Report of the Woodley Team

This is an overview of the report produced by the Independent Review Team headed by Len Woodley QC into the killing which took place in Worland Day Centre in Newham, East London July 1994. In comparison with some other Inquiry Reports the Woodley Report is relatively little known but it does raise important issues for housing and community care services and especially for providers of day centre facilities.

The case

The killing was sudden and ferocious with the victim (identified in the report as BB) *[Brian Bennett]* receiving over sixty stab wounds. Both the perpetrator (identified in the report as SL) *[Stephen Laudat]* and the victim were users of mental health services in Newham. BB had used the day centre for many years whilst SL had become a regular user of the drop-on run by the Homelessness Outreach Support Team (HOST) which shared premises with the day centre. Just eight days before the fatal incident the Health Authority and the Social Services Department removed SL's name from the '117 Register', thus bringing to an end their statutory aftercare duties; at the same time the HOST team supporting SL closed his case.

Like other similar reports the authors take a broad view of the events, hearing evidence on and looking into all the circumstances and background. In particular the report considers the treatment and care given to SL, tells the story of the actual incident, and looks at what happened to the day centre users, staff, relatives and others who were affected (and in many cases traumatised) by the event. Like those reports it makes compelling, if sometimes depressing, reading as it tracks one person's mental health problems and journey through homelessness, prison, and secure unit back into the community; and while the authors state that 'the killing could not reasonably have been prevented on the day' it highlights in sharp relief the need for good safety measures to minimise the risks in running drop-in day centre services.

The perpetrator

SL was born in Newham in 1968 to parents who had emigrated from Dominica. His mother had a history of schizophrenia, and his parents separated when SL was three years old although his father kept in close contact. Newham Social Services were involved with the family although this involvement was adult centred (concerned with his mother's mental health) rather than child centred (looking at the effect of the mother-s behaviour on the children). After doing well at school he worked for a local electronics company between the ages of 17 and 21.

SL's mental health problems stared to emerge around the age of 21. He left his job suddenly and for no apparent reason, he was referred to CPN for persistent and lengthy panic attacks, and he received outpatient treatment at Newham General Hospital. Later he was diagnosed as suffering form schizophrenia. He left home and moved between his

father's house, his brother's, and a cousin's flat. He approached Newham Housing Department for help but was not seen as in priority need: 'Ironically, had the reasons for his vulnerability been recognised at this stage, he would have been assisted as a homeless person.'

In early 1991 he attempted a series of robberies on shops, threatening the store owners with a knife. He was arrested, held on remand, and after sentencing sent to prison. It was not until six months later that his mental health problems were acknowledged as having a bearing on his offending behaviour. He was then transferred to a secure unit at Hackney Hospital for four months before going for eighteen months to Kneesworth House, a large and privately run hospital where the care and treatment was described as 'barely adequate'. During his time in prison and in hospital there were repeated incidents where SL assaulted prison officers and hospital workers.

In December 1993 he was discharged to a Bed and Breakfast hotel following a review meeting that didn't involve either his GP or the Consultant Psychiatrist who would become responsible for his care. He was also assigned a keyworker form the Homeless Outreach Support Team (HOST) which was a part of Newham Social Services. Neither of the people who subsequently became his keyworkers had much experience in mental health work, but they were regularly supervised and both were highly commended for their work.

"Our main criticism over the period of SL's care and treatment in the community (which lasted for just six months) is that attempts to provide him with good social care were undermined by inadequate health care … we were impressed by the approach, commitment and sensitivity shown to SL by two inexperienced and unqualified workers (from HOST). This was not matched, or supported, by more experienced health colleagues."

The main aim of the HOST keyworkers was to help SL though the transition into more settled accommodation. His stay in B&B lasted for two weeks after which he was offered a temporary private flat. Five moths later in May 1994 he took up a tenancy with East London Housing Association. Neither Newham Housing Department or the Housing Association were informed of SL's history of violence.

In January 1994 SL was referred to the Worland Day Centre (who were also not informed about the history of violence). The Worland Centre is run by Social Services for people with mental health problems and offers a programme of structured activities. SL visited but didn't engage with the day centre and was not entered as a client. He did however regularly use the drop-in sessions run by HOST in the same building, sometimes going as often as four times a week. The HOST drop-in consists of a small reception area with soft chairs and a friendly environment leading to a central area shared with the day centre which contains a tea bar and a games table. SL became friendly with some of the others who came including the cleaner – with whom he enjoyed playing music and swapping tapes. As one of the workers commented:

"Whilst he did not want to participate in any of the activities he could use it to sit down, listen to music, play pool and that is the way in which he wanted to use the day centre services… He was using the drop-in informally for social relationships."

One of the themes throughout the report is that as a young black man SL was very poorly served by many of the mental health services. The users of the Worland Day Centre were mostly aged between 40 and 60 and predominantly white. In hospital and prison there was a disproportionately high number of black patients but almost no black staff to whom he could relate. (SL's father commented ruefully: 'As a black boy I know my son will be drugged up in your prison and hospital. I don't expect the best for my son, I expect the worst'). Throughout the period it was the keyworker from HOST, who was black and recruited by HOST using Section 5.2d of the Race Relations Act, who was most effective in supporting SL.

Since his discharge from hospital in December 1993 there had been almost no health service follow-up, no CPN involvement, no professional advice given to HOST, and little action taken when SL did not keep his appointments. There was a statutory aftercare review meeting held in June 1994 which went ahead without SL's GP or even SL's Consultant Psychiatrist. The meeting was brought to a close half way through when the duty psychiatrist who was chairing the meeting was called away. No minutes were taken or distributed. Although no final decision was made there SL's name was subsequently removed form the '117 register' and Social Services and the district health authority ended their period of statutory duty to provide aftercare. He was also told that he could continue to use the host drop-in but his case would be closed and he would no longer have a keyworker. This was consistent with the HOST team's policy of working for people for a temporary period whilst they move into permanent accommodation but in the authors' view *'was premature, not in SL's best interests, and not in keeping with the broader principles of community care.'* The paperwork for SL's discharge from aftercare was completed just eight days before the killing.

SL had made progress in the six months from leaving hospital but around this time in June 1994 his mental health deteriorated 'gradually but severely'. He had a dispute with a neighbour with whom he had previously been very friendly and began to act more strangely. By his own account he lost all self-control over the voices he was hearing, which led to the fatal killing.

The incident

BB was in his mid 50's and had lived in Newham all his life. He was described as a 'quiet family man' and looked after his elderly mother. He had used the Worland Day Centre for five or six years: it was where he did the crossword with his friends, helped organise social events and helped out on the rota as a 'user receptionist'.

SL met BB for the first time at he centre a few days before the fatal incident and, in his delusional state, became convinced that BB was one if the Kray twins. On Wednesday 27 July he returned to the day centre, entered the room where most of the users were, took

out a knife and repeatedly stabbed BB. Some users shouted at him to stop, another ran to get help from staff (who were all in a distant room having their staff meeting), a social work manager who happened to be in the building also tried to appeal to SL to stop, and shortly afterwards a policemen arrived who persuaded SL to put down the knife.

The aftermath

One of the final sections of the report movingly documents the aftermath and the distress and the trauma for both sets of relatives, the workers involved, SL's neighbours, and the other day centre users. Many good steps were taken to provide specialist counselling and follow-up support but still what comes through strongest is the grief and shock people were still living with one year one: 'staff and service users are left with feelings of 'if only' they had done something, the tragedy may have been prevented', and when the authors met with SL he talked about 'the harm that he had done to BB and his family, and was expressing deep remorse for what had happened'.

Safety issues for the day centre

The Review Panel reiterates that this was an unpredictable attack that could not have been prevented by anyone's actions on the day.

Nonetheless the report highlights several areas of concern which are relevant for other centres and drop-in services.

Inadequate cover arrangements

The Day Centre workers held their weekly staff meeting on Wednesday lunchtime in a room down lengthy corridors which was a minutes and a half's walk from the main body of the Day Centre. This left service users in the building unsupervised and 'meant that safety standards for the Day Centre service users were inadequate'.

Problems over shared use of premises

The Worland Day Centre premises were shared between the Day Centre, HOST and a crisis intervention project. There was a history of tension and confusion "with Day Centre staff and users feeling imposed upon". Users for the HOST drop-in came through a separate side entrance but, once in the building, used some of the same facilities including the tea bar ad central area. SL was not a client of the Day Centre (although he had been referred) but he did come regularly to the HOST drop-in.

Reception arrangements

It is unclear how SL got into the building. He was not seen by any of the HOST workers and didn't go into the HOST reception. Access at the main entrance the Day Centre was via a push-button entry system operated by a person on reception. The reception was not being monitored by workers who were in the staff meeting in another part of the building.

One immediate change after the incident was to introduce a more rigorous ‘signing in’ procedure at the Day Centre.

Failure to pass on information about the risk of violence

HOST were aware of SL’s history of violence (the top sheet of his file was marked to make this clear to all HOST workers and volunteers) but other services to which HOST had referred SL were not informed. This included the Housing Department, his Housing Association, and Worland Day Centre. The authors recommended that where there is a risk of violence this must be disclosed on a ‘need to know’ basis to other agencies providing community care services.

Other issues for day centres

The importance of ‘court diversion’ schemes

The link between SL’s mental health problems and his offending behaviour was not acknowledged when he was first before the courts and an important opportunity for intervention and support was missed: ... our findings add support to the current policy of diverting people with severe mental health problems, so far as is possible, away from the criminal justice system.

The use of B&B accommodation

Due to a chronic lack of planning, not helped by a shortage of appropriate accommodation, SL was discharged, after three years in prison and psychiatric hospital, to a B&B hotel: *"It is the recommendation of this report that bed and breakfast should not be used for homeless people with mental health needs."*

Confidentiality

... housing authorities and housing associations must have a policy on confidentiality which enables transmission of personal confidential information on the basis of ‘need to know’ for the purposes of determining suitable hosing allocation, and for the subsequent protection of service users, staff, and members of the public.

*Race and mental health**

"... if mental health services are to work effectively for black and minority ethnic groups, racism in all its forms must be identified and recognised. There are many strategies that health agencies can use to address this: equal opportunities policies for service access, ethnic records and monitoring, interpretation and language facilities, … , and developing ways of combating racial harassment."

The need for longer term support work

Like many resettlement agencies HOST was set up to provide short term support and had *'a policy of case closure once people were in permanent accommodation'*. However *'SL had established a relationship of trust with his key worker. To transfer him to another worker may have jeopardised his acceptance of ongoing assistance'* and *'in terms of outcomes SL had not secured training or employment for himself, no individualised day programme was offered other than his contact with HOST drop-in service, and his social isolation was not fully addressed.'*

The Woodley Team Report is available from: East London and City Health Authority 97-99 Bow Road London E3 2AN 020 8983 2900

http://handbooks.homeless.org.uk/daycentres/risks/woodley