our website here.

Ends

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