

**Action Plan following the Independent Investigation into the Mental Health Homicide 2015/37663**

In July 2016 NHS England (South) commissioned Anne Richardson Consulting Ltd to conduct an independent investigation into the care and treatment of Mr. B to review the events that led up to the death of Mr. X on 7th December 2015 and to consider if the incident was predictable or preventable. The final report is available on NHS England’s website.

## Summary of incident:

## Mr. B, who was diagnosed as suffering from paranoid schizophrenia exacerbated by substance misuse, entered a shop in Abingdon town centre on 7th December 2015 and, having picked up a knife from a display shelf, attacked several members of the public. Subsequently one man died of his injuries and 2 other people were injured. He was restrained at the scene by members of the public before being arrested and detained by the police.

## At the time of the attack Mr. B was under the care of Oxford Health NHS Foundation Trust South Oxfordshire Adult Mental Health Team. Mr. B had been reviewed at an outpatient appointment on 4th December 2015 and had also made a telephone contact to the team earlier in the day on 7th December when a meeting was arranged for 12:30. The team was then contacted by the Court Liaison and Diversion team to inform them that Mr. had been arrested.

##  Mr. B was convicted of manslaughter by reason of diminished responsibility in June 2016. The sentence passed was under the Mental Health Act ‘’Hybrid Order’’. This imposed a hospital treatment order and a life sentence for manslaughter with a minimum term of 18 years. Mr. B remains detained at the present time in a high security hospital and will be returned to prison when his treatment is completed.

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## Action plan:

The below action plan has been developed by Oxford Health NHS Foundation Trust in response to the findings from the independent investigation.

Action plan Steis 2015/37663 (SI 2015/104) -Mental Health Homicide FINAL (V5) February 2018

| Recommendation  | Action and evidence to confirm action has taken place  | Person responsible for the implementation of action  | Date for completion of action  |
| --- | --- | --- | --- |
| 1.Dual diagnosis and the management of risk  | A) Implementation of the standard template for psychiatric consultants to use to ensure consistency of information around risk in patients with dual diagnosis in al clinic correspondence e.g. to GP’s Evidence for this will be an audit of Cluster 16 and 17 patients, point in time audit of 10 patient records in each Adult Mental Health Team B) Mandatory e-learning training in dual diagnosis Evidence will be % of staff trained in all Adult Mental Health teams and in in- patient wards. Goal of 10% improvement to baseline in 6 months C) There is a Management of Mental Health Crisis Interagency Agreement between Oxford Health NHS Foundation Trust, Thames Valley police and other urgent care services. There is a monthly ‘Partnership in Practice’ meeting between Oxford Health and a variety of urgent care partners and 3rd sector partners. A revised copy of the protocol is in the process of being approved.D) We have commissioned a PSI course for 24 staff which will include effective interventions for working with patients with dual diagnosis. This is due to be delivered in the summer of 2018. Turning Point currently also offer dual diagnosis training. Evidence will be by an audit of staff currently trained and the goal of a 10% increase in 6 months E) Monitor substance abuse data through physical health screening tool Evidence will be audit of Cluster 16 and 17 patients, point in time audit of 10 patient records in all Adult Mental Health teams  |  Psychiatric Consultant Lead for Oxfordshire  Psychiatric Consultant Lead for Buckinghamshire  Clinical Practice Lead – Adult Directorate Supported by Business and Performance team  Clinical Practice Lead – Adult DirectorateSupported by Learning and Development  Adult Mental Health Service Manager, OxfordshireHead of Service, Buckinghamshire Clinical Practice Lead – Adult Directorate Clinical Practice Lead – Adult Directorate With support from Business and Performance team  | 1st audit 31st March 2018Re-audit 31st August 201831st March 2018 – baseline % 30th September 2018 re- measure 30th September 2018 (complete revised partnership protocol) 28th February 2018 – Obtain baseline numbers of staff trained by Response/ Turning Point 31st July 2018 – Re-measure numbers of staff trained. Baseline audit 31st March 2018 Re-audit 31st August 2018  |
| 2. MAPPA and complex case reviews  | A) Develop and share a local working guide to assist staff in making decisions and to provide guidance for staff to use to navigate processes and agencies appropriately.Communicate working guide across all Adult Mental Health teams and wards through clinical leadership meetings.B) ‘Complex Case Review’ – the amended guide has been approved through both clinical governance and senior leadership meetings  |  Adult Mental Health Service Manager, Oxfordshire Head of Nursing – Adult Directorate Associate Clinical Director – Forensic Services  |  ‘soft ‘launch with teams end of April 2018 Full launch 30th June 2018 COMPLETE  |
| 3.Care Planning  | A) Oxford Health clearly defines the provision of a care plan as a requirement for all patients. Compliance is audited and monitored through CPA audit quarterly Evidence will be through the CPA audit results B) Comprehensive review of OHFT CPA policy is underway currently. Next workshop is planned end of February 2018 with a completion date of end of April 2018.Communications and launch May 2018  |  Clinical Director – Adult Directorate Head of Nursing – Adult Directorate Clinical Director – Adult Directorate  Head of Nursing – Adult Directorate | COMPLETE31st May 2018  |
| 4.Changes in Care Coordinator  | A) Develop and implement a protocol for the handover of the care of patients when a care coordinator is changedCirculated to all team leaders in January 2018  |  Adult Mental Health Service Manager, Oxfordshire  | COMPLETE  |
| 5.Monitoring change in service model  | A) The ‘new’ model of care remains under constant review including two CQC inspections which has seen OHFT Mental Health services progress from ‘Requires improvement ‘to ‘Good’.B) Local service review of care model conducted in March 2017 by service managers C) By continuing to conduct regular and vigorous peer reviews across Mental Health services D) Continue to be informed about the experiences of service users and carers by the use of ‘iwantgreatcare’ on-line feedback and patient & carer forums. E) Planning and embarking on service transformation in line with the ‘Five Year Forward View for Mental Health ‘ F) Invitation to external investigation team to monitor and report on progress in 6 months’ time (Aug/Sept 2018) | Head of Nursing, Clinical Director and Service Directors Service Managers Head of Nursing – Adult Directorate Head of Nursing – Adult DirectorateHead of Nursing, Clinical Director and Service Directors External investigation team | COMPLETE – next inspection due by end of April 2018 COMPLETE On-going -South Oxon Adult Mental Health Team last peer review in November 2017. Results reported to directorate quality meetings.COMPLETE – routinely capturing and reviewing feedbackWorkstreams for next 3 years to be identified by 31st May 201830th September 2018  |

NOTE: ACTION PLAN REVIWED AND APPROVED BY OXFORDHEALTH FOUNDATION TRUST EXECUTIVE BOARD FEBRUARY 2018