



## NEWS RELEASE

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# PUBLICATION OF INDEPENDENT INVESTIGATION REPORT INTO THE CARE AND TREATMENT OF MS Z

24 July 2017

Today NHS England [publishes the independent investigation report](#) into the care and treatment of Ms Z.

Sincerest sympathies are offered to all the people who have been affected by this tragic incident. We speak of two victims in this incident, the victim who was tragically killed and Ms Z, who was let down by the NHS.

Ms Z was charged with the murder of the victim and found guilty of manslaughter on the grounds of diminished responsibility. She had previously had contact with mental health services in the North Midlands and had a longstanding psychotic illness. NHS England commissioned an independent investigation following the initial internal review undertaken by Derbyshire Healthcare NHS Foundation Trust. The aim of this investigation is not to investigate the circumstances of the offence, but to thoroughly review the care and treatment received by the patient. This is so the NHS can be clear about what, if anything, went wrong with the care the patient received; minimise the possibility of a reoccurrence of similar events and to make recommendations for the delivery of health services in the future. 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 Independent Investigation Team's view is that it was predictable that Ms Z could have committed a violent attack upon either her mother or an individual known to her. However, it did not consider it predictable that she would have committed a violent attack upon a randomly encountered, previously unknown individual such as the victim. The team considered whether there were "actions that healthcare professionals should have taken, but which they did not, that could in all probability have made a difference to the outcome". The team determined that the homicide was not "preventable".

**Dr David Levy, Regional Medical Director at NHS England – Midlands and East said:** "The health and social care system responds to the needs of individual people and their families. Sometimes, and in this case, the system can fail the patient and the consequences when this happens can be devastating. This is not acceptable and I unreservedly apologise to both families on behalf of NHS England and Derbyshire Healthcare NHS Foundation Trust which delivered the mental health care and treatment to Ms Z before this incident took place."

Derbyshire Healthcare NHS Foundation Trust took the findings of their initial investigation very

seriously and in doing so have largely addressed and responded to the recommendations cited in the report we publish today. The recommendations cited in the report are published today for the first time. It is important to recognise that the closure of an incident and the publication of a report mark the completion of the investigation process only. In fact, all recommendations have already been responded to by the Trust and are either complete or in progress. Implementing change and improvement can take time, particularly where this relates to behavioural and cultural change. It is not unreasonable for improvement to take many months or even years in some cases and the actions already taken by the Trust have made significant changes to way in which care and treatment is now delivered.

There is clear commitment from Derbyshire Healthcare NHS Foundation Trust to continue its work to improve the healthcare delivered to patients. In addition to this, significant changes have been made nationally to how mental health care is delivered since this devastating incident took place in 2013. The report notes that the developments in the delivery of mental health services seen nationally and locally since 2013, including the Care Act and the Duty of Candour, mean much has changed in the treatment of patients with mental health problems.

**Dr David Levy said:** “Our thoughts today are with the victim’s family whose lives have been irrevocably changed as a result of this tragic event. We are sorry for the failings identified by the independent investigation report and we apologise for them and for the distress this has caused both families. It is our responsibility to continue this work and ensure that all the recommendations within this report being published today are acted upon and the learning is shared not only across the North Midlands but nationally to reduce the risk of reoccurrence of a similar incident in the future.”

## **Ends**

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