THE REPORT OF THE INQUIRY INTO THE DEATH OF MR DAVID PHILLIPS

Report of the Independent Inquiry Team to
Kensington & Chelsea and Westminster Health Authority
and Westminster City Council

April 2000

REPORT OF THE INQUIRY

INTO THE DEATH

OF MR DAVID PHILLIPS

The Inquiry was set up in August 1999 to undertake an independent investigation into the death of Mr David Phillips. It was commissioned jointly by Westminster Social Services Department and Kensington & Chelsea and Westminster Health Authority.
The Inquiry began work in October 1999.

The Inquiry would like to thank all those who contributed to its investigation either in writing or by meeting with the Panel. Without the cooperation given its task would have been very much more difficult.

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1. INTRODUCTION

1.1 Outline of events

David Phillips, a resident at 42 Queen's Gardens, Bayswater, a rehabilitation hostel for people with mental health problems, was stabbed to death by Andre da Conceicao, a previous resident of the hostel, on 25 September 1998.

Andre, a refugee from Angola, entered Britain in July 1995, taking up residence in Paddington, in the north of Westminster. There is a lack of firm evidence but apparently several months of heavy substance misuse followed, culminating in a compulsory admission to Park Royal Centre for three months. He was diagnosed there as suffering from polymorphic psychotic disorder.

On discharge in June 1996 to a bed and breakfast hotel in Nottingham Place W1, in the south of Westminster, he was referred to the West End Community Mental Health Team (CMHT) where he received substantial care and support from a psychiatrist, a community psychiatric nurse (CPN) and a care manager. The latter continued as his care manager and Care Programme Approach (CPA) key worker for just over two years, providing a continuity of support broken only by a period of professional training in the latter part of 1997. For a year he remained in the care of the West End CMHT who treated both his mental health difficulties and problems in relation to his asylum-seeker status and accommodation. The psychiatrist treating him described him in September 1996 as 'very psychotic'.

In October 1996, application was made for a place at 42 Queen's Gardens but admission was delayed because of building works there. Three months later, in January 1997, Andre was admitted on a voluntary basis to the Gordon Hospital to check on his disturbed sleeping patterns. He was kept under observation for a week and given a final diagnosis of paranoid schizophrenia.

In February 1997, following his discharge from hospital, Andre finally took up residence at 42 Queen's Gardens and was assigned a key worker from among the staff. By April 1997, a CPA meeting held by the West End team noted that his progress at the hostel was substantial, an observation confirmed by a further CPA meeting in June 1997.

At this point, because Andre had moved from his bed and breakfast placement in the south of Westminster, which was within the West End CMHT patch, to the hostel in Bayswater, responsibility for his clinical care was formally transferred to another team, the Community Rehabilitation Assertive Focus Team (CRAFT). This was a 'supra-locality' team, concerned particularly with assertive outreach but also carrying a subsidiary responsibility in north Westminster for hostel residents with a severe and enduring mental illness. Partly as a result of the Social Services Department (SSD) policy, partly because there was no social worker in the CRAFT team, responsibility for Andre's care management remained with the West End CMHT. His diagnosis at handover was paranoid schizophrenia.

In July 1997, Andre was seen by the CRAFT psychiatrist who diagnosed him as suffering from drug-induced psychosis. Depot medication was stopped but anti-depressants continued to be prescribed for a further five months. Throughout the rest of the year Andre lived at 42 Queen's Gardens, reportedly in some form of part-time employment and remaining free of psychotic symptoms. Active care management came temporarily to an end between September 1997 and January 1998 when the care manager was away on a training course, though it resumed in February 1998 on her return. In December 1997, he was taken off his remaining medication by the CRAFT team psychiatrist.

Records from the Social Services Department and from 42 Queen's Gardens indicate that, although appearing to have made a remarkable recovery, Andre remained an enigma to his key worker and care manager: secretive about his background and elusive about his source of income and good quality clothes. It was noted on a number of occasions in the Social Services file that he had a predisposition to violence when under stress and was a troubled individual under his smart and able exterior.

In December 1997, and again in February and March 1998, he was involved in violent incidents, the first time in a record shop with an assistant, twice in the hostel with the visitors of other residents. Despite this, and because of his apparent recovery and the increasing inappropriateness of his placement at the hostel, efforts began to be made in early 1998 to find alternative accommodation. As an asylum-seeker, his only option was to return to bed and breakfast and a place was found, despite his reluctance to move, in a nearby hotel in Bayswater. He moved into the hotel on 22 April 1998.

Two weeks later, on 6 May, he was discharged from CRAFT's caseload. Between early January 1998 and 6 May, he was seen only once in passing by the CRAFT team CPN. Queen's Gardens offered their normal outreach service to Andre and he visited the hostel on several occasions up to the beginning of August 1998.

On 31 July, the care manager and the hostel key worker held a review meeting with Andre. He was described at the meeting as evasive, physically restless and avoiding eye contact. It was concluded that he was more a risk to himself than to others and the case was formally closed by Social Services. From this date, he had no formal connection with any of the mental health or social services. His last informal contact with 42 Queen's Gardens was when he attended the hostel summer party on 6 August when all the staff commented on how well he looked.

On 9 September 1998, Andre was arrested in Hammersmith for an unprovoked attack on a Japanese tourist. Following a mental health assessment, he was compulsorily admitted to Blair Ward, a secure unit run by the West London Mental Health Trust at Ealing. Diagnosed as suffering from some form of psychotic illness, he remained there until 24 September, when he escaped early in the morning through a bathroom window. The local police were informed and his details were circulated as a Missing Person.

He turned up at 42 Queen's Gardens about mid-morning. Hostel staff phoned Blair Ward to alert them and a group of nurses was gathered together to go and retrieve him. By the time they reached Bayswater, he had disappeared. He then re-appeared at the hostel about the same time as the team of nurses arrived back at Blair Ward. Attempts were made by two senior nurses to secure co-operation from the Paddington Green police to hold him until a second team could arrive but the police declined to provide help. Again he disappeared before the second team arrived.

He returned to the hostel later that night after the staff had gone off duty and, despite warnings to residents not to let him in, he was allowed to stay overnight. He disappeared again before staff came on duty, to re-appear finally at about midday. Shortly after that, the killing took place.

Andre was detained in Wandsworth and Belmarsh prisons, charged with the murder of David Phillips. Psychiatric reports from that period indicate that he was severely disturbed. He was transferred under Section 48/49 to Ashworth Hospital on 22 December. On 8 April 1999, he was found guilty of manslaughter with diminished responsibility and returned to Ashworth Hospital. His current diagnosis is paranoid schizophrenia.

1.2 Terms of Reference

In August 1999, an independent inquiry into the death of Mr David Phillips was commissioned jointly by Westminster Social Services Department and Kensington & Chelsea and Westminster Health Authority with the following terms of reference:

- To review the appropriateness and suitability of the care and treatment received by Mr da Conceicao from Health and Social Services

- In co-operation with the Metropolitan Police, to review the appropriateness of responses to Mr da Conceicao's absconsion from West London Mental Health Care Trust on 24 and 25 September 1998

- To assess the extent to which the care and treatment received by both Mr da Conceicao and Mr Phillips met with statutory obligations, relevant guidance from the DoH and local policies and procedures

- To prepare a report and make recommendations to KCW Health Authority and Westminster City Council

The methodology for undertaking this inquiry is set out in Appendix 2.

2. FRAMEWORK OF SERVICES IN WEST LONDON: MENTAL HEALTH, SOCIAL SERVICES AND POLICE

At the time the killing took place in September 1998, the structure of health and social services in the part of West London where Andre moved about was extremely complex. This position was compounded by the way the Metropolitan Police service was organised, with police divisions cutting across Borough boundaries. Taken together, the structures of the organisations most closely involved in Andre's care, and the resulting complexity of inter-agency communication and co-operation, illustrate the difficulties experienced by staff of all agencies on a day-to-day basis in London. This is the background to the events that took place.

The police revised their community structure in 1999, aligning divisions (renamed Operational Command Units) to Borough boundaries. Similarly, some rationalisation of the mental health services was undertaken in April 1999, simplifying the Trust structure across three Boroughs. The manner in which social and community mental health services are delivered otherwise remains unchanged (see map at Appendix 3).

The following paragraphs set out the configuration of the services that dealt with Andre between 1996 and 1998.

2.1 The local health services in West London

2.1.1 Commissioners

The structure for *commissioning* health services, including mental health services, was relatively simple. In 1998, there was a single Health Authority serving the two Boroughs of Kensington & Chelsea and Westminster City Council (KCW HA). This remains the case. Further to the west, the Ealing, Hammersmith and Hounslow Health Authority (EHH HA) was responsible for commissioning services for those particular Boroughs.

2.1.2 Providers

Much more complex was the structure for the *delivery* of mental health services. The mental health services commissioned by KCW HA at the time of the killing were delivered by three Trusts: the North West London Mental Health Trust, the Riverside Mental Health Trust and the Parkside Health Trust. The first two of these were responsible for services (hospital, community services and hostel) used by Andre between 1996 and 1998. Further west, there was the West London Healthcare Trust whose services were commissioned by a number of health authorities but principally by the EHH HA. This Trust was responsible for Blair Ward, in which Andre spent two weeks before his escape in September 1998.

In 1998, there was no correlation between the geographical areas of the Boroughs and the areas for which the Trusts were responsible. The North West London Trust, for example, covered the geographical area of the Borough of Brent, North Kensington and the northern part of Westminster. The Riverside Mental Health Trust covered the whole of the Borough of Hammersmith and Fulham, South Kensington and Chelsea and the southern part of Westminster. Parkside Health Trust was confined to North Kensington.

Nor did the three Trusts provide a uniform range of services. Superimposed on the geographical configuration of Trusts was a complex arrangement of commissioned services providing statutory mental health care of different kinds. While the Trusts broadly took responsibility for all age groups and types of service within their geographical area, two Trusts (North West London and Riverside in one area, and North West London and Parkside in the other) shared responsibility for the provision of statutory mental health care. This resulted in each of these two Trusts providing certain types of service to specified age groups within the other Trust's geographical boundaries (see map at Appendix 3).

This particular Trust configuration, initiated in 1993, was swept away in a re-organisation that resulted in the Trusts' amalgamation into the Brent, Kensington & Chelsea and Westminster (BKCW) Mental Health Trust in April 1999. This took place seven months after the killing. Mental health services in each of these three Boroughs are now under a designated Director of Operations. The Borough of Hammersmith and Fulham, part of the earlier structure, has been hived off and linked to the Borough of Ealing.

2.2 Mental health service provision

2.1.2 Hospital services

KCW HA, as commissioner for Westminster and Kensington & Chelsea, commissioned a variety of mental health services, including community services, acute in-patient care and specialist in-patient services. The HA's principal providers were the three local Trusts, North West London, Riverside and Parkside, who provided in-patient, out-patient and community services mainly within their geographical areas. In addition, the HA commissioned places from other providers for patients needing secure beds. Blair Ward, run by the West London Healthcare Trust (now Ealing, Hammersmith and Fulham Mental Health Trust), was one such location.

Three Trusts providing in-patient facilities are relevant to this story. First is the North West London Mental Health Trust which includes the Paterson Centre, based at St Mary's Hospital, Paddington. This principally provides in-patient facilities of a non-secure nature but also some secure beds. The local police at Paddington Green were well acquainted with this facility. Second is the West London Healthcare Trust which provides facilities for psychiatric patients requiring a variety of levels of security. Blair Ward is technically a secure intensive care ward but in practice provides a higher degree of security. Third is the Riverside Mental Health Trust which encompasses Charing Cross Hospital which offers a number of acute, non-secure beds for psychiatric patients.

One of the characteristics of Andre was that, over a two year period, he lived in a variety of places in West London and travelled around the area frequently. This, together with his status as asylum seeker with no housing rights, illustrates some of the difficulties facing mental health workers in London. Had he been living in North Westminster and required a secure bed, he would have been the unequivocal responsibility of the Paterson Centre. Picked up as he was in Hammersmith in September 1998, he was assessed at the local police station by two authorised doctors and an Approved Social Worker who concluded that he needed compulsory admission to a secure bed. The assessment was conducted in difficult circumstances and no firm address was obtained: there was only the suggestion that he lived in Willesden, outside the Hammersmith & Fulham catchment area. Charing Cross Hospital did not provide secure facilities and it was not thought possible to keep him there while he continued to present a danger. While Andre remained in police custody, Blair Ward was contacted first but had no spare bed. Three further secure units were approached for a bed but also had none. Finally, on the second approach, Blair Ward found a spare bed.

In addition to shortages of beds, there remains a constant difficulty establishing who takes financial responsibility for such peripatetic patients. As a former resident of north Westminster, where he had received sustained psychiatric treatment, Andre was deemed to be the financial responsibility of KCW HA, in whose area he was last known to have been living.

Blair Ward forms part of the Forensic Directorate of the Ealing Hammersmith and Fulham Mental Health Trust, based close to Ealing Hospital. There is in addition a Regional High Secure Unit on the same site. The buildings that are used for secure services are listed by English Heritage. In 1998, despite being a secure facility, window bars to ensure an appropriate degree of security on Blair Ward were forbidden. The escape happened through an unprotected if very narrow bathroom window. A report commissioned from external mental health professionals into Andre's escape noted that there had been four or five successful abscondings from the ward in the previous 12 months, three failures to return from unescorted leave, one successful absconding from escorted leave and two failed attempts to abscond from escorted leave. This was observed to be a high level of absconding.

Since 1998, following the recommendations of the report, there has been substantial refurbishment of Blair Ward, resulting in a much better physical environment and higher standards of security.

2.2.2 Community Mental Health Teams in Westminster (see map at Appendix 4)

The Community Mental Health Teams (CMHTs), which began to evolve in the early 1990s, were the joint responsibility of Westminster City Council and the three Mental Health Trusts covering Westminster's geographical area.

In 1998, in the south of Westminster, there were three small CMHTs based in Victoria, together with a larger fourth one, the West End CMHT, based in Soho. These were the joint responsibility of Riverside MH Trust and Westminster SSD, with operational management for the care managers falling to the SSD Team Manager (South) and for the health professionals to the Riverside MH Trust. The north of Westminster followed the same pattern, with the three CMHTs the joint responsibility of the SSD, under the operational management of the Team Manager (North) and the North West London MH Trust.

In April 1999, when the multiple Trust configuration was simplified in the single BKCW Trust, responsibility for health professionals transferred to the Director of Operations (Westminster) within the BKCW Trust. Responsibility for care managers remained with Westminster Social Services Department.

Their historical development under the different Trusts has resulted in varying degrees of integration within the CMHTs. Despite the SSD policy to work towards integration, there appears to be further progress in the teams in the south than in the north of the Borough. In the north, the social workers and health workers in the CMHT are on different floors of the same building, have separate managers, computers and information systems and largely separate team meetings attended by only a representative of the other profession. There have been some moves towards greater integration over the last two years. In 1998, the separateness was even more pronounced, with separate referral and filing systems. The health workers also carried responsibility for day care, a secure ward and A&E liaison, spreading their functions well beyond those of a typical CMHT.

There was a further complication in relation to the community mental health services in the north. Bolted on to the three northern CMHTs was a special community mental health team, the Community Rehabilitation Team, known as CRAFT. Set up in 1994 and funded by the London Implementation Group to undertake a three-year research project evaluating assertive outreach case management in North Kensington and North Westminster, it was managed by the North West London Mental Health Trust. Concurrently with the research, CRAFT provided a Liaison Service link to the hostels in North Westminster, including providing a community service to residents. The research project came to an end in 1997.

However, funding for CRAFT was continued by KCW HA from 1 April 1997 as part of its Core Service Contract with the North West London Trust. Its specification describes CRAFT as a supra-locality specialist team, providing assertive outreach community services support to the three CMHTs for North and South Paddington and North East Westminster. It ceased to do that for North Kensington only in November 1999. Its erstwhile responsibility for linking with the hostels appears gradually to have transferred to the local CMHTs, though CRAFT has remained responsible for individual patients resident in hostels requiring its specialist services.

The clarity of its formal function vis-a-vis the local CMHTs has become muddied over time. Funded to act as a supra-locality team and support to the local CMHTs, CRAFT in practice provides an assertive outreach model of community mental health care. Until recently, when a part-time social worker was attached to the team, there were no social workers at all. When a case is referred to CRAFT for intensive support, the care managers in the CMHTs, who are frequently the key workers, only remain involved if asked by CRAFT's clinical director, nullifying the value of a joint approach or social services perspective. It is said that most of the long-term work has been taken over by CRAFT from the CMHTs and that the care management approach, involving both health and social services, is not practised. Now, as in 1998, two different models supposedly acting in tandem give the appearance of working across one another.

2.3 Social Services Department

Westminster Social Services Department was one of the earliest Social Services Departments to split its providing and commissioning functions and contract services to external providers. Mental health services were no exception. It was thought that the value of care management within the SSD could be enhanced if services were provided externally: maximum benefit could be obtained by separating one from the other. When Westminster SSD set out its plans for creating the split, it offered its mental health staff the chance to be care managers or to go over to the provider side. A number chose to be 'providers'. They became part of the Community Support and Rehabilitation Services (CSRS), which collectively offered five different sorts of care and support to Westminster residents with mental health problems to enable them to remain in the community. 42 Queen's Gardens was one of the five services offered under CSRS.

The contract to manage CSRS, including 42 Queen's Gardens, was won by Riverside Mental Health Trust which became, unusually, a provider of both health and social care services. The hostel staff, who used to be directly employed by Westminster SSD, were transferred to Riverside Mental Health Trust when the Trust took over responsibility for the hostel. It is an oddity in this complex kaleidoscope of Trusts and services that responsibility for the hostel became Riverside's yet the hostel was situated in the North West London Mental Health Trust's geographical patch. This peculiarity was to have significant repercussions in the story of Andre as he moved from south to north Westminster, transferring as he did so from one team's responsibility to another's.

42 Queen's Gardens, a 10-bedded supported residential house in Bayswater, provides social care to people with severe and enduring mental illness. Originally designed to offer support to people who have been long stay patients in hospital, it has gradually changed its clientele and is offering places to younger, more volatile patients. Staff are on duty during the day, including Saturday, but the hostel is unstaffed overnight and on Sundays.

As supported housing, it is not subject to independent inspection and registration though there are quarterly management reports on progress. Referrals come exclusively from Westminster care managers. Staff work with the residents in the house and also provide outreach support to about 35 clients. Once clients are settled in the house, the referring care manager is not expected to work actively with the client but rather to remain involved only on a review basis. Clinical care is provided by the CRAFT team as part of its remit to look after the residents of hostels in that part of North Westminster. Where a client has moved from the south of Westminster into a hostel in the north, as was the case with Andre, responsibility for his clinical care transfers from his CMHT in the south to the CRAFT team.

2.4 The Metropolitan Police

2.4.1 Organisational factors

The organisational structure of the police force in London has changed in the last year though, from the point of view of this case, the change would not have had a material effect on the outcome of events.

Formerly, the police operated in divisions, normally under a Chief Superintendent. Divisions could contain a number of police stations, one of which would be the managerial headquarters. Their geographical patches sometimes crossed Borough boundaries. In mid-1999, Divisions were replaced by Operational Command Units (OCUs). These were deliberately aligned to Borough boundaries.

In the case of the western part of the London Borough of Ealing, the OCU encompasses four subsectors: Southall police station (the OCU headquarters and containing the senior police officers), Greenford, Northolt and Norwood Green. Police inspectors are in charge of the latter three police stations. Norwood Green's patch included the West London Healthcare Trust, based close to Ealing Hospital, in which was situated Blair Ward. Westminster, being a relatively large Borough with special problems and considerations, is overseen by a Borough Commander in charge of five OCUs: Belgravia, Charing Cross, West End Central, Marylebone (and a satellite police station) and Paddington Green and its satellite, Harrow Road.

Ease of liaison between the police and the health and social services depends to a large extent on the way the service structures fit together. Revising the complexity of the Divisions that crossed over Borough boundaries may now have helped some of the earlier problems. There do not appear to have been particular difficulties of liaison at the local level between police and Trust staff within the Southall Division either in the mid-nineties, or currently. Practice now is for twice yearly meetings between police and the Trust Board, and quarterly meetings between the police, social services and Trust staff. Similarly, in Westminster, police co-operation with social services in practical day to day work with psychiatric patients is said to be good though there are problems for social services at the more strategic level relating to the large number of OCUs within Westminster's boundaries.

2.4.2 AWOL problems

For a number of years, there has been a London-wide concern within the police about their role in relation to persons reported missing and in particular to patients reported AWOL by hospitals. The problem emerged in the early 1990s when the police became conscious of the burden of retrieving all missing people. In 1995, the Metropolitan Police solicitor advised that the police had a *power* to re-take people missing under mental health legislation but not necessarily a *duty*. This led the police to consider how their time and resources could be more efficiently used. From this starting point developed a new policy in relation to missing persons that eventually became operational in December 1998. Essentially the new policy attempts to categorise missing persons as high, medium and low risk, a device that can assist the police to consider more objectively where to put their resources. Where patients go missing from mental health facilities, they are defined as high risk if they constitute a danger to themselves or others.

The necessity to re-consider the handling of missing persons is illustrated by the situation that arose in the West London Healthcare Trust. Good relations between local police and Trust staff meant that Blair Ward had an agreed AWOL policy which made a suitable distinction between level of risk and required staff to get in touch with police only for high risk absentees such as Andre. However, in practice, the numbers of reported missing patients (310 in 1999 and similar numbers in earlier years) indicated that staff tended to report all missing patients rather than the particularly risky ones. The Ealing police themselves compounded this by responding to the reports and providing resources to find the patients. At the time of Andre's escape, therefore, the Blair Ward nurses had an unstated expectation that police from elsewhere would be as helpful as their Ealing colleagues. Instead, they encountered a sergeant at Paddington Green who was wanting to discourage what he judged to be inappropriate use of police resources.

2.4.3 Planned developments

Major changes are now planned by the Metropolitan Police in the way they handle calls, including emergency calls, from the public. The proposed Command, Control, Communications and Information (C3i) project is a means of 'managing public demand for police attendance at incidents and providing support and information to operational officers'. Due to start in 2002, it is envisaged to be a more sophisticated response to public calls, with a particular ability to filter out calls considered unsuitable for police handling and respond with an appropriate level of support to calls that are police business.

While organisational changes have been planned or completed, there have been similar movements in relation to police policies and procedures. One such change has been in the handling of missing persons.

The police are planning on a much bigger scale, through C3i, a means by which they can use their resources more efficiently and to better effect. In relation to the handling of missing persons, it is clear that there is a need for a more organised, objective and sophisticated approach. In the new policy, the police accept responsibility for patients who can be defined as a danger to themselves and to others, wherever they are.

3. SEQUENCE OF EVENTS

3.1 Andre's early history

One of the notable characteristics of Andre is that no-one knows for certain about his origins and background: there is no reliable source of information and very little corroborative evidence to support his own statements. He himself has given a variety of versions to different people. Even the name by which he is called varies and he answers equally to either Andre or Jose.

It is generally agreed that he was born in Angola in 1967. He was brought up against a background of war, first of independence against Portugal, then a civil war. He appears to have had a reasonably stable family life and successful educational career, culminating in a short spell at the University in Luanda. There is no suggestion of a history of mental illness.

Andre's reasons for leaving Angola are obscure. One version is that he was attempting to evade national service, another that he was escaping the repercussions of operating on the black market. It appears that he fathered a daughter with his girlfriend and has not seen either since he left the country. At the age of 25 he left Angola for Lisbon where he stayed working on a building site. Three years later, as Portuguese immigration tightened up, Andre left Lisbon and came via France to Britain.

He entered Britain in 1995 and initially stayed with friends. He undertook casual work in hotels and began to learn English at Westminster College. He then reportedly began to take drugs in the company of his friends and within three months was using cannabis, cocaine and amphetamines daily. Two incidents involving violence then ensued. The first involved damage to a car at Westminster College, resulting in a police caution. The second, at Wembley Stadium in March 1996, led to compulsory admission under Sections 136 and 2 of the Mental Health Act at Park Royal Mental Health Centre. He was described during the admission as psychotic, with persecutory delusions and auditory hallucinations. He stayed at Park Royal for three months and received his first formal diagnosis of acute polymorphic psychotic disorder.

3.2 Chronology of Andre's psychiatric and social history up to clinical discharge

This section traces the course of Andre's illness and treatment by health and social services between his discharge from Park Royal in June 1996 and his discharge from the psychiatric services in May 1998.

3.2.1 Initial treatment and care

Park Royal discharged Andre into Greylings Hotel, a bed and breakfast hotel in W1, on 19 June 1996, though he continued to receive out-patient treatment at Park Royal for a short time. On 20 June, he was formally referred to the West End Community Mental Health Team in Westminster for continued clinical and social care. A care manager was allocated to him, followed within days by a Community Psychiatric Nurse (CPN).

Andre received a great deal of care and attention from the West End CMHT, with regular meetings with his care manager (who was also his CPA keyworker), psychiatrist and CPN. Considerable work was put into providing day services, to his great benefit, and sorting out his housing problems, asylum status and medication. During his time in the care of the West End CMHT, there were occasions when his psychosis worsened and his depot medication was increased. However, his overall progress was good and, by October, he was considered suitable for supported accommodation in 42 Queen's Gardens. Application for a place was made and accepted, though admission had to be delayed for a number of months while various refurbishments were taking place. Meanwhile, Andre began to complain of an inability to sleep. He was admitted to the Gordon Hospital on 27 January 1997 for a week for investigations.

In February 1997, following his discharge from the Gordon Hospital, Andre finally took up residence at Queen's Gardens and was assigned a key worker from among the staff. In April 1997, a CPA meeting held by the West End CMHT noted that his progress while resident at the hostel had been substantial. Such was Andre's progress that both care manager and hostel workers felt confused about the exact nature of his mental illness.

At this point, because Andre had moved from his bed and breakfast placement in the south of Westminster, which was part of the West End CMHT patch, to the hostel in Bayswater, responsibility for his clinical care had to be formally transferred to another team, CRAFT. The CPA meeting held in April by the West End CMHT confirmed the need to transfer to CRAFT.

3.2.2 Transfer to CRAFT

CRAFT was not a conventional CMHT like the West End team. Rather it was a 'supra-locality' team, concerned particularly with assertive outreach but also carrying a subsidiary responsibility in north Westminster for hostel residents with a severe and enduring mental illness. It was in this latter capacity that CRAFT took over Andre's clinical care. However, it was Westminster SSD's policy to maintain continuity of care manager wherever possible and responsibility for Andre's care management remained after clinical transfer with his care manager in the West End CMHT. She also retained responsibility as his CPA keyworker. It is worth noting that there was no social worker within the CRAFT team to whom Andre might have been transferred. A CPA meeting was held on 19 June by the West End team and the transfer was conducted following all formal protocols. His diagnosis at handover was paranoid schizophrenia.

In July 1997, Andre was seen by the clinical director of CRAFT, who diagnosed him as suffering from drug-induced psychosis. Depot medication was immediately stopped though the anti-depressants continued to be prescribed. Throughout the rest of the year Andre lived at 42 Queen's Gardens, apparently in some form of part-time employment and remaining free of psychotic symptoms. By October, he appeared to be so well that Queen's Gardens staff no longer regarded him as mentally ill.

Involvement by social services, vigorously pursued so far, falls at this stage into abeyance. Active care management by the West End CMHT came temporarily to an end between September 1997 and January 1998, when the care manager was away on a training course, though it resumed later in February 1998 on her return. A replacement care manager was appointed in November 1997 but did not actively manage the case in any way. However, the CPN from CRAFT with special responsibility for the hostels monitored Andre on a monthly basis in the late summer and autumn, noting how well he seemed. In December 1997, the clinical director of CRAFT formally took him off his remaining anti-depressant medication and recommended further monitoring with a view to being discharged.

3.2.3 Process of discharge from CRAFT

Andre was next seen by the CPN on 8 January 1998, and then briefly for the final time on 12 February as he was on his way out of the hostel. The casenotes indicate that he was well and that all involved in his care at the hostel agreed that he should be discharged. On 24 April, the CPN duly discharged him from her caseload without further contact with him.

However, it is clear from SSD records stretching over the period July 1996 to the summer of 1997 that, although appearing to have made a remarkable recovery, Andre remained an enigma to his key worker and care manager: secretive about his background and elusive about his source of income and good quality clothes. It was noted on a number of occasions in the Social Services file that he had a predisposition to violence when under stress and was a troubled individual under his smart and able exterior. These prescient concerns were confirmed in December 1997, and again in February and March 1998, when he was involved in violent incidents, the first time in a record shop with an assistant, twice in the hostel with the visitors of other residents. The CPN, at that stage working towards discharge, was not told of these incidents by the hostel keyworker.

In February, the care manager, by this time back from her training course, undertook an Assessment of Vulnerability (Mental Health) for the Homelessness Team, expressing concern about the effects on Andre of being in bed and breakfast. She also noted signs three weeks later that Andre was 'not OK' and questioned whether he was 'reacting to the difficult situation (of planning to move) or deteriorating in his mental state'. She suggested that his violence might indicate a relapse.

However, because of his apparent recovery and the judgment among Queen's Gardens staff that he was inappropriately placed with them, efforts to find alternative accommodation were pursued. As an asylum-seeker, his only option was to return to bed and breakfast. Despite his reluctance to move and the care manager's reservations about the unsettling effect of this form of accommodation on his mental state, a place was found for him in a nearby hotel in Bayswater. He moved into the hotel on 22 April 1998.

On 5 May, a series of messages was left between the care manager and the CRAFT CPN. Neither appears to have managed to speak to the other personally. The care manager rang and left a first message for the clinical director alerting him that a CPA meeting for Andre would need to be arranged within the next three months. The CRAFT CPN later returned the call and left a message that she was no longer involved with Andre. The care manager left her second message for the clinical director, asking him to see Andre in out-patients, to which the CPN replied that Andre had been discharged from the CRAFT caseload.

3.2.4 Discharge from Social Services

Andre appears to have been officially discharged from CRAFT's caseload on 6 May Between early January 1998 and 6 May, he was seen only once in passing by the CRAFT team CPN and not since December 1997 by the clinical director. Communication took place between the CRAFT CPN and the hostel keyworker, when the CPN visited the hostel as part of her duties, and between the care manager and the hostel keyworker, who worked actively together. There appears to have been no discussion about the advisability of Andre's discharge from clinical care between the clinical director, his CPN and the care manager. Nor was there a formal CPA discharge meeting where a joint agreement might have been made. Effectively throughout Andre's stay in the hostel, his care management and his clinical care were provided as parallel rather than joint services.

Support continued to be offered to Andre by the Queen's Gardens keyworker as part of their normal outreach service, though it proved difficult to see him in person because Andre was always out. This problem extended to considerable efforts to resolve his asylum seeking situation about which he continued to prevaricate. By July, the care manager was thinking that the case should be closed. A meeting was arranged for 31 July. The meeting was duly held at which the care manager, the Queen's Gardens keyworker and Andre were present. The care manager noted that Andre seemed evasive and physically restless and avoided eye contact. It was concluded at the meeting that he was more of a risk to himself than to others and the case was formally closed to social services. Shortly afterwards, in early August, the keyworker left Queen's Gardens for employment elsewhere. From this date, Andre had no further formal connection with any of the mental health or social services. His last informal contact with 42 Queen's Gardens was when he attended the hostel summer party on 6 August.

3.3 David Phillips

David Phillips had suffered a history of mental illness from about 1976 when he first reported problems. In 1995, he was referred to the West End CMHT and received a variety of services, including some in-patient treatment. For several years, he had shared a flat with his brother but, by 1996, this no longer proved viable. Towards the end of a spell of in-patient treatment at the Gordon Hospital, a CPA meeting was held where it was suggested that a move towards independent living would help Mr Phillips. He was admitted to 42 Queen's Gardens on 5 May 1998, two weeks after Andre had left, and took up residence in Andre's vacated room. There was general acknowledgement that Queen's Gardens was a suitable place for his care needs.

3.4 Events leading to the death of David Phillips

3.4.1 Arrest and escape

On 9 September 1998, Andre was arrested in Hammersmith for an unprovoked attack on a Japanese tourist. Following a mental health assessment, he was compulsorily admitted to Blair Ward. Diagnosed as suffering from some form of psychotic illness, he remained there until 24 September, when he escaped at about 8.00am through a bathroom window.

At 8.15am, a member of the nursing staff discovered the escape and the West London Healthcare Trust AWOL policy was put into effect. Under the terms of this policy and procedure, Andre was classified as a high risk patient. Notes from the police and Blair Ward, together with witness statements, suggest that the policy was followed by the nursing staff on duty. The Unit Co-ordinator was informed, together with the Responsible Medical Officer (RMO) and a person thought to be Andre's next of kin. A search of the extensive hospital grounds, where absconders were frequently found, was undertaken and then, at 8.45am, the police at the local Norwood Green Police Station were informed. A Mental Absconder report was created and Andre's details, including a note of his history of aggression, was placed on the Police National Computer.

Andre, meanwhile, left the hospital grounds and returned to Queen's Gardens, his former home. The hostel administrator rang the hostel manager at 9.40am to say that Andre had turned up. The hostel manager instructed her to tell Andre to return at 11.00am when she would be back to meet him. This he did and was met by the manager who subsequently described him as more dishevelled than usual and quite sedated, though responding to her appropriately. About midday, the manager rang Blair Ward to report that Andre was there but that he was not a problem.

3.4.2 First recovery attempt

Evidence from now on becomes contradictory and hard to corroborate. The hostel manager says that she suggested to the nursing staff that they call Paddington Green Police Station (nearest to Queen's Gardens) to pick Andre up and hold him until nursing staff could collect him but it was clearly conveyed to her that the police would not be willing to do that. In her view, it was the responsibility of Blair Ward to make arrangements for his retrieval and she left them to do so.

At Blair Ward, there seem to have been various discussions and decisions about how to handle the situation. First, despite staff shortages, the Unit Co-ordinator decided not to follow the hostel manager's suggestion about ringing Paddington Green but rather to organise a rescue team from the hospital once the afternoon nursing shift came on. No attempt appears to have been made to report to Norwood Green Police Station on the discovery of Andre at Queen's Gardens and this police station, currently undertaking enquiries about Andre as a missing person, remained unaware of the events surrounding him and his possible whereabouts until 8 o'clock that evening.

Another discussion took place between the RMO and the Nursing Manager of Blair Ward at about 1.30pm, shortly after the Nursing Manager had returned to the ward from other duties. Between them, they decided that the police probably would not give the matter priority and that a team should go to retrieve Andre, calling on the police only if he gave them any trouble. Police records confirm that no call was made to them at this stage.

By 3.00pm, a team of nurses, led by the Nursing Manager, arrived at Queen's Gardens, only to find that Andre had disappeared. The Nursing Manager's statement indicates that, before departing, he told the hostel manager that Andre was dangerous and that she should tell the police if he came back. However, the hostel manager's testimony indicates that the Nursing Manager told her that they had been in contact with the police and the police were very clear they would not come. He did not tell her who he had discussed this with.

3.4.3 Second recovery attempt

At 5.00pm, the nursing rescue team returned to Blair Ward where the Nursing Manager told his Clinical Team Leader (CTL) that he had instructed the hostel manager to ring both the police and Blair Ward if Andre came back. Shortly after this, the hostel manager rang Blair Ward and spoke to the CTL to say that Andre had returned. When he suggested she ring the police, she declined on the grounds that she was occupied with another emergency.

The CTL agreed to ring the police himself. His call, at about 5.15pm, was initially taken by a male civilian communications officer at Paddington Green police station. Receiving what he regarded as an unsatisfactory response from this official, the CTL was handed over to the duty sergeant in charge of the control room. There was a conversation lasting an estimated range of 5-15 minutes. The CTL claims that he told the duty sergeant that the escaped patient was potentially dangerous and had assaulted a member of the public; the duty sergeant claims that in a lengthy conversation no mention was made of the danger posed by the absconder until the end. He formed the impression that the nurses, having failed to find Andre the first time, were asking the police as a favour to pick him up and hold him until they arrived in case their second trip was unsuccessful. On hearing of the alleged risk, which he understood to be related to an assault on police officers, he decided that the patient's violence had been occasioned by police uniforms, that he had to be mindful of the safety of his officers and therefore a police presence was inappropriate.

While the CTL was talking to the Paddington Green police, the Nursing Manager was assembling another rescue team. After the CTL had concluded his conversation with the duty sergeant and reported his lack of success with the police, the Nursing Manager decided to try for himself. He spoke to a second, female, civilian communications officer and explained the situation to her. He claimed to have told her that Andre was potentially dangerous, had been violent to the police and would probably not be at the hostel by the time the nursing team arrived. The communications officer said she would refer the matter to the duty sergeant who was then on his dinner break and would ring the Nursing Manager back.

While waiting for the communications officer's call, the Nursing Manager phoned the Trust's Clinical Director who advised him to wait for the police call and, if they proved unwilling to help, to take the team to retrieve Andre but to ring 999 if necessary. The communications officer then phoned back to confirm the duty sergeant's earlier decision that the police 'would not be deployed as requested'.

The second nursing team set off at about 5.30pm, arriving at Queen's Gardens at 6.20pm. Again Andre could not be found. The hostel manager did not wait for the team to come but instead wrote a note to her replacement, the hostel's Senior Practitioner, saying that the police (she meant Blair Ward staff) were coming to pick Andre up. Returning home off-duty, she subsequently had two phone conversations with the Senior Practitioner, including one at 8.55pm about the risk presented by Andre and how best to handle it. The team, meanwhile, finding Andre absent, left the hostel at 7.30pm and returned to Blair Ward. There they phoned to inform Norwood Green Police Station about the situation, which the police subsequently noted in their Missing Persons Report. The Senior Practitioner then went off duty at 9.00pm, the usual time for staff to leave the hostel, warning residents, as agreed with his manager, to contact him or the police should Andre return and not to let him in the hostel.

At 9.20pm, when most of the residents were in their own rooms, Andre came back to the hostel and was allowed in by one of the residents. No effort was made to contact the Senior Practitioner or the police. Andre slept overnight in the hostel lounge and left before staff came back on duty in the morning.

3.4.4 The day of the tragedy

The following morning, one member of the hostel staff, on her way to work, spotted Andre in the street near Paddington Station and this was reported to Blair Ward at 9.00am. The hostel manager, occupied elsewhere on other business for most of the morning, returned to the hostel at midday. Half an hour later, Andre arrived. Having described him the previous day as no problem, the hostel manager was now disturbed by Andre's deterioration and she noted he was 'somewhat agitated and giggling inappropriately'. Suggesting to him that he make himself a drink, she rang Blair Ward about 12.45pm to say that Andre was back and behaving in a menacing manner.

There is some dispute in the evidence about whether the CTL asked her to phone the police. In the event, the CTL rang his local police station, Norwood Green, and asked them to alert Paddington Green to the new situation. About 1.00pm, as this process was under way, the hostel manager was ringing 999 to report a stabbing. Shortly afterwards Andre confessed that he had killed the man in his room.

Andre was detained in Wandsworth and Belmarsh prisons, charged with the murder of David Phillips. Psychiatric reports from that period indicate that he was severely disturbed. He was transferred under Section 48/49 to Ashworth Hospital on 22nd December. On 8 April 1999, he was found guilty of manslaughter with diminished responsibility. His current diagnosis is paranoid schizophrenia.

4. EVALUATION AND CONCLUSIONS

Inquiries such as these attract the criticism that, in describing what happened in chronological order of events, they suggest a deterministic inevitability about the outcome. Hindsight about the actual outcome can lead to a deliberate or subconscious suppression of key data or to an emphasis on details that might have led to happier or alternative outcomes. It may also obscure the point that, however good the quality of practice, disastrous deaths such as Mr Phillips' can still sometimes happen.

Writing such a report such as this is bound to focus on certain elements of practice familiar to all mental health professionals. Deficiencies in some of these key aspects have been raised in other Inquiry reports – for example, the Care Programme Approach, the complexity of organisations in London and the associated problems of communication and liaison between them. It is no surprise therefore that these are mentioned here too because they were important and did play a part in the eventual shocking conclusion.

Conscious of the need not to seem wise after the event and to produce recommendations that can make a difference for mental health professionals in the future, the team thought it worth emphasising various crucial aspects in this case which, in combination, did contribute to this particular outcome. Had any of them been different – better background knowledge, more active communication, different decisions, integrated CPA/care management within the CRAFT team, and so on – this tragedy *might* have been avoided.

4.1 The salient points

- No-one knew for certain Andre's background. It was a consistent feature for the professionals caring for him that there was no corroborated history, including the history of drug-taking. Only since his imprisonment in Ashworth Hospital have facts about his early life begun to emerge principally through the assistance of a Portuguese-speaking psychologist. Hospital, CMHT and hostel staff were all dealing with an enigma who showed considerable skill in concealing facts about himself. Fuller knowledge about his background might have assisted the diagnosis and treatment.

- The complexity of arrangements in Westminster meant that Andre had to be transferred to the clinical care of CRAFT which did not practise integrated working and whose clinical director actively disparaged the CPA.

- The substantial diagnosis at handover from West End CMHT was paranoid schizophrenia. This was changed to drug-induced psychosis on the basis of one interview. The different diagnoses suggested the wisdom of thorough monitoring of the effects of withdrawing depot medication but this was not done.

- Clinical discharge took place without any consultation with Andre's care manager and CPA keyworker. The clinical director who took the decision had not seen him for four months and the CPN for three months. There was no CPA meeting to discuss the discharge.

- Communication between the professionals dealing with Andre was inadequate. The hostel keyworker did not tell the CRAFT CPN about the violent incidents in the early part of the year at the stage when she was considering discharging him. There was also very little contact between the CPN and the care manager – the most substantial contact was at the point when the care manager learned that Andre had been discharged from clinical care and even that was through a series of messages rather than speaking personally.

- No substitute care manager was provided for Andre, while his regular one was undergoing training, until November 1997. Even then, the substitute provided little active help.

- It was a particular problem with Andre that, being an asylum seeker, his only option, on leaving Queen's Gardens, was to go into bed and breakfast accommodation. This illustrates the general point that there is a severe shortage of supported housing for the variety of mentally ill patients presenting in London. Andre's previous experience was that he found this environment mentally unsettling, as confirmed by hostel residents who spoke to him the night before the stabbing. It was precisely at this particularly risky point that he was sequentially discharged from everyone's caseload.

- From August 1998, Andre had no formal association with the health and social services.

- Blair Ward was unable to provide a secure facility and lacked a comprehensive policy for recovering out of area AWOL patients.

- A misjudgment was made by the police at Paddington based on an inadequate assessment of the risk posed by the absconder.

There are several clear issues that arise out of these points and the sequence of events:-

4.2 Complexity of the health and social services structure

First, the organisational complexity within which the incident at Queen's Gardens took place is striking. London, with 33 local authorities grouped within 16 Health Authorities and served by a multitude of Trusts, is necessarily complex. It creates problems in relation to commissioning and financial responsibility and to liaison at a strategic and operational level.

Commissioning health services in West London was to a large extent a localised business, drawing on the services of the locally-based Trusts, but sometimes had to go beyond local boundaries to supplement insufficient facilities or purchase specialist provision. It can pose a particular problem in relation to the substantial transient population, when responsibility for providing a bed and the associated financial responsibility is not always clear. There are ground rules but, as the case of Andre illustrates, clarity in individual cases is not necessarily obvious. While the Trust structure serving Westminster has now resolved into something far simpler, it was at the time of the killing a pattern of service delivery that only the most determined of enquirers could understand. The legacy of that structure continues for social services, with differential development of the CMHTs in the south and the north of the Borough.

Such complexity exacerbates problems with liaison, both at the strategic level and the operational level, despite the current political imperative for joined up working, partnerships and co-operation between organisations that are structured in different ways for different purposes.

The result in practice in this case was for clinical care to be transferred from one CMHT to CRAFT when Andre moved from bed and breakfast accommodation in the south to the hostel in the north. This was not necessarily a major problem per se but it meant that Andre was transferred from a well-integrated team that offered an excellent combination of medical and social care to a medical team that was more specialised and showed very limited integration with social care.

4.3 Care and treatment given by West End CMHT

The care and treatment given to Andre by the West End CMHT were outstanding. The vigour with which his various problems, medical, social and asylum status, were addressed by all the team members was impressive. Despite being hampered by inadequate and often variable information about him, the team members nevertheless did their best for him and handed him over to their colleagues in the north in a settled state both psychologically and socially.

4.4 CRAFT

4.4.1 Role of CRAFT

CRAFT plays a crucial role in this story, having taken over, as part of its secondary function, the clinical care of a hostel resident. The clinical director revealed that about 5% of the total population of the Paddington area (approximately 4,000) was referred to mental health services each year. The CRAFT intensive assertive outreach team, containing 10 staff, had a caseload of 200 patients and a further 30-40 hostel residents. In addition the clinical director had a consultant caseload of 200 patients in North Paddington CMHT, was responsible for 6 dedicated rehabilitation beds and undertook two ward rounds a week. The size of the caseload meant that much responsibility for patients was delegated to other members of the team.

The peripheral nature of CRAFT's hostel role was illustrated by the position of the CPN responsible for the hostels. She had a heavy caseload varying between 30 to 40 individual patients in addition to the task of supporting hostel staff. Having no part in the team's research role or with the regular caseload, she described herself as isolated and unsupported within the CRAFT team.

A further problem with CRAFT lay with its approach to handling psychiatric patients in the community. Set up as a specialist service alongside the local CMHTs, the clinical director of CRAFT explicitly rejected the CPA, describing himself as extremely unhappy with CPAs which were an interference with good clinical care. While regular meetings to discuss patients in their care were said to take place within CRAFT, there was no social worker within the CRAFT team and no opportunity to provide an alternative view to their predominant model. Furthermore, when care managers retained responsibility for cases transferred to CRAFT, this was acknowledged to provide the 'advantage of continuity' but 'because the social worker is extraneous to your normal team working, you forget about him'.

The presence of CRAFT, with the sheer size of its workload and permeated by the clinical director's values, has a distorting effect on the development of the conventional CMHTs in this part of Westminster. For these reasons alone, there is a case for evaluating the contribution of this team to the local community psychiatric services. There are also questions to be answered about assertive outreach and how best it should be managed and delivered. A more integrated model, with assertive outreach being provided by the CMHTs, would reduce the opportunities for patients to fall between organisational cracks. Also to be considered, though, is a point firmly made by the clinical director about the handling of the many transient patients in London whose transience poses problems for conventional geographically based CMHTs.

The handling of Andre illustrates some of these more general observations.

4.4.2 Diagnostic issues

All the notes accompanying Andre on handover from West End CMHT to CRAFT were in order, including the substantial diagnosis of paranoid schizophrenia. Despite the documented evidence about his diagnosis and the course of his treatment, the clinical director changed the diagnosis on the basis of one interview with him and immediately stopped his depot medication.

Hindsight might suggest that this was crucial to what subsequently happened. However, establishing a firm diagnosis in this instance, without a clear background history, is not easy. Andre typically received a number of diagnoses, illustrative of an evolving psychotic illness. On his initial admission to Park Royal Mental Health Centre, he was diagnosed as suffering from 'acute polymorphic psychotic illness' (International Classification of Disease (ICD) -10 F23.1) which essentially defines someone as suffering from a relatively brief episode of psychosis, with possible psychogenic, drug-induced or other causative factors. Patients recover 'often within a few weeks', and the relationship with more long-term illnesses is uncertain. Given Andre's self-confessed history of drug-taking (albeit unconfirmed by tests), it was assumed at Park Royal that this habit had been the key factor.

Nevertheless, he was discharged on continuing medication (a depot preparation) and continued to receive this under the care of the West End CMHT. Following his admission to the Gordon Hospital early in 1997, the West End CMHT arrived at the substantial diagnosis of paranoid schizophrenia (ICD-10, F20.0). As is common with such individuals, Andre returned to an excellent level of functioning showing, by the time he was assessed by CRAFT's clinical director, no evidence of either positive or negative symptoms. Discontinuing medication at that time, on the basis that a drug-induced psychosis had been the substantial diagnosis, was not unreasonable. However, given the established course and symptoms of his illness while under the care of the West End CMHT, he clearly required close and regular follow-up in case of relapse.

The issue of drugs has been a continuing source of confusion in this case. Close inspection of the medical notes shows no evidence of drug-using behaviour, of positive urine specimens or of being under the influence of drugs in the presence of mental health staff. The staff at Queen's Gardens had noticed no kinds of equipment (eg packages or syringes) in his room, nor any other behaviour associated with regular drug use. The only positive urine specimen has been within Ashworth Hospital, following Andre's conviction, with no obvious impairment in his mental state. It is worth noting that the diagnosis of a drug-induced psychosis can only be substantiated if an illness is relatively brief in duration (that is, a matter of days) and there is positive evidence of a urinary drug screen.

It is similarly worth noting that it is not uncommon for those who have been on depot to remain at least apparently well for a number of months and this can be prolonged by some individuals who are able, with good social skills, to mask their symptoms. Andre's breakdown in September 1998 and his subsequent history are characterised by behaviours, symptoms and treatment responses typical of a relapse of a severe psychotic illness. Evaluation of his condition over a period of months both in prison and in Ashworth Hospital confirm the diagnosis of paranoid schizophrenia.

The key factors in Andre appearing so well in the latter part of 1997 and the early part of 1998 (despite three incidents of unusual and aggressive behaviour) seem to have been his excellent social skills, his ability to mask symptoms, cultural differences and the fact that he was often not seen by staff at Queen's Gardens for days at a time.

4.4.3 Conclusions

In conclusion, while the substantial diagnosis of paranoid schizophrenia was established before Andre's transfer to CRAFT and has been confirmed subsequently, it is possible to understand why a trial without medication might have been made. However, such an approach necessitated much closer and more regular follow-up by a CPN or psychiatrist to pick up any changes in behaviour or mental state in case of relapse.

It is unfortunate that the care manager, who was more keenly aware of Andre's problems, was away on a training course over the autumn. There was also a lack of liaison between the CRAFT CPN and the care manager in the early part of 1998 and therefore no care management input to CRAFT discussions of Andre. Given that he had had two admissions to hospital prior to moving into Queen's Gardens, the likelihood of a further relapse was always a possibility whatever the substantial diagnosis and this was exacerbated by the skilful masking of his underlying mental state.

Andre was discharged from clinical care without any final assessment or formal CPA meeting. Lacking any clinical support, the care manager subsequently did not feel justified in keeping the case open.

4.5 Lack of communication between key staff

From being well-supported by an integrated CMHT, Andre, now established at Queen's Gardens, began to receive parallel services from the clinical team on the one hand and the care manager on the other. This was unfortunately punctuated by the absence of the long-standing care manager on a training course during vital months in the autumn of 1997. Lack of effective cover for such absences, even for serious cases such as Andre's, seems to have been normal practice.

Evidence from case files suggests close co-operation between the care manager and hostel keyworker who between them worked on his housing problems in particular. The hostel keyworker also regularly saw the CPN when she visited the hostel. Crucially, however, according to the CPN, the keyworker did not tell her about the violent incidents. This was just at the time when she was preparing to discharge Andre from her caseload.

There was very little communication between the CPN and the care manager. Certainly there was no acknowledgement by the CRAFT team of the care manager's role as CPA keyworker and there is no evidence that she was involved with any of the clinical team's discussions where the significance of the violent incidents or any other concerns about him might have been examined.

4.6 42 Queen's Gardens

The role and function of 42 Queen's Gardens is also a matter of concern. Originally designed for re-located long-stay psychiatric patients who would, over years, learn to achieve independence, its staffing policy is consonant with chronic, non-relapsing clientele. Now, however, it is taking on more volatile, psychotic patients liable to relapse. The change in practice about admissions raises questions about the type and training of hostel staff and particularly about the management of the hostel. It continues to be unstaffed at nights and parts of the weekend and consideration should be given to adapting its staffing practices to handle its new type of residents. It should also be noted that while the building appears homely it has a number of features not compatible with accommodating volatile residents.

4.7 The West London Healthcare Trust (now the Ealing, Hammersmith and Fulham Mental Health Trust)

Time has moved on since the killing of Mr Phillips and some substantial changes have taken place in the West London Healthcare Trust following the report of the external mental health professionals. Blair Ward has been entirely re-furbished internally and its windows and garden secured to a degree that satisfies the Trust's obligation to keep patients from escaping and the aesthetic requirements of English Heritage.

While the response to a patently absurd situation has been satisfactory, there remain concerns about other aspects of the handling of Andre's escape. It was a serious oversight for the staff of Blair Ward not to have immediately informed Norwood Green Police Station, once they had learned of Andre's whereabouts from the hostel manager, that the absconder, whom they knew to have a history of violence, was at Queen's Gardens.

More generally, while there was a Trust AWOL policy that staff knew and followed, it was written to apply only to local situations and not to abscondings over a wider area than Ealing itself. No provision was made for the handling of out of area abscondings. This left Blair Ward staff to react in an ad hoc way and to choose a wholly exceptional course of action – to send six nursing staff several miles to collect what their own policy classified as a high risk absconder. The potential risks to the nursing staff arising from this decision seem not to have been fully assessed. While out of area abscondings are rare, the manner in which they should be handled must still be encompassed in the Trust AWOL policy.

A further gap that became apparent as Andre successfully frustrated efforts to retrieve him was the lack of a designated senior person within the Trust to take responsibility for co-ordinating the nurses' effort to find him. Between 1.30pm, when a team of nurses under the direction of the Nursing Manager began to be assembled, until 8.00pm, when he went off duty, considerable time and manpower went into retrieving Andre. After that, despite him still being at large near an identified place to which he was likely to return, the Trust appears to have made no effort to continue the search or to discuss arrangements for liaison between themselves, the police and Queen's Gardens.

4.8 The Metropolitan Police

The police share some responsibility for the difficulty in which the Blair Ward nurses found themselves. It stretches credulity that the nurses phoning Paddington Green Police Station to tell them about the escape would not have mentioned the risk posed by the absconder, given his history and recent clinical presentation. The duty sergeant, knowing little about Blair Ward and the patients it contained, stuck too doggedly to his belief that the nurses were asking him to do them a favour. He was insufficiently rigorous in establishing the circumstances leading to Andre's arrest and how much of a risk he now was and frankly misguided in concluding that Andre was a danger only to the police.

The combination of these various circumstances led in September 1998 to a man's death. The possibility of it happening again remains: as interviews have revealed, the new police policy on missing persons is still not yet sufficiently rigorous in categorising risk and Queen's Gardens staff even now profess uncertainty about what they would do if a similar situation arose.

4.9 Conclusions in relation to the Terms of Reference

Our conclusions, within the terms of reference, are as follows:

- **Review the appropriateness and suitability of the care and treatment received by Mr da Conceicao from Health and Social Services.**

Andre received good clinical care from Park Royal Mental Health Centre, from which he was properly discharged into the care of the West End CMHT. For a period of a year, he received excellent, caring treatment from the West End CMHT, which undertook a careful, multi-disciplinary assessment of his mental state, leading to a considered conclusion about his diagnosis. His social, financial and housing needs received similarly thorough attention. CPA meetings were held and he was transferred with full documentation to CRAFT.

The CRAFT clinical director made a swift diagnosis that was at variance with the diagnosis provided at Andre's handover. It was not unreasonable to make an alternative diagnosis, leading to withdrawal of depot medication. However, given the nature of the diagnosis at handover, the level of support provided over the previous year and the fact of two previous admissions, there was inadequate follow-up to monitor the effects of the withdrawal. This was possibly an outcome of CRAFT's heavy caseload and over-extension of its original role. This was further compounded by lack of contact with Andre for a number of months prior to his discharge by either the clinical director or the CPN and no formal discharge meeting.

Westminster SSD policies and procedures in relation to mental health are thorough and comprehensive. They did not appear to include guidance on the circumstances and procedures governing termination from CPA.

The care manager in the West End CMHT was active, caring and perceptive in her handling of Andre. During her absence on a training course, the SSD did not provide a substitute care manager until several months later and even this was a nominal appointment. Active care management only resumed when the original care manager returned from training.

The West London Healthcare Trust had a written AWOL policy which covered degrees of risk and the appropriate procedures to follow. Both Trust staff and local police negated this policy, the Trust staff by notifying police of AWOLs who were not high risk and the police by responding to the Trust staff's calls. The current AWOL policy does not contain guidance on out of area abscondings and how to handle them. There appears to be no senior member of staff within the Trust responsible for the absconders and co-ordinating the effort to retrieve them.

Queen's Gardens has not been adapted in design or staffing to the new type of residents coming into its care. The type of staff, their training and hours on duty need to be considered in the light of the more psychotic patients they deal with. Consideration should be given to guidance about the circumstances when it is appropriate to get in touch with the police.

Mental health professionals are well aware of the shortage of resources in London and this case points up the lack of secure beds in particular. Consideration should be given to developing more local secure facilities to avoid the need for residents of Kensington & Chelsea and Westminster being placed in Ealing.

- **Review, in co-operation with the Metropolitan Police, the appropriateness of responses to Mr da Conceicao's absconsion from West London Mental Health Care Trust on 24 and 25 September 1998.**

The staff on Blair Ward followed their Trust's AWOL procedures but, lacking guidance on handling out of area abscondings, these were inadequate to meet this particular situation. Experience of the help provided regularly by the local Ealing police led to certain expectations by the Blair Ward staff about the help that might be provided by the Paddington police. These expectations were disappointed as the Paddington police, following their own emerging policies about the kinds of help they were able to provide, declined to help. The police judgment was flawed particularly in failing to establish the degree of risk posed by the absconder. While a new procedure has been recently launched to clarify this area, there is room for improvement in its definitions of risk.

- **Assess the extent to which the care and treatment received by both Mr da Conceicao and Mr Phillips met with statutory obligations, relevant guidance from the DoH and local policies and procedures.**

The evidence indicates that Department of Health and local policies and procedures have been followed. The exception to this is the CRAFT team, whose clinical director took the view that the statutory requirement of CPA was unnecessary. This resulted, in Andre's case, in the care manager's contribution being ignored.

Some aspects of the policies and procedures of the Ealing, Hammersmith and Fulham Mental Health Trust and Westminster SSD need to be written or supplemented as suggested above.

- **Prepare a report and make recommendations to KCW Health Authority and Westminster City Council.**

The Inquiry's recommendations follow in the next section.

5. RECOMMENDATIONS

General observations

During our inquiries, we were very conscious of the complex mental health issues facing Health agencies, Social Services and the Metropolitan Police. We also appreciate that, despite this unfortunate case and other similar instances in recent years, there are many mentally ill patients in London who are living safely in the community.

We realise that resources are always in short supply for all the services involved. This has been particularly in evidence for health and social services as the policy of care in the community has developed. The police are known to have had a substantial reduction in manpower available to deal with mental health matters. At the same time, it was clear from our discussions with the police that they had been aware for some time of the need for a new approach towards the handling of mental health patients and AWOL patients in particular. They believe that adequate systems and policies already exist and it is the implementation of these where further co-operative work is needed.

We have already referred to the complexity of the organisations serving mental health patients in the area in which the incident occurred. No one should underestimate the differences between the various services involved and the considerable effort required by all parties to introduce and vigorously implement changes across these services.

It is against this background that we make the following recommendations:-

5.1 Local Services - policies and procedures

We have examined the policies and procedures for dealing with mental health patients for the police, mental health trusts and the social services. In general, we believe these to be appropriate and adapting to changing circumstances. Our main concern has been with the way they have been interpreted and implemented during the period relating to the incident. Even closer working relationships and practices are becoming necessary.

We recommend that:

R.1 The local police command units continue to develop and improve working practices with Mental Health Trusts and Social Services, with increasing emphasis on team work and partnership by the use of joint protocols.

R.2 Joint protocols and working practices be "audited" annually with a joint annual report being made to the respective management Boards of each service.

R.3 AWOL procedures are reviewed and amended as appropriate to ensure they are able to cope with "out of area" as well as local AWOL patients.

R.4 Local police become well acquainted with the mental health facilities in their area, both hospitals and residential accommodation. They must ensure they are familiar with their "patch".

In the context of the above proposals, the team are aware that similar recommendations have been made in previous inquiry reports. An example is the Clunis Inquiry Report where the following recommendations (at para.54.0.8) are made:

"An Officer should be appointed at every Police Station to deal with mental health issues."

"The Police should be encouraged to liaise with local community mental health services."

A further example is Recommendation 3 in the Dixon Team Inquiry report where the following recommendation is made:

"That Westminster Social Services reviews its operational guidelines for mental health professionals to include arrangements for liaison with the Metropolitan Police Service ..... and provide appropriate training for staff."

The team have noted that there have been changes made in the local areas with which this inquiry has been concerned.

5.2 Risk Assessment

The Metropolitan Police have been implementing their revised policy on "*Missing Persons (Special Notice 37/98)* since December 1998. This Special Notice sets out the Metropolitan Police Service policy about the investigation of missing person reports. Given the reduced police resources available to deal with mental health matters, there is a need to reassess the risk assessment procedure so that the police are used only when there is a real need. A clear definition of risk levels must be agreed with all the parties likely to be involved in AWOL situations so that misunderstandings are minimised.

We recommend that:

R.5 Health and Social Services recognise the reduced resources of the police for dealing with mental health issues and particularly AWOL patients and develop their own procedures for retrieving low risk patients.

R.6 All service agencies involved build on the *Special Notice 37/98* in arriving at an agreed definition of risk assessment, possibly via a checklist.

The team would also like to draw attention to and support Recommendation 5 in the recent Dixon Team Inquiry report:

"That the Health Services, Social Services and other relevant statutory authorities in London, together with service user representatives, undertake a joint review with the Metropolitan Police Service into the arrangements for responding to potentially violent mentally ill persons."

5.3 "Out of area" incidents

While the number of AWOL mental health patients who present serious problems are relatively few and the ones who are go missing outside the local area even fewer, they can have a disproportionate impact on the police and the other services involved.

We have found during our investigation that the procedures and protocols for dealing with "out of area" AWOL situations are not as clear as they might be. For example mental health units do not know which police station to contact; there are no agreed criteria between the police and psychiatric services about levels of risk; both police and mental health services lack knowledge of the local availability of mental health expertise.

We recommend that:

R.7 The London Office of the NHS Executive should take the lead in establishing effective inter-agency arrangements for managing AWOL mental health patients including the clear definition of responsibilities and procedures.

The inquiry team was aware that there had been progress in the development of a pan-London approach towards mental health issues. The Camden and Islington Area Mental Health Committee (AMHC), involving senior representatives from ten statutory agencies including primary and secondary health care, social services, the police and probation services, has produced a number of jointly agreed protocols for mental health patients. They include a joint protocol for dealing with missing/AWOL mental health patients. A pilot scheme has started, with the Camden and Islington AMHC and with the borough of Westminster, to develop protocols for exchange of information between agencies where there is a perceived risk of serious harm to self or others.

In addition the London Mental Health Learning Partnership with partners spanning health, local authorities and criminal justice, collaborating with service users and carers, has just been established to help staff in their efforts to deliver better mental health care across London. This new body, set up by the NHS Executive and the Social Services Inspectorate London Social Care Group, provides the opportunity, across London, to achieve greater consistency and genuine, meaningful joint resolution of mental health issues. These are important developments and there will be other areas of good practice about which we are unaware.

5.4 AWOL policies and procedures - Blair Ward

The AWOL of Andre from Blair Ward highlighted both the problem of "out of area" cases and issues about the responsibility for returning patients to secure premises. This could well be a problem for similar intensive care units.

The failure of the Blair Ward team to locate Andre on Thursday evening and to enlist the help of the police at Paddington left matters unresolved at that point. Our discussions left us unclear about the line responsibilty for retrieving Andre and for pressing the police for their help in what was clearly a potentially dangerous situation.

We recommend that:

R.8 A senior manager be appointed by the Trust to take responsibility for AWOL policies and procedures. This would include accountability for the retrieval of all high risk absconders.

5.5 Community Rehabilitation Assertive Focus Team (CRAFT)

As stated in this report, CRAFT is an additional service operating as a supra locality team, with an often confusing relationship with the local CMHTs.

During our investigation, we became aware of the heavy case load which the CRAFT team has handled. Despite the excellent work that has been carried out over the last six years we consider that its supra locality responsibility has been inhibiting a closer integration of the relevant locality mental health agencies.

We recommend that:

R.9 Attention be paid to accelerating the greater integration of health and social services.

R.10 The CRAFT team be absorbed into the local CMHTs and consideration be given to more integrated methods of delivering assertive outreach services.

5.6 Residential Houses: 42 Queen's Gardens

Our meetings with the staff involved with 42 Queen's Gardens showed that the nature of the clientele using the house had changed over recent years. Initially the house was set up to rehabilitate long stay hospital patients. The current trend is towards providing accommodation for younger, more volatile patients. At the same time, staff numbers at the house are reported to have been reduced.

We were concerned that the changes taking place at 42 Queen's Gardens may also be happening on a wider scale across London.

We recommend that:

R.11 The level and skills for staff at 42 Queen's Gardens and other similar establishments across London be reviewed to ensure the staffing is appropriate for the changing care needs.

R.12 Various measures to meet the greater needs of more volatile residents be considered (eg 24 hour staffing and door locking policy).

APPENDICES

Appendix 1

PANEL MEMBERS

Julian Bell – Independent person and Chair.
Former Chairman of an NHS Trust.

Dr Alison Campbell, MA, PhD, CQSW
Independent Social Services Consultant and former Inspector in the Social Services Inspectorate of the Department of Health.

Dr Trevor Turner, MD, FRCPsych
Consultant in General Adult Psychiatry.
Current Clinical Director and former Medical Director of an NHS Community Trust.

Inquiry Co-ordinator: Jane Savory

Appendix 2

METHODOLOGY

Information was gathered by the Inquiry team in a variety of ways. Full details of the sources of information are given in Appendices 5 and 6.

The team started by examining a number of internal inquiry reports following the murder, together with casefiles and medical records, and the policies and procedures of the various organisations involved (see Appendix 5).

Interviews were conducted with relevant staff from the police, health and social services and included Andre himself, a resident of 42 Queen's Gardens and the mother and brother of David Phillips. The team were conscious that a year had elapsed between the death of Mr Phillips and the setting up of the inquiry. We were therefore anxious to hear the family's views before interviewing others. Their comments underline the importance of keeping the victim's family aware of what is happening throughout the process of internal inquiries, police investigations, trial and the independent inquiry.

Many of the staff interviewed also submitted to the Inquiry team letters or further reports to supplement evidence given earlier to internal inquiries. Interviewees were accompanied where they so wished by a counsellor to support them during the interview. Virtually all of the interviews were taped and noted by a stenographer and subsequently transcribed. Each interviewee was given a copy of the transcription and asked to make factual corrections or add supplementary thoughts.

Visits were made to Queen's Gardens hostel, Ashworth Hospital and Blair Ward. Blair Ward itself had been completely re-furbished since the escape, though one member of the Inquiry team had known it as it was when Andre was an in-patient there.

The Inquiry team also received a letter from a neighbour of 42 Queen's Gardens on behalf of the Trustees of 40/41 Queen's Gardens. This was followed up but the Trustees felt they had already made their position clear and declined an invitation to meet the Inquiry team.

We are grateful to all those people who helped us, either through being interviewed, writing reports or letters, providing information and enabling us to visit them.

Appendix 3

PROVISION OF STATUTORY MENTAL HEALTH CARE IN KCW BY LOCALITY AND AGE, 1993 - 1999

	0 - 15	16 - 64	65+	Other
1(a)	NWL	NWL	NWL	RMH - Social care
1(b)	NWL	RMH	NWL	NWL - Social care
2	NWL	NWL	PHT	RMH - Social care
3	NWL	PHT	PHT	NWL - Adult psychotherapy Substance misuse
4	RMH	RMH	RMH	
5	RMH	RMH	RMH	

Trusts

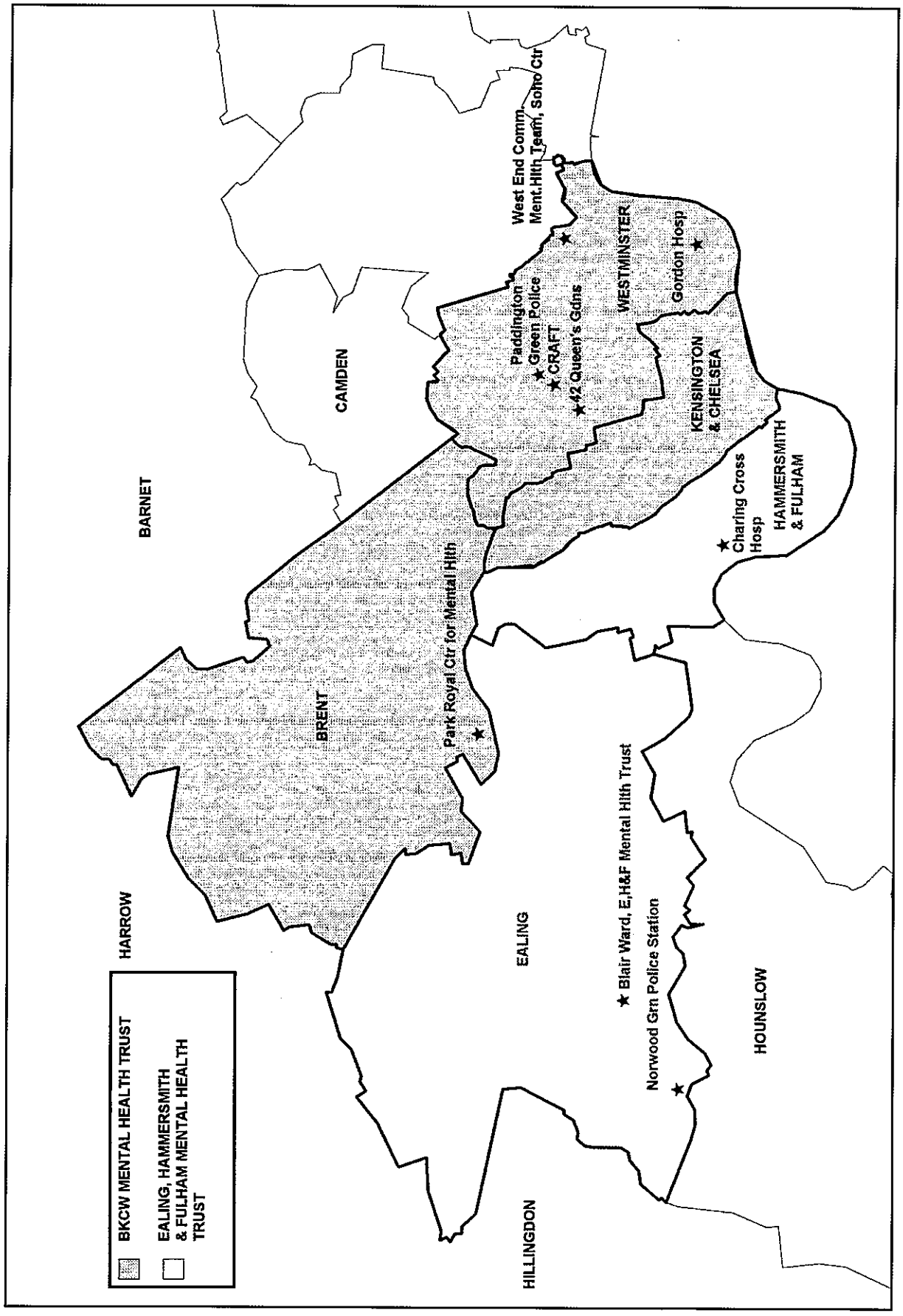
North West London Mental Health NHS Trust (NWL)

Riverside Mental Health Trust (RMH)

Parkside Health NHS Trust (PHT)

Appendix 4

MENTAL HEALTH AND BOROUGH/SOCIAL SERVICES BOUNDARIES AS AT 1 APRIL 1999



Appendix 5

BACKGROUND TO PUBLIC SERVICES FOR PEOPLE WITH MENTAL HEALTH NEEDS

Includes some extracts taken from the Dixon Team Inquiry Report

5.1 The National Health Service Act 1977 places a duty on the Secretary of State for Health to promote a comprehensive health service designed to secure improvement (a) in the mental health of people in England, and (b) in the prevention, diagnosis and treatment of illness. The 1977 Act obliges both the NHS and local Councils with responsibility for social services to provide services for the purposes of prevention, treatment, care and after-care. It places a duty on Health Services and Social Services to co-operate with one another, and a duty to deploy health and social services staff in order to assist each service to carry out their functions. The Mental Health Act 1983 places a duty on local health and social services to provide after-care services for individuals who have been compulsorily detained in hospital for treatment until both authorities are satisfied that the individual is no longer in need.

5.2 In 1991 (and reiterated in 1996), the Department of Health issued written guidance on arrangements for the care and treatment of mentally ill people in the community. Known as the Care Programme Approach (CPA), it sets out the principles and framework for health service managers and practitioners to work with other service providers. For persons with a severe and enduring mental illness, the approach requires a systematic assessment of health and social care needs, a care plan, a key worker to co-ordinate the individual's care arrangements, and regular review. The CPA can and should be applied to all individuals who are accepted by the specialist psychiatric services and is not contingent on hospital admission and discharge.

5.3 The duties and responsibilities on local Councils to provide community care services are listed in Schedule 1 to the Local Authority Social Services Act 1970, and derive from different statutes – notably, the above mentioned 1977 Act and 1983 Act, the Chronically Sick and Disabled Persons Act 1970, the Disabled Persons (Services, Consultation and Representation) Act 1986 and the Carers (Recognition and Services) Act 1995 – all of which include provisions for people with a mental disorder and their carers. Local Councils are obliged to have regard to directions issued by the Secretary of State for Health on social services matters.

5.4 Under the NHS and Community Care Act 1990, where it appears to a local Council that any person for whom they may arrange or provide community care services may be in need of such services, they must carry out an assessment of that person's needs. The statutory requirement is so worded that an initial assessment must be undertaken where it appears the person has a mental disorder and may benefit from community care services, even where an individual has made no such request, or is not co-operating in the process. Other statutory agencies (Health and Housing) may be requested to co-operate in the assessment. Quality assessment is regarded as the cornerstone to the provision and management of community care services for people with a severe mental illness, and arrangements are the same as those in the NHS – a comprehensive approach, leading to a care plan, a key worker and regular reviews. The agreement and involvement of the individual and any informal carers in the care plan then becomes essential.

5.5 Efforts have been made over the years to achieve co-terminosity and to integrate health and community care services for people with mental health needs – based on local geographical areas ("catchment areas"), eg locality psychiatric teams and community mental health teams. Place of residence remains the most significant factor determining access to primary health care, community care services, specialist health care, housing services and welfare benefits. Eligibility criteria for services are locally determined and there are wide variations between areas influenced by demands and available resources. Thus, health service trust definitions of levels of need for full or partial assessment under the Care Programme Approach (including entries on and access to Supervision Registers for persons at significant risk) for mentally disordered people vary within the NHS, as do Councils' definitions of levels of need for community care assessment and care management throughout the country. People with a mental disorder most likely to fall through the net are those who move or are moved from one locality to another. There are often disagreements about the transfer of care arrangements, enhancing these difficulties.

5.6 The Mental Health Act 1983

Health Authorities have responsibility for appointing doctors who have special experience in the diagnosis or treatment of mental disorder – ie doctors approved under Section 12(2) of the 1983 Act. Local Social Services Authorities have responsibility for appointing Approved Social Workers (ASWs) for the purposes of the 1983 Act. ASWs are professionally qualified social workers who have undergone specialist training. The role of an ASW is to assess jointly with doctors the condition and circumstances of people who may require compulsory hospital admission or Guardianship, and, if they consider there is no alternative, to authorise such admission after medical recommendation. Except in emergencies, one medical recommendation must be from a S12(2) approved doctor. Where possible, the medical examination of a patient should be from a doctor who knows the patient eg their GP. The nearest relative of a patient can make an application for hospital admission, and has the power to discharge a patient in certain situations. ASWs should consult nearest relatives. The Police and others also have responsibilities under the 1983 Act.

5.7 The Sections of the Mental Health Act, relevant to the Inquiry, which confer compulsory powers, are:-

Section 2 – admission to hospital for up to 28 days for assessment and treatment on the grounds that:

a) the individual is suffering from a mental illness of a nature or degree which warrants detention for at least a limited period, and
b) the individual ought to be detained in the interest of their own health or safey or with a view to the protection of other persons.

Section 135 – empowers a Justice of the Peace, on the application of an ASW, to issue a warrant for the Police to remove a person with a mental disorder at risk, who is living alone and unable to care for themselves, from a private place. The Police must be accompanied by an ASW and a doctor.

Section 37 – empowers a court to order hospital admission for a mentally disordered offender given recommendations by two specialist doctors. Its duration is for up to six months.

Section 41 – empowers a Crown Court to restrict discharge from hospital and is thus commonly termed a "Restriction Order". The combined Section 37/41 order therefore empowers hospital treatment and continuing powers over discharge arrangements (eg insistence on continuing medication).

Section 48 – empowers the Secretary of State, given two doctors' reports to transfer a remand prisoner to a hospital for treatment for mental illness.

Section 49 – empowers restriction on the discharge of prisoners who have been moved from prison to hospital under Section 48.

Section 136 – empowers a police constable to remove a person thought to be suffering with a mental disorder and at risk to themselves or others from a public place to a place of safety for medical examination by a doctor and assessment by an ASW.