An independent investigation into the care and treatment of TW

A report for NHS London

July 2008

NHS London

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INVESTIGATIONS – REVIEWS – INQUIRIES

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1. Introduction

1.1 This investigation into the care and treatment of TW was commissioned by NHS London. It follows guidance in Department of Health (DH) circular HSG (94)27, *The discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-36 issued in June 2005. The terms of reference for the investigation are given in full in section two of this report.

1.2 On 17 February 2006 TW stabbed his wife LW to death. He stood trial at the Old Bailey on 12 February 2007 and a fitness to plead hearing took place. The crown did not contest the defence submission that the defendant was unfit to plead. A trial of issue was held and on 13 February 2007 the jury returned a unanimous verdict that TW *"did the act of killing his wife as charged"*. A hospital order under section 37 of the Mental Health Act 1983 (the MHA) was imposed, coupled with a restriction order (section 41) without time limit.

1.3 TW was known to South West London and St George's Mental Health NHS Trust (the trust). Two weeks before he killed LW he had been referred to the Tooting and Furzedown community mental health team (the CMHT). He had had contacts with the CMHT since December 2004 and the full extent of his contact with psychiatric services is described later in this report. The trust established an internal investigation panel to examine the circumstances surrounding the critical incident on 17 February 2006 when LW was killed. The panel completed its investigation and produced a report in May 2006 which reviewed the history of contact between TW and the CMHT and made recommendations for improvements to services. This internal report was not published.

1.4 Our investigation began in December 2006 when we were given a copy of TW's case notes. We have had the full cooperation of the trust in completing the investigation, both in relation to access to documents and to staff, several of whom were interviewed as witnesses. We have also had the full cooperation of other public services including the Wandsworth Primary Care Trust (the PCT), Wandsworth Council and the Metropolitan police.

1.5 We are particularly grateful to members of TW's family for their contribution to the investigation. They agreed to be interviewed and gave us background information. In

particular, we would like to thank TrW and MW, TW and LW's children, for helping us understand the events that led up to the tragic death of their mother.

Background to the incident

1.6 TW is a 56-year-old white British male. He is the second eldest of four siblings and was brought up in the Tooting area of south west London. His early family life is not well documented and he has remained reluctant to talk about his past or present circumstances. Other family members said he had difficulties at school and never learned to read and write. As a teenager he spent some time at an approved school after committing offences. His only paid work as an adult seems to have been helping his father as a painter and decorator. For some years TW was unemployed and spent time looking after a large collection of birds and other animals he kept at the family home in Topsham Road, Tooting.

1.7 Family members described TW as an isolated and uncommunicative man with few friends or social contacts. He had a history of difficult relationships with some family members and was often accused of threatening and aggressive behaviour towards them. Some of them were afraid of him. He was married to LW for 30 years. LW worked part time for a local bookmaker. The couple had two children, MW and TrW. MW and TrW lived in the locality and kept in touch with their parents. They both experienced difficulty at times with their father; for example, MW had arguments with him and had moved out of the family home to live with his girlfriend. TrW said she had a more positive relationship with her father who showed kindness towards her and her young children. However, he could be irritable and did not like noise and intrusion when she visited.

1.8 TW's father died in 1999. His mother, PW who is now 85 lived locally. TW had a close relationship with her and visited on a daily basis. He saw himself as her main carer. He often talked in his contact with health and social services about the problems of looking after her. There is equivocal evidence about their relationship. Some family members thought he exploited his mother and tried to gain financial advantage by, for example, having the ownership of the house signed over to him. There were also reports that he abused her. The police and social services investigated these claims from time to time. On the other hand, although PW sometimes complained about his behaviour towards her, she described him positively and refused to support action against him for alleged abuse.

1.9 TW visited his mother every day and for a period in 2005 he moved to her home. This followed action by the local council to stop him keeping large numbers of birds and other animals at the family home. He felt the council had treated him unfairly and he was being victimised. He later returned to live with LW, but the frequency of his contact with his mother was a source of tension between them. Some witnesses described PW's influence over TW as manipulative and their close relationship as a source of argument between TW and LW. PW had contact with Wandsworth social services and the trust over a number of years and we have reviewed the history of contact as part of this investigation.

1.10 Relations between TW and the wider family were often difficult and at times he had threatened violence towards individuals and they in turn had threatened him. There was a culture of accusation and threat, with some family members refusing to have anything to do with TW because of his behaviour.

1.11 TW first became known to the trust in December 2004. His nephew, RW, referred him to the duty social worker at the CMHT with allegations that he had physically assaulted his mother and was not feeding her properly. RW also said that TW had threatened him with a hammer. He alleged that TW had thrown his father down the stairs five years earlier. At this time a police officer also visited TW at home, who reported that he was "paranoid" and hearing his deceased father's voice instructing him to dig in the garden where he would find £3,000. He also believed that he was a ghost and could walk through walls. He changed the locks at his mother's house several times because he believed that people were trying to get into her home.

1.12 There were further contacts between the trust and TW in 2005 when police were called to the family home after an argument between TW and his son, MW. The police gave TW a warning and his general practice referred him to the CMHT. In July 2005 members of the CMHT assessed him and offered medication and further outpatients appointments. He kept one of these, in September 2005, but then missed three and was discharged from the CMHT caseload in January 2006.

1.13 On 3 February 2006 TW's GP re-referred him to the CMHT. This followed a home visit by the GP and concerns that TW was not taking medication, had attacked his mother and head-butted his son MW. The GP described TW as "*distraught, losing weight and irritable*". The CMHT received the referral and arrangements were being made to visit TW. Before this visit, TW attacked his wife at the family home on 17 February 2006,

stabbing her 77 times with a kitchen knife. MW reported the attack to the police. He had visited the home because he was concerned for his mother's safety after she failed to answer telephone calls.

1.14 Police arrested TW. He also had stab wounds that needed hospital treatment. It is not clear whether these were inflicted by LW in the course of a fight, or were self-inflicted. TW has remained uncommunicative since his arrest and has not spoken in any detail about the incident or its circumstances. After a short period on remand at Wandsworth Prison, he has been detained under the MHA at the Shaftesbury Clinic, part of South West London and St. George's Mental Health NHS Trust. The most recent clinical assessment is that at the time of the incident TW was suffering from a depressive illness characterised by agitation, restlessness, paranoia and low mood. He is often confrontational and uncooperative with his care plan and it has been impossible for staff at the clinic to establish a close working relationship with him. His sleep is poor and he eats little. There has been no evidence of psychosis but he frequently complains of physical symptoms, particularly gastro-intestinal complaints. TW's low intelligence and long-term personality traits have made it difficult to engage him in treatment.

Action after the critical incident

1.15 The killing of LW prompted a number of actions by public services involved with the family. The trust convened an internal investigation panel as required by the DH guidance to examine all aspects of the care and treatment provided to TW during the time he was known to the trust. Sandy Gillett, the human resources director at the trust, chaired the investigation panel. The panel interviewed a number of witnesses. The internal investigation was completed in May 2006 and reported to the trust board in November 2006. Representatives of the trust met MW and TrW to discuss the findings of the investigation.

1.16 There was significant contact from Wandsworth social services with PW over a number of years and TW featured in many of the case records held by the council. PW had also been a trust inpatient and community patient. Wandsworth Council commissioned an independent consultant to review the case and she completed her report in 2007. The independent consultant reviewed the involvement of Wandsworth social services with PW and particularly their actions under the procedures for protecting vulnerable adults.

1.17 Wandsworth Council accepted the recommendations of the independent consultant and commissioned a review under the safeguarding adults policy and procedures into the care of PW. The findings of this review were reported to the council in July 2007.

1.18 NHS London commissioned Verita to complete an independent investigation into the care and treatment of TW. Details of team members are outlined in 4.7. The terms of reference for the investigation are in chapter two of this report.

Reading this report

1.19 One of the aims of our investigation is to identify service improvements by reviewing the case history and making recommendations. This is to help the trust to learn lessons from the incident, to implement change and reduce the likelihood of similar incidents in the future. We have therefore identified a number of themes in the report and taken a wider view of TW's contact with public services than that used by the internal investigation which had a narrower remit. We also acknowledge that the trust has already made a number of changes to policies and procedures as part of their response to the internal investigation. We have reviewed the evidence and set out our findings in a way that identifies themes. The value of a thematic approach is that it takes a broader view of critical incidents than that which looks only at the immediate antecedents of an event.

1.20 The remainder of the report is organised as follows:

- chapter two gives the terms of reference for the investigation
- chapter three is an executive summary that identifies the key findings and recommendations of the investigation
- chapter four describes the method used by the investigation team for completing the investigation
- chapter five reviews the history of TW's contact with primary care
- chapter six looks at the operation of the CMHT
- chapter seven reviews decision-making by the team and the use of the Mental Health Act 1983
- chapter eight looks at the trust operational policies in relation to the work of the CMHT
- chapter nine examines links between the CMHT and the older person's team in Wandsworth social services
- chapter ten reviews trust performance management and operational issues

- chapter eleven reviews the action taken by the trust and partner organisations after the internal investigation.

1.21 We include a number of appendices that contain supporting information or evidence and documents referred to in the text of the report.

Abbreviations and references

1.22 Throughout the report references to TW, LW and their relatives are anonymised.

1.23 We refer to the names of many individuals. Where necessary we identify the person's relationship with TW or the job title of the professional at the point of their introduction in the text. A list of those who we interviewed as part of the investigation is given in appendix H.

2. Terms of reference

2.1 The terms of reference for this investigation, agreed by NHS London, were:

"The aim of the investigation and review is primarily to evaluate the care and treatment provided by the trust to [TW] *and understand the circumstances and root causes of events leading up to the death of his wife* [LW]*. The scope of the investigation will also include, where relevant and as much as possible, the interventions offered and provided to* [TW] *and, in connection with the incident, his mother, from partner agencies such as primary care and the local authority. The investigation and review will ascertain whether the recommendations of the internal investigation are being implemented and additionally will provide further recommendations to the trust and the SHA to assist in helping to ensure future best practice in the provision of mental health care.*

The investigation panel will:

- *investigate the mental health care and treatment offered and provided to* [TW]
- *investigate and identify the root causes of events leading up to the death of* [LW]*:*
    - *specifically, this will include a comprehensive chronology of the incident identifying any care and service delivery problems as well as the factors that contributed to the incident thereby facilitating the identification of root causes.*
- *as appropriate, and in the interests of avoiding duplication of effort, draw upon the work and findings of the internal investigation carried out by the trust into the circumstances surrounding the death of* [LW]
- *consider the actions taken by the trust in response to the death of* [LW] *and review any previously made recommendations and the progress made in their implementation*
- *make clear, sustainable and targeted recommendations, based upon and arising from its investigations and review. Such recommendations:*
    - *to be aimed at ensuring that the lessons arising from the investigations are learned, acted upon and shared*

- o *to include, as appropriate, recommendations as to the future provision, operation and management of services and how such recommendations are implemented*

- *provide a written report including recommendations to NHS London, the trust and its commissioning primary care trusts (PCTs)*
- *meet with key staff to outline the recommendations and assist them in developing an implementation plan as a means of ensuring full interpretation of the recommendations.*

Approach

The investigation and review will consist of two phases:

1. *An information and fact-finding phase incorporating the gathering and review of relevant pieces of information to help establish the scope of the second phase of the review,*
2. *Interviews with key staff and managers – either individually or in groups with fieldwork carried out as required.*

As well as interviewing key staff and managers the investigation panel will also aim to engage with [TW] *and his family. This will help ensure that the investigation and review achieve a thorough understanding of the incident from the perspective of those directly involved.*

We will tell the SHA and the trust immediately if we find a serious cause for concern.

The written report will include recommendations to inform the appropriate commissioning of the service by Sutton and Merton PCT and Richmond and Twickenham PCT as the lead commissioner of mental health services.

Publication

The outcome of the review will be made public. The SHA will determine the nature and form of publication. The decision on publication will take into account the views of the chair of the investigation panel, those directly involved in the incident and other interested parties.

The investigation panel

The investigation panel will consist of an appropriately knowledgeable chair, helped by advisers with nursing, medical or other relevant experience.

Timescales

The process of the investigation and review depends on the panel having access to the necessary records relating to the care and treatment of [TW]*. The investigation and review will aim for completion within six months of when the panel is given access to the records.*

The investigation panel will provide a monthly progress report to the SHA and the PCT."

3. Executive summary and recommendations

3.1 TW killed his wife LW on 17 February 2006. She died from multiple stab wounds inflicted at the family home in Tooting. After arrest, TW was held in prison and then at the medium secure psychiatric unit at South West London and St George's Mental Health NHS Trust. He appeared at the Old Bailey on 12 February 2007. He was unfit to plead and was made subject to an order under section 37 of the MHA on 13 February 2007.

3.2 The SHA commissioned this independent investigation in December 2006. The trust had completed their internal investigation in May 2006. The terms of reference for our investigation are stated in chapter two of this report. TW had contact with a number of public services in the years before the incident. These included the local primary care services, Wandsworth social services, the police and the trust. In particular we were asked by NHS London to review the contact between TW and the CMHT in the weeks before LW's death. We set out the details of this contact and comment on the service development issues that arise from the case. Our report is organised in themes and the recommendations for future action are arranged accordingly.

3.3 We found that TW had a number of contacts with the primary care services provided by the Howard Freeman Partnership based at Tooting Bec Medical Centre. The practice offered a good level of service and a number of general practitioners (GPs) saw TW in the months before LW's death. They identified mental health problems and prescribed medication that TW was reluctant to take. They also referred him to the CMHT for a specialist assessment. TW was seen by members of the CMHT on a home visit and once as an outpatient but did not attend several further appointments. There were shortcomings in the communication to the GP practice of these non-attendances. The trust has reviewed and changed its operational policy on action when people do not attend an appointment.

3.4 There had been earlier efforts to refer TW to the mental health service in 2005. The GPs who saw TW were concerned about his mental health and made efforts to treat him and seek a specialist opinion. TW's main contact with the primary care service was with Dr Simon Rohde. Dr Rohde saw TW at the surgery several times and visited him at home. He saw him on 3 February 2006, concluded he was suffering from mental illness and re-referred him to the CMHT. In chapter five we review these contacts in detail and we comment on the range of mental health treatment available through primary care

services, the linkage between primary and secondary care and the issues in engaging with people who are reluctant to use specialist mental health services.

3.5 The trust internal investigation looked in detail at the response of the CMHT to the referrals from Dr Rohde and his colleagues. We also review the contacts between the CMHT and TW. We looked in detail at the functioning of the CMHT as part of the background to the team response to the referrals. We found long-standing operational difficulties in the CMHT. These included poor administrative support to its routine work and unsatisfactory arrangements for dealing with sickness absence. The systems for the allocation and monitoring of work had improved since the arrival of the team manager, but the daily organisation of work, recording of team allocation meetings, and case recording were inadequate. There was a failure to use the care programme approach (CPA) and its systems to assess and plan care for TW. The team failed to articulate differences of opinion about the case and decide on a clear course of action. The systematic difficulties led to the team manager taking on too much work to attempt to cover for operational problems.

3.6 The trust internal investigation criticised Jeremy Walker, the CMHT manager, for failing to respond to the urgent referral from the GP on 3 February 2006. It said that the team was "*frozen by indecision*". We found that several team members who had some knowledge of the case were not sufficiently engaged in decision-making at the critical time after the referral. There were differences of opinion about TW that were not aired and resolved through team discussion, the management line or the clinical supervision systems. The differences of opinion contributed to a lack of urgency in responding to the GP's request. The regular team meeting was not used effectively to discuss the case. The assessment and detention powers of the MHA were not used in a timely way. Intervention at this point could have changed the course of events that led to LW's death.

3.7 We considered whether the trust operational policies were adequate to support the work of the CMHT. The CPA policy and procedures were not enacted because the case was dealt with as an outpatient referral. Dr Fowad Choudhury, the specialist registrar (SpR) who saw TW as an outpatient, did not believe he was mentally ill, but offered further appointments which were not kept. The possibility of alternative action based on social intervention was not explored. If TW had been registered on the CPA system, a more rigorous risk assessment would have been completed as part of the standard

documentation. At the time the trust did not have a robust policy on patients who do not attend (DNA) appointments and has taken action to introduce a more active approach.

3.8 TW's relationship with his mother, PW, was important to him and before the incident he regarded himself as her main carer. He visited her every day and for one period in 2005 lived at her house in Tooting. His relationship with his mother was a source of tension between TW and LW. PW was well known to Wandsworth social services older person's team. From time to time the Metropolitan police community support unit were involved because of allegations PW made about TW's behaviour to her. Wandsworth social services commissioned an independent case review after LW's death and acted positively on its findings. They also commissioned a case review under the inter-agency safeguarding adults procedures. Wandsworth Council accepted the recommendations of both reviews.

3.9 The broad conclusion of the Wandsworth Council reviews was that opportunities to engage with PW were missed. The case was not allocated to a care manager until after LW's death. Before then it was dealt with by a number of social workers on the duty rota. Despite a high number of contacts with the family, the case did not meet the threshold for allocation. The inter-agency policy on the protection of vulnerable adults (POVA) could have been used to arrange a strategy meeting where all agencies could pool their knowledge of the family. The equivocal evidence presented by different family members and by PW herself should have triggered a more rigorous assessment.

3.10 Communication between the older person's team and the CMHT was weak and there was a failure to act together on the evidence known to both agencies. Knowledge of the POVA and safeguarding policies and procedures was low among team members on the CMHT. The police were involved intermittently in investigating allegations about TW's treatment of his mother but no active intervention followed. The police community support unit visited PW but it largely focused on inconclusive investigations of particular allegations as one off events. PW did not make a formal complaint about her son and the police did not have enough evidence to act. Some family members remained concerned about TW's potential for violence. Family members contacted the police and other agencies at different times to voice their concerns. All agencies failed to bring together the concerns of the family and the evidence from the professionals' contacts with TW and PW.

3.11 We reviewed the management of the CMHT and the roles of the team manager and the clinical team leader. We found that the CMHT manager, Jeremy Walker, had made many improvements to the functioning of the team, including reducing the team caseload to the numbers required by the trust operational policy. He was well respected and many witnesses thought he had been unfairly criticised in the trust internal investigation report. There was a lack of clarity about the roles of the team manager and the clinical team leader. We received evidence of differing clinical views on the CMHT about TW. These differences were never effectively aired and resolved.

3.12 The line management system and the clinical supervision system were not effective in identifying and acting on long-standing operational difficulties on the CMHT. Professional supervision of the team manager was sporadic and ineffective. Clinical supervision of the doctors working on the team was disrupted by changes of personnel and had not established a regular pattern. Performance management was insufficiently focused on quality of work. Performance indicators did not identify the operational problems team members faced in organising their work. Senior managers did not know about the impact of poor administrative support on the day-to-day functioning of the team.

3.13 We reviewed the response of the trust and partner agencies to the death of LW. We found that the trust was timely in organising an internal investigation and acted on the recommendations. The internal investigation identified some "causal factors". We found that some of these would be more accurately described as "service delivery failures" and were not in themselves *causes* of the incident. We were given full access to Wandsworth social services records and staff. We found that Wandsworth Council responded positively to the independent reviews of the care of PW. We found that for all agencies, at the time of the incident, the profile of vulnerable adults investigations was low and the possibility of using the agreed inter-agency protection procedures was not explored.

3.14 Our report makes recommendations for improvements to service delivery. These are directed to the trust and partner agencies and flow from the findings of the investigation.

3.15 We would like to thank members of TW's family for their help in completing the investigation. In particular, MW and TrW, TW and LW's children, gave evidence as witnesses and helped the investigation team at a time of great personal loss.

Recommendations

Contact with primary care services

R1 The PCT and the trust should review the range of specialist mental health services available through primary care in line with the expectations of the national service framework for mental health services.

R2 The trust should monitor compliance with its policy on notifying primary care services when patients do not attend appointments (the DNA policy).

R3 The PCT and the trust should review practice and procedures for the management of referrals of patients whose mental illness makes them reluctant to engage with services.

CMHT meetings

R4 The trust should ensure that all CMHTs are given clear guidance on the standards for recording team meetings. Records of team meetings should show who attended, the range and content of discussion on individual cases and the decisions made by the team.

R5 The trust should ensure that managers regularly audit records of team meetings to assess their quality and compliance with trust standards.

Administrative support

R6 The trust should ensure that operational managers monitor the impact of sickness absence and take action to minimise its effect on the functioning of CMHTs.

Case recording and clinical notes

R7 The trust should ensure that all team members maintain trust standards for case recording.

R8 The trust should ensure that as far as possible case notes are always available for outpatient appointments wherever they take place.

Use of the MHA

R9 The PCT and the trust should clarify the systems for GPs requesting action under the MHA. The trust should ensure that all CMHT staff who act as the first point of contact are clear about expectations and responsibility for follow through action after requests are made for assessment under the MHA.

R10 The trust should ensure that managers allocate cases in a timely way after a request from a GP for an urgent assessment under the MHA.

The CPA

R11 The trust should ensure that team managers implement the CPA policy and procedures, that all CMHT staff have training and refresher training in the operation of the CPA and that risk assessments are completed as part of the CPA process. The trust should undertake frequent audits to ensure compliance with this recommendation.

Links between the CMHT and social services: safeguarding and the protection of vulnerable adults

R12 The trust should ensure that all CMHT staff have training in safeguarding and the protection of vulnerable adults.

R13 The trust should ensure that a senior manager has responsibility for linking with other partners in the Safeguarding Adults Partnership.

R14 The trust should ensure there is improved liaison between its CMHTs and the local authority teams for adults and older people.

R15 The trust should ensure that all staff have training in assessing the needs of carers and are aware of their duties under the Carers (Recognition and Services) Act 1995.

Management and leadership in the CMHT

R16 The trust should review the roles of clinical team leader and team manager to ensure clarity about decision-making within the CMHT. The trust should ensure there is clear clinical leadership in decisions where action under the MHA is requested.

R17 The trust should ensure that clinicians are aware of the range of social interventions available for patients referred to the service, including carer's assessments.

Trust management, performance management and operational issues

R18 The trust should ensure that managerial supervision meetings take place as required, are recorded, and include a full discussion of the operational issues in the manager's remit. The trust should ensure that managers report operational difficulties systematically and in a timely way through the management line.

R19 The trust should ensure that professional supervision takes place as set out in the trust policy and that it is recorded and decisions acted upon.

Summary timeline of contact with TW

Monday 24 May 2004: TW registered as a new patient with the Howard Freeman Practice. At this time he was also becoming known to Wandsworth Council older adults services and the metropolitan police because of concerns about the welfare of his mother PW.

Wednesday 1 September 2004: A neighbour made allegations about TW's treatment of PW. This led to a visit by Detective Constable (DC) Simon Nolan and Phil Howell, a Wandsworth Council older adults services social worker.

Wednesday 6 October 2004: DC Simon Nolan visited PW in response to further allegations about TW's ill treatment of her.

Monday 11 October 2004: TW attended Tooting Police Station alleging that his mother's neighbour was harassing her. The police noted that TW had put his mother's house on the market.

Tuesday 30 November 2004: During a visit to PW, DC Simon Nolan had an opportunity to speak to TW. He alleged that he was in communication with his deceased father and that

money had been stolen from his mother's house. DC Simon Nolan later rang Phil Howell to inform him of the outcome of his visit.

Monday 6 December 2004: The police received a third-party report advising that TW had moved into his mother's house.

Wednesday 8 December 2004: PW alleged that she was unhappy in her home and went to stay with TW's nephew.

Monday 13 December 2004: Phil Howell rang the CMHT and spoke to Sue Armstrong, an approved social worker (ASW) with the team. He told her of his concerns: that TW was exhibiting mental health problems and that he was abusing his mother. He asked for TW to be assessed.

Wednesday 15 December 2004: Sue Armstrong contacted PW's nephew to obtain background information. He told her that TW had a history of violence and that he was abusing his mother. Later that day the CMHT meeting discussed TW. It was suggested that a joint visit with the police should be undertaken.

Monday 20 December 2004: Sue Armstrong phoned DC Simon Nolan. He told her that TW appeared paranoid and was hearing the voice of his deceased father. Sue Armstrong discussed the call with the CMHT manager and he said he might be able to visit TW. It was concluded afterwards that a visit was unnecessary because PW had been taken to live with TW's nephew.

Monday 6 June 2005: TW visited the Howard Freeman Practice complaining of weight loss. He was seen by GP Dr Rohde who found him to be experiencing stress and anxiety.

Thursday 16 June 2005: TW again visited the Howard Freeman Practice and saw GP Dr Veiras. He was agitated and during the appointment asked to be referred to a psychiatrist as he was hearing voices and seeing people in his house. In a letter dated 22 June 2005 Dr Veiras referred TW to the CMHT. It was later decided that the case should be allocated to SHO Dr Tahmina Baksh.

Friday 1 July 2005: TW was phoned at home and an appointment was made for Dr Baksh and Jeremy Walker to see him there on Monday 4 July 2005.

Monday 4 July 2005: TW was seen at home in the presence of his wife LW. During the meeting he complained of weight loss. He was agitated and paranoid. Later Jeremy Walker rang DC Simon Nolan, who reiterated his previous concerns. A decision was made that Dr Baksh would see TW at the outpatients department on Monday 1 August 2005 – an appointment which did not take place.

Wednesday 7 September 2005: Associate Specialist Dr Fowad Choudhury saw TW at the outpatients department. He presented with low mood and weight loss and had stopped taking the medicine that had previously been prescribed. He was diagnosed as having a mixed anxiety and depressive reaction. A further outpatient appointment was sent to TW for Wednesday 2 November 2005.

Wednesday 2 November 2005: TW did not attend the outpatient appointment. A further appointment was sent for Wednesday 30 November 2005.

Wednesday 30 November 2005: TW did not attend the outpatient appointment. A further appointment was sent for Wednesday 11 January 2006.

Wednesday 11 January 2006: TW did not attend the outpatient appointment. Dr Choudhury wrote to TW advising him that he would be discharged if he did not make contact with the CMHT within two weeks.

Tuesday 31 January 2006: TW was discharged from the CMHT.

Friday 3 February 2006: After it was alleged that TW had assaulted members of his family Dr Rohde rang the CMHT and also faxed them a letter to express his concerns. Emmanuel Ofori-Danso, a community psychiatric nurse, rang Dr Rohde later that day and told him TW would be visited early the next week.

Wednesday 8 February 2006: TW rang the CMHT and said he did not want to be visited.

Thursday 9 February 2006: Jeremy Walker faxed a letter to Dr Rohde that said the situation was complicated because TW did not want to be seen. Jeremy Walker suggested that an assessment under the MHA might be required. Dr Rohde told Jeremy Walker about

his concerns during a telephone call and Jeremy Walker agreed with him that he would visit TW on Monday 13 February 2006.

Friday 10 February 2006: Jeremy Walker tried to telephone LW to obtain background information about her husband. TW answered the call and said he did not want to be visited. In light of this conversation it was decided that TW would only be visited with advance warning and the planned visit on Monday 13 February was cancelled.

Wednesday 15 February 2006: At the CMHT meeting Jeremy Walker and Dr Choudhury agreed to visit TW without giving him prior notice.

Friday 17 February 2006: Jeremy Walker emailed Dr Choudhury and suggested that they visit TW on either Friday 24 or Tuesday 28 February 2006. Later on Friday 17 February TW fatally stabbed his wife LW.

DETAILS OF THE INVESTIGATION

4. Method used by the investigation team

4.1 The DH issued guidance for internal investigations by mental health trusts in HSG (94)27. The guidance requires them to conduct formal internal reviews of critical incidents. In the case of homicides and other exceptional events the strategic health authority has to commission an independent investigation into the circumstances of the incident. In June 2005 the guidance was updated and required trusts to conduct an investigation into the circumstances surrounding any critical incident and to use a structured investigation process such as root cause analysis (RCA).

4.2 RCA is a structured and systematic approach to incident investigation and analysis of healthcare incidents. RCA is composed of five main steps:

1. getting started
2. gathering and mapping evidence
3. identifying the problems
4. analysing the problems
5. generating recommendations and solutions.

4.3 Our investigation began with a review of key policies and procedures and TW's medical records. A full list of all the documents we reviewed is contained in appendix I.

4.4 We examined TW's case notes in detail and produced a timeline, highlighting in chronological order the main events associated with his care and treatment, along with the names of staff delivering care. Our timeline extended the one developed by the trust to contain information in the following fields:

- event date and time
- event
- supplementary information – other relevant information at the time of the event
- source of information
- notable practice.

The timeline is in appendix G.

4.5 We held interviews between January and April 2007. We interviewed people we considered central to the investigation during the middle and end of the investigation, so that we had a detailed understanding of all the issues in the case before their interviews.

4.6 Interviewees received a letter explaining the following items before their interview:

- the nature of the investigation and the purpose of the interview
- who they would be interviewed by
- the date time and location of the interview
- the option to bring a friend or colleague for support.

4.7 Alan Watson chaired each witness interview and two other team members attended: David Watts and either Dr Sally Adams or Christine Brougham who both provided RCA advice. Dr Timothy Amor, a consultant psychiatrist, reviewed the medical notes and gave his opinion of the medical treatment provided to TW. We felt this approach streamlined the investigation process and offered proportionality. The full list of formal interviews and transcripts is shown in appendix H.

4.8 We adopted a themed analysis approach to allow for a more detailed and linked analysis. Some RCA tools such as fishbone diagrams were completed to identify the causal and influencing factors. These are contained in appendix E and F.

4.9 We made recommendations on completion of the themed analyses.

5. Contact with primary care services

5.1 TW and his wife LW were patients at the Howard Freeman Partnership based at Tooting Bec Medical Centre. TW registered at the surgery on 24 April 2005. His previous medical records did not include any psychiatric history and the reasons for his move to a new practice are unknown. LW had been a long-term patient of the practice. Between registration and 3 February 2006 TW had 14 contacts, mostly visits to the surgery, but also home visits by a GP. He failed to attend the surgery for a booked appointment three times.

5.2 TW presented with a number of physical and mental health problems. Several GPs saw him and commented on his experience of weight loss, anxiety and stress that he associated with the burden of caring for his mother PW. He saw himself as her main carer. On 16 June 2005 Dr Veiras saw TW. He reported visual hallucinations and said he saw people in the house and heard voices. TW requested a psychiatric referral and Dr Veiras referred him by letter on 22 June 2005 to Dr Prakash Gangdev, a consultant with the CMHT.

5.3 Dr Veiras's letter referred to auditory and visual hallucinations *"where he sees people in his house".* Dr Veiras reported that TW was not keen to talk about these experiences but he was asking for referral to a specialist. Dr Veiras recorded that *"he describes poor sleep, lack of appetite, weight loss and just in surgery it was very apparent that he was very on edge and anxious and wanted to leave quickly"*.

5.4 Dr Tahmina Baksh, a senior house officer, and Jeremy Walker, the team manager, saw TW on 4 July 2005 as a response to the referral. After their assessment and recommendations Dr Rohde started TW on risperidone and diazepam. The assessment was recorded on the CMHT case notes and summarised in a letter to Dr Veiras on 6 July 2005. Dr Baksh's conclusion was that "*he is a 54 year old man suffering from anxiety and symptoms of psychosis. He is experiencing a lot of problems with his mother at present and this is contributing a lot to his symptoms*". Dr Baksh arranged a follow-up appointment for TW at the outpatient clinic at Clare House on the site of St George's Hospital.

5.5 TW's next contact with the CMHT was his outpatient appointment at Clare House on 7 September 2005 when he saw Dr Choudhury, the associate specialist psychiatrist.

There was a gap of about two months between the assessment by Dr Baksh and the outpatient appointment with Dr Choudhury. During this period TW visited his GP surgery five times.

- On 11 July 2005 he saw Dr Rohde who noted that he seemed much calmer on medication and prescription of diazepam was repeated.
- On 18 July 2005 he saw Dr Rohde who treated him with amoxicillin and no concerns about mental health were noted.
- On 22 July 2005 he saw Dr Veiras who reviewed his medication and noted that "*he was not keen to see the psychiatrist again […] keeps saying he needs to look after mum*".
- On 29 July 2005 Dr Dutta, a GP registrar, saw him and noted that he was "*feeling very stressed and anxious with Mum's accusations of theft and in need of further diazepam"*. Dr Dutta also tried to make a further outpatient appointment for TW but was unsuccessful noting that "*all staff away on holiday, first available slot is end of August*".
- On 15 August 2005 TW saw Dr Dutta again who noted that he was not tolerating diazepam which made him feel lethargic, he was still having paranoid thoughts, but his insight was retained and he was polite and cooperative.

5.6 The next event in the GP notes is the receipt of the letter from Dr Choudhury after TW's attendance at the outpatient clinic at Clare House on 7 September 2005. This said Dr Choudhury felt that TW had a diagnosis of mixed anxiety and depressive reaction to stress in his life, largely centred on his relationship with his mother and other family tensions. Dr Choudhury had started TW on citalopram 20 mg once daily.

5.7 The next contact between the practice and TW was on 7 November 2005 when Dr Rohde made a home visit at the request of MW. MW described an incident in which TW had asked LW to stab him. Dr Rohde's assessment was that TW seemed rational, was not hearing voices and there was no obvious paranoia. Dr Rohde noted that the main feature of TW's presentation was anxiety and that issues between himself and his mother troubled him. Dr Rohde recommended risperidone to alleviate the stress and TW took medication in the doctor's presence. Dr Rohde did not think hospital assessment was necessary or that TW would meet the criteria for compulsory admission under the MHA. Dr Rohde asked TW to keep his next appointment with Dr Choudhury on 30 November 2005.

5.8 TW missed his next two appointments with Dr Rohde on 10 November 2005 and 14 November 2005. On 11 November 2005 Dr Rohde telephoned TW, who said he was continuing to take his medication as prescribed.

5.9 On 18 January 2006 the practice received a copy of a letter to TW from the team secretary of the CMHT saying the team would discharge him because he had not attended outpatient appointments on three dates, unless TW contacted them within two weeks of the letter being sent.

5.10 On 2 February 2006 MW contacted the surgery because he was concerned about his father. He said TW's mother, PW, had accused TW of stealing and he had thrown a bin at her which cut her face. TW had also head-butted MW and had allegedly assaulted PW during the Christmas and New Year period. Dr Rohde agreed to visit TW the next morning.

5.11 Dr Rohde visited TW at home on 3 February 2006. He saw TW and LW. Dr Rohde established that TW was not taking medication. TW said he did not want to be locked up in Springfield Hospital and left to cycle to his mother's home. Dr Rohde was concerned about TW's mental state and contacted the CMHT to make an urgent referral. He told Emmanuel Ofori-Danso, a CPN, about his concerns and followed up the conversation with a faxed request for an urgent assessment. In the fax Dr Rohde asked for "*an urgent home assessment"* and referred to two incidents in which TW had been violent – head-butting his son and throwing a bin at his mother. Dr Rohde wrote that "*Mr.* [W] *is distraught/losing weight, but won't take medication because it affects his balance - he is worried about admission and his wife reports he is very irritable*". The fax was timed at 9.28am.

5.12 Later that day TW came unannounced to the surgery and asked for blood tests. Dr Rohde saw him and recorded that he seemed much calmer, was no longer agitated and he was not aggressive. He agreed to a physical examination. Dr Rohde thought that TW was neither depressed nor suicidal. He said he was being followed, but was vague about who was following him. TW could not explain the incident when he allegedly threw a bin at his mother, but was worried about being "locked up" if he was referred to the psychiatric team. TW said he was not taking risperidone because it made him feel dizzy and Dr Rohde gave him an alternative prescription for trifluoperazine. Dr Rohde recorded that Emmanuel Ofori-Danso called him later that day to say that a visit from the CMHT would be scheduled for early the next week.

5.13 On 9 February 2006 Dr Rohde received a fax from Jeremy Walker, the CMHT manager, in which Jeremy Walker reported that there had been a telephone call "*from TW himself telling us very clearly that he does not want to be seen*". Jeremy Walker wrote:

> *"In the light of Mr* [W]*'s call to the office yesterday, we are not quite sure how we should proceed but will be guided by you. Going by what we learnt when we visited him last summer and other background information, it maybe that we should be thinking about invoking the Mental Health Act but perhaps you could ring me as soon as you can to discuss how we are to manage this […]".*

5.14 Dr Rohde told us that he spoke to Jeremy Walker on the same day by telephone and indicated his concern that TW should be visited as soon as possible, and said he would be prepared to complete a recommendation for compulsory admission under the MHA if necessary. Dr Rohde recalled that Jeremy Walker said he would carry out a joint visit with Dr Alex Butt, the CMHT consultant psychiatrist, when Dr Butt returned from annual leave on 13 February 2006.

5.15 We interviewed Dr Rohde and Dr Veiras and had access to TW's primary care records. We found that the practice responded in a timely and appropriate way to specific contacts with TW. He was seen either at the surgery or at home, in some cases as an urgent response to concerns from family members. The consultations were thorough and included a full consideration of the mental health issues raised by the case. Three members of the practice saw him, and all made both physical and mental state examinations.

5.16 In relation to events leading up to the incident, we found that Dr Rohde responded quickly to family concerns by making an early morning home visit on 3 February 2006 and then saw TW later at the surgery and made a referral to the CMHT. Dr Rohde followed up his telephone referral with a fax and had two conversations with a CMHT member about the case. The week after Dr Rohde responded to a fax from Jeremy Walker by reiterating his request for an urgent assessment and indicated his willingness to complete a medical recommendation for assessment under the MHA if necessary.

5.17 The GPs who saw TW followed agreed procedures in referring him to the CMHT for a specialist opinion. These procedures were well known and usually worked well. As Dr Veiras said in interview:

> *"We generally refer to the Tooting and Furzedown CMHT, as that was the CMHT who were seeing TW. To be quite honest, there has not really been a problem. If I need someone seen today, generally I can speak to somebody today and it is organised. That has happened on a couple of occasions in the last year. If I refer someone routinely, they are usually seen within two or three weeks, which I feel is adequate. If I need advice within a few days they will always get back to me. I have not had a problem."*

5.18 Both Dr Veiras and Dr Rohde spoke positively about the relationship with the CMHT and the team manager, Jeremy Walker.

5.19 TW had a good relationship with the GP practice and asked for help on several occasions. In contrast to his view about the CMHT and the specialist psychiatric services, he was willing to seek help. Dr Veiras recalled that in one consultation TW kept saying, *"I need you to refer me"*. He was appropriately referred for specialist help, to the psychiatric services and also the audiology service, because he complained about hearing problems (he was referred to the Department of Audiological Medicine at St George's Healthcare NHS Trust but did not attend his appointment on 6 August 2005). The GPs followed the advice of the specialist mental health service after TW's contacts with Dr Baksh and Dr Choudhury.

5.20 Dr Rohde clearly indicated in his referral to the CMHT that TW needed to be seen urgently, and CMHT contact remained a high priority in spite of TW's voluntary visit to the surgery later on 3 February 2006. Dr Rohde reinforced this view in his conversation with Jeremy Walker on 9 February 2006.

Comment

In considering the more general issues raised by this case, we draw attention to the relationship between the GP practice and the CMHT:

- ***Although all concerned felt that the relationship between the practice and the CMHT was good, there was no systematic way of notifying GPs when a***

referred patient did not attend an outpatient appointment. TW did not attend three appointments with Dr Choudhury, but the practice did not know. From the point of view of the practice, TW was receiving care from the CMHT. It was not routine for the specialist to notify the practice of non-attendance. Vulnerable patients could fall between the contact systems of the primary and secondary care services.

- ***There would be value in providing specialist psychiatric services in primary care settings for patients who have an antipathy to hospital based services. TW had a long-standing fear of being admitted to Springfield Hospital, based on his view of the hospital as a resident of the area. The hospital had a negative connotation and stigma for him, which the GP practice did not. The only other form of mental health intervention available through the GP practice was the primary care counselling service and the GPs who treated TW did not think this would have been appropriate. There would be value in providing a more flexible approach to delivery of secondary care services, somewhere other than the hospital campus at St George's Hospital or Springfield Hospital***
- ***The GP practice relied on the CMHT to provide specialist advice for people with mental health problems. Although the GPs who saw TW had experience in the diagnosis and treatment of mental illness, they recognised that a more specialised opinion was needed. In TW's case the response from the CMHT was unusually slow. As Dr Veiras stated:***

> **"My only real feeling is that if TW had been seen following Dr Rohde's urgent referral within a week, this could well have been prevented. I feel that for some reason Jeremy Walker was let down and for some reason no two people could go and visit TW. For one thing he didn't want to be visited, but, of course, if you don't think you are ill, you don't want to be visited. There was quite a big window of opportunity for someone to go and see him and it did not happen. That is a tragedy because it could well have been prevented."**

Recommendations

R1 The PCT and the trust should review the range of specialist mental health services available through primary care in line with the expectations of the national service framework for mental health services.

R2 The trust should monitor compliance with its policy on notifying primary care services when patients do not attend appointments (the DNA policy).

R3 The PCT and the trust should review practice and procedures for the management of referrals of patients whose mental illness makes them reluctant to engage with services.

6. The role and function of the Tooting and Furzedown CMHT

6.1 This section of the report reviews the response of the CMHT to the referral and the history of contact with TW. It looks at the functioning of the team during the time that TW was known to mental health services. The function of the trust CMHTs is described in the CMHT operational policy 2003-2006. In 2006 there were 23 CMHTs in the trust providing mental health and social care to an adult population of around 750,000 from the boroughs of Kingston, Merton, Richmond, Sutton and Wandsworth.

6.2 Before 1 September 2005 all CMHTs for adults of working age were located in a trust-wide adult services directorate. From 1 September 2005 the Tooting and Furzedown CMHT became part of the Wandsworth borough aligned set of trust services.

6.3 The trust CMHT operational policy 2003-2006[1] states that each CMHT should have no more than 300 cases. The CMHT had an estimated caseload of 290 at the time of LW's killing. The staffing establishment for the CMHT for the period reviewed by this investigation fell within the DH, *Mental Health Policy Implementation Guide for Community Mental Health Teams*.[2] The CMHT had a full staffing establishment within nationally recognised caseload parameters.

Working methods and recording in the CMHT

6.4 Several interviewees spoke about the operational difficulties facing the CMHT. When Jeremy Walker became the team manager in 2004 the team had a large caseload that was above the recommended limits for CMHTs set by the trust. Systems to allocate work and review progress were inadequate and the team manager had difficulty tracking the allocation of work and team members' involvement in cases. He successfully introduced a more systematic approach. He actively managed the work and cut down the numbers of cases held by team members.

6.5 By early 2006 Jeremy Walker had achieved a better balance of work and the team caseload was within the limits required by the trust, about 290 active cases. He told us about the team allocation meetings that were the main method of assigning work to individual team members. When he joined the team the meetings lacked discipline and he

[1] Community Mental Health Team Operational Policy 2003-2006
[2] Department of Health, Mental Health Policy Implementation Guide

tried to introduce a more orderly approach. Other members of the team confirmed that he had brought greater consistency to the allocation of work.

6.6 We found that despite these improvements the records of team meetings were sparse. The roles of chair and note taker were rotated. At the time of the incident the chair was usually the CMHT manager, Jeremy Walker, and Costas Michael, a CPN on the team, completed the recording. The record contained the initials of the team members present, those of the new referrals discussed at the meeting, and other patients whose cases were reviewed. There were also sections in the meeting for discussion of community discharges, ward discharges and "community concerns". There was no recording of the content of discussion of the cases, details of the outcomes, and actions proposed.

6.7 Individual care coordinators from varying professional backgrounds were responsible for taking forward decisions of the meeting. It was difficult for us to establish a definitive list of who was at a particular meeting from the records. There was also confusion when individuals had the same initials, making identification of those present impossible. It was also difficult to assess their contribution to discussions and decision-making.

6.8 The team meeting on 18 January 2006 noted that TW was a "community discharge". This recorded Dr Choudhury's decision to discharge him from the CMHT caseload after non-attendance at three outpatient appointments. The team manager, Jeremy Walker, was not present. The recording of the decision to discharge TW meant that Jeremy Walker was not aware of it until a following team meeting. In interview he recalled:

> *"Then I discovered on 7/8 February that he had not been to these three appointments and had been discharged on 18 January. I am not sure of the right words, but I couldn't believe it. I was shocked and indignant. I was not hostile, but I couldn't believe that this had happened and that with his background he had not been pursued when he didn't turn up. I said to Dr Choudhury and to everybody: 'This shouldn't have happened'."*

6.9 There was a meeting on 8 February 2006, after Dr Rohde's referral on 3 February 2006, at which there was no written reference to TW as a new referral or as a "community concern", although team members told us he was discussed. The recording of the meeting

on the next Wednesday 15 February 2006 was extremely brief, and did not refer to TW as a patient for whom there was action considered in the "community concern" part of the meeting.

Comment

The records of team meetings were inadequate in relation to:

- ***keeping an accurate record of attendance***
- ***sufficient recording of the range of work that the team was involved in***
- ***detail of cases and the outcomes of intervention by team members***
- ***decision-making and the expectations on team members to take action***
- ***monitoring of the overall pressures on the team and trends in work e.g. the peaks and troughs in referrals and the impact of staff absences through annual leave or sickness on capacity to respond***
- ***key issues and discussions about risk and the relative priorities of a number of competing work demands***
- ***there being no record of statutory work under the MHA as a part of the team's work, or record of the plans of action in relation to specific interventions***
- ***there being no mechanism for recording the views of team members who were unable to attend the meeting.***

Recommendations

R4 The trust should ensure that all CMHTs are given clear guidance on the standards for recording team meetings. Records of team meetings should show who attended, the range and content of discussion on individual cases and the decisions made by the team.

R5 The trust should ensure that managers regularly audit records of team meetings to assess their quality and compliance with trust standards.

Administrative support

6.10 There were also a number of operational difficulties for the team as well as the shortcomings of the team meetings.

6.11 Donzaleigh Wilson, the team administrator, provided administrative support to the team. A clerical support worker helped her, but there had not been a permanent member of staff in this role for some time and the team relied on temporary agency staff. The team administrator's role was crucial to the efficient operation of the team. Donzaleigh Wilson described it as follows:

> *"[…] I concentrate more on the figures that are expected of each of the teams that are delivered each month. I will set up records for patients if they are new, collect them. Once a patient comes, has been referred to the CMHT, then my job is to check if they have been seen before, if they are known to the trust and if they are, then get their notes from wherever it is, whether it be medical records or another department, then set them up for the team – open them up to the team. And I work with three different database systems: an excel system which is just for the team. Only myself and the other team secretary really have access, and the members of the team. Then there is a CMIS, which is the trust system, which everybody has access to, basically, within the trust, and that is what gives them the hospital numbers and that. Then the eCPA system, which is a recent thing, about two years ago that has been set up. So I work within those three systems."*

6.12 In practice administrative support was patchy due to the frequent absence through sickness of Donzaleigh Wilson. Jeremy Walker said "*I think roughly 40 per cent of the time she was away on sick leave and then annual leave, so that was a big problem before I went to the team and throughout; it had a major effect on the workings of the team*".

6.13 Sickness absences were unpredictable and it was difficult for the team manager to plan adequate cover. When the team administrator was absent the burden of team support fell to temporary agency staff. Some were able and well motivated but they did not have access to the full range of systems used by the CMHT. One member of the CMHT said *"[…] we are having a constant change of temporary secretaries. They usually stay quite a long time, maybe several months or a year. But you usually get a crisis when if we have had a temp for a year – we have had S now for about a year. If she goes and we have a temp in and D is off sick, then it is just chaos, we just cannot cope. So we have devised a system where really we are bypassing admin*".

6.14 When administrative support was not available, team members tried to cover for the absence. Jeremy Walker often performed this role that added to his demanding

workload. At different times team members described the systems supporting the team as *"chaotic"*. Senior managers in the trust (above the level of team manager) did not know about long-standing difficulties in providing administrative support until after the incident in February 2006. The system for management supervision of Jeremy Walker failed to identify this issue, and managers above the level of team manager said that they were not aware of the disruption of daily work caused by sickness absence.

6.15 There were other difficulties in the organisation of support to the team. One issue was the availability of files. Some interviewees said files could *"go missing"*. There was some distance between the CMHT base and the location of administrative support staff, although both were on the trust site. One consequence was that team members made rough notes on cases that had to be transferred manually to the case file later. In TW's case there were gaps in recording that could be attributed to the failure to record telephone conversations in a timely way on the file.

Comment

The absence of efficient systems and reliable support to the team placed additional work on Jeremy Walker and other team members who attempted to cover for the system faults though personal intervention. Jeremy Walker said:

> **"I absorbed a lot of the pressure and it created inefficiency. When I first went to the team, there was a massive number of DNAs and a backlog of months of typing. The DNAs I mention because it worried me a lot. Some DNAs are trivial and some are important. If you have too many, you can't tell which are which".**

One consequence was that the team manager worked long hours, often until the early evening in an attempt to keep up with the demands on the team. There were particular difficulties in tracking the progress of work, the outcomes of intervention by members of the team and in building a picture of the team caseload.

The pressure on Jeremy Walker, an experienced and well-regarded manager, was compounded by his own tendency to take on more work and feel responsible for tasks that had fallen to him by default. For example, he retained a caseload of "more difficult" cases that he considered appropriate to his experience and expertise. At the time of the incident he was carrying a caseload of 15 cases. Trust guidelines now recommend a maximum of five cases. The cumulative effect was that his assumption

of responsibility to cover for the inadequacies of the system became the norm rather than a short- term measure.

Managers in the trust did not deal with the frequent but unpredictable absence of the team administrator effectively. Managers above the level of Jeremy Walker underestimated or did not know about the impact on the reliable operation of systems to support the work of the CMHT. Team members covering for absence was a pragmatic short-term reaction but an inadequate solution to a long-standing problem.

Recommendation

R6 The trust should ensure that operational managers monitor the impact of sickness absence and take action to minimise its effect on the functioning of CMHTs.

Case recording by the CMHT

6.16 The trust internal investigation reported that the clinical record "*illustrated an informal and unprofessional referral process that lacked clarity and decisiveness"*. In TW's case there was no formal allocation of status under the CPA. Jeremy Walker told us that TW was on standard CPA "by default". This meant that patients who did not meet the criteria for the enhanced level of CPA were *de facto* on the standard level of CPA. Members of the CMHT acknowledged that some referrals were held in a "pending" tray. They were not formally allocated a status under the CPA or allocated a key worker who would be responsible for the case within the CMHT. Such cases might be discussed at weekly team meetings where a team member could offer to take them on, but they often remained unallocated.

6.17 One implication of this practice was that a formal assessment process did not always take place and cases were sometimes left "in limbo". Jeremy Walker told us that: "*for patients who are not on enhanced CPA, there is no clear policy on the kind of risk assessment you do for standard patients. There is a very complicated electronic form for enhanced CPA patients […]*" The approach the team took to CPA status created a lack of clarity about responsibility for following up actions. TW's notes demonstrated this at several points in the case history.

6.18 In the early contact with TW Sue Armstrong, a social worker on the CMHT, made a note on 13 December 2004 that refers to concern from the team working with PW. The concern was about TW's treatment of his mother and allegations of physical, financial, sexual abuse and neglect. Sue Armstrong followed this up with a telephone conversation with Detective Constable (DC) Simon Nolan of the Wandsworth Community Safety Unit on 20 December 2004. DC Nolan reported that TW was "*paranoid and is hearing his father's voice*". According to the record of the conversation with DC Nolan, TW said:

- he had been instructed by his dead father to dig in the garden to find money buried there
- he thought he was a ghost and could walk unseen into people's houses and gardens
- he believed that other people were trying to gain entry to his mother's house and had changed the locks several times.

6.19 Sue Armstrong's record ends with the statement: "*Suggested to DC N that we could do a joint visit with him and he agreed. I said I would get back to him. D/W (discussed with) JW. He may be able to visit*". The next entry on the case notes is on 4 July 2005, recording a conversation with Phil Howell, a social worker from the older people's team at Wandsworth social services. There is therefore a gap of six months on the record when no action has followed from the discussion recorded in December 2004.

6.20 The entry in the case notes on 4 July 2005 records a telephone conversation between Jeremy Walker and Phil Howell. On the same day Jeremy Walker and Dr Baksh visited TW at home. Dr Baksh recorded the outcome of the joint assessment and noted that TW was suffering from "*anxiety and symptoms of psychosis"*, in particular that the police and others were after him and would put him in prison. The risk assessment, as part of the recording, included the information that he had suicidal ideation, e.g. he had thoughts about going out into the traffic, drowning or using a gun, but no stated plans. Risk to others was "*no stated intent, but risk high if paranoia increases*". The recording included a four point plan of action.

6.21 There is a record of a conversation between Jeremy Walker and DC Nolan on 5 July 2005. Unusually, it is typewritten and records concerns about TW's recent behaviour including the statement that he has "*become more obsessed and changed locks on his mother's house 7 or 8 times*". It also includes the allegation that TW and PW had "sexual

relations" and that all PW's money had been withdrawn from the bank. The case was then presented at the team meeting the next day, 6 July 2005, and the case note entry says *"T [Dr. Baksh] will see and then we should investigate concerns of police further, I think"*. This entry is signed by Jeremy Walker. In fact Dr. Baksh left the team to take maternity leave and her placement as a SHO came to an end.

6.22 The next entry in the notes is a date (7 September 2005) with no recording. This was the next contact with TW when he saw Dr Choudhury at an outpatient appointment. Dr Choudhury did not record his findings on the running record in the case notes but wrote a letter to the GP which noted his assessment of TW's mental state. Dr Choudhury told us he had not seen TW's notes before the appointment with him and had not read Dr Baksh's recording after the home visit:

> *"Q: […] when you saw him on that day did you have access to the previous records?*
> *A: No. If this record was present I would have jotted down something".*

6.23 Dr Choudhury said he could not remember reading Dr Baksh's assessment until after the critical incident on 17 February 2006:

> *"Q: […] So when you saw the notes after the incident, yes? When you saw it did you think it was a good assessment?*
> *A: Well, it's a very difficult question to answer whether it was a good assessment or not. But certainly what she has dictated, it's her personal opinion of the situation at that time. She notes that he was severely psychotic or something like that. But when I saw him he wasn't psychotic at all".*

6.24 The case record then notes three appointments which TW did not attend: 2 November 2005, 30 November 2005 and 11 January 2006. Against the last of these dates is the entry: *"Plan: Discharged, to inform CMHT"* made by Dr Choudhury. Dr Choudhury told us it might be necessary to see a patient several times before a firm diagnosis could be made:

> *"So this was an individual who was quite normal and if I had seen him once or twice more, then probably my view about the situation could have changed. I don't know".*

6.25 There is no record on the case note of a report to the CMHT or any discussion that followed. On the record of the team meeting on 18 January 2006 there is a note that TW is a "community discharge". The next entry in TW's case note is for 3 February 2007. Emmanuel Ofori-Danso, a CPN on the team, recorded a telephone conversation with Dr Rohde. The GP re-referred TW because he had seen him at the surgery that morning, "*he presented as being thought disordered and expressed paranoid ideations*". Dr Rohde reported that TW had been aggressive towards *"his brother* [MW]*"* yesterday (this was in fact his son MW) and wanted him to be seen as soon as possible. Dr Rohde followed up his telephone call with a fax message to the CMHT asking for *"an urgent home assessment"* for TW. The fax also said that "*Mr* [W] *is distraught/losing weight, but isn't taking medication - because it affects his balance - he is worried about admission and his wife reports he is very irritable*".

6.26 The case record entry by Emmanuel Ofori-Danso continued by noting a second conversation with Dr Rohde on 3 February 2006. Dr Rohde said that TW had visited the surgery later in the morning, had appeared much calmer, Dr Rohde had taken some blood for a test and given TW a prescription for stelazine 5mg to take daily. *"Dr R [referring to Dr Rohde] still wants TW to be follow up"*.

6.27 The next *consecutive* entry in the case notes is for 15 February 2006, by Jeremy Walker: *"[TW] discussed at team meeting, Dr C [referring to Dr Choudhury] and I will try again"*. From interviews it appears that this entry was mistakenly added to the foot of a continuation sheet and therefore appears out of sequence. This is because different pages in the running record were sometimes in different locations. In fact the next entry after 3 February was for 9 February by Jeremy Walker. He stated *"Dr R [referring to Dr Rohde] rang me - he is still concerned about Mr* [W] *though he has agreed to take a blood test - we agreed we would try to visit him at home even though he rang on 8.02.06 saying he doesn't want to be seen - may need assessment under the MHA"*.

6.28 The next entry is for 10 February 2006 by Jeremy Walker and notes *"Dr C [referring to Dr Choudhury] and I will visit 11:30ish on 13/02. Rang hoping to speak to Mrs W [LW] but Mr W [TW] answered the phone "there's no need (to visit) - everything's all right"*. Jeremy Walker made the next entries in the record as follows:

"13 February 2006 rang to check if mother PW is still under Dr C's [referring to Dr Colgan, old adults consultant psychiatrist] team - no, discharged 7/05".

"15 February 2006 discussed at team meeting. Dr C and I will try again".

6.29 This is the last written note on the continuous record. There is an e-mail dated 17 February 2006 from Jeremy Walker to Dr Choudhury which states "*I think we said we'd call round on TW. I can do pm 24th or any time on 28th".*

Comment

The following comments are a summary of our view of the case record as a working tool:

- ***the record is mostly hand-written and in some places difficult to read***
- ***there are significant gaps in the record after decisions to take action***
- ***there is no CPA documentation on the record***
- ***there is little recording of decisions made at the weekly team meeting that had a bearing on the case***
- ***there is one entry that provides a useful assessment and summary of TW's mental state – the record of the joint assessment of TW on 4 July 2005 by Jeremy Walker and Dr Baksh***
- ***there is a recording by Jeremy Walker of concerns after a conversation with DC Nolan that is typed and therefore stands out in the record as an accessible document***
- ***there is no formal risk assessment although there are references to risk in Dr Baksh's formulation***
- ***there is no managerial oversight of the case or formal recording of allocation***
- ***the case note was not always available to individual professionals who contributed to it e.g. entries were recorded on continuation sheets and then attached to the record later***
- ***there is lack of clarity about responsibility for the case***
- ***a key professional in the care of TW, Dr Choudhury, could not recollect seeing the case notes and reading the formulation by Dr Baksh.***

Recommendations

R7 The trust should ensure that all team members maintain trust standards for case recording.

R8 The trust should ensure that as far as possible case notes are always available for outpatient appointments wherever they take place.

7. Decision making by the CMHT and the use of the MHA

7.1 This chapter focuses on the short period after the referral to the CMHT by Dr Rohde on 3 February 2006 to the death of LW on 17 February 2006. Decision making during this time was crucial to the care of TW. The key dates and contacts during this period are as follows.

- On 3 February 2006 Dr Rohde visited TW at home at the request of his son MW and was concerned about his mental state. He made requests to the CMHT by telephone and fax for an urgent assessment.
- TW visited the surgery in a calmer state later that day and the request for an assessment was repeated in a second telephone conversation with Emmanuel Ofori-Danso from the CMHT.
- Jeremy Walker telephoned and faxed Dr Rohde on 9 February 2006 to discuss the case and agree a course of action.
- On 10 February 2006 Jeremy Walker telephoned TW's home. TW answered and said that he did not wish to be visited by the CMHT.
- On 13 February 2006 Jeremy Walker and Dr Choudhury decided to visit TW.
- On 17 February 2006 Jeremy Walker sent an e-mail to Dr Choudhury suggesting a visit to TW on 24 or 28 February 2006.

7.2 The interpretation of events by the trust internal investigation was that the CMHT had failed to take action after the referral from Dr Rohde:

> *"[…] his GP had requested an urgent referral and was prepared to complete section papers if necessary. The CMHT appear to have become frozen with indecision at this point".*

7.3 The crux of the argument about the CMHT's response is whether the referral from Dr Rohde was a request for an urgent assessment under the MHA. If this was the case, then the response time of the CMHT was slow. The assessment had not been made by 17 February 2006, two weeks later. Dr Rohde told us he believed he had requested an urgent assessment on both occasions he communicated with the CMHT:

"It was a straightforward request for an urgent assessment on the first occasion, followed by a straightforward request for an urgent assessment on the second occasion".

7.4 Dr Rohde put this in the context of a good working relationship with the CMHT:

"I think that it is exceptional for it to take so long to see a patient."

7.5 From the point of view of Dr Rohde, the CMHT failed to respond to his request in a timely way.

7.6 The view from the CMHT was that the request from Dr Rohde was not for an emergency assessment under the MHA that required a response within 24 hours. The first response from the CMHT was from Emmanuel Ofori-Danso who took the referral on 3 February 2006. He reported the conversations with Dr Rohde to Dr Choudhury who had seen TW at the outpatient clinic and had some knowledge of the case.

"After I finished I went round and I saw one of doctors, Dr Choudhury who from looking at the notes was the last person – no, the notes I think weren't at the team base at the time, but I spoke to Dr Choudhury that this is what Dr Rohde has reported about TW, that at first this is how he reported it, and the second 'phone call, this is how it was reported- so since you were the last person to see him, I think I had to let you know, so that whatever measures that need to be taken can be carried through".

7.7 The case was next discussed at the weekly team meeting on 8 February 2006. Neither the record of the team meeting nor TW's notes show whether the case was discussed in detail. However, Jeremy Walker recalled in evidence to us that:

"I read the notes and realised who it was that had been referred and that he had missed all these appointments with Dr Choudhury and had been discharged I was very concerned"

7.8 During the meeting there was a message from the team secretary to say, "*the new referral had rung up and doesn't want to be seen*".

7.9 Jeremy Walker told us he had a strong feeling about the TW case and he was surprised that TW had been discharged from the team's caseload on 18 January 2006 after three non-attendances at outpatients' clinic:

> *"[…] I discovered on 7/8 February that he had not been to these three appointments and had been discharged on 18 January. I am not sure of the right words, but I couldn't believe it. I was shocked and indignant. I was not hostile, but I couldn't believe that this had happened and that with his background he had not been pursued when he didn't turn up. I said to Dr Choudhury and to everybody, 'This shouldn't have happened'."*

Comment

There was only a limited discussion about the case at the team meeting on 8 February 2006. The discussion did not have the benefit of all potential contributors being present. The issues about the urgency of the assessment were not aired and the differences of view about diagnosis and approach were not discussed or resolved. The team meeting could have been a forum for an informed decision about what course of action to follow, but in fact it was a missed opportunity to bring together members of the team who knew about the case. The net effect of the meeting was to leave responsibility for the next steps with Jeremy Walker, who thought the case was important but not urgent. No team member involved in the case raised the issue of Dr Rohde's referral as a request for a MHA assessment.

A central paradox in the case was that although Jeremy Walker felt strongly that TW could be dangerous to himself or others, the response from the CMHT did not reflect this perception and it treated the case as a routine referral of low priority. As Jeremy Walker said:

> **"The fact that we had very different views wasn't discussed. I can't remember what happened in that meeting but I had certainly two, maybe four, conversations with him [Dr Choudhury] in the team base in his room about TW and about my feelings about him. I said on every occasion that I had a bad feeling about him and I thought he was a dodgy character, that I thought he was paranoid and I thought these allegations about what he had been doing to his mother were almost certainly true."**

Another factor in the urgency attached to the case was the reporting of the second conversation between Dr Rohde and Emmanuel Ofori-Danso on 3 February 2006. This effectively reduced the seriousness of the acute mental health crisis by implying that TW had become calmer and more cooperative with treatment. Similarly the CMHT received two messages from family members which were recorded in the team diary. On 1 February 2006 LW rang to say that they did not need anybody to come round, then on 7 February 2006 there was a message from TW's "son/nephew" that they did not need a visit. The latter was the message that was reported to the team meeting on 8 February 2006.

Our view of the action after Dr Rohde's referral is therefore different to that of the internal investigation. Rather than a team* "frozen by indecision"*, we see a team where the everyday systems and working practices were functioning at a level that made it difficult to judge priorities and make accurate assessments of competing demands. This placed greater reliance on individual professionals to flag the highest priorities, and in TW's case there were differences of opinion about diagnosis and risk that were not resolved. The team did not discuss clinical differences and differing views about the priority of the referral were not resolved.

The provisions and powers of the MHA were never used to assess TW. Jeremy Walker and Dr Choudhury were experienced mental health professionals qualified to make judgments under the criteria of the MHA, but they did not work closely enough to coordinate a timely response. Dr Butt could not take part in an assessment because he was on annual leave until 13 February 2006. We discuss the roles of clinical team leader and team manager as they apply to the CMHT in a later chapter.

Recommendations

R9 The PCT and the trust should clarify the systems for GPs requesting action under the MHA. The trust should ensure that all CMHT staff who act as the first point of contact are clear about expectations and responsibility for follow through action after requests are made for assessment under the MHA.

R10 The trust should ensure that managers allocate cases in a timely way after a request from a GP for an urgent assessment under the MHA.

8. The trust's operational policies and the CMHT

8.1 This chapter reviews the trust policy on the CPA and the CMHT's application of it, including the action when patients do not attend appointments (DNAs). The trust implemented an agreed CPA policy in February 2001 and reviewed it in March 2003. The policy was trust-wide and all CMHTs were expected to use it to guide their work. The DH originally set out policy for CPA in circular HSC (90)23 and further guidance was issued in circular HSC (99)34[3].

8.2 The trust CPA policy was consistent with national guidance and incorporated operational guidance for CMHTs. It described two categories of CPA. Enhanced CPA applied to people with severe mental health problems resulting in chronic disability or those who:

- needed a medium/high level of support, generally from more than one professional or agency
- were subject to section 117(2) of the MHA or supervised discharge under section 25(a)
- were on the supervision register.

8.3 The trust internal investigation took the view that TW should have been placed on the enhanced level of CPA when he was referred by Dr Veiras in June 2005 and visited by Dr Baksh and Jeremy Walker from the CMHT.

> *"The assessment conducted by Dr Baksh raised concerns within the multidisciplinary team. It was known at this stage that TW was in regular contact with Social Services and the police. He had been diagnosed as being paranoid and had a documented*

[3] The CPA was introduced in England in the joint Health and Social Services Circular HC(90)23/LASSL(90)11 'The care programme approach for people with a mental illness, referred to specialist psychiatric services' published by the Department of Health in 1990, effective from 1 April 1991.
'Effective care co-ordination in mental health services: modernising the care programme approach: a policy booklet' published in 1999 by the Department of Health (HSC (99)34) sets out the current policy on CPA. It states that the four main elements of CPA are:

- systematic arrangements for assessing the health and social needs of people accepted into specialist mental health services;
- the formation of a care plan which identifies the health and social care required from a variety of providers;
- the appointment of a care co-ordinator to keep in close touch with the service user and to monitor and co-ordinate care; and
- regular review and, where necessary, agreed changes to the care-plan.

history of aggression and violence. However the team meeting did not decide the level of CPA as is usual directly after an assessment visit. By default TW was placed onto standard CPA where all his follow up was to be at an outpatient clinic."

8.4 There were indicators at this time. Several agencies had been involved with TW, there was a record of violence, and there were allegations of abuse of his mother PW.

8.5 At an earlier stage of the CMHT's involvement with TW in December 2004 there were risk factors that could have triggered a mental health assessment and CPA review, if the trust CPA policy had been followed. These included:

- allegations of cruelty and neglect by PW
- a report from a relative that TW had tried to strangle PW
- an allegation that TW had punched PW in the eye and may have sexually assaulted her
- an allegation that TW was trying to sell PW's house against her wishes
- a threat to harm his nephew with a hammer
- an allegation that TW had thrown his father downstairs
- a corroborating report from the police community safety unit that TW was hearing voices and acting on them
- a report that he said he was a ghost and could walk unseen into people's houses and gardens.

8.6 At this point neither standard nor enhanced CPA documentation was completed. If the CPA documentation had been used, a risk assessment would have been completed. Annex A to the clinical policy said:

"Considering and recording the process of risk assessment should be part of everyday practice. The CPA guidance on a patient's current risk status and the questions on the CPA form […] act as a remainder of the key components of risk assessment when deciding if there is a need to move to a more comprehensive assessment of risk".

8.7 There were therefore two opportunities, in December 2004 and July 2005, when TW met the criteria for CPA, or warranted further assessment to determine if the criteria were met.

8.8 If the trust risk policy had been followed there would have been a completed "risk history form", contained in annex B of the CPA policy. Evidence about TW's behaviour would have been entered on the form.

8.9 The team manager told us TW was on *"standard CPA by default"*. This meant he met the criteria for standard CPA although no formal CPA documentation was completed. According to the trust policy standard CPA applies when:

> *"A patient has contact with one member of the team, or is getting low-key support from more than one member of the team or more than one agency. Such patients will be more able to manage their mental health problems, will pose little risk to themselves or others, and will normally keep in regular contact with services."*

8.10 The policy said that for standard CPA *"need and risk must always be assessed and a care plan drawn up […] the GP must be informed of the care plan, usually in the form of a letter, a copy of which should be kept with the risk documentation in the appropriate section of the clinical notes"*.

8.11 TW was the subject of a letter to Dr Veiras the referring GP, but no other formal CPA documentation was completed.

8.12 Annex D to the clinical policy draws attention to the Carers Act and the potential for people with mental health problems to be eligible for an assessment under this legislation. If TW was subject to social stress partly because of his perceived role as a carer for his mother, as suggested by Dr Choudhury, then action to complete a carer's assessment would have been appropriate. Alternatively, a referral to another member of the CMHT with more expertise in carers' assessments could have been a possibility.

8.13 After the visit to outpatients to see Dr Choudhury TW did not attend three successive outpatient appointments. After the review of the clinical policy in October 2006, there is now a "did not attend" (DNA) policy. At the time of TW's contact with services this was not in place. After each DNA a brief note of the non-attendance was made on the case record, and a further appointment was sent. After the third DNA Dr Choudhury wrote to TW and the GP on 18 January 2006 to say that if TW did not make

contact within the next two weeks he would be discharged from the service. LW rang the CMHT on 1 February 2006 to say that he did not want to be seen.

8.14 The GP was not told about each non-attendance so he believed TW was under the care of the CMHT, until he was informed in January 2006 that TW was being discharged from Dr Choudhury's care as an outpatient. Dr Rohde told us:

> *"Q In the period that TW was being offered the appointments and not attending them with the CMHT or at the Outpatients Department at Clare House, would there have been an assumption on the part of the GP that he was still being actively treated by the CMHT, even though he was not attending and had not been seen for several weeks?*
> *A. Yes. My assumption would be that there would be some ongoing contact or at very least letters to him"*

8.15 This was a significant gap in the continuity of care and a systemic problem that had important consequences for the relationship between GPs and CMHTs (performance figures for 2005 and the first quarter of 2006 show that across Wandsworth Borough DNAs were at 25%). The trust has now introduced a DNA policy in response to the recommendations of the internal investigation report. In chapter 11 we comment more generally on the response of the trust to the investigation.

8.16 There was a continued failure by the CMHT to use CPA documentation in the cluster of referrals in February 2006. We think that the trust CPA policy was largely fit for purpose but it omitted to give guidance on what to do if people did not attend appointments. There was no active approach to non-attendance. For example, the appointment time was not used to make enquiries about the patient or to find out whether non-attendance was significant.

Comment

The CMHT failed to use the CPA consistently as a working tool. Instead it relied on ad hoc working arrangements and the capacity of the team manager to hold on to several strands of work. We acknowledge that Jeremy Walker, who had been invited to lead the team because of his good reputation in the trust and experience in managing another team, made improvements to its operation from 2004. However, long-standing difficulties remained in:

- ***maintaining accurate and up-to-date records with varying degrees of administrative support***
- ***dealing with work that was held in a "pending" tray***
- ***allocating work in a timely way***
- ***monitoring the progress of work through supervision systems***
- ***incorporating formal CPA processes as set out in the trust policies into everyday work***
- ***using team meetings as an efficient and effective way of managing work***
- ***using team meeting to identify levels of risk***
- ***planning intervention under the MHA.***

An associated issue was management's awareness of the team's compliance with trust operational policies and knowledge of performance through the trust's performance management systems. We look at these issues in more detail later.

Recommendation

R11 The trust should ensure that team managers implement the CPA policy and procedures, that all CMHT staff have training and refresher training in the operation of the CPA and that risk assessments are completed as part of the CPA process. The trust should undertake frequent audits to ensure compliance with this recommendation.

9. Links between the CMHT and the older people's team in Wandsworth social services department

9.1 This chapter reviews the links between the mental health services and the services for older people provided through Wandsworth Council. An important theme in the history of TW's contact with services was his relationship with his mother PW. At the time of writing she is 85, a widow who has lived alone since the death of her husband, TW's father, in 1999. She and her husband had four children. Before the critical incident she had no contact with two of her children, some contact with her daughter, AY, who lives in the area and frequent contact with TW. The significance of TW's relationship with his mother was that:

- he regarded himself as the main carer for PW and frequently reported this as a source of anxiety
- he spent a great deal of time with her and appears to have been living at her address during part of 2005
- his relationship with his mother and the time he spent with her was a source of tension between TW and LW
- in terms of contact with public services, there was a greater frequency of referral of the family to Wandsworth social services department (SSD) because of concerns about PW than to the CMHT
- a number of sources registered concern with Wandsworth SSD and the police that TW was assaulting PW
- Wandsworth SSD and the police followed up some of these concerns but found evidence gathering difficult because of conflicting accounts by family members and PW herself
- there was a history of equivocal evidence about TW's relationship and behaviour towards his mother that was not satisfactorily resolved.

9.2 The importance of the relationship between TW and PW is reflected in two reports commissioned after the death of LW. The trust internal investigation was completed as required within 60 days of the incident. Wandsworth Council commissioned an independent report into PW's case that was given to council members in February 2007. Wandsworth Council commissioned a serious case review under the safeguarding adults partnership procedures after this report.

The trust's internal investigation

9.3 The trust internal investigation highlighted a number of issues in relation to the protection of vulnerable adults.

- The panel took the view that there were significant risks to several members of TW's family during the period of time that he was known to the trust and the SSD. Concerns were repeatedly raised concerning the safety and welfare of PW.
- The investigation panel could not find any evidence that either statutory agency had considered instigating proceedings as set out in the *Protection of Vulnerable Adults and Borough Multi-Agency Management Committees Guidance 2004.*
- TW's anxieties about caring for his mother appeared to be consistent throughout the period of his treatment with the trust. However, during its investigation the panel heard from representatives of the older people's service at Wandsworth SSD that TW was not regarded as a carer in the strict sense of the word, because he was not eligible to receive benefits for this role. Dr Colgan, PW's consultant psychiatrist, also considered that she was not in need of a carer.
- The panel accepted that although TW may not have been legitimately regarded as a carer, the stress caused by his perception of himself as her carer was real, and this should have prompted a formal assessment. All agencies knew he spent a lot of time with his mother and he was periodically staying at her house. The panel noted that the CMHT did not know TW was not a formal carer until after the killing.
- The investigation took the view that the CMHT should have taken TW's concerns seriously and instigated a joint review with the older people's social services. The panel was unconvinced that adequate processes and procedures were in place to support the carers of service users within the CMHT service.

Independent review commissioned by Wandsworth Council

9.4 After LW's death Wandsworth Council commissioned an independent report with the following terms of reference:

- to examine the circumstances surrounding PW and to establish whether there are lessons to be learned from the case about the way in which staff in Wandsworth social services respond to safeguarding vulnerable adults

- to establish what these lessons are, how they will be acted upon and what is expected to change as a result
- to consider any implications for inter-agency work in safeguarding adults in Wandsworth
- to improve safeguarding vulnerable adults in Wandsworth.

9.5 The review covered January 2000 to June 2006 and had access to Wandsworth SSD records and staff. The Wandsworth report summarised the history of contacts between Wandsworth SSD and PW. In the shorter period we considered between January 2004 and January 2006 there were 65 entries recording visits and telephone contacts related to the case, according to the electronic case notes held by Wandsworth SSD.

9.6 The case did not have "open" status with an allocated caseworker at this time but was dealt with by a number of different people as a "duty case". The worker who was on rota was to provide a first line of contact with the public on behalf of the older person's team and dealt with it on an *ad hoc* basis. There were several workers on the older people's team who had significant involvement in PW's care, and liaised with other agencies like the police about her case, even though it did not achieve open status until after the death of LW.

9.7 The independent report "*did not identify any major failing by any individual within Wandsworth social services that would have altered the outcome regarding TW's wife's death*". However it raised the following issues of concern:

- poor practice in assessment and risk assessment
- procedures for safeguarding adults that could be more helpful to practitioners
- existing procedures for the Protection of Vulnerable Adults (POVA) not being followed
- a failure of the whole system to protect PW
- poor inter-agency work
- whether current thresholds for receiving a service from Wandsworth Social Services were adequate in safeguarding vulnerable adults
- the potential to learn from safeguarding children practice.

9.8 The report said there was little evidence of a comprehensive assessment of PW's circumstances until after the killing in February 2006, when the case was allocated to a

case manager instead of being dealt with through the duty system. The report said it was difficult to form a view of what daily life was like for PW from the information on the file. The assessments that took place were geared towards offering a limited range of existing services, for example, attendance at a day centre, rather than establishing a consistent relationship to investigate the allegations made by her and about her. The report said:

> *"Throughout that year (2005) a significant amount of social work activity took place. There were twenty-five pages of recorded notes yet* [PW] *received no tangible service and there was no change in her circumstances."*

9.9 The case notes record a number of concerns about PW. The following are illustrative rather than comprehensive and are taken from February 2004 to February 2006.

- A number of reports by PW that she was robbed or had money taken from her home. She accused various family members, including TW.
- Reports from PW that TW was beating her.
- The police were involved in investigating the allegations about money and saw TW about it.
- It was alleged that PW's house had been put on the market and that TW would benefit from the sale.
- The police community support unit was involved a number of times, but formal action was not taken because PW usually refused to make a complaint about TW and insisted that he was "a good boy".
- Police and social services made a number of joint visits. Other family members said that PW was frightened of TW. After one of these visits TW threatened his nephew (PW's grandson) with a hammer and as a result PW went to stay with her sister in Eastbourne for a while.
- An anonymous caller said TW had *"moved into PW's house with lots of animals"* and the property now *"looks like a zoo"*. The caller said PW was frightened of TW and did not want him to stay.
- PW's sister in Eastbourne reported that TW was violent, had assaulted his father before he died and had also assaulted his mother. Another brother, DW, refused to see his mother due to TW's violent behaviour, but was willing to talk to social services about the situation.

- There were several telephone conversations between the police community support unit and social services about the case. In one recorded exchange (12 January 2006) an officer from the community safety unit said *"the family have to make a complaint to police"* before action can be taken. The duty social worker recorded speaking to AY, PW's daughter, who made a complaint to the police and obtained a crime number. The police are said to have commented *"there is little they can do until Mrs.* [W] *makes a complaint herself"*. The duty social worker recorded that a referral to the vulnerable adults coordinator might be appropriate.
- On 3 February 2006 PW had called in distress at her daughter AY's home, saying that TW had thrown a bin at her and cut her head. When these allegations were investigated PW denied TW had hit her and said he did everything for her. The case was closed.
- A member of the older persons team referred the case to the vulnerable adults coordinator. He replied in an email on 15 February 2006, *"it sounds like a long-standing situation of abuse, where the police claim their hands are tied because the victim retracts her story/doesn't want to press charges"*.

Comment

The pattern of contact with social services was one of reactive intervention in response to a series of incidents. PW, other family members, and neighbours alleged that TW abused his mother financially, physically and emotionally, but she denied the allegations when they were investigated. The case did not reach the threshold for allocation to a social worker until after LW's death, when PW became an open case to social services.

Protection of vulnerable adults procedures

9.10 The protection of vulnerable adults from abuse (POVA) procedures were introduced in Wandsworth in 1996 and revised in September 2003. The inter-agency policy was supported by the London Borough of Wandsworth, Wandsworth Primary Care NHS Trust, South West London and St George's Mental Health NHS Trust, the Metropolitan police and the Commission for Social Care Inspection (CSCI). The procedures set out the responsibilities of agencies under the policy and gave guidance on action to be taken, agency roles and how investigations should be completed.

9.11 The independent review of PW's care commissioned by Wandsworth Council concluded that procedures had not been followed in several examples:

> *"On one occasion the referral was not recognised as requiring a response under POVA procedures. On two occasions the social service response was outside the procedures time scale. There was no attempt made to have PW medically examined, although this is recognised as important in the procedures. Although PW had physical injuries and gave different explanations of how these happened, the police officer and social worker concluded that there was no additional evidence of abuse. The fact that no expert medical opinion was sought meant that there was no way of knowing if her injuries were consistent with her varied accounts of what happened. It also meant that any opportunity to see bruising to other parts of the body was missed. If her son TW had beaten her, as she originally claimed, it is very possible that other bruising would have been present."*

9.12 The CMHT case notes show times when the CMHT and members of the Wandsworth older people's team communicated. These were in December 2004 and July 2005. In the first, Sue Armstrong, social worker on the CMHT, had telephone contact with the older person's team, PW's grandson RW and the police. Sue Armstrong recorded a number of concerns and concluded with an entry proposing a discussion of the case with Jeremy Walker, the team manager of the CMHT. In the second example in July 2005 there were discussions between Jeremy Walker, the police and Phil Howell from the older person's team. There is no record of the POVA procedures being used to coordinate a multi-agency response. We asked Jeremy Walker about the POVA policy:

> *"Q. From those entries there seems to be quite a heightening of concern about TW and about his mother. There is a suggestion from Simon Nolan (referring to DC Nolan of the Community Support Unit) of sexual abuse, financial abuse and physical abuse. You made contact with Dr Colgan's team and spoke to Phil Howell. In the context of what we were just talking about, did you see this as a case for vulnerable adult proceedings?*
>
> *A. I didn't, no. I don't think it crossed my mind. I can't say that definitely. My focus was very much on TW and what was going on in Topsham Road, and his mental state and what he was up to, seeing him – he was a patient – assessing him and that kind of thing. Psychologically I left PW with the old people's service. It didn't occur to me to have a network meeting or anything at that stage."*

9.13 Interviewees from Wandsworth SSD acknowledged that the POVA policy had not been used to bring agencies together for a strategy meeting. Trisha Comley, a manager at Wandsworth older adults team, told us:

> *"I think that what was recognised in the* [PW] *case was that there were deficiencies undoubtedly in a number of areas. Weaknesses around the assessment of risk, weaknesses around the coordination and the gathering of information from other involved parties. Certainly a failure to grapple with TW, and to find a way into meeting with this person and challenging him around some of the allegations that we had received on and off for a long period of time from third parties about his behaviour to his mother."*

9.14 As a result of this case Wandsworth SSD commissioned a serious case review through the Wandsworth safeguarding adults partnership after the completion of the independent consultant's report. The review analysed contact with PW between 1 January 2002 and 1 February 2007.

9.15 There was an acknowledgment that PW's case should have triggered more active intervention under the protection of vulnerable adults procedure. The serious case review and the revision of procedures introduced on September 2006 recognised that the profile of vulnerable adults work had grown and that extra resources were needed to meet the demand and the higher expectations of local authorities and partners. We comment later on the changes to policies and procedures since the case review.

Comment

We make the following comments about the information that was known about PW and the wider family at the time of LW's death.

- ***In terms of weight of evidence, social services and the police community safety unit had significant numbers of contacts with PW in the period leading up to the death of LW.***
- ***PW was equivocal in her reporting of evidence of TW's behaviour towards her, and gave positive and negative views to a range of family and professionals she had contact with. The combination of positive and negative views led to inertia and a failure to reach the threshold for the case to be***

accepted. An alternative interpretation could be that equivocal evidence should trigger more intervention to make a full assessment of areas of disagreement. There was no active decision to take the case on and complete a comprehensive assessment, pulling together all the known information about the family.

- ***Family members described PW as a victim and a manipulator. According to some accounts she was physically, financially and possibly sexually abused. Others described her as someone who manipulated TW and was able to "pull the strings", and that she had a negative influence on TW's relationship with LW.***
- ***TW saw his mother as the root cause of problems in the family and the source of tension between himself and LW, because of his mother's demands on his time and accusations about him.***
- ***Awareness of the vulnerable adults procedures and requirements was low in both the CMHT and the older persons team. Whatever the truth about allegations made by different family members, there was enough evidence to prompt the next stage of inter-agency action, which would have been a strategy meeting. This would have been the appropriate action under the inter-agency agreement for the protection of vulnerable adults.***
- ***Opportunities to share knowledge between the CMHT and the Wandsworth older adult team were missed. Contacts between the teams were unproductive. The working relationship between the teams was not close.***
- ***The vulnerable adults coordinator was not involved sufficiently as an adviser and source of expertise on the way to proceed with the case.***
- ***All agencies consistently underplayed the domestic violence aspects of the case, particularly the police, who suggested they could not take action unless PW pursued a complaint. Both the police and Wandsworth SSD had contact with her over a long period and their interventions remained reactive, with no monitoring of the cumulative effect of referrals.***
- ***TW's vulnerability was not appreciated or assessed, in particular his lack of reading and writing, his long-standing behavioural traits that brought him into conflict with a series of authorities including the local council, and his poor adaptation to stress that led to anxiety and paranoia. Reports of his mental state, well known to the police and social services, should have added to the weight of evidence supporting a case review through the existing protecting vulnerable adults procedures.***

Recommendations

R12 The trust should ensure that all CMHT staff have training in safeguarding and the protection of vulnerable adults.

R13 The trust should ensure that a senior manager has responsibility for linking with other partners in the Safeguarding Adults Partnership.

R14 The trust should ensure there is improved liaison between its CMHTs and the local authority teams for adults and older people.

R15 The trust should ensure that all staff have training in assessing the needs of carers and are aware of their duties under the Carers (Recognition and Services) Act 1995.

10. Trust management, performance management and operational issues for the trust

10.1 The trust internal investigation concluded that there had been failures in management and leadership in the case of TW. The investigation report said:

> *"It is the view of the Investigation Panel that the CMHT senior management had a distinct role to play in ensuring that basic clinical management processes were in place and adhered to. In the case of the Treatment and Care of TW they appear to have failed"*

10.2 The independent investigation's reference to "senior management" meant the team manager and the clinical team leader for the CMHT.

Management and leadership of the CMHT

10.3 These two roles were distinct but complementary in the trust management structure. The trust operational policy described them as follows.

> *"The Consultant Psychiatrist is the Clinical Team Leader. The Clinical Team Leader is accountable for the delivery of the service and is responsible for:*
>
> - *clinical leadership of the CMHT*
> - *prioritising the resources deployed by the team*
> - *ensuring effective assessment, planning, delivery of care and clinical governance within the team.*
>
> *Accountability for clinical care and delivery of the service rests with the Clinical Team Leader. The Clinical Team Leader has the final authority in the allocation of resources, including inpatient resources.*
>
> *Each CMHT has a Team Manager who may be a senior professional from any mental health profession. The CMHT Team Leader works in conjunction with the Clinical Team Leader to ensure:*
>
> - *effective day to day management of the team;*
> - *financial management and deployment of staff;*

- *systems are in place for the supervision and appraisal of staff;*
- *clinical governance targets are met, and that the team collects the information required for performance monitoring and audit.*

The posts of CMHT Manager and Clinical Team Leader are complementary to each other. The effective management of the CMHT relies on a collaborative working partnership between these two key post-holders."

10.4 Jeremy Walker was the CMHT manager in the period under review. He joined the team in 2004 and had previously managed another CMHT in the trust. He was an experienced social care professional and one reason the trust asked him to become the team manager was his success in managing other trust teams. Jeremy Walker had a very good reputation within the trust as someone with a proven record of good leadership. He had also achieved recognition beyond the trust for his expertise in mental health and had been a member of independent investigation and inspection teams. All the witnesses we interviewed spoke highly of his dedication and commitment to the job. Jeremy Walker was very frank in his evidence to us and it was clear that the events surrounding the death of LW and the investigation process afterwards had been distressing to him on a personal and professional level.

10.5 Several doctors performed the role of clinical team leader during the period under review. When Jeremy Walker became the team manager in 2004 the clinical team leader was Dr Prakash Gangdev. Dr Baksh who was a senior house officer, and who was involved in the assessment visit to TW in July 2005, assisted Dr Gangdev during part of 2005. Dr Gangdev left the trust in July 2005 for a senior position in Canada. Dr Baksh left the CMHT at the same time at the end of her attachment on the senior house officer rotation. Dr Choudhury, an associate specialist who had joined the trust in 2005, provided consultant cover after Dr Gangdev's departure. Dr Choudhury saw TW as an outpatient. He provided associate specialist cover to two CMHTs (Balham and Tooting, and Tooting and Furzedown) and divided his sessional time equally between them. Dr Alex Butt was then appointed as a locum consultant in September 2005 and as a full-time consultant from January 2006. When Dr Butt was a locum, Dr Hughes provided consultant overview for both CMHTs.

10.6 The job descriptions of the team manager and the clinical team leader show that their roles are designed to be complementary. In the period under review Jeremy Walker

was in post continuously and provided more leadership of the day-to-day operational functions of the team for the following reasons.

- He was an experienced manager who had been asked to improve the team's performance.
- Clinical input to the team was provided by a number of doctors with varied experience, some junior and some who had locum status.
- Dr Choudhury, the associate specialist on the team, was providing cover to two CMHTs and his availability for the Tooting and Furzedown CMHT was limited.
- When Dr Butt took over the consultant post he was new to the role and looked to Jeremy Walker as an experienced manager. Dr Butt told us: "*What they had was an excellent team manager. I had never worked with Jeremy Walker before, but he had a very good reputation and when I knew the job was available and I was discussing with human resources and personnel whether I wanted the job or not, one of the draws to the team was for me the fact that Jeremy was there.*"
- Jeremy Walker, as he and other team members agreed, had a tendency to take on a large workload. As Dr Butt commented "*Jeremy Walker was really a very key member of the team, and did a lot of work that should have been farmed out to other members of the team. He was capable of doing that, and he was capable of managing very complex cases where other team members with less experience would have made some mistakes.*"

Assessment of TW by the team manager and the clinical team leader

10.7 Jeremy Walker and Dr Choudhury both saw TW. Dr Butt did not meet TW but provided clinical leadership to the CMHT during a period of the team's involvement and during the critical time in February 2006. In evidence to the internal investigation and this investigation these key managers disagreed about the nature of TW's difficulties. Dr Choudhury thought that TW was experiencing social stress. When asked about the outcome of Dr Choudhury's assessment, Dr Butt, who was Dr Choudhury's clinical supervisor said:

> *"[…] Dr Choudhury had wasted several appointments on a man who didn't have a mental disorder. Dr Choudhury was very clear that his mental state was normal and that he wasn't mentally ill, but that it was social distress and arguments within the family. So I said to him: 'Why did you offer him a follow-up appointment after you saw him for the first time? Okay, he didn't come to that appointment, but then you went on and offered him even another one. Surely, was it really necessary?'*

10.8 Jeremy Walker felt the decision to discharge TW from the CMHT caseload on 18 January 2006 was not warranted because he thought TW needed to be seen, and he had *"a bad feeling"* about him. Senior members of the clinical team had different views and there is no evidence that their differences were resolved through the systems in operation at the time.

Comment

The weekly clinical team meeting was the principal channel for discussion and agreement of a course of action. However, records give no insight into decision-making and the case status under CPA was ill-defined. There was a lack of clarity about the course of action to follow, underpinned by differing views of key team members about the nature of TW's problems. Both Jeremy Walker and Dr Butt told us they had a close and positive working relationship characterised by frequent contact and an open door policy to consultation. We acknowledge that there was a lot of informal discussion between team members that was not captured in the written records of the case or the team meetings.

It was clear that Jeremy Walker took greater responsibility for the day-to-day running of the team - organising team meetings, supervising staff and covering for shortfalls in administrative support. Jeremy Walker worked long hours and was often in the office until early evening to complete the tasks he had set for himself.

We believe there was too much reliance on informal and unstructured decision-making by key managers of the CMHT - the team manager and the clinical team leader. Despite the limited contact TW had with the CMHT there were significant differences of opinion about diagnosis and risk that were not formally considered and resolved. In particular, Dr Choudhury's stressing of social factors in the life of TW did not lead to a positive social intervention, rather an exclusion from specialist psychiatric services.

Recommendations

R16 The trust should review the roles of clinical team leader and team manager to ensure clarity about decision-making within the CMHT. The trust should ensure there is clear clinical leadership in decisions where action under the MHA is requested.

R17 The trust should ensure that clinicians are aware of the range of social interventions available for patients referred to the service, including carer's assessments.

Management accountability, performance management and supervision

10.9 The management line for the CMHT ran from the team manager to a general manager, Robert Sookoo, who reported to the borough director for Wandsworth, Stuart Thompson. The borough director reported to the deputy chief executive and chief operating officer of the trust, Maressa Ness. The trust had a management supervision policy dated September 2005. This was supplemented by an appendix that set out arrangements for supervision in the CMHTs under single management.

10.10 The appendix set out accountability structures as follows:

> *"The CMHTs will each have a clinical team leader and a team manager. The clinical team leader is the consultant psychiatrist and is responsible for the team's clinical performance. This clinical team leader (CTL) is accountable to the Clinical Director who has overall accountability for the clinical performance of the Directorate and is in turn accountable to the trust Chief Executive. The Team Manager is appointed from one of the main clinical professions and is responsible for the effective day-to-day management of the team, including ensuring that supervision and appraisal systems are in place. The Team Manager is accountable to the Service Manager, but works to the clinical team leader."*

10.11 The guidance gave details of frequency of meetings for the CMHT manager and team staff. They should be *"at least once a month*" and last for *"about an hour".* Staff were also expected to have professional supervision from a more senior professional at a frequency *"appropriate to the individual's needs".*

10.12 The management supervision policy gave guidance on the content, process and functions of management supervision, summarised as:

- the managing function-planning, distribution, administration, setting, monitoring and evaluation of work objectives and associated tasks
- the developmental function - identifying training needs and promoting experience and practice

- the supportive function - this recognises the potentially stressful nature of the work and ensures a supervisee is valued and supported as an individual and as a member of the team.

10.13 We found that supervision arrangements were different for all staff on the CMHT. Meetings did not always take place as often as the trust policy recommended. There were two main reasons.

- The pressure of competing work demands, which meant time for supervision was not always available.
- Individuals' perceptions of the need for supervision. Some of the more experienced staff were not always willing to take up supervision opportunities.

10.14 In looking at the specific management arrangements for the Tooting and Furzedown CMHT, we noted that supervision meetings took place for Jeremy Walker, the team manager, and Dr Choudhury, the associate specialist. There was also some informal or "as required" consultation on a day-to-day basis. Recording of the content of meetings was poor, and there was a reliance on the supervisee to flag up problems. A factor in the supervision relationship was that those supervised were very experienced mental health professionals who were used to operating independently and taking responsibility for decisions. The impact of supervision was limited in the case of Jeremy Walker particularly, who had been brought to the team to improve its operation.

10.15 We note that the general manager Robert Sookoo, the immediate line manager of Jeremy Walker, had a broad span of control. He was one of three general managers who reported to the service director for Wandsworth. He described his responsibilities:

> *"[…] one acute ward, one low secure ward, two community mental health teams, one assertive outreach team, one rehabilitation community team, a neuro-psychiatry service, and mother and baby service, a liaison psychiatry service, three hospital hostels, four 24-hour supported houses, four social care housing projects, and responsibility for seven peripatetic nurses, which the community mental health team has sole nomination rights into."*

10.16 Operational decisions were devolved to the team manager who was expected to manage day-to-day business in relation to the team caseload.

10.17 Trust managers had access to a quarterly performance report for their borough. The report included activities and outputs from the teams operating in the borough. In Wandsworth there were seven CMHT's, the early intervention service, the crisis and home treatment service, assertive outreach rehabilitation team and hostel services, vocational services, inpatient services, family therapy, liaison psychiatry and psychological therapies in primary care. The performance report included data on the older people's services, addiction services and the children and adolescent services.

10.18 In a relevant sample quarter, January to March 2006, the total CMHT caseload for the borough was 2346, which was 246 above the recommended maximum target caseload of 2100 (300 cases per CMHT). An average of 57% of those active cases was on enhanced CPA, which was within the target range of 40-60%. The proportion of people who did not attend their first outpatient appointment in Wandsworth was 25%, more than the national target of 18%. It should be noted that for Wandsworth this percentage included people who did not attend *any* appointment, not just the first consultation. The performance report included data on carers' assessments. In this quarter the Tooting and Furzedown CMHT completed three. There were 35 patients with an identified carer, of whom 19 had been offered an assessment.

10.19 The Tooting and Furzedown CMHT had 291 active cases when TW was referred to the team in February 2006, which was within the norm for CMHTs in the borough. The team had a full staff complement. We agree with the assessment of the internal investigation that *"the staffing establishment for the Tooting and Furzedown CMHT for the period reviewed by this investigation fell exactly within the Department of Health, Mental Health Policy Implementation Guide for community mental health teams".* The performance management information available showed nothing remarkable about the Tooting and Furzedown CMHT's profile.

10.20 However, the impact of staff absence is not reflected in that profile and we found that the frequent absence of the team administrator was an important factor in the management of the team's workload. There is no evidence of action by managers to address this long-standing problem through personnel policies, and the team largely covered for this shortfall on an ad hoc basis. The cover provided by temporary workers was not adequate because they did not have full access to the trust's systems nor a full appreciation of the CMHT's workload. Our interviews showed that senior managers did not

know about or understand the impact of this problem. Stuart Thompson, the service manager for Wandsworth said:

> *"It seems that everyone apart from Robert Sookoo and me knew there was a problem with a secretary and Jeremy Walker was not dealing with it. It seems to have been going on for years, but that came out later on".*

10.21 The general manager, Robert Sookoo, said:

> *"Subsequently I found out that there was an administrator [referring to Donzaleigh Wilson] – that there still is an administrator – who was having a lot of performance issues, but the expectation would be that would be managed in conjunction with HR [human resources department] within the team".*

10.22 The "performance management data set" collected by the trust summarised quantitative information. The quality of work was less well evaluated and documented. It relied on the supervision and professional support networks in place. These were through the team manager for members of the CMHT, supplemented by professional consultation for some members of the team. The team manager had meetings with the line manager, Robert Sookoo, and the professional social work lead in the trust, Des Muller. He became the professional social work lead for Wandsworth in August 2005. He reported to the service manager, Stuart Thompson. Des Muller directly supervised about 18 staff, and was also the operational manager of ASWs in the borough. His duties included the organisation of the ASW duty rota and leading on professional issues. His main role was to provide professional leadership and supervision for social workers, rather than line management.

10.23 Between his appointment and February 2006 Des Muller had one formal meeting with Jeremy Walker. Des Muller recalled that meeting:

> *"I think Jeremy had told me he had admin difficulties, which are probably well-documented, and for that reason he was doing a lot of his performance targets himself. Indeed when I saw him in his office that is what he was doing. I went over to see him in December for that one supervision we had, and he was half worrying about these performance targets".*

10.24 Des Muller also commented on the fact that Jeremy carried a number of cases as well as being a team manager:

> *"Jeremy Walker's view was as a very, very hands-on person. That is what I guess anybody who knew [him] would tell you. He was very, very caring, in my experience, and he was one of the opposite side of the table I was talking about in the run-up to whether people should have cases or whether you had to be team-managing. He thought it would be a bad thing for social workers not to be doing that".*

10.25 In summary, Jeremy Walker chose to carry a caseload in addition to covering the administrative functions of the team partly because he believed that it was professional good practice. This raises the issue of how active the senior managers should have been in monitoring the team manager's use of time and ensuring that the workload was manageable.

10.26 Des Muller did not recall discussing TW with Jeremy Walker before February 2006. We did not have evidence about audits of the quality of casework in the period of this investigation.

Comment

We conclude that the professional supervision arrangements and line management did not provide a sufficiently challenging overview of the work of the team manager. Long-standing problems remained unresolved and in particular staffing issues were not addressed actively. Similarly, line management did not help the team manager deal with some long-standing personnel issues.

The CMHT thought the trust management had not tackled some of the team's day-to-day difficulties with support systems, either physical ones to with their office accommodation and information technology, or personnel issues. The team felt it was left "to get on with things". The CMHT said it had been blamed for the shortfalls in service identified by the internal investigation. It thought that senior trust managers had not responded to their everyday working difficulties with support systems. Senior managers, for their part, told us about an active approach to operational

management and the introduction of planned changes to the working of the mental health service as part of their response to the internal investigation report.

Recommendations

R18 The trust should ensure that managerial supervision meetings take place as required, are recorded, and include a full discussion of the operational issues in the manager's remit. The trust should ensure that managers report operational difficulties systematically and in a timely way through the management line.

R19 The trust should ensure that professional supervision takes place as set out in the trust policy and that it is recorded and decisions acted upon.

11. Action by the trust and partner agencies in response to the incident

11.1 The previous chief executive of the trust, Christine Carter, set up an internal investigation after the incident on 17 February 2006. The investigation panel was made up of managers and clinicians from the trust and was project managed by the health and social care advisory service (HASCAS). The panel's terms of reference are reproduced in appendix C. The panel published its report on 25 May 2006.

11.2 The panel interviewed seven health and social care professionals from a list of 10 potential interviewees. Some people were not available for interview due to emigration, maternity leave or extended annual leave. The internal investigation acknowledged the limits of its work imposed by the tight timescales in the DH guidance for the conduct of internal reviews. They have to be completed within 60 days of the incident.

11.3 The panel also reviewed documents including the case notes on TW held by the CMHT. In its report the panel identified the following key causal factors that contributed to the events leading up to the killing of LW on 17 February 2006:

1. TW's initial referral from Wandsworth social services was not followed up by an assessment visit
2. following assessment no decision was made regarding CPA and no care co-ordinator was allocated
3. lack of continuity of care
4. TW's non-attendance at outpatient clinic
5. lack of communication between the CMHT and the Howard Freeman practice
6. the decision to discharge TW from the CMHT caseload
7. the urgent GP referral
8. TW's refusal to meet with the CMHT for assessment
9. the attempted telephone contact to LW by Jeremy Walker
10. the decision not to visit TW on the 13 February 2006
11. failure to set new assessment date.

11.4 We have had had full access to the internal report which has not been published, and the trust has cooperated fully with requests for documents and interviews with staff. The internal panel's recommendations have been taken forward by the trust in an action plan.

Comment

- ***The internal investigation reported in a timely way.***
- ***The report identified key issues that led to a corrective plan of action.***
- ***The "key causal factors" identified in the report are more accurately described as service delivery failures. The list of events does not establish a causal link and fails to prioritise the factors.***
- ***Trust management responded quickly to the report and has implemented the recommendations.***
- ***Policy and guidance for CMHTs have changed because of the report.***
- ***Working practices have changed.***
- ***The review was limited to the role of the CMHT in the care of TW and had neither the remit nor the resources to look at the broader picture of care for TW as a family member.***
- ***The composition of the investigation panel would have been improved by the inclusion of a senior social care representative.***
- ***The family of TW were not interviewed and have not seen the final report.***
- ***Some key professionals criticised in the report have not seen it (in particular the team manager and the GP)***
- ***The National Patient Safety Agency's Incident Decision Tree (IDT) might have been usefully applied during the internal investigation.***
- ***The impact of identifying shortcomings of staff was disproportionate on the team manager, Jeremy Walker. He was suspended from work and the subject of disciplinary procedures by his employing authority, Wandsworth Council. We believe there were more general systemic failures in the service and it was unfair to identify one member of staff above others.***

Action by the trust after the internal investigation

11.5 Part of the terms of reference for this investigation is to review the response of the trust to the internal investigation report and its recommendations, and assess the progress made on policy and practice highlighted by the TW case.

11.6 Referral systems for all CMHTs have become more systematic and formalised. The Tooting and Furzedown CMHT piloted a new referral system in May 2006 that requires a named new referrals co-ordinator to review new referrals daily with the team manager

and, if necessary, the consultant psychiatrist. A lead assessor and a care co-ordinator are allocated to each new referral at the next multi-disciplinary team meeting. This was in response to comments in the internal investigation report about uncertainty about case responsibility and the lack of systematic processing of work.

11.7 The trust has produced a new information booklet for referrers on the work of CMHTs that was circulated from July 2006.

11.8 The senior professional within the CMHT monitors all patients in its care. A zoning system has been introduced for patients who are subject to the enhanced care programme approach. The zoning system prioritises patients and should ensure that they are appropriately monitored.

11.9 The trust has defined the maximum numbers of cases that should be held by team managers as five and line managers monitor this. There is a requirement that all staff receive supervision as directed by the trust policy. Senior managers' monitoring of supervision practice has been improved by recording supervision on a shared area of the computerised record.

11.10 The trust reviewed its policy on the care programme approach, care management, and risk assessment and management in October 2006 and introduced some important changes. The trust has taken action to ensure that teams are aware of and follow agreed policies and procedures. This has been achieved through briefing events and reinforced through the line management system. The appointment of a care co-ordinator was mentioned explicitly in the revised procedures for both standard and enhanced levels of CPA. Responsibilities of care coordinators are described in the policy.

11.11 There is funding for induction training for all new staff members of CMHTs. A new two day induction programme has been introduced. The CPA policy is included in clinical risk assessment training which is mandatory for clinical staff. In the Tooting and Furzedown CMHT the consultant psychiatrist and the team manager induct junior doctors. The associate specialist receives monthly supervision and the consultant psychiatrist supervises the senior house officer weekly. All new doctors are expected to be given a period of induction which should include reading all case notes for patients they will be responsible for.

11.12 The trust has taken action to ensure that workforce planning takes place and that absences from work are managed actively and effectively. Managers' responsibilities have been reinforced and a workshop was held in October 2006 to clarify the partnership arrangements between senior clinical team leaders.

11.13 Performance management of the compliance of team managers and clinical team leaders has been strengthened. Monthly CMHT performance reports are available to senior managers.

11.14 A policy on dealing with patients who do not attend appointments has been introduced (the DNA policy). For example, this says a person should not automatically be sent a second appointment when they fail to attend the first. Attempts to contact them must be made. It also says that GPs should be informed of all DNAs.

11.15 The trust has started to audit clinical records to ensure that they comply with trust policy. An audit of the Tooting and Furzedown CMHT case notes has been completed and a rolling audit programme has been established. The trust requires clinical records to be brought to supervision sessions and the team manager reviews them.

11.16 The policy gives guidance on how to deal with *"difficult to engage patients"*. This includes discussion at the next multi-disciplinary meeting after a non-attendance. In higher risk cases there should be an immediate case discussion at which the team manager, the designated key worker and a senior member of the medical team agree a course of action.

11.17 The trust took a number of actions in response to the internal investigation's recommendations about the CMHT's functioning and competence. A new team manager was seconded to the team and has been confirmed on a permanent basis. Performance management of the team has been enhanced. The trust has begun action to improve the team's compliance with reviewed policies for day-to-day handling of work. The team told us about its mixed feelings about the trust's response to the internal investigation. Team members acknowledged that changes were necessary and had been implemented, but they felt that Jeremy Walker had been unfairly criticised and that senior management had implicitly or explicitly questioned their competence as professionals. Some team members felt that the trust had made only nominal changes and that they were largely left to "get on with it" after the internal investigation.

11.18 The CMHT thought the trust management had not tackled some of the team's day-to-day difficulties with support systems, either physical ones to do with their office accommodation and information technology, or personnel issues. The CMHT raised a number of issues in their meeting with us to show how they felt they were blamed for the shortfalls in service identified by the internal investigation. They thought that senior trust managers had not responded to their everyday difficulties with support systems.

11.19 To improve multi-agency working, six-monthly meetings have been established with the metropolitan police commanders, the crown prosecution service, the probation service and the directors of social services within the five boroughs served by the trust. The main aim has been to improve information sharing and risk management.

11.20 Action has been taken to improve the awareness of operational staff of the protection of vulnerable adults policy and procedures, completed in October 2006. There has been trust-wide training for all staff in relation to adult protection, child protection and public protection.

11.21 The latest available trust action plan is given in appendix D of this report.

Comment

We found that the trust had responded positively to the recommendations of the internal investigation report. There remain a number of areas for action that are contained in the recommendations of this review. In broad terms, the message for trust management is that the systems underpinning operational effectiveness needed more active oversight by managers at all levels. These include arrangements for clinical supervision, line management meetings and the day-to-day administrative support to CMHTs.

The response of Wandsworth Council

11.22 Wandsworth Council's response to the death of LW was first to commission an independent social care consultant to review the council's handling of the PW case, and then to commission a serious case review under the safeguarding adults procedure. It was completed by the same consultant in June 2007. We were given full access to both reviews

and to the case notes on PW held by the SSD. The serious case review was reported to the safeguarding adults partnership board on 18 July 2007.

11.23 The council also took action to strengthen the capacity of the team with a specialist role in relation to vulnerable adults. New safeguarding procedures were introduced and the safeguarding adults partnership board was re-launched with more senior representation from member agencies, and chaired by the director of social services.

11.24 The conclusions of the serious case review emphasise the importance of accurate record keeping, sharing of information between agencies and activation of the agreed multi-agency procedures to initiate a strategy meeting. The review makes eight recommendations that are reproduced in appendix B of this report.

11.25 In February 2006 the SSD allocated a care co-ordinator to PW and the report summarises the pattern of contact with her from that time. It notes that she continued to make allegations of financial and other forms of abuse but notes that there were no physical injuries. PW received treatment as an inpatient at Springfield Hospital under the provisions of the MHA in January 2007 and remained a patient until February 2007.

11.26 Our view is that Wandsworth Council has been active in considering the implications of the case for their services and has taken positive steps to improve action under the safeguarding adults procedures. In particular, the council has recognised that thresholds for allocation of a care co-ordinator need to take account of vulnerable adult issues. The need to gather evidence in a systematic way and make analytic judgments leading to intervention should be recognised by social care workers. The council is more aware of the danger of treating a series of incidents as unrelated events.

APPENDICES

Appendix A - Recommendations of the trust internal investigation

It has been noted by the internal investigation panel that the trust has in existence a wide range of evidence-based and fit for purpose clinical policies, protocols and guidelines. However in the course of this investigation the panel has concluded that at times individual teams may have deviated from understood corporate procedure and clinical best practice guidance. This section lists all of the recommendations identified in section eleven, and also provides some additional recommendations in regard to trust policy and procedure.

Recommendation 1

It is acknowledged by the Panel that the trust has fit for purpose referral procedures. However it is noted that the referral system operated by the CMHT needs to be more formalised in nature. Referrers to the CMHT need to know exactly what to ask for and how to initiate the appropriate actions. The CMHT needs to align its local operational procedures in accordance to trust procedure and policy.

Recommendation 2

The trust has fit for purpose Job Descriptions and Operational Policies and Procedures that define the roles and functions of key members of the Multidisciplinary Team. However it is noted that the CMHT should ensure that its senior clinical leaders monitor the continuity of care of all patients.

Recommendation 3

As a point of good practice the trust should consider the appropriateness of CMHT Team Managers holding a caseload as this may prevent them from taking an overview of the needs of the team.

Recommendation 4

The new Policy an the Care Programme Approach, Care Management, and Risk Assessment and Management, Trust-Wide Clinical Policy should make it an explicit point of guidance that a Care Co-ordinator should be appointed at the Multidisciplinary Team Meeting directly following a new client's assessment as advised by the patient's need.

Recommendation 5

The trust should provide induction and training for all new members of clinical staff deployed to a CMHT to ensure that they are familiar with the requirements of eCPA.

Recommendation 6

The trust must ensure that all members of CMHT senior clinical leadership and management workforce have their distinct responsibilities outlined in regard to workforce planning and management. The trust needs to ensure that all absences, where possible, are planned for and managed appropriately.

Recommendation 7

CMHT Team Managers and Clinical Team Leaders should be performance managed on the tangible effectiveness of their Team's compliance with trust-wide clinical operational processes.

Recommendation 8

All new doctors to the trust must be given a period of time to allow themselves an induction to their new clinical caseloads, whereby it is ensured that all case notes are read. This is especially pertinent to doctors working alone in outpatient contexts.

Recommendation 9

All doctors should receive clinical supervision for their caseload from the Clinical Team Leader who is ultimately responsible for that group of patients.

Recommendation 10

All CMHTs must ensure that their client's GPs are kept fully informed of any DNA issues.

Recommendation 11

That the trust initiates a full clinical records audit throughout its CMHT Team bases against its current Record Keeping Policy.

Recommendation 12

Clinical records should be brought routinely into clinical supervision to ensure that the supervisee is fully compliant with the trust record keeping policy.

Recommendation 13

That the trust should develop a policy on how mental health services should engage with service users who are reluctant to engage with them, and advice on what to do when attempts to engage do not succeed. This would be in line with the Confidential Inquiry into Suicides and Homicides by People with Mental Illness that stated in 1999 that all Mental Health Trusts should have such a policy.

Recommendation 14

It was noted by the Investigation Panel that no member of the CMHT knew how to operate within the context of family experiencing domestic violence. The trust should develop a clear set of guidance for the communication, liaison and support of families experiencing domestic violence from patients held as part of the CMHT caseload.

Recommendation 15

The Panel recommends that the trust considers remedial action with regard to the Tooting and Furzedown's CMHT's level of competency and functioning with a degree of urgency.

Recommendation 16

The trust Policies and Procedures are evidenced based and representative of nationally considered best practice. However they are very long. The trust should consider executive summary pages that spell out appropriate operational procedure in a concise and user friendly fashion.

Recommendation 17

New trust Policies and Procedures require a more formalised introduction into the trust. This introduction needs to take the form of training and awareness events. The informal current practice does not ensure the effective and efficient adoption of safe and appropriate practice.

Recommendation 18

It is not enough to issue Policy and Procedure. The trust should institute a formalised audit process to ensure that all Policies and Procedures are adhered to and to also ensure that appropriate actions can be taken where these same Policies and Procedures, on implementation, are found to be impractical when put into practice.

Recommendation 19

On analysis of the evidence presented to the panel it became clear that interagency working and communication processes between the trust, Wandsworth Social Services, the Police Service and Primary Care Services were not functioning at their optimum level. TW at times appeared to be passed around various services like a parcel. Once TW had been referred by one agency to another, communication and seamless working came to a sudden and abrupt halt. Although Root Cause Analysis is supposed to confine itself only to internal management issues that are within the gift of the organisation being examined, it is clear that all health and social care agencies in Wandsworth need to come together to

work through referral, communication and pathway protocols. The Police Service also needs to be explicitly included in this process.

Recommendation 20

The trust should make training around the issues regarding Vulnerable Adults mandatory. All trust clinical personnel should attend training events as a matter of urgency and maintain a register in order to ensure compliance.

Appendix B - Recommendations of the serious case review commissioned by the safeguarding adults partnership board for Wandsworth

Recommendation 1

It is recommended that Wandsworth Safeguarding Adult Partnership Board (SAPB) ensures that all member agencies are familiar with the Procedures relating to completing a Serious Case Review and in future do provide internal Management Reports. These must be written by a senior manager, who has no direct or managerial involvement with the case and must be agreed by the Chief Officer within the organisation.

Recommendation 2

It is recommended that Wandsworth SAPB clarifies with the Metropolitan Police which section within the Met will be responsible for such independent reports. It may be that Safeguarding Adults Reports will be dealt with in the same way as Safeguarding Children reports, i.e. by the Serious Crime Review Group.

Recommendation 3

It is recommended that Wandsworth SAPB amends it's procedures to clarify which section of the Metropolitan Police work with Social Services on Joint Investigation of Alleged Vulnerable Adult Abuse.

Recommendation 4

It is recommended that Wandsworth SAPB asks the Metropolitan Police to clarify which section of the Met, within each borough, will respond to requests for a Joint Investigation of Alleged Vulnerable Adult Abuse to ensure a standard response across London. This is especially important where families move between different boroughs.

Recommendation 5

Wandsworth SAPB has commissioned a comprehensive multi-agency Training Programme to support their new procedures. It is recommended that this programme is made available to relevant staff in all partner agencies, to include Social Services, other departments within the council, the Metropolitan Police, the PCT including GPs, St. George's Hospital and SWL&STG's Mental Health Trust. It is recommended that this programme needs to include:

- Recognition of Vulnerable Adult abuse
- Joint Investigation Skills
- Risk Analysis
- Clarity about the importance of medical examinations
- Clarity about the importance of evidence
- The value of a Safeguarding Conference as a mechanism to share information
- The need for follow through
- Working with Violent Service Users

Recommendation 6

It is recommended that Wandsworth SAPB ensures this training to the appropriate level is mandatory for all relevant staff. There needs to be regular refresher courses and systems in place to enable senior managers to know exactly the proportion of the workforce who are trained. There also needs to be a programme of audit to ensure that procedures are being followed.

Recommendation 7

It is recommended that each agency reinforces the importance of accurate detailed recording on files, particularly during an investigation of a potentially criminal offence. Each Agency must also be responsible for file audits to ensure this happens. This recommendation is particularly important for the CMHT.

Recommendation 8

It is recommended that each agency reinforces the need for managers to have information on all Vulnerable Adult Abuse cases. Each agency must ensure systems to record their referral to Wandsworth Older Peoples Social Services. Social Services must ensure they have systems to record the number of cases, the number of investigations and the outcomes. Each agency must record management involvement such as supervision and managers endorsing decisions made.

Recommendations 6.2 and 6.4 have wider implications that go beyond the remit of Wandsworth Safeguarding Adults Partnership and need to be considered by the London Metropolitan Police.

The Wandsworth SAPB may wish to consider that further weight is added to these recommendations by the obvious possibility that the victim of this murder could well have been PW, a Vulnerable Adult who was entitled to Protection from all partner agencies working together.

Appendix C - Terms of reference for the internal investigation panel

The investigation panel was given its terms of reference by the chief executive of the trust. The terms of reference for the Investigation Panel were to:

- compile comprehensive documentary and qualitative evidence relevant to the incident;
- recommend the scope of the internal investigation based on the above and agree this with the trust board;
- establish a clear chronology of events leading up to the incident including a chronology of police involvement with TW;
- determine any underlying causes and contributory factors using appropriate root cause analyses techniques;
- establish whether action needs to be taken with respect to policies, procedures, environment or staff;
- maintain comprehensive indexed records of the proceedings of the investigation;
- make a report to the Board by the 20 of April 2006;
- to have prepared a final report by the 3 May 2006.

Appendix D - Trust action plan (revised July 2007)

TB(06)132

TW: Wandsworth / trustwide action plan (revised 19 July 2007)

Recommendation 1 TW	Action	Progress to date	Lead	Expected Completion date	Reviewed 19 July 2007	Lead
It is acknowledged by the Panel that the Trust has fit for purpose referral procedures. However, it is noted that the referral system operated by the CMHT needs to be more formalised in nature.	The Tooting & Furzedown Community Mental Health Team must produce and implement a formal written protocol for the efficient management of new referrals. This protocol must be clearly understood and practised by the entire team.	The CMHT piloted a new referral system in May 2006. This system requires that a designated new referrals co-ordinator reviews all referrals received each day in conjunction with the Team Manager and Consultant Psychiatrist if necessary, and books them into an assessment rota. A lead assessor identified to each referral. Patient allocated to a care coordinator at the clinical multi-	Cheryl Hunter General Manager	Completed August 2006		

		disciplinary meeting immediately following initial assessment. Finally, an interim DNA policy, in accordance with Trust policy, for new referrals has been formulated to ensure that missed appointments are not overlooked.				
Referrers to the CMHT need to know exactly what to ask for and how to initiate the appropriate actions.	All South West London & St. George's CMHT's and the Tooting & Furzedown CMHT in particular need to raise the awareness of referrers of the team's functions.	A new booklet describing the functions of Community Mental Health Teams and what should be expected has been circulated amongst referrers to CMHT's	Maresa Ness Chief Operating Officer	Completed in July 2006	Update – In Use, routinely sent with assessment letters	
The CMHT needs to align its local operational procedures in accordance to Trust procedure and policy.	All South West London & St George's CMHT's and the Tooting & Furzedown CMHT must be reminded of the importance	All Team members of the Tooting & Furzedown CMHT have been given a pro-forma to write back to referrers in the event of	Cheryl Hunter General Manager	Completed in July 2006	A proforma for details for recording referrals is in place. Unclear	

	of following Trust procedure and the consequences of not doing so.	incomplete or unclear referrals in order to raise awareness of what the team needs in order to act effectively. The Tooting & Furzedown Team has had refresher sessions on the Trust's policies and understands the Trust emergency deadlines with regard to urgency. The Chief Operating Officer has reinforced the need to follow CMHT policy in a memo to all Team Managers of Community Mental Health Teams. The respective General Managers presented headline learning from the	Cheryl Hunter General Manager Maresa Ness Chief Operating Officer Stuart	Completed in June 2006 Completed Completed in June 2006	referral letter, check reference protocol check Review in August 2007	Nicola Gower Team Manager

		internal enquiry to all teams in Wandsworth. This included the requirement to follow Trust policies.	Thomson Service Director			

Recommendation 2 TW	**Action**	**Progress to date**	**Lead**	**Expected Completion date**	**Reviewed 19 July 2007**	**Lead**
The Trust has fit for purpose Job Descriptions and Operational Policies and Procedures that define the roles and functions of key members of the Multidisciplinary Team. However, it is noted that the CMHT should ensure that its senior clinical leaders monitor the continuity of care of all patients.	The Tooting & Furzedown Team must implement a caseload management system such as zoning. All team members must receive the opportunity to discuss their caseload in clinical supervision	A zoning system for Enhanced Care Program Approach patients has been implemented in the team with support from the Zoning Project Team. All staff receive supervision as specified by the Trust policy. This is to be monitored via a shared drive to which senior management has access. The database for Wandsworth is in the process of being populated.	Cheryl Hunter General Manager Stuart Thomson Service Director	Completed August 2006 Expected Completion November 2006.	Zoning is working successfully and is being reviewed regularly. Shared drive available. Need to ensure all database recorded on the drive. Regular documented updated is in place information is in place	Nicola Gower Team Manager

Recommendation 3 TW	**Action**	**Progress to date**	**Lead**	**Expected Completion date**	**Reviewed 19 July 2007**	**Lead**
As a point of good practice the Trust should consider the appropriateness of CMHT Team Managers holding a caseload as this may prevent them from taking an overview of the needs of the team.	A Trust standard is to be applied which requires that Team Managers do not hold a caseload of more than 5 clients.	All Team Managers of Community Mental Health Teams within the Trust no longer hold a caseload that exceeds 5 patients. This is monitored on a continual basis within boroughs.	Service Directors Stuart Thomson Wandsworth	Completed	Managers do not have a case load.	

Recommendation 4 TW	**Action**	**Progress to date**	**Lead**	**Expected Completion date**	**Reviewed 19 July 2007**	**Lead**
The Care Programme Approach, Care Management, and Risk Assessment, Trust-wide Clinical Policy should make it an explicit point of guidance that a Care Co-ordinator should be appointed at the Multi-Disciplinary Team Meeting directly following a new client's assessment as advised by the patient's need.	The relevant Trust policies should be reviewed (i.e. the Community Mental Health Team Policy and The Care Programme Approach, Care management and Risk Assessment policy)	A new Community Mental Health Team Operational Policy is in the final stages of being ratified. The Trust-wide Care Programme Approach, Care management and Risk Assessment policy is currently under the process of review.	Mark Potter Associate Medical Director (Wandsworth) Maresa Ness Chief Operating Officer	December 2006 December 2006	Completed Completed	

Recommendation 5 TW	**Action**	**Progress to date**	**Lead**	**Expected Completion date**	**Reviewed 19 July 2007**	**Lead**
The Trust should provide induction and training for all new members of clinical staff deployed to a CMHT to ensure that they are familiar with the requirements of CPA.	The Trust induction programme needs to be reviewed in light of this recommendation. Local induction programmes need to incorporate discussions around the requirements of CPA.	A new two-day Trust induction programme has been devised, and will be rolled out in early 2007. The CPA policy will be included in the Clinical Risk Assessment training, which will require mandatory attendance for all appropriate clinical staff. The Associate Directors of Psychology and Nursing have reminded all Tooting & Furzedown CMHT staff members of the Trust CPA and Risk Assessment requirements in	Sandy Gillett Director of Human Resources Cheryl Hunter General Manager	January 2007 July 2006	This has been rolled out. An audit is planned to monitor adherence in September 2007	Vanessa Flagg Performance Manager

		supervision, team meetings and in facilitated sessions. Additionally, the local induction to the team now comprises a discussion on Trust expectations.				

Recommendation 6 TW	**Action**	**Progress to date**	**Lead**	**Expected Completion date**	**Reviewed 19 July 2007**	**Lead**
The Trust must ensure that all members of CMHT senior clinical leadership and management workforce have their distinct responsibilities outlined in regard to workforce planning and management. The Trust needs to ensure that all absences, where possible, are planned for and managed appropriately.	A Trust-wide review of the responsibilities of the Clinical Team Leader and Team manager needs to be put in place. Service Directors and Associate Medical Directors are responsible for ensuring appropriate cover is available at all times.	A workshop was held on the 16th October 2006 at the Kairos Centre to clarify the partnership arrangements between Senior Clinical Leaders. All Senior Managers are aware of their responsibilities since the new management structure came into effect on the 1st of September 2005.	Maresa Ness Chief Operating officer Medical Director Service Directors Associate Medical Directors	January 2007 Ongoing	Continue to monitor	Vanessa Flagg Performance Manager

Recommendation 7 TW	**Action**	**Progress to date**	**Lead**	**Expected Completion date**	**Reviewed 19 July 2007**	**Lead**
CMHT Team Managers and Clinical Team Leaders should be performance managed on the tangible effectiveness of their Team's compliance with Trust-Wide clinical operational processes.	CMHT's need to be performance managed under the indicators of 1) The difference between CMIS and CPA caseloads 2) The 28 day waiters list 3) The 7 day follow-up target 4) The availability of a crisis and relapse plan 5) Up-to-date CPA records and care plans	Regular (monthly) CMHT performance reports are now produced in all boroughs, consistently meeting targets.	Maresa Ness Chief Operating Officer	Ongoing	Team now consistently meeting targets	

Recommendation 8 TW	Action	Progress to date	Lead	Expected Completion date	Reviewed 19 July 2007	Lead
All new doctors to the Trust must be given a period of time to allow themselves an induction to their new clinical caseloads, whereby it is ensured that all case notes are read. This is especially pertinent to doctors working alone in outpatient contexts.	As per recommendations. Attention needs to be paid in the area of medical induction.	Within the Tooting & Furzedown Team junior doctors are inducted by the Consultant Psychiatrist and the Team Manager in the areas of Team practice and Trust procedures and guidance using the local induction document. Trust-wide, local induction procedures are to be used to ensure their consultants properly induct medical doctors.	Alex Butt Consultant Psychiatrist Tooting & Furzedown CMHT Mark Potter Associate Medical Director Medical Director	Ongoing Ongoing	Confirmed Trust and Local	

Recommendation 9 TW	Action	Progress to date	Lead	Expected Completion date	Reviewed 19 July 2007	Lead
All doctors should receive clinical supervision for their caseload from the Clinical Team Leader who is ultimately responsible for that group of patients.	At a local level, the Tooting & Furzedown CMHT needs to improve its medical supervision arrangements.	The Associate Specialist (who is shared between two Teams) receives monthly supervision. The Consultant Psychiatrist offers weekly supervision for one hour with the Team Senior House Officer. The Consultant Psychiatrist in turn receives clinical supervision from a quarterly peer group meeting. Trust-wide these arrangements are mirrored in all boroughs.	Alex Butt Consultant Psychiatrist Tooting & Furzedown CMHT Mark Potter Associate Medical Director Medical Director	Ongoing	Confirmed, alternating between Dr Butt and Dr Hughes (neighbouring CMHT consultant).	

Recommendation 10 TW	**Action**	**Progress to date**	**Lead**	**Expected Completion date**	**Reviewed 19 July 2007**	**Lead**
All CMHTs must ensure that their client's GPs are kept fully informed of any DNA issues.	GPs must be routinely informed by care co-ordinators of any DNAs	In the Tooting & Furzedown Community Mental Health Team a local interim Did Not Attend (DNA), policy has been drawn up and discussed with Team members, which requires liaison with General Practitioners in such circumstances.	Nicola Gower Team Manager	July 2006	Written CPA Policy revisited with teams	Nicola Gower Team Manager

Recommendation 11 TW	**Action**	**Progress to date**	**Lead**	**Expected Completion date**	**Reviewed 19 July 2007**	**Lead**
That the Trust initiates a full clinical records audit throughout its CMHT Team bases against its current Record-Keeping Policy.	Local borough based rolling auditing procedures need to be developed within all boroughs.	An audit of the Tooting & Furzedown case notes was conducted from a random sample. Generally, documentation was of an acceptable standard. A rolling audit programme has been organised. All boroughs have initiated their own auditing procedures.	Paul Lewis Assistant Service Director Wandsworth Service Directors	Ongoing Ongoing	Date of next Audit September 07	Vanessa Flagg Performance Manager

Recommendation 12 TW	Action	Progress to date	Lead	Expected Completion date	Reviewed 19 July 2007	Lead
Clinical records should be brought routinely into clinical supervision to ensure that the supervisee is fully compliant with the Trust Record-Keeping Policy.	A random sample of each employee's allocated caseload records should be scrutinized in supervision sessions.	The Tooting & Furzedown Team Manager regularly reviews case files as required in supervision.	Nicola Gower Team Manager	Ongoing		Confirmed in place supervision with manager/Deputy and Clinical Leads with Medical Staff

Recommendation 13 TW	Action	Progress to date	Lead	Expected Completion date	Reviewed 19 July 2007	Lead
That the Trust should develop a policy on how mental health services should engage with service users who are reluctant to engage with them, and advice on what to do when attempts to engage do not succeed. This would be in line with the Confidential Inquiry into Suicides and Homicides by people with mental illness that stated in 1999 that all Mental Health Trusts should have such a policy.	A new Trust wide DNA policy is required.	A new Trust-wide DNA policy is currently being written and being consulted on.	Glynn Dodd Director of Service Development	December 2006	Contained within CPA policy.	

Recommendation 14 TW	Action	Progress to date	Lead	Expected Completion date	Reviewed 19 July 2007	Lead
It was noted by the investigation panel that no member of the CMHT knew how to operate within the contact of family experiencing domestic violence. The Trust should develop a clear set of guidance for the communication, liaison and support of families experiencing domestic violence from patients held as part of the CMHT caseload.	The Team must receive training in the protection of vulnerable adults procedure.	Training in the protection of vulnerable adults has been organised through Wandsworth Borough. All Team members will be trained through a team-based programme. This programme is to be rolled out across Wandsworth and monitored by the boroughs training systems. Trust-wide training for all clinical staff was delivered October 2006-January 2007. It covers: Adult Protection Child Protection Public Protection	Mark Barnard Lead Social Worker Maresa Ness Chief Operating Officer Medical Director	Training was delivered on the 25.10.06	Presentation by Mick Haggar	

Recommendation 15 TW	Action	Progress to date	Lead	Expected Completion date	Reviewed 19 July 2007	Lead
The panel recommends that the Trust consider remedial action with regard to the Tooting & Furzedown's CMHT's level of competency and functioning with a degree of urgency.	Tooting and Furzedown CMHT requires intense input to increase its performance and competency	The following actions have been taken • A new Team Manager has been seconded into the Team to improve its practise. • The Team along with all other Wandsworth CMHT's are performance managed in line with indicators as described in item 7. • An audit of Team case notes and its CPA documentation has taken place. • Learning headlines have been provided to the Team from the TW incident • An Away Day that was externally facilitated has taken place to deal with anxieties following the critical incident. • The relevant professional leads have assessed the competence of individual Team members. • The Associate Director of Psychology and the Associate Director of Nursing have examined risk assessment procedures within the Team and contributed to the	Cheryl Hunter General Manager	Completed July 2006 Review meeting held 19 July 2007 with Stuart Thomson, Mark Potter, Alex Butt, Vanessa Flagg, Martin Cottington and Costas Michael		

		new system pending the Trust-wide roll out of the new risk assessment training.
		• Written protocols and systems have been devised for
		  • Referral tracking and new assessments
		  • File tracking
		  • Lone working
		  • Dealing with DNA's				

Recommendation 16 TW	**Action**	**Progress to date**	**Lead**	**Expected Completion date**	**Reviewed 19 July 2007**	**Lead**
The Trust policies and procedures are evidenced based and representative of nationally considered best practice. However, they are very long. The Trust should consider executive summary pages that spell out appropriate operational procedure in a	All clinical policy authors will produce summaries as policies are introduced or revised.	Work in progress for 3 major policies.	Tyrone Blackford-Swaries, Governance Director (Acting)	April 2007	Implemented and monitored regularly	

concise and user-friendly fashion.						

Recommendation 17 TW	Action	Progress to date	Lead	Expected Completion date	Reviewed 19 July 2007	Lead
New Trust policies and procedures require a more formalised introduction into the Trust. This introduction needs to take the form of training and awareness events. The informal current practice does not ensure the effective and efficient adoption of safe and appropriate practice.	A Trust-wide group is devising a new two-day induction programme for all staff.	Several meetings have taken place with stakeholders.	Sandy Gillett Director of Human Resources	August 2007		

Recommendation 18 TW	**Action**	**Progress to date**	**Lead**	**Expected Completion date**	**Reviewed 19 July 2007**	**Lead**
It is not enough to issue policy and procedure. The Trust should institute a formalised audit process to ensure that all policies and procedures are adhered to and to also ensure that appropriate actions can be taken where these same policies and procedures, on implementation, are found to be impractical when put into practice.	A stronger audit and performance management culture is required reinforced by good supervision and appraisal.	Priority clinical audits have been identified in the Wandsworth Clinical Governance Group, which includes a race equality audit and note-keeping audit. These commenced in November 2006, subject to a satisfactory trial of the new audit tool by the Clinical Governance Manager. Clinical activity is performance managed in CMHT's through the regular collection (monthly) and	Mark Potter Associate Medical Director Wandsworth Performance Managers Paul Lewis Assistant Service Director Sandy Gillett	Ongoing Ongoing Ongoing November	January 2007 Trustwide record keeping/CPA/risk management audit. Monitored in Clinical Governance Group Monthly Performance meetings take place	

		monitoring of performance indicators Revised supervision policy rollout.	Director of Human Resources	2006		

Recommendation 19 TW	Action	Progress to date	Lead	Expected Completion date	Reviewed 19 July 2007	Lead
On analysis of the evidence presented to the panel it became clear that inter-agency working and communication processes between the Trust, Wandsworth Social Services, the Police Service Primary Care Services were not functioning at their optimum level. TW at times appeared to be passed around various services like a parcel. Once TW had been referred by one agency to another, communication and seamless working came to a sudden and abrupt halt. Although Root Cause Analysis is supposed to confine itself only to internal management issues that are within the gift	Local multi-agency meetings have taken place.	Six-monthly meetings have been established with the 5 Borough Commanders and now also include the Crown Prosecution Service and Probation Directors of Social Services. Three meetings have taken place to date with the CEO. COO, Service Directors and Trust Police Liaison Officers. The main focus is information sharing and risk management. The current information sharing agreements that have been signed by Local Authorities and the Trust are now being shared with the 5 Borough Commanders to explore 3-way sign-up.	Stuart Thomson Service Director Maresa Ness Chief Operating Officer	Ongoing Ongoing		

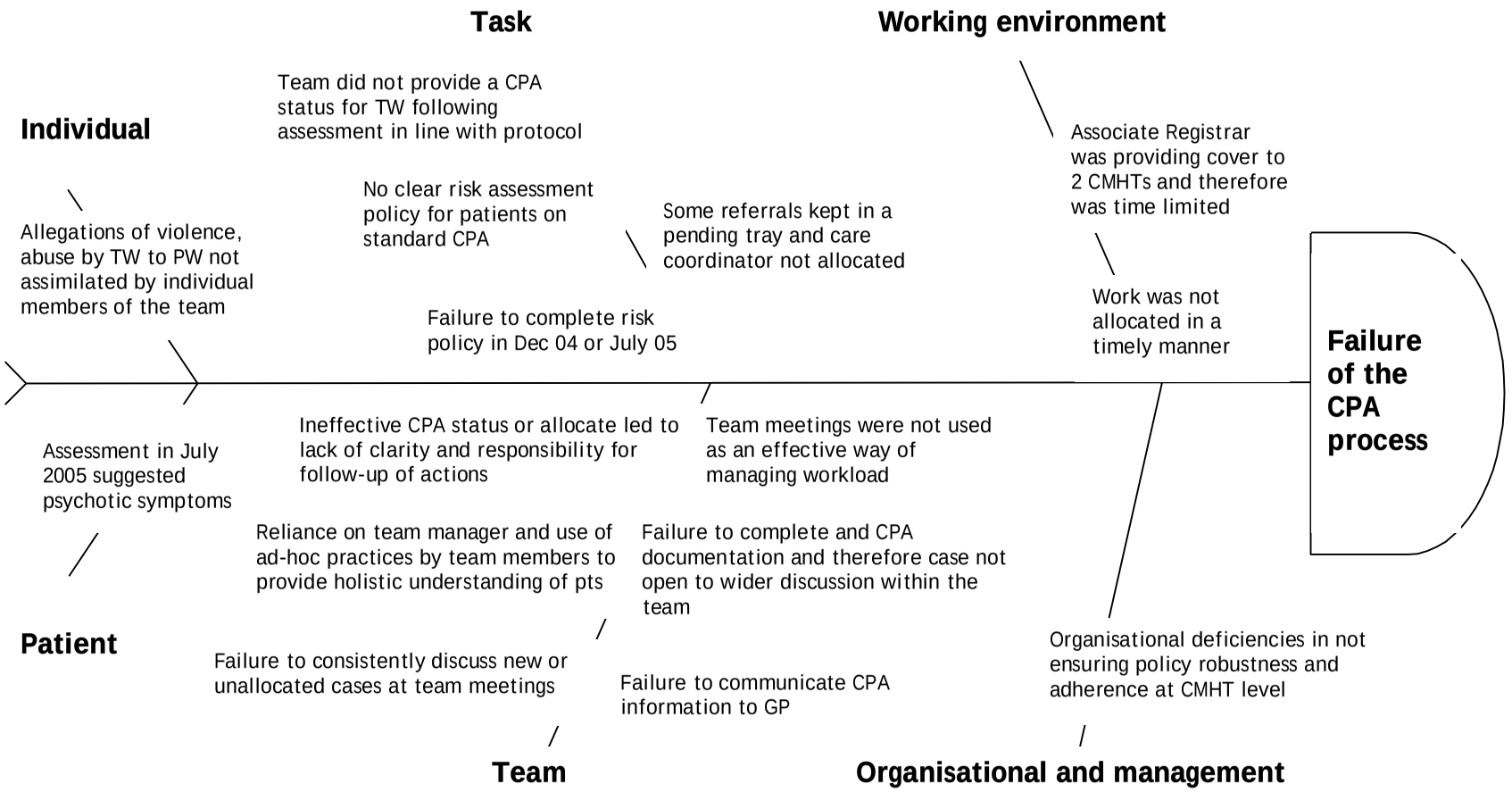
of the organisation being examined, it is clear that all health and social care agencies in Wandsworth need to come together to work through referral, communication and pathway protocols. The Police Service also needs to be explicitly included in this process.						

Recommendation 20 TW	Action	Progress to date	Lead	Expected Completion date	Reviewed 19 July 2007	Lead
The Trust should make training around the issues regarding vulnerable adults mandatory. All Trust clinical personnel should attend training events as a matter of urgency and maintain a register in order to ensure compliance.	There is a need to oversee and monitor training.	At present, local arrangements are in place to record and review/monitor training via a database and meetings procedure. In addition to all mandatory courses specified by the Training & Development Department, local arrangements now permit the Training, Education & Development Committee (WTED) to give each mandatory course a priority level, attached to the course and staff group it targets.	Paul Lewis Assistant Service Director Darren Langridge Performance Manager Sandy Gillett Director of Human	Ongoing Ongoing Ongoing	Database being used Rolled Out	

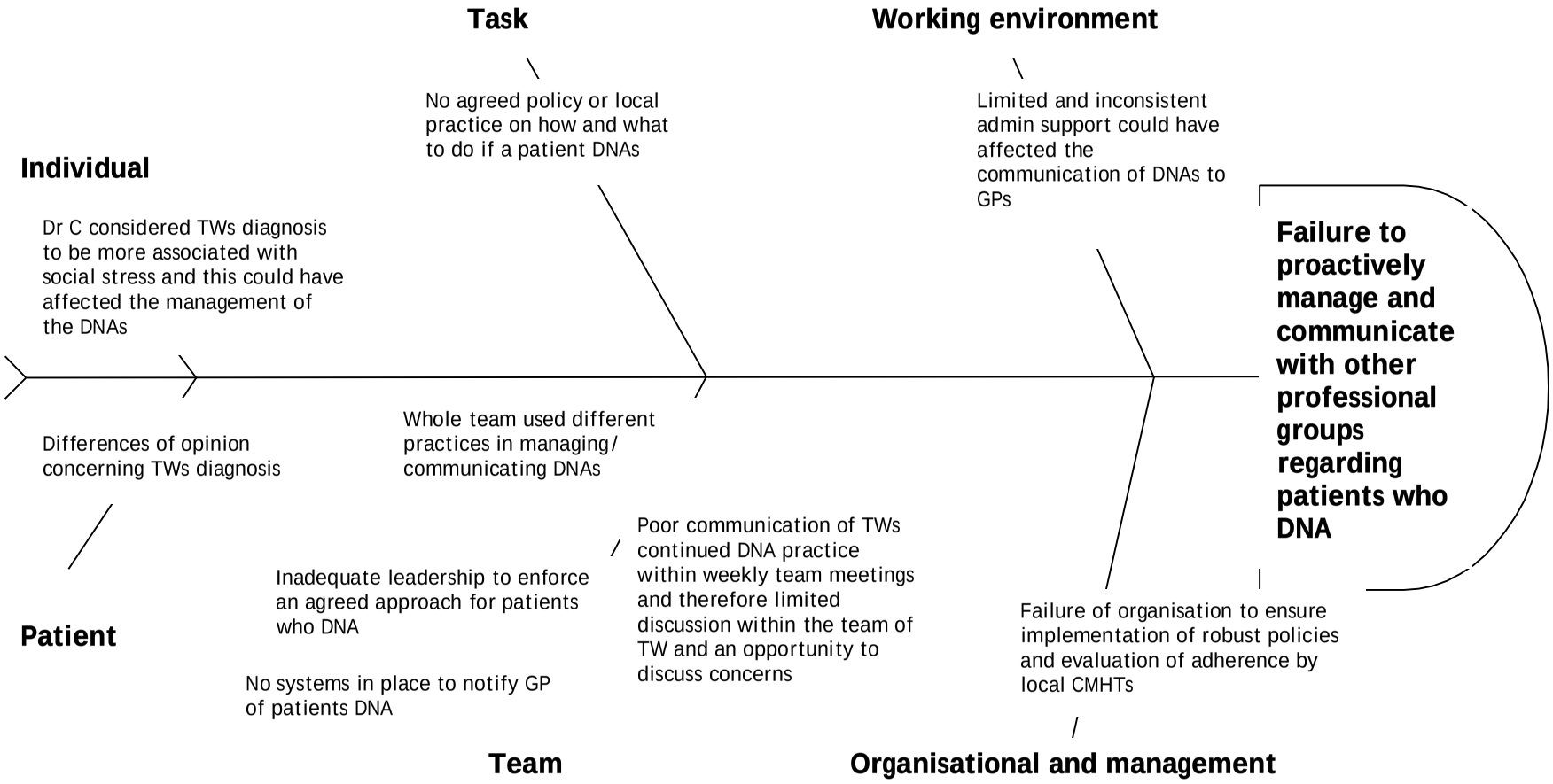
		At a Trustwide level, a new electronic staff record system (ESR) is being implemented, and this will capture training attendance for each staff member. This information will be used to review/monitor training at a local level, and discussions in shortfalls will be addressed in staff supervision. The Training & Development Department are to be trained in the scope and functions of ESR before it goes live. The Training & Development Department are	Resources Daran Golby Workforce Development Manager Daran Golby Workforce Development Manager	December 2006 Ongoing	August	

		currently revising the Mandatory & Statutory training list; the revision will include Risk Assessment training, and a section for profession-specific training needs.				

Appendix E - CPA fishbone



Appendix F - DNA fishbone



Appendix G - TW timeline – outlining main sequence of events

Key to timeline

DC N = Simon Nolan (police detective constable)

Dr B = Dr Tahmina Baksh (senior house officer)

Dr C = Dr John Colgan (elderly care consultant)

Dr Ch = Dr Choudhury (associate specialist)

Dr G = Dr Gangdev (consultant psychiatrist)

Dr R = Dr Rohde (general practitioner)

Dr S = Dr Smith (general practitioner)

E OD = Emmanual Ofori–Danso (community psychiatric nurse)

Dr V = Dr Bernadette Veiras (general practitioner)

JW = Jeremy Walker (team manager for Tooting and Furzedown CMHT)

LW = wife of patient and victim

MW = son of patient

PH = Phil Howell (approved social worker, older peoples services of Wandsworth social services)

PW = mother of patient

RW = nephew of patient

SA = Sue Armstrong (social worker within Tooting and Furzedown CMHT)

TW = patient

Date/Time	24 May 2004	1 September 2004	6 October 2004	11 October 2004
Event	TW registered as a new patient with the Howard Freeman Practice.	A neighbour made allegations about TW's treatment of PW.	DC SN visited PW in response to further allegations about TW's ill treatment of her.	TW attended Tooting Police Station alleging that his mother's neighbour was harassing her. The police noted that TW had put his mother's house on the market.
Additional Information	At this time he was also becoming known to Wandsworth Council older adults services and the metropolitan police because of concerns about the welfare of his mother PW.	This led to a visit by Detective Constable (DC) Simon Nolan and Phil Howell, a Wandsworth Council older adults services social worker.		
Good Practice				
Source of Material	Trust Records	Trust Records	Trust Records	Trust Records

Date/Time	30 November 2004	6 December 2004	8 December 2004
Event	During a visit to PW, DC SN had an opportunity to speak to TW. He alleged that he was in communication with his deceased father and that money had been stolen from his mother's house. DC SN later rang PH to inform him of the outcome of his visit.	The police received a third-party report advising that TW had moved into his mother's house.	PW alleged that she was unhappy in her home and went to stay with TW's nephew.
Additional Information			
Good Practice			
Source of Material	Trust Records	Trust Records	

Date/Time	12 December 2004	13 December 2004	15 December 2004	16 December 2004
Event	Phone call from PH to SA due to concerns about PW.	SA makes entry in clinical notes. PW made allegations of cruelty and neglect by TW. Mother had moved to grandson's house for safety.	SA met RW, TW 's nephew and he alleged that TW was abusing his mother. Tried to punch her in the eye, sexual abuse and not feeding her properly. Trying to sell PW's house.	SA contacted police and had a discussion. DC N was advised that CMHT would only get involved if there was evidence of mental illness
Additional Information			Discussed at team meeting. Agreed joint visit should take place with police.	
Good Practice				SA contacted police promptly to find out more information.
Source of Material	Trust Internal Investigation Report	Trust records	Trust records	Trust records

Date/Time	20 December 2004	06 June 2005	16 June 2005	22 June 2005
Event	Notes report that DC N had visited TW at his mother's house and that TW was paranoid and hearing his father's voice. TW thought he was a ghost. Believed others were trying to get access to his mother's house.	TW presented at GP surgery (seen by Dr R) complaining of weight loss. He appeared stressed and anxious.	TW presented at GP surgery again, this time seen by Dr V. It was noted he was agitated and could not sit down for long. TW asked to be referred to a psychiatric specialist as he was hearing voices. A psychiatric referral was made.	Referred by GP to CMHT
Additional Information	Neighbour reported alleged abuse of PW. Case discussed with JW who said he might be able to visit. Information obtained by SA.		Referral letter made by Dr V on 22 June 2005 to Dr G.	
Good Practice				
Source of Material	Trust records	GP Notes	Dr V Referral letter	Dr V Referral letter

Date/Time	26 June 2005	01 July 2005	04 July 2005	04 July 2005
Event	Letter received by CMHT and TW allocated to Dr B (Senior House Officer).	TW phoned at home by CMHT to notify him that a home visit would take place on 4 July 2005. Letter sent by CMHT confirming appointment.	TW seen at home in the presence of his wife (LW) by Dr B and JW. TW risk assessed as suicide risk low to moderate and risk to others low. TW still c/o weight loss and low mood. TW talked about being a carer to his mother and mentioned that the police had been called due to an argument he had with his son. Medication prescribed. Decision made to follow up at Clare House.	Message left in the telephone message book for JW regarding a message from PC N concerning TW.
Additional Information			Plan: start medication: Risperidone and Diazepan. Contact Dr C regarding mother. TW to be seen by Dr B on 1st August 2005	
Good Practice		Letter sent to TW on 1 July 2005 for 4 July 2005.	Full and complete record of this assessment contained in the notes.	
Source of Material	Trust records	Trust records	Trust records	Telephone message book

Date/Time	05 July 2005	06 July 2005	06 July 2005	06 July 2005	1 August 2005
Event	Letter in notes outlining conversation between JW and DC N.	Telephone call between Dr C and Dr B.	Case discussed at the MDT. JW not present. Decision made that concerns about TW should be discussed with the police. Dr B had a discussion with Dr C.	Letter sent to Dr S (GP) outlining assessment of TW and management thereafter.	Previously on 4 July an appointment with Dr B was scheduled for 1st August 2005, but this did not take place.
Additional Information		Dr C last saw PW on 23 June 2005. Felt not to have dementia and there were more likely to be problems with children. Dr C advised more information to be obtained from PC N.		Letter ended with Dr B suggesting a follow-up appointment with TW at Clare House on 1 August 2005 at 10am. Dr B then went on maternity leave and this appointment was not actioned.	Dr B went on leave and the TW case was not handed over to another Dr until later in the month
Good Practice					
Source of Material	Letter from JW in SWL and St Georges MHT notes	Trust records	Trust records	Trust records	Trust Records

Date/Time	07 September 2005	08 September 2005	02 November 2005	30 November 2005
Event	TW (accompanied by LW) seen by Dr Ch at Clare House. TW diagnosis was changed to mixed anxiety and depressive reaction. TW had stopped taking his medication. TW said he was too frightened to leave the house due to threats from nephew.	Letter from Dr Ch to GP outlining that next appointment with TW would take place on 2 November 2005	TW did not attend outpatient appointment.	TW did not attend outpatient appointment.
Additional Information	Decision made to review TW in eight weeks time. Medical notes were not available/reviewed by Dr Ch at this appointment	Diagnosis changed to Mixed Anxiety and Depressive Reaction. Commenced on Citalopram. Symptoms were directly related to emotional disturbances, distress and stressors seemed to be triggered with a number of social issues as well as a fear of being picked up by the police following LW's complaints.	Another appointment offered for four weeks time.	Another appointment offered for four weeks time.
Good Practice				
Source of Material	Trust records	Letter from Dr Ch in SWL and St Georges MHT Notes	Trust records	Trust records

Date/Time	11 January 2006	13 January 2006	18 January 2006	31 January 2006
Event	TW did not attend outpatient appointment.	Clinical notes show that TW was discharged.	Letter sent from Tooting and Furzedown CMHT to TW suggesting he will be discharged back to GP due to 3 x DNA, if they did not hear back from him within two weeks.	TW discharged from CMHT caseload.
Additional Information	Letter written to TW advising that if he did not contact services within two weeks he would be discharged. Letter copied to TW's GP.			
Good Practice				
Source of Material	Trust records	Trust records	Trust records	Serious Untoward Incident Draft Timeline

Date/Time	01 February 2006	03 February 2006	03 February 2006	03 February 2006
Event	LW rang to say that TW does not need to be seen.	Dr R rings Tooting and Furzedown CMHT and asked for TW to be visited as soon as possible.	Dr R (GP) faxed a request for an urgent home visit to assess TW.	Dr R rang to say he had seen TW again and he was much calmer. Asked for TW to be followed up.
Additional Information			Referral prompted by allegations from TW's son (MW) that TW had been physically aggressive to both his mother and wife.	
Good Practice		Dr R followed procedure to obtain help for TW.		
Source of Material	Telephone message book	Telephone message book	MDT notes and SUI draft timeline (Handwritten draft letter to E from Dr R)	

Date/Time	07 February 2006	08 February 2006	09 February 2006	10 February 2006
Event	Message left for JW by TW son who rang to say they do not need anyone from the Tooting and Furzedown CMHT to visit.	TW rang the CMHT and said he did not want to be seen	JW wrote to Dr R suggesting that TW may need to be assessed at home under the Mental Health Act.	GP rang JW and said he would still like TW to be seen. JW agreed to carry out a home visit.
Additional Information				
Good Practice				
Source of Material	Telephone Message Book		Trust records	SUI draft timeline

Date/Time	10 February 2006	10 February 2006	13 February 2006	15 February 2006
Event	JW and Dr Ch arranged to visit TW on 13 February 2006.	JW rang TW's house (hoping to speak to LW). TW answered the phone and said everything was alright.	Decision made not to go and see TW without advance warning.	TW discussed at MDT. Decision made to see him at home without advance warning.
Additional Information				
Good Practice				
Source of Material		SUI draft timeline	Trust records	Trust records

Date/Time	17 February 2006	17 February 2006	19 February 2006
Event	JW emailed Dr Ch and suggested visiting on 24 February 2006 or 28 February 2006.	TW stabbed LW resulting in her death.	TW seen by liaison psychiatry.
Additional Information			
Good Practice			
Source of Material	Email from JW to Dr Ch	Police reports	SUI draft timeline

Appendix H - Record of witness hearings completed

Key to interviewers:
AW – Alan Watson
DW – David Watts
SA – Sally Adams
CB – Chris Brougham

Witness	Title/role	Interviewers	Date of interview
TrW	TW & LW's daughter	AW/DW/SA	30 January 2007
MW	TW & LW's son	AW/DW/SA	30 January 2007
Dr Choudhury	Associate specialist with CMHT	AW/DW/SA	31 January 2007
Dr Alex Butt	Consultant psychiatrist	AW/DW/SA	1 February 2007
Jeremy Walker	Team manager/Leader: CMHT	AW/DW/SA	1 February 2007/7 March 2007
Dr Simon Rohde	TW's GP	AW/DW/CB	5 February 2007
Phil Howell	ASW	AW/DW/CB	6 February 2007
Belinda Murphy	QA contract & review manager council safeguarding adults lead officer	AW/DW/CB	6 February 2007
Paul Mc Hugh	Interim director of social services/chair of safeguarding adults board	AW/DW/CB	6 February 2007
Robert Sookoo	Wandsworth south manager	AW/DW/CB	7 February 2007
Stuart Thomson	Wandsworth borough director	AW/DW/CB	7 February 2007
Des Muller	Trust social services lead	AW/DW/CB	7 February 2007
Emmanuel Ofori-Danso	CPN with CMHT	AW/DW/SA	19 February 2007
Susan Armstrong	ASW with CMHT	AW/DW/SA	19 February 2007
Jill Shears	Secretary	AW/DW	20 February 2007
Maresa Ness	Trust operations manager	AW/DW	20 February 2007
Dr Simon Rohde	TW's GP	AW/DW	20 February 2007
Dr Veiras	TW's GP	AW/DW	20 February 2007
Donzaleigh Wilson	Secretary	AW/DW/SA	1 March 2007
Costas Michael	Acting team manager/CPN	AW/DW/SA	1 March 2007
Tahmina Baksh	Previous SHO	AW/DW/SA	1 March 2007
Dr John Colgan	Consultant psychiatrist older persons team	DW/SA	15 March 2007
AY	TW's sister	AW/DW/CB	23 April 2008
Simon Nolan	Community PC	AW/DW	24 April 2007

Appendix I - Reviewed documents

1. Trust organisational chart
2. Wandsworth Key Staff (15/12/2006)
3. Policy on the care programme approach, care management and risk assessment and management (March 2003)
4. Community Mental Health Team operational policy, adult directorate (September 2003 to September 2006)
5. Management supervision policy (September 2005)
6. Job description - clinical team leader
7. Risk assessment policy and guidance (July 2006)
8. Policy and procedures for safeguarding vulnerable adults (September 2006)
9. Protecting vulnerable adults: inter-agency guidelines for Wandsworth (revised 2003)
10. The protection of vulnerable adults and borough multi agency management committees (March 2004 to March 2007)
11. Development review policy and procedure: trust-wide policy and procedure (October 2006)
12. Performance report: Wandsworth quarter 2 July to September 2006
13. Performance report: Wandsworth quarter 4 January to March 2006
14. Initial assessment protocol Tooting and Furzedown CMHT (6 July 2006)
15. New assessment protocol Tooting and Furzedown CMHT
16. Referral pathway and initial assessment protocol for Tooting and Furzedown CMHT (July 2006)
17. Community visiting policy including lone worker
18. File tracking system
19. Initial action plan: Tooting and Furzedown CMHT implementing robust systems (meetings and minutes 13 July 2006)
20. Record keeping check – Tooting and Furzedown (19/20 June 2006)
21. Team contacts - November 2005 to January 2006
22. Team contacts - February 2006

23. Contact following discharge - February 2006

24. GP referrals audit - February 2006

25. DNA rate - December 2005

26. 28 day readmission rate

Appendix J - List of abbreviations

CMHT	Community mental health team
CMIS	Clinical management information system
CMP	Care management problems
CPA	Care programme approach
DC	Detective constable
DH	Department of Health
DNA	Did not attend
eCPA	Electronic care programme approach
GP	General practitioner
HR	Human resources
MHA	Mental Health Act 1983
PCT	Primary care trust
POVA	Protection of vulnerable adults
RCA	Root cause analysis
SAPB	Safeguarding adults partnership board
SHA	Strategic Health Authority
SSD	Social services department