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# PUBLICATION OF INDEPENDENT INVESTIGATION REPORT INTO THE CARE AND TREATMENT OF P

14 June 2017

Today NHS England publishes the independent investigation report into the care and treatment of P.

Sincerest sympathies are offered to all the people who have been affected by this tragic incident. We speak of two victims in this incident, Christina who was tragically killed and P, who was let down by the NHS and other organisations involved in his care and treatment.

P was charged with the murder of Christina. He had previously had contact with mental health services in the West Midlands. NHS England commissioned an independent investigation following the initial internal review commissioned and published by Birmingham CrossCity CCG in 2014. 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.

**Dr David Levy, Regional Medical Director at NHS England – Midlands and East said:**
"Many NHS and non-NHS organisations were involved in the care and treatment of P and this is not unique to this case. Treating patients is seldom done by one organisation, the health and social care system responds to the needs of individual people and their families. Sometimes, and in this case, the system gets it wrong and the consequences of when this happens can be devastating. This is not acceptable and I unreservedly apologise to the families of both victims on behalf of NHS England and the organisations involved in delivering care to P before this incident took place."

Services have taken the findings of the initial investigation very seriously and have largely addressed and responded to the recommendations. There are also key recommendations in the report published today that require a national response including; improving arrangements for discharge planning of vulnerable prisoners with mental health problems who are released earlier than planned; ensuring the care for released prisoners makes adequate provision for those needing to access mental health services; and that the Department of Health, NHS England and the Ministry of Justice strenuously work together to improve the care and aftercare of prisoners with mental health problems.

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. The delivery of action and improvement at this stage may be in its infancy. In fact, 14 of the 25 recommendations have already been completed by the system and the rest are 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. This is particularly true for actions requiring changes to national frameworks and policies.

NHS England is already in active discussion with the Ministry of Justice and the Department of Health to resolve the issues raised in this report. We are working in partnership to explore how we can implement solutions which mitigate against the risks outlined in this report relating to unplanned early release of prisoners. NHS England is due to pilot a new way of managing the transfer of information for prisoners either being released or transferred. This piece of work will be fully implemented and embedded nationally by the end of 2017.

Additionally, NHS England is working with Her Majesty's Prison and Probation Service (HMPPS) to consider a system which allows healthcare staff in prisons to access appropriate and relevant information about prisoners that is currently stored in the prison's records. This will promote better working between those responsible for the care of prisoners and help the transfer of relevant information when they are due to be released.

The Serious Incident Framework was revised and published by NHS England in March 2015 and describes the process and procedure necessary to make sure that Serious

Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again. This framework includes clear guidance for the ownership, commissioning and oversight of all serious incident investigations and helps the health system, nationally and locally, manage serious incidents that cross service and agency boundaries which is exactly what we see described in the report we publish today.

The NHS system remains committed to working together to fix the problems that are identified in the report and to improve the healthcare delivered to patients. A lot of changes have already been made by the organisations cited in the report and by the wider health and social care system both locally and nationally:

An independent Mental Health Taskforce was formed in 2015 and brought together health and care leaders, people who use services and experts in the field to create a Five Year Forward View for Mental Health for the NHS in England. This national strategy, which covers care and support for all ages, was published in February 2016 and signifies that, for the first time, there is a strategic approach to improving mental health outcomes across the health and care system, in partnership with the health system's arm's length bodies.

In July 2016, NHS England published an Implementation Plan to set out the actions required to deliver the Five Year Forward View for Mental Health. The Implementation Plan brings together all the health delivery partners to ensure there is cross-system working to meet the recommendations made by the Taskforce. One year on since initial publication real changes have been made which positively benefit patients including the expansion of liaison and diversion services to cover police custody suites and courts in areas representing 68% of the population of England; a new model for community forensic services developed in partnership

with those using secure services and clinicians; and over 72,500 more people with common mental health problems accessed psychological therapies compared with the previous year.

**Dr David Levy said:** “Our thoughts today are with Christina’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. The report notes that the developments in the delivery of mental health services seen nationally and locally since 2013 mean that P would have benefited greatly from them if they had existed when he needed to access them. It is our responsibility to continue this work and ensure that all the recommendations within the independent investigation report being published today by NHS England are acted upon and the learning is shared not only across the West Midlands but nationally to reduce the risk of reoccurrence of a similar incident in the future.”

**Ends**

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