Summary Report of the Independent Inquiry Into the Care and Treatment of Richard Gray

A report commissioned by Wiltshire Health Authority and Wiltshire Social Services

Published October 2001

PREFACE

We were commissioned to undertake this Inquiry by Wiltshire Health Authority and Wiltshire Social Services. We have followed the Terms of Reference specified to us and followed the Procedure for the Inquiry which was subsequently adopted and issued to all witnesses and their representatives.

In accordance with the Terms of Reference we prepared a full report for presentation in confidence to Wiltshire Health Authority and Wiltshire Social Services. We prepared an anonymised summary of the full report containing the findings and recommendations of the Inquiry as required by the Terms of Reference.

This anonymised and further abbreviated executive summary has been prepared at the request of the Health Authority and Social Services.

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Introduction

1.1 At Bristol Crown Court on 19 March 1999 Richard Gray was found unfit to plead to a charge of manslaughter of Ms Ginny Sivil on 12 February 1998, but was found to have carried out the act of killing her by strangulation. She had been in the very early stages of labour at the time. The baby did not survive. An admission order was made under s5(2)(a) Criminal Procedure Act (Insanity) Act 1964 as substituted by s3 of the 1991 Act. Richard Gray remains detained at Broadmoor Hospital.

1.2 Mr Gray had known Ginny Sivil since 1991. She was fourteen years younger than he. She had two children born in 1992 and 1996. Mr Gray was the father of both children and Ms Sivil had a firm conviction that he was the father of the baby which she was expecting at the time of her death. The two children now live with Ms Sivil's parents, whose lives have been overturned by this tragedy and its practical consequences. Mr Gray's parents assist with their care and the Inquiry wishes to record that it has been impressed with the commitment of both families to these children under such painful circumstances.

1.3 In June 1999 Wiltshire Health Authority and Wiltshire Social services jointly commissioned a Panel to conduct an Independent Inquiry into the care and treatment of Richard Gray. Complications concerning disclosure of his documents to the Inquiry delayed its start by five months. Mr Gray gave limited consent to disclosure on 25 October 1999 and the Terms of Reference were drafted to reflect this.

1 Organisations and Agencies

2.1 The Inquiry received a great deal of documentation in the course of conducting its investigation. Mr Gray had been in contact with some form of mental health service from his teens onwards. From 1984 to 1998 he was continuously and intensively in receipt of psychiatric, social work and nursing services.

2.2 Ms Sivil received services including ante-natal and midwifery care, brief contact with Social Services, support from a CPN and out-patient care at the Royal United Hospital (RUH), Bath.

2.3 Mr Gray received his care and treatment from hospitals in Bath, (the RUH), and Devizes (Roundway and then Green Lane Hospitals), from the community mental health team (CMHT) in Chippenham and from the day hospital at Rowden Hill House, also in Chippenham.

2.4 He was admitted to hospital on thirteen occasions between 1985 and 1998. The longest period was for seven months and the shortest for one day. He was admitted to hospital both informally and under civil and criminal procedure sections of the Mental Health Act 1983 (MHA).

2.5 Mr Gray was an in-patient at the then *'Regional Secure Unit'* at Knowle Hospital during 1989.

2.6 Wiltshire Social Services were responsible for Mr Gray's social care and social supervision throughout the time of his contact with adult mental health services.

2.7 He appeared in court for sentence on 23 occasions and was convicted of 62 offences including assaults against the person and sexual offences.

2.8 Between 1990 and 1998 Mr Gray was subject to s37 of the MHA with a restriction order under s41.

2 Early History

3.1 Richard Gray was 39 years old when he killed Ms Sivil. For 27 years, from his adolescence onwards, he was receiving mental health care. His early history was often lost in the later years as the crisis of the moment was prioritised.

3.2 There is no evidence that Mr Gray comes from a dysfunctional family but there is clear evidence that he was an unusual child. He was reported to have used illegal drugs from 12 years of age. He was disruptive at school, was suspended, seen by Child Guidance and went away to a special school as a boarder. By the age of 18 his offences included burglary, indecent exposure, rape and aiding and abetting rape. He had seen a psychiatrist who diagnosed him as having a personality order.

3.3 Mr Gray was referred to adult psychiatric services in 1984 where he admitted to a long history of drug misuse. He was admitted to a psychiatric hospital five times between 1985 and 1988.

3.4 After leaving his parents home in the north of Wiltshire he adopted a nomadic lifestyle before obtaining his own flat in Corsham in 1988.

3.5 By 1986 a diagnosis of paranoid schizophrenia had been established. Further offences included indecent exposure and actual bodily harm.

3.6 Mr Gray was thought to be a risk to female staff in the hospital and during this period he began to experience bizarre psychotic thinking around death, self mutilation and guilt.

3.7 He absconded frequently and was reluctant to accept medication.

3.8 On 7 March 1989 Mr Gray was convicted of common assault at Swindon Crown Court. This occurred after he had absconded from hospital and forcibly taken a driver from her car. He was made subject to a hospital order under s37 MHA with a restriction under s41.

4. Detention under Section 37/41 MHA

4.1 Richard Gray spent nearly seven months at the Knowle RSU between March and September 1989. He was found to be suffering from a schizophrenic illness characterised by persecutory delusions, severe thought disorder and hallucinations. He was described as floridly psychotic at the time of the offence.

4.2 He told both medical and nursing staff that although he did not kill her, he felt he might have been implicated in the murder of a young woman in Bath in 1984.

Comment

4.3 Relatively high medication and a secure setting seemed to benefit Mr Gray although he tested the boundaries of his care.

4.4 He refused to address his sexual offending with the RSU psychologist and this was never addressed thereafter.

4.5 After his transfer to Roundway Hospital in September 1989 Mr Gray continued to test out the boundaries of his care both in relation to management by staff and return from leave. Although the forensic psychiatrist had concluded that he responded to strict measures it was difficult for staff to sustain this approach.

Comment

4.6 No final decision was made as to which agency (Social Services or Probation) should provide the social supervisor until February 1991 even though he was conditionally discharged by a mental health review tribunal (MHRT) on 13 June 1990. This was unacceptable.

5. First Conditional Discharge

5.1 The first period of conditional discharge ran from June 1990 until recall in June 1993. The conditions of discharge were to reside as directed, attend the day hospital, take such medication as was prescribed and accept such visits by the CPN and the social worker as they deemed necessary. There were three responsible medical officers (RMOs) during this time. Once appointed the social supervisor and CPN remained constant figures. There were no hospital admissions and Mr Gray remained at his flat in Corsham throughout. There was one MHRT which upheld the pre-existing conditional discharge conditions.

5.2 Early attempts were made with the Home Office to establish ground rules in relation to Richard Gray's offending and illicit drug use. Five

further actual or alleged sexual incidents followed during the period up to recall

5.3 The relationship with Ginny Sivil began during this period of conditional discharge and she became pregnant. She was spoken of as a stabilising influence and Mr Gray appeared more settled. The social supervisor wrote to Ms Sivil about him and she informed him that she was aware of his background. Following concerns expressed by Miss Sivil's mother about the child her daughter was expecting a child protection conference was called at which it was decided not to place the unborn child on the child protection register.

5.4 Recall was considered on several occasions before it took place in June 1993. He frequently tested out the boundaries of his restriction order, for example, allegedly exposing himself in a shop, driving without a licence and being in possession of drugs.

5.5 Recall was discussed at a case conference in May 1993 where his conditional discharge was said to be *'teetering on the brink of disaster'*. He had not attended outpatient appointments and been arrested hitchhiking on a motorway in Lancashire.

5.6 At a review case conference three weeks later he had reportedly exposed himself to some young girls and he was admitted to hospital at his on request on 15 June 1993. He was recalled three days later at the request of his RMO.

Comment

5.7 After the first Home Office warning to Mr Gray about the risk of recall should he continue to commit sexual offences there were no further formal warnings. There should have been a low threshold of alert after the first warning.

5.8 The Home Office were not notified of how close he was to recall in May 1993.

6. Recall and Second Conditional Discharge

6.1 Richard Gray was formally admitted to Roundway Hospital as a recalled patient on 28 June 1993. He was therefore detained again under s37/41 of the MHA.

6.2 In July 1993 he again reported to a member of staff that he had murdered a woman in Bath several years before. He was noted as thought disordered.

Comment

6.3 ***From 1993 until 1998 Richard Gray periodically mentioned thoughts involving an unsolved murder. The social supervisor sought and received reassurance from the local Police in connection with the matter, and that reassurance was conveyed to others involved with Richard Gray. Mr Gray nevertheless had a capacity to produce unease in people and the topic continued to produce extreme discomfort. It was undoubtedly an indication that his inner world concerned thoughts of killing. The Home Office told the Inquiry that a repeated pattern of thinking like this was significant because it represented a person's perception of reality.***

6.4 Mr Gray became increasingly preoccupied with his thoughts and was uncooperative with ward routine. There were at least four incidents of absconding during this time.

6.5 On 8 October 1993 a MHRT *'reluctantly'* discharged Mr Gray subject to the same conditions as had previously existed. The Tribunal made some strong criticisms of the care and treatment he had received; in essence that his *'criminality'* and his substance misuse had been underestimated and that those charged with supervising him had not taken sufficient notice of this.

Comment

6.6 ***The Home Office had resisted discharge. We consider that a forensic assessment or advice would, during recall, have assisted the MHRT. Their decision caused a shake up in his care planning which was both necessary and constructive.***

6.7 Mr Gray was seen by a consultant forensic psychiatrist from Knowle Hospital in November 1993. He advised that there was nothing the psychiatric supervisor could do to prevent him offending or abusing drugs although he should be referred to the local drug counselling service. Mr Gray had refused to discuss his sexual behaviour in the context of his offending.

Comment.

6.8 ***No further requests for a forensic psychiatric opinion were sought.***

6.9 In November 1993 Mr Gray told the CPN that he had thought of taking his own life and that of his family. The CPN recorded this and advised the social supervisor. It is thought that this referred to his parents rather than Ms Sivil and his child although it is not clear from the notes.

Comment

6.10 This was the first recorded reference to thoughts of killing his family but the Home Office was not informed. It should have been.

6.11 During 1994 the RMO recorded that thoughts of the murdered woman in Bath had sent him *'over the edge'* in 1984 and that this had recently been at the forefront of his mind. The Home Office were informed of this recent preoccupation via the case conference minutes.

Comment.

6.12 During much of 1994 Mr Gray was reported to be stable and settled mentally. A fairly high dosage of medication may have contributed to this.

6.13 Further remarks about doing something he might later regret were not referred to the Home Office.

6.14 There were further allegations or offences during this period including indecent exposure, self reports of drug misuse and positive drug test results, unsupervised contact with his daughter and persistent complaints from his neighbours about loud music.

7. Conditional Discharge 1995 to 1997

7.1 This two year period seems to have been the most unsettled and stressful of Richard Gray's conditional discharge, although not all individual members of the care team were aware of the extent of disturbance in all areas of his life. There were two brief informal admissions, his medication was reduced twice during 1995, urine screening for drugs was terminated in September 1995 and day hospital attendance ceased after March 1997. The Home Office removed attendance at the day hospital from his conditions of discharge in June 1997. The social supervisor and CPN remained constant figures and there were two changes of RMO.

7.2 Richard Gray was franker than usual about his substance misuse which included a variety of drugs in addition to alcohol and cannabis. He was almost in a state of war with his neighbours about his loud music, a noise abatement order had been served on him and he was under threat of eviction for much of the time. His relationship with Ms Sivil was variable and he had problems in accessing his children because of her brief marriage to someone else. He had formed a female relationship which created tensions with Ginny.

7.3 Compliance with the conditions of his discharge loosened considerably, he missed day hospital appointments, challenged increases in his

medication, absented himself from the area twice and was often out when the social supervisor or CPN called.

7.4 There was a shift of diagnostic emphasis during this period with anti-social personality disorder becoming the more dominant focus.

7.5 Thoughts and actions over this period involving violence and sexual intent included three incidents of damage to property or assault on a person linked to the noise problem and indecent exposure to young girls. He expressed a fear he might '*do something*'.

7.6 He told his GP in August 1996 that he might '*do away with his parents*'. These thoughts were reported to the RMO who passed them on to the Home Office.

7.7 Mr Gray continued to voice his concerns about the Bath murder and this was reported to the Home Office. This was checked out with the police by the social supervisor who advised that they had questioned him at the time. He told his social supervisor that he felt '*out of control*'.

7.8 In early 1997 Mr Gray reported to the CPN that he had feelings of wanting to kill someone, he also talked to him about his frustrations of with the conditional discharge and asked whether he had to kill his parents or Ginny and their daughter.

Comment

7.9 The Home Office should have been notified of Mr Gray's many thoughts about killing and this information should have been shared across the care team.

7.10 This was the first time he had specifically mentioned killing Ms Sivil or their child. This was not conveyed by the CPN to the social supervisor or the RMO and was therefore never known to the Home Office. Nor was Ms Sivil informed of this risk.

7.11 The Home Office was not notified by the RMO of the re-emergence of thoughts concerning the past death nor of the reassurance she had received from the police through the social supervisor.

7.12 There were further offences of indecent exposure in front of young girls. The view was taken that this was a consequence of substance misuse but that was not confirmed by any expert opinion and no considered view was ever taken of his sexual disinhibition.

7.13 In December 1996 he was admitted to Green Lane Hospital where he stayed for eight days. Neighbour disputes and possession proceedings produced some noticeable stress in Mr Gray.

7.14 During 1997 Ms Sivil became pregnant for the third time. She thought the child might have been his. He had mixed feelings about this, not wanting a closer relationship with Ms Sivil at this time and was reportedly feeling dissatisfied with further parenthood.

Comment

7.15 Despite the many signs of deterioration in Mr Gray's ability to cope both the social supervisor and RMO's reports to the Home Office were often optimistic. At no time was Mr Gray reported to be a danger to self or others.

8. The Final Four Months

8.1 On 7 October Richard Gray visited his GP. By her own account he terrified her by his graphic description of the murder of the woman in Bath. The CPN visited urgently the same day and found him low in mood. The CPN was informed by fax that Richard Gray had expressed to his GP ideas of harming both himself and his children.

8.2 The CPN did not pass this information on to the social supervisor.

8.3 Mr Gray was admitted to Green Lane Hospital on 10 October. Medical notes recorded morbid thoughts towards himself and his children. The admission nursing assessment also noted that he was expressing thoughts of killing himself, his family, Ginny Sivil and the children.

8.4 He was noted to be masturbating in front of a window three days later. On the same day Richard Gray asked the social supervisor to take him home and he discharged himself from hospital on 13 October.

Comment

8.5 He was not seen by a doctor prior to his discharge. Internal procedures for discharge were not followed.

8.6 There was no RMO available on this date (a Monday) to follow up the weekend admission. The RMO was part-time and cover was for emergencies only. The arrangements for part time working were extremely unsatisfactory for this conditionally discharged patient.

8.7 The social supervisor received insufficient information from the CPN and the ward staff to enable him to carry out his supervisory function or protect Ms Sivil and the children.

8.8 The RMO should have written a discharge letter to the GP as soon as he became aware of this admission (this was 23 October) but he did not write to her until 21 November and the earlier admission was not mentioned. Neither were issues of risk

covered. The RMO seemed unaware of the fax, medical or nursing notes from this admission until advised by the Panel.

8.9 No information concerning the thoughts of killing Ms Sivil or the children reached the Home Office.

8.10 Whilst back in the community Mr Gray voiced a thought about needing to kill his parents. He went missing for six days in early December and on his return told a CPN that he had thought of killing himself.

8.11 He was re-admitted to Green Lane Hospital on 12 December where paranoid thoughts and delusions were evident. He said he wanted to be murdered. He still referred to the Bath Murder.

8.12 No mention was made at the case conference on 18 December about thoughts of self harm or killing others. His mental state appeared to have deteriorated and it was decided to change his medication.

8.13 The RMO's report to the Home Office was three months late. Despite medical and nursing notes referring to thoughts of harm to self and others he reported that there was no indication that Mr Gray was a danger to self or others.

Comment

8.14 The RMO should have referred to these notes in writing his report for the Home Office

8.15 No thoughts of self harm or harm to others was mentioned in the social supervisor's report to the Home Office.

8.16 Mr Gray was not happy about changing medication but did accept Clopixol in January 1998. He complained about side effects but proceeded with further doses.

8.17 Some confusion seemed to exist over leave arrangements and legal status. A Section 17 leave form was completed even though he had the status of an informal patient.

8.18 The last care planning meeting took place on 23 January under the umbrella of the Care Programme Approach (CPA).

8.19 During this meeting a note was passed to the RMO from a doctor who had seen Ms Sivil that day. She had been referred for a psychiatric assessment because of her low mood and poor social support during the pregnancy. She had reported to this doctor that Richard Gray had referred to killing his father on the telephone. Whilst she did not feel threatened herself she did not know how to respond to this. She wished to be involved in Richard Gray's care and was reportedly angry

that she had not been invited to the CPA meeting. Her doctor asked by way of this note that Mr Gray's RMO make contact with Ms Sivil.

8.20 There was no discussion of this matter in the CPA meeting nor any reference to the impending birth. The RMO later recorded that Richard Gray could have leave to attend the birth although he was not permitted to stay out overnight. The assumption was that the birth was to be in hospital. Mr Gray's RMO went on leave after the CPA meeting and did not see him until after the killing.

Comment

8.21 There should have been a formal multi-disciplinary discussion about Mr Gray's attendance at the birth. It was not discussed with the Home Office. The Home Office told the Inquiry they expected to be told in advance about this decision.

8.22 The RMO was asked to see Ginny Sivil but did not do so because he was going on leave the next day. He should have arranged for another doctor to follow this up.

8.23 The RMO specified that there should be no overnight leave for the birth and his parents were to escort him (to what he thought would be a hospital delivery) although the latter was not fully detailed in the medical notes. He told us that had he known that it was to be a home delivery he might have reconsidered his decision to allow him to attend.

8.24 The confusion over leave status was regrettable because it was assumed that hospital staff had an authority over Richard Gray that they did not have. They had no right of veto, he was an informal patient and he could attend the birth and stay overnight if he wished whilst he retained this status.

8.25 There was confusion on the ward about whether or not Mr Gray was *'allowed'* to attend the birth and uncertainty over the interpretation of the RMO's *'leave'* conditions. A duty psychiatrist denied him leave but two days later he was permitted to go home on leave by nursing staff. He returned two days later as Ginny Sivil had not started labour.

8.26 During this time a risk assessment, piloted by Social Services, was completed by the social supervisor as part of a gradual transfer to another social supervisor. This stated that he did not act out his delusions but he was a risk to self and others.

Comment

8.27 Unfortunately, this risk assessment was not shared with anyone else because it was a pilot only. This was the only structured risk

assessment done over the period of Richard Gray's two conditional discharges.

8.28 On 9 February Richard Gray requested further home leave as Ms Sivil's baby was due any time. The duty consultant agreed to leave as he had been on leave recently with no problems, Ms Sivil wanted him there and he had been reported to be helpful at the other two births. He was granted leave until 12 February.

Comment

8.29 Because there had been no change of plan (the RMO had already agreed to his leave) the duty consultant saw no reason to inform the Home Office. RMO leave and duty cover arrangements should be clearer and formal responsibility transferred where a patient is conditionally discharged

8.30 Ms Sivil had still not had her baby when Mr Gray returned to the ward on 12 February. Later that day it was reported that she went into labour. Mr and Mrs Gray collected him and took him to Ms Sivil's home. The midwife was leaving the house when Richard Gray arrived. Labour had not become established and the midwife expected that Ginny Sivil would be taken to hospital when the labour started.

8.31 Mr Gray was asked by Ms Sivil to go on a walk in order to encourage the labour. Twenty minutes later he returned alone and said '*Ginny's dead. I've killed her. I was told to do so'.* A police and family search confirmed the death, due to strangulation.

8.32 Richard Gray said later that he had heard a voice and been sent a message that now was the time to kill Ginny Sivil.

9. Conclusions

9.1 The Inquiry concludes that Richard Gray was suffering from a psychotic illness that was active at the time he killed and was probably the cause of the killing. It finds that there was no one point at which things went wrong. No single action led to the fatal outcome. However, had the Home Office been told about the birth arrangements and been aware of the thoughts about killing Ms Sivil they might have questioned the wisdom of his attendance the birth. A number of serious criticisms are made but no single failure of services or professional care is found to have led directly and inevitably to Ms Sivil's death.

9.2 The most powerful impression has been that of intensive provision of care by many committed, hard-working professionals. Without exception they spoke warmly of Richard Gray. All had been shocked by his killing of Ginny Sivil, some distressed by it. Ginny Sivil had been known by a number of those involved.

9.3 Commitment to maintaining Richard Gray in the community was evident. Those lengthily involved in his care had built up a relationship with him. They worked to the best of their ability to meet his needs and to balance those with the requirements of control and protection of others. Their integrity is not in any doubt.

9.4 Key areas of concern are:

- the care of conditionally discharged patients within local general psychiatric teams and the need for forensic support and training
- the availability of substance misuse services to general psychiatry
- risk assessment
- multi-disciplinary communication
- Home Office reporting

Forensic Support and Training

9.5 During the seven years of his conditional discharge Richard Gray was seen by a forensic psychiatrist on only one occasion at the request of the RMO for the purpose of a written advice. There was no arrangement for regular forensic review nor any arrangement for routine forensic assessment upon recall. General psychiatric services coped largely alone with this diagnostically complex and difficult to manage man. Most of the professionals involved in his treatment and supervision had little or no forensic experience, training or supervision. He was the only conditionally discharged patient for most of them.

9.6 Throughout the conditional discharge there were points when further forensic advice may have assisted, in particular upon continued management of substance misuse, to examine the reasons for Richard Gray's sexual offending, to explore the possibility of therapeutic approaches to his personality disorder, to obtain advice upon a change in medication, to advise upon the management of hospital admissions, to re-assess long term goals and objectively review his maintenance in the community given unresolved housing and neighbour difficulties.

9.7 The Inquiry considers that it is unsatisfactory and potentially unsafe for conditionally discharged restricted patients to be managed for lengthy periods in the community by general psychiatric services without active forensic support and training. Regional forensic services, health authorities and social services departments should jointly plan co-ordinated forensic training and support for all those involved in the care of such patients. This should include provision for regular forensic review and routine assessment by forensic services upon recall tailored to the needs of individual patients.

9.8 Government guidance in the form of HSG (94)27 states that expert forensic help should be accessible to local psychiatric teams and refers to the need for local agencies and medium secure units to develop effective arrangements for continuing care. Future guidance should consider strong emphasis upon the need for joint planning and co-ordination of safe care for forensic patients in the community.

Substance Misuse Services

9.9 The Inquiry heard convincing expert evidence that substance misuse including the use of cannabis aggravates schizophrenia. Regular cannabis use, amongst other drugs, was a feature of Richard Gray's life throughout his conditional discharge. Despite efforts this never reduced. There was no substance misuse service available locally to advise upon the management of the problem. Forensic and local psychiatric teams should have access to substance misuse training and expertise when managing the care of schizophrenic patients who have co-existing problems of illicit drug use.

Risk Assessment

9.10 There were a great number of multi-disciplinary meetings, reports and assessments concerning Richard Gray. But there was no planned or coordinated arrangement for risk assessment. Responsibility for risk assessment was diffuse and unclear. Multi-disciplinary meetings overlapped. No joint policy or procedure had been agreed between the Trust and social services despite the requirements of HSG (94)27. Risk assessment did not always take place upon discharge from hospital. There was no formal multi-disciplinary assessment of the risk to Ginny Sivil of Richard Gray's attendance at the expected home birth of their child.

Multi-Disciplinary Communication

9.11 Poor communication between practitioners has been a feature of other inquiries after homicide. It is repeated here. Key information concerning Richard Gray's thoughts of killing Ginny Sivil and his family did not become known to all professionals involved and did not reach the Home Office. This was despite many opportunities for multi-disciplinary exchange of information. Case conferences were designed specifically for conditionally discharged restricted patients and the Care Programme Approach was intended to ensure close inter-disciplinary working. At policy level HSG (94)27 stressed a need for inter-agency planning of care arrangements and that was repeated in Building Bridges. Yet communication still remains a common area of weakness. Proposals for expanded community care within the Government's White Paper *'Reforming the Mental Health Act'* must be based upon sound arrangements for communication of information concerning dangerousness. This Inquiry commends to readers those partnerships between NHS Trusts and social services departments that have brought under one umbrella the funding and planning functions of mental health care.

Home Office Reporting

9.12 The Home Office have described their willingness to receive information, not only from supervisors, but from a wide range of people involved with the care of conditionally discharged patients. An opening up of the flow of information concerning risk may improve the management of high risk patients in the community. This Inquiry

recommends that the Home Office consider how it might encourage the reporting of risk and ensure that it is able to provide the necessary safety-net should local systems break down.

9.13 Conditionally discharged patients may remain in the community for very long periods. Government proposals in the *White Paper* for compulsory treatment orders in the community bear similarities to conditional discharge arrangements. Planning for the management of compulsorily treated patients in the community should take account of the difficulties encountered by those supervising and caring for conditionally discharged patients.

10. Recommendations

Home Office

1. **The Home Office should consider the preparation of an information leaflet for distribution by social supervisors and supervising psychiatrists to professionals, police, family and carers involved with conditionally discharged restricted patients. The leaflet should explain the legal status of the patient and that the named social supervisor and supervising psychiatrist have a responsibility to report to the Home Office upon any concerns about risks to the patient or safety of others. Those receiving the leaflet should be invited to make contact with the social supervisor or supervising psychiatrist if they have any concerns of this nature.**

2. **Home Office Guidance Notes to Supervising Psychiatrists and Social Supervisors should be updated. Revised guidance should add:**

   i. **A recommendation that in addition to the exchange of reports between supervisors they be copied to other relevant professionals, for example CPN's.**
   ii. **More detailed guidance on the reporting of risk indicators. The importance of identifying patterns and trends should emphasised. Information should specifically be sought by the Home Office on any risk to named others including family. The guidance should provide specific examples of matters which should be reported to the Home Office with indications of relative urgency and pointers to recall.**
   iii. **Amended sample forms to encourage reporting of all mention of self-harm and harm to others. The Home Office should make plain that it seeks all information concerning possible risk together with the supervising psychiatrist and social supervisor's assessment of dangerousness and the rationale for that assessment.**
   iv. **Reference to the importance of regular review of long term goals where there is little indication of progress and reinforcement of the advice that in some circumstances the**

decision to recall or admit to hospital is both a necessary and positive step.

3. The Home Office should consider revision of their Guidance to Social Supervisors to include advice upon

   i. The legal framework within which social supervision may be provided by social services and probation and Home Office powers to vary the conditions of discharge.
   ii. the desirability of developing local joint policies between social services departments and probation services on resolution of disputes over the agency to undertake social supervision.
   iii. the importance of explaining the purpose of the conditional discharge to patients frequently and clearly, being aware that mental illness might at times prevent a full understanding of its implications.
   iv. the responsibility of the social supervisor actively to seek information concerning risk from other professionals closely involved with the patient.

4. A copy of the guidance for supervising psychiatrists should be sent automatically to each new RMO.

5. The Home Office should consider how it may most effectively maximise its accessibility to mental health staff working with conditionally discharged patients.

Mental Health Review Tribunals

6. MHRT guidance should include a requirement that upon making an order for the conditional discharge of any patient subject to a Home Office restriction the agency and individual who will undertake social supervision be identified and named. If the Tribunal has insufficient information to identify the appropriate individual and agency the implementation of the order should be deferred until the necessary information is obtained. This is already good practice in some areas of the country.

Department of Health

7. Independent mental health inquiries held under HSG(94)27 may suffer considerable delay as a result of the absence of a patient's consent to release of confidential documents. The Department of Health should consider the issue of guidance to health authorities on the management of this problem.

Wiltshire Health Authority and Regional Forensic Services

8. Wiltshire Health Authority (WHA) should work jointly with regional forensic services to produce proposals that will ensure adequate forensic support is available to general psychiatric practitioners dealing with conditionally discharged restricted patients

particularly where those practitioners are geographically isolated and/or inexperienced in dealing with forensic patients. Forensic support may be achieved by the appointment of a community forensic psychiatrist so that advice is easily accessible.

Forensic Services and Good Practice

9. Regional forensic services should be notified of all conditionally discharged restricted patients in their area and should consider some form of regular monitoring, advice and review service. The level of service provided in any particular case should take into account the need for continuity of psychiatric and other professional input.

10. Regional forensic services should be notified of the recall of a conditionally discharged restricted patient to a general psychiatric hospital in their area and a forensic review should always be undertaken.

Wiltshire Health Authority

11. WHA should ensure that there is an adequate alcohol and substance misuse service available to the Trust and that expert consultant advice is available to psychiatrists dealing with multiple diagnosis. In making provision for such services policy-makers should be aware of and disseminate current research on the influence of all drugs including cannabis on the presentation of patients with severe mental disorder.

Avon and Western Wiltshire Mental Health Care NHS Trust

12. Avon and Western Wiltshire Mental Health Care NHS Trust ('the Trust') should review their policy on emergency cover and working arrangements for part-time psychiatrists, with particular reference to those who are supervising psychiatrists for conditionally discharged restricted patients. This policy should include:

    i. Arrangements for adequate handover and follow through between colleagues who cover for each other so as to ensure that patients are safely managed between contacts with different consultant psychiatrists.
    ii. Procedures for immediate notification to the RMO or colleague providing cover should a conditionally discharged restricted patient be admitted to hospital.
    iii. Clarification of the Home Office reporting responsibilities of psychiatrists providing cover during the absence of the RMO.

13. The Trust should take urgent action to improve upon the disordered state of medical files. Where a patient has a very long history and a number of files, a chronology and comprehensive

summary of their risk history should be available and easily accessible on their present file or on computer.

14. The Trust should review the standard of its clinical recording and give consideration to the use of a unified records system where a patient is in a category of being at high risk to others and being supervised by a number of different agencies.

15. The Trust should ensure that hospital discharge procedures:

    i. Comply with the requirements of HSG (94)27 or the assessment of risk
    ii. Include within the nursing discharge checklist a requirement that ward staff should, where possible, request a psychiatric assessment prior to a patient taking his or her own discharge.

16. The Trust should review its policy on standards of nursing supervision to ensure that adequate and regular supervision takes place.

17. The Trust should ensure that CPN's, ward staff and their supervisors are reminded of their responsibility to keep the supervising psychiatrist and social supervisor informed of risk incidents and changes in risk level.

18. The Trust should ensure that general psychiatrists and nursing staff expected to undertake work with forensic patients receive training for this role. Consideration should be given to provision of such training jointly with social services.

19. The Trust should ensure that all medical and qualified nursing staff receive training and updates on mental health law particularly as it relates to conditionally discharged patients. Expert advice should be available within the trust and this should be easy to access by all disciplines. Urgent advice should be issued to all relevant staff concerning the legal status of conditionally discharged restricted patients who are informally admitted to hospital.

20. The Trust should develop a policy to deal with the problem of illicit drug use by patients on acute admission wards at Green Lane hospital.

21. The Trust should examine the service provided by its acute admission wards and its suitability for the care of forensic patients with complex multiple diagnoses. The Trust may wish to consider the provision of a small secure unit for short-term management of acute problems.

Wiltshire Social Services

22. Social Services should develop or secure forensic training for staff working with higher risk clients including social supervisors. Consideration should be given to the provision of this jointly with the Trust.

23. Social Services should review and revise its current policy and procedures relating to social supervision so as to take the lessons from this Inquiry into account. These should include guidance on supervision requirements including the role of the team manager in overseeing the social supervisor's work, quality standards for his or her supervision and adjustment of the social supervisor's workload to allow for the demands of the role.

Trust and Wiltshire Social Services Joint Action

24. The Trust and Social Services should jointly review their procedures for managing the care of conditionally discharged restricted patients to ensure that:

i. Social supervisors and supervising psychiatrists provide other relevant professionals with copies of the Home Office reports.
ii. There is an agreed and clearly understood joint procedure for the assessment of risk and the management of risk information. This should include the expectation that all information received that could indicate risk to the patient or others be recorded, discussed with the supervisor concerned and passed on to either the supervising psychiatrist or social supervisor.
iii. The social supervisor and supervising psychiatrist follow Home Office guidance notes using the sample reporting form recommended by the Home Office.
iv. There is guidance on the importance of including in Home Office reports all information received that might indicate the patient is a risk to himself or others.
v. All professionals regularly and closely involved with the care of such patients are aware that they are able to report directly to the Home Office should they feel it necessary.
vi. Patients, relatives, partners and carers are invited to case conferences and CPA meetings unless there is a reason why they should not be and they are then informed of this reason.
vii. Efforts are made with the patient to nominate a person as a contact in the community as required by the Trust's CPA procedures.
viii. Any named person thought to be at risk from a patient is informed of that risk.
ix. The six-monthly case conference thoroughly assesses risk on each occasion, and a regularly updated list of risk incidents is maintained.

x. A full account of the family background of a patient is compiled and is easily accessible on all medical, social work and nursing records.

25. The Trust and Social Services should jointly review policies and procedures for the various multi-disciplinary meetings (including case conferences under the procedure for conditionally discharged restricted patients, CPA, s117 after-care, Supervision Register Review and ward M-D meetings) to ensure that there are jointly agreed arrangements for multi-purpose meetings. There should be one agreed accountable process for delivering care plan objectives. If more than one kind of multi-disciplinary meeting is routinely held there should be a clear agreement and understanding as to who is responsible for convening, chairing and taking minutes or recording each meeting.

26. The Trust and Social Services should jointly develop or secure training for clinical teams working with forensic patients.

Housing

27. Social Services, North West Wiltshire Council and local housing associations should consider a joint forum at senior management level for discussion of issues/cases concerning vulnerable adults and the strategic development of supported housing for those with special needs.

Previous Inquiries

28. All professionals involved with the care of conditionally discharged restricted patients should ensure that they have knowledge of the findings and recommendations of previous independent inquiries. Trusts and Social Services should ensure that they are available to professional practitioners and those responsible for shaping policy.

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Appendix A

INDEPENDENT INQUIRY: RICHARD ALFRED GRAY
TERMS OF REFERENCE

1. With reference to the incident which took place on 12 February 1998, to examine the circumstances of the treatment and care of Mr Richard Alfred Gray by the mental health services, in particular:

   (i) the quality and scope of his health care, social care and risk assessments;

   (ii) the appropriateness of his treatment, care and supervision in view of:
   - (a) his assessed health and social care needs;
   - (b) his assessed risk of potential harm to himself and others;
   - (c) any previous psychiatric history;
   - (d) the number and nature of any previous court convictions;
   - (e) the history of Mr Gray's medication and compliance with that regime.

   (iii) The extent to which Mr Gray's care corresponded to statutory obligations, in particular national guidance (including the Care Programme Approach HC(90)23/LASSL(90)11, Supervision Registers HSG(94)5, the discharge guidance HSG(94)27 and mandatory supervision with reporting to C3 Division of the Home Office) and local operational policies for the provision of Mental Health Services.

   (iv) The extent to which Mr Gray's prescribed treatment and care plans were:
   - (a) documented
   - (b) agreed with him
   - (c) communicated appropriately within and between relevant agencies and his family
   - (d) effectively delivered
   - (e) complied with by Mr Gray.

2. To examine all the circumstances surrounding Mr Gray's visit on 12 February 1998 to the Green Lane Hospital, Devizes.

3. To examine the adequacy of procedures for collaboration and co-operation between and within all agencies involved in the care, treatment and control of Mr Gray, the provision of services to him, and between the agencies and Mr Gray's family.

4. To examine the appropriateness of the training and development of those involved in the care of Mr Gray.

5. To prepare a full report of the Inquiry's findings and recommendations for presentation in confidence to Wiltshire Health Authority and Wiltshire County Council.

6. To prepare an anonymised, executive summary report of the Inquiry's findings and recommendations for dissemination by Wiltshire Health Authority and Wiltshire County Council to interested parties.