

## Yorkshire and the Humber Strategic Health Authority

5 June 2007

### Independent Inquiries (SUI Ref: 2005/2100 and 2005/3404)

- In 2005 two homicides were committed in the Dewsbury area by two different service users who had either been referred to, or were receiving treatment from secondary mental health services provided by the South West Yorkshire Mental Health NHS Trust (SWYMHT).
- Following the completion of the subsequent trials the former West Yorkshire Strategic Health Authority commissioned separate Independent Inquiries into the care and treatment of the convicted offenders in accordance with Health Service Guidance HSG(94)27 (and its addendum, dated June 2005). These were both commissioned from Dr Geoff Roberts, a clinician who has held posts as Medical Director with three Mental Health NHS Trusts and has substantial experience of mental health reviews and inquiries.
- Ms Ann Gorry co-wrote the report on SUI<sup>1</sup> 2005/2100. Ms Gory has extensive experience in dual diagnosis.
- The reports of both these inquiries, with action plans, are attached<sup>2</sup>. The reports have been accepted by both the Trust and Kirklees Primary Care Trust (which is the organisation responsible for commissioning mental health services on the behalf of the two service users in question). The action plans have been jointly drawn up and agreed by both SWYMHT and Kirklees PCT.
- Following the production of the reports Dr Roberts produced a commentary on the reports. This stated :

“ The inquiries have found that the circumstances of presentation, care and treatment of the two service users had no common ground. In the case of patient B (SUI reference 2005/2100) the patient never actually accessed the service, although this was the wish of his general practitioner. Instead, he was referred on to voluntary sector substance misuse services.

In the case of patient F (Sui reference 2005/3404) the patient was in regular contact with outpatient services for several years. He had been able to build up a successful business and to function in society. The offence came as a complete surprise to his health care providers. The common ground in the two cases came in the form of the response of SWYMHT to the events. An inadequate investigation in each case led to an incomplete assessment of the events and inappropriate recommendations which did not directly relate to the events. These shortcomings have now been rectified by SWYMHT”

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<sup>1</sup> SUI – Serious Untoward Incident

<sup>2</sup> Copies of the reports have been circulated to Board members only. Copies of the report will be available at the Board meeting

## **Recommendations**

- To formally receive the reports of the Independent Inquiries.
- To approve the action plans developed in response to the recommendations within the reports.
- To note that Dr Sue Proctor will act on recommendation 3 in report reference SUI 2005/3404:

“The Strategic Health Authority should write to the British Psychological Society and the Council for the Regulation of Health Care Excellence to raise concerns regarding the guidance in respect of sharing of clinical information. “

- To agree to receive quarterly reports on progress against the action plans.

**Dr Sue Proctor**  
**Director of Nursing and Patient Care**