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INTRODUCTION

This is a complex case, involving a person who, at the time of his arrest for murder in 1999, had been in contact with specialist psychiatric services for almost 30 years; it also includes a catalogue of anti-social and offending behaviour, and substance abuse. Mr Winston Williams committed murder while subject to community supervision which involved psychiatric and social services and the Home Office, and which is designed to protect the public from serious harm. Whilst recognising that no system of risk management is absolutely safe we have a duty to ask if all reasonable actions were taken to promote public safety. This inquiry report does not relate a simple narrative, and although chronologically based we have had to follow themes to make issues clear. We have confined the factual basis of our work to the early sections, adding our comments and recommendations later.

The first 7 sections comprise the factual background: the establishment of 2 inquiries following Mr Williams arrest for murder (section 1); local general psychiatry and forensic psychiatry services (3 & 4); the framework of care in the community and the role of the Home Office in cases such as this (section 5); Mr Williams' own background (6 & 7).

The major part of the inquiry panel's work is covered in sections 8 to 11 (psychiatric and social supervision, and nursing care); section 12 deals with risk management; housing is at section 13. The period immediately after Mr Williams' arrest is covered in section 14. The concluding sections cover: responses to the homicide (15), our conclusions and the actions which arise from them (16), the bibliography (17), and the appendices (18) which includes a list of abbreviations).

On 23rd May 2000 a jury at the Central Criminal Court found Mr Winston Williams guilty of the murder of Ms Katie Kazmi (aged 25) and he was sentenced to life imprisonment. The killing is thought to have occurred on 16th September 1999 at Mr Williams' bedsit at Lyon Square, Reading.

Mr Williams was arrested on suspicion of murder on Monday 20th September 1999 and transferred on a warrant authorised by the Secretary of State to a high security hospital on 22nd September. While awaiting trail Mr Williams was seen by several psychiatrists who supported a plea of guilty to manslaughter on the grounds of diminished responsibility. However, Mr Williams denied the murder and so only a plea of not guilty of murder was available to him. On the day of his conviction for murder 8 months later the Secretary of State directed that Mr Williams be transferred back to a high security psychiatric hospital (subject to Sections 47 and 49 Mental Health Act 1983) [2].

At the time of the murder Mr Williams was a conditionally discharged patient [3(v)] (and section 5 D), subject to treatment and supervision from both a psychiatrist and social worker, and monitoring by the Home Office [4].

A. Internal Inquiry.

In September 1999 the Wallingford Clinic closed and was replaced by a forensic service based at Littlemore Hospital, Oxford. The Oxfordshire Mental Healthcare NHS Trust (OMHT) assumed responsibility for the Internal Inquiry set up following the death of Ms Kazmi. (A list of all abbreviations is to be found at section 18, appendix A). The inquiry's remit was:

'To assess the care, treatment and support offered to Mr Williams in the community between his conditional discharge (section 37/41) from the Wallingford Clinic, Fair Mile Hospital in November 1995 and his arrest on 20th September 1999 in connection with the murder of Ms

Kate Kazmi, and whether the provider agencies fulfilled their obligations to him and the general public'.

The report was dated 4th November 1999 and its recommendations and the action plan it generated are reported in section 15.

B. The independent inquiry.

'(the fact) that Winston Williams was using class A drugs necessitated a review of his release into the community' (Victim's mother to trial judge).

'…public concern is well founded'. (Trial judge to Lord Chief Justice, 26.05.00).

Following the completion of court proceedings in May 2000 Berkshire Health Authority declared the intention of establishing an independent inquiry as required by NHS Health Service Guidelines HSG(94)27. The panel was appointed by September of that year; terms of reference were agreed (see section 18, appendix B) and defined the purpose of the inquiry:

'To examine the relevant circumstances surrounding the treatment and care of Winston Williams by the mental health services and from the criminal justice and social services'.

The panel members were:

Geraldine Johns (chairperson) solicitor and mental health review tribunal president,

Dave Sheppard (social work member) specialist trainer,

Dr. Paul Bowden (medical member) consultant forensic psychiatrist.

i. The approach of the independent panel.

'Winston Williams, a diagnosed schizophrenic, with a history of violence and drug abuse…was allowed to roam the streets of Reading as a so-called 'care in the community' patient…

My constituents wish to challenge the procedures which allowed Mr Williams to remain at large'.(A Reading MP to the Home Secretary 24.05.00 & 19.09.00).

We informed ourselves as comprehensively as possible about the background of the case and approached taking evidence as both a means of gaining further information and a way of seeking an understanding of judgements and practices. We were acutely aware of the influence of hindsight bias [5] and tried always to use the model of good practice, putting aside, if possible, the tragic outcome in this case. However, behind it all was the fact of Ms Kazmi's death, and the circumstances in which it occurred, and in the end we had to make judgements and identify any shortcomings in Mr Williams' treatment and care. We believe that where there is a conflict of interests in the community management of patients such as Mr Williams public protection is the priority, and all other management issues flow from that. We have tried to be fair and have only made criticism when the panel members have been in agreement on a particular matter. It is our hope that the report will be a positive contribution to the management of patients such as Mr Williams.

A great deal of information was collected in producing this report. We have attempted to give a full account of Mr Williams' care and supervision [6], (attention is drawn to section 18 appendix F which for convenience has been placed at the end of the report and which summarises professionals contact with Mr Williams). Personal background information about non-professionals and the use of their names have been kept to a minimum. This is in

accordance with the Health Authority's obligations under the European Convention of Human Rights with particular regard to the right to respect for private and family life (Article 8). As far as professionals are concerned we have only included names where not to do so would have added to the report's complexity.

We also hope that those working in the field of mental health will benefit from reading a comprehensive audit of one particular case, not because general conclusions can be drawn from a very rare, and therefore unlikely to be repeated outcome, but because the processes which contributed to the outcome are commonplace.

ii Procedure.

The panel adopted the procedure set out at appendix B section 18; appendix C sets out a sample of the letter sent to witnesses. This report is based on their evidence and consideration of the records, policies and other documentation made available to the panel. Panel members are not aware that any documents have been withheld, although some nursing and social work records were untraceable.

The panel visited: the Reading area, including Lyon Square; the former base of the Wallingford Clinic at Fair Mile Hospital; the Oxford Clinic. The panel studied all the available medical and nursing notes, probation records, police statements relating to the trial, and Home Office and social service records.

In order to consider the treatment, care, and support and supervision provided in this case it has been necessary to review Mr Williams' personal history; to become familiar with the individual and the background to the situation and circumstances; to identify any factors and events which may have affected his behaviour in the course of his illness; to clarify to what extent those factors and circumstances were taken into account by those responsible for providing the care, treatment and support.

The panel was able to gain information about Mr Williams' personal and family history not only from records but also from family members and Mr Williams himself. The panel also met with members of Ms Kazmi's family.

All witnesses were asked to confirm that in matters of fact their evidence would be true. In the bulk of this report the panel have taken what is contained in the background papers, and what was said to them at face value; by repeating it they are not, and cannot, confirm its veracity. Where evidence has been conflicting, or contradictory, they have sought to make a judgement as to the likely true state of affairs.

The inquiry panel is particularly grateful to family members for their co-operation and openness. It is hoped that the inquiry may serve in part to provide them with information which we hope will help them understand the course of events.

Inquiry panel members are also grateful to Dr Michael Farrell and Mr Bill Jackson who acted as expert witnesses. Dr Farrell is a consultant psychiatrist at the Maudsley Hospital and senior lecturer at the Institute of Psychiatry. He has responsibility for a large community drug and alcohol service in south-east London and has particular research interests in population-based studies of patterns of drug use, co-morbidity and also in treatment evaluation and broader drug policies. Mr Jackson, a social worker, has been a specialist trainer in forensic mental health social work practice.

Mrs Lynda Winchcombe of GW Management Consultants Ltd acted as manager to the inquiry, a role she fulfilled excellently. She also brought a deep knowledge of local mental health services and their development, and her wise counsel made a significant contribution to the panel's work.

The report was delivered to the health authority in late spring 2002 to enable the responsible authorities to address the recommendations and produce a response to each, together with an action plan.

NOTES.

1. The term **Internal Inquiry** is used to refer to the review set up by Oxford Mental Healthcare Trust in September 1999. The term **independent inquiry (or panel)** is used to refer to the review set up by Berkshire Health Authority in May 2000 and is the body responsible for this report.
2. Section 47 Mental Health Act 1983 relates to the removal to hospital of persons serving sentences of imprisonment. The Secretary of State must be satisfied that the person is mentally disordered, that it is appropriate for him to be detained in hospital, and that it is expedient to make an order. When the Secretary of State is satisfied that it is no longer appropriate for Mr Williams to be detained in hospital for medical treatment he will be transferred back to prison. Section 49 MHA 1983 restricts the discharge of prisoners removed to hospital.
3. i Hospital order

   Section 37 Mental Health Act 1983 empowers a Crown Court to order a person's admission to and detention in a hospital specified in the order (a hospital order).

   The court can only make a hospital order if it is satisfied on the evidence of 2 registered medical practitioners that the offender is mentally disordered and that:

   (a) the disorder is of a nature or degree which makes it appropriate for him to be detained in a hospital for medical treatment and that such treatment is likely to alleviate or prevent a deterioration of his condition, and

   (b) the court is of the opinion that the most suitable method of disposing of the case is by a hospital order.

   ii. Restriction order

   Section 41 of the 1983 Act empowers a Crown Court at the same time as it makes a hospital order to make a restriction order (either time-limited or without limit of time).

   A restriction order may be made if it appears to the court, having regard to the nature of the offence, the antecedents of the offender and the risk of his committing further offences if set at large, that it is necessary for the protection of the public from serious harm to make the order.

   iii. Application to the mental health review tribunal

   Under section 70 of the 1983 Act a person who is subject to a hospital order and a restriction order (a restricted patient), and who is detained in hospital, can apply to a tribunal after he has been detained for 6 months. After he has been detained for 12 months he can re-apply annually. (Under section 71 of the 1983 Act the Secretary of State may at any time refer the case of a restricted case to a tribunal and must do so when his case has not been considered by a tribunal for 3 years).

iv. Absolute discharge

Under section 73(1) of the 1983 Act, read with section 72(1), where an application is made to a tribunal by a restricted patient, or where his case is referred to the tribunal by the Secretary of State, the tribunal is required to direct the absolute discharge of the patient if satisfied:

(a) (i) that he is not suffering from mental illness, psychopathic disorder or from any of those forms of disorder of a nature or degree which makes it appropriate for him to be liable to be detained in a hospital for medical treatment; or

(ii) that it is not necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment;

AND

(a) that it is not appropriate for the patient to remain liable to be recalled to hospital for further treatment.

By virtue of section 73(3), where a patient is absolutely discharged he ceases to be liable to be detained by virtue of the hospital order and the restriction order ceases to have effect.

v. Conditional discharge

Under section 73(2) where the tribunal are satisfied as to either the matters referred to in paragraph (a) above, but not as to the matters referred to in paragraph (b) above, they are required to direct the conditional discharge of the patient. By virtue of section 73(4) a patient who has been conditionally discharged may be recalled by the Secretary of State under section 42(3).

vi. Secretary of State's power of recall

The Secretary of State has power to recall a patient who he himself has conditionally discharged or who has been conditionally discharged by a tribunal. This power is given by section 42(3) of the 1983 Act which says:

> 'The Secretary of State may at any time during the continuance in force of a restriction order in respect of a patient who has been conditionally discharged under sub-section (2) above by warrant recall the patient to such hospital as may be specified in the warrant.

4 The panel was told that at the beginning of February 2001 there were 1114 conditionally discharged patients in the community. Between 1996 and 2001, 326 individuals were recalled on 373 occasions (some, like Mr Williams, being recalled more than once).

5. Hindsight means perception after an event. In the context of homicide inquiries the phrase 'hindsight bias' is often used to suggest that the fact of the homicide influences the way in which events which occurred beforehand are viewed. This retrospective judgement, made after the outcome (of homicide) is known, assumes that the outcome was predictable and even inevitable, with an understandable causal structure. In this report a distinction is drawn between events which could have been known about if a reasonably inquisitive approach had been adopted, and those which could not. The question which must be asked repeatedly is: 'Did the professionals put themselves in a position of knowing?' It does not, of course, follow that if the answer is 'Yes', that they would have had a full (or fuller?) picture; it simply means that putting oneself in a position of knowing provides the *possibility* of having a fuller picture. Not to put oneself in the position of knowing precludes having more information.

6 Of 425 patients discharged from Special Hospitals in 1982 and 1983, 34% were convicted of any offence 10 ½ years after discharge, 15% of an offence of violence, 7.5% of a sexual offence, and 15% of 'any serious offence' (see Buchanan, 1988).

2 SUMMARY

Section 2 provides a resume of the main findings of the report.

A. The subject. On 23rd May 2000 Mr Winston Delorn Williams (aged 54) was found guilty of the murder of Ms Katie Kazmi. Ms Kazmi (aged 25) was stabbed to death at Mr Williams' Lyon Square home in September 1999. At the time of his arrest in September 1999 Mr Williams was subject to psychiatric and social supervision in the community under the aegis of the Home Office.

In both 1976 and 1978 Mr Williams was made the subject of hospital orders after attacking men with knives. In 1976 the attack was prompted by the conviction that the victim intended to harm Mr Williams' daughter. In 1978 similar delusional beliefs concerned Mr Williams' wife and his ex-employer. The 1978 attack also involved a passing paper boy. Both the 1978 attacks were life-threatening and on his conviction an order was made restricting Mr Williams' discharge from hospital; the order also brought his case under the purview of the Home Office.

In addition, Mr Williams has 4 other convictions for offences of violence (2 involving a knife), and 2 for possession of an offensive weapon (knives). Mr Williams was diagnosed as suffering from the severe mental illness schizophrenia in 1972 and spent short periods in hospital in both 1972 and 1976, on both occasions as a detained patient (i.e. formal or compulsory admissions). Following his conviction in 1979 Mr Williams was admitted to a maximum security hospital; he was conditionally discharged (i.e. with the continuing power of recall to hospital) to accommodation in Reading in 1984.

A year later Mr Williams' mental illness relapsed and he was recalled to a maximum security hospital in 1985 after making a very serious suicide attempt. In 1989 he was transferred to the Wallingford Clinic from where he was conditionally discharged (again, by a mental health review tribunal) 11 months later. He was recalled to the Wallingford Clinic in late-1994 after refusing medication and making threats to kill his social worker. By the time he was conditionally discharged for the 3rd time, in October 1995, he was known to be a problem drinker, and to be a user of both cannabis and cocaine.

At the time of Mr Williams last discharge from hospital his personality profile would have included the following: a lack of insight/denial (not acknowledging his illness, and denying or minimising his offence behaviour); avoidant (evasive, secretive, untruthful, devious); violent (aggressive, impulsive, demanding, truculent, selfish); jealous (manipulative, exploitative, invasive, arrogant); substance abusing (alcohol, cannabis, cocaine).

Mr Williams has always denied killing Ms Kazmi and so the immediate sequence of events which led to her death remains unknown. It is, however, this panel's view that Mr Williams' continuing cocaine use played a central role in the unfolding tragedy, with its direct (intoxicating) and indirect (on life-style and relationships) effects. The factors determining the eventual outcome were: a combination of cocaine, a violent man, and a man with severe mental illness.

B. Findings.

i. Institutional shortcomings. Management and clinical staff at Wallingford Clinic failed to follow CPA guidance. The forensic team worked from a hospital base which was relatively isolated from the community it served.

The Home Office failed to update its *Guidelines* (particularly for psychiatric supervisors), to respond appropriately to some reports, to advise supervisors on legal matters, and to hold

an internal review of the case. Furthermore, more than 2 years after the release of the report of the Internal Inquiry, the Home Office had not requested a copy of the document. Information provided by the Home Office to the police failed to give any useful information on Mr Williams.

ii. **Shortcomings in the multi-disciplinary team.** National and local guidance on the Care Programme Approach were largely ignored, including: allocation of a key worker, completion of a care plan, systematic assessment, regular review. The patient and significant others were always absent from CPA meetings, and the process was eventually abandoned. No centrally held CPA documentation for Mr Williams exists.

Patchy, partial, and sometimes idiosyncratic recording and reporting raises questions of professional practice.

Risk management was basically flawed because professionals did not put themselves in a position of knowing (e.g. by visiting Mr Williams at home, by using informants, seeking expert advice regarding urine testing in the context of his substance abuse). The good-practice-goal of informed objectivity was replaced by a position of mutual reassurance, and in the end Mr Williams' management was largely on his own terms. There was an absence of any consideration of several major risk indicators; threats to kill the social worker; pathological jealousy; carrying a weapon. Relapse profiles were not identified, and a child protection team and named worker were not contacted when concern was raised about Mr Williams' behaviour. The significance of substance abuse was never fully appreciated, and the cornerstone of risk management, urine testing, was abandoned. There was an absence of sustained (and, sometimes, any) increased vigilance in periods of increased risk.

Communication and its recording were deficient. Corridor chats, more suited to discussing in-patients where other contemporary records are made, replaced formal, recorded case discussions. There was no systematic recording of goals and progress, and no handover notes. Failures in communication in this case can be judged from the following list which illustrates subjects of which one or other parties to the supervision were unaware: that Mr Williams carried weapons; that there were threats to kill a social supervisor; about the 'phone call alleging cocaine dealing, involvement in prostitution, and tampering with urine samples; that he had lost his driving licence; that he was driving school transport whilst unlicensed; about rent arrears; about the frequency and nature of the other supervisor's contact. Furthermore, a clinician standing-in for one supervisor who was on leave did not know of Mr Williams' cocaine use. Reporting to the Home Office was often late, sometimes misleading (always in the direction of minimising risk), and sometimes contained significant omissions. There was no evidence of any system of recording, storing, or culling notes.

Despite obvious difficulties there were failures in the development of constructive links with family, friends, girl friends, or other informants, and later contact with housing and the benefits agency was minimal or absent. While work load was a significant issue for Mr Williams' last social supervisor it had little direct bearing on the psychiatric supervision he provided.

iii. **Individual shortcomings.** There was no attempt to outline the main features of Mr Williams' psychiatric history and mental state in narrative form as a diagnostic formulation. Psychological interventions were almost completely disregarded, as were social and environmental factors; management was reactive, and limited to the prescription and administration of a single drug.

Out-patient management was unplanned and chaotic. There were no effective forward-appointment or bring-up systems. There were long periods with no contact and a reliance on nurses' monitoring the mental state when, in reality, they were not doing so. Social and psychiatric supervision was not staggered. There were failures of recording and reporting.

There was a failure to follow a risk assessment protocol.

Much was known about Mr Williams but there were failures in recording and communication; much more could have been known about him, and fuller knowledge could well have brought a sustained increase in the quality of supervision he received. The absence of that knowledge led to one supervisor believing he had a satisfactory supervisory relationship with Mr Williams while another believed that it was not necessary to follow supervision guidance in the case. Mr Williams response to his supervisors' complacency was to tell them different lies, apparently secure in the knowledge that, if it happened at all, it would be some time before his supervisors compared accounts.

The manner in which the competent multi-disciplinary team assessment undertaken after Mr Williams' arrest was over-ridden was not in keeping with good practice.

C. Conclusions. If he had been managed in a proactive, assertive, intrusive and informed way Mr Williams would still have been an extremely difficult patient to supervise. However, by 1999 he had been allowed to progressively undermine his supervisors' control of his community care so that he came to be managed as if he were a minimal risk, socially stable, and not substance abusing. If Mr Williams had been managed assertively the conflict of interest between public safety and his own wishes would have been inescapable. However, the factors indicating public risk were gradually eroded, and denied in the psychological sense; they were replaced by complacency. That complacency led to three serious shortcomings: of communication, as was reflected in the uninformed and incorrect expectations regarding others' activities in Mr Williams' case management; the maintenance of CPA processes; in seeing Mr Williams frequently, or at his home.

Section 16 outlines both the report's main recommendations and the actions which have been, are, and will be taken to tackle the shortcomings identified.

A number of comments were brought to the inquiry panel's attention at the beginning of its investigations. We have quoted some comments in the body of the report; others are listed below.

'Mr Williams, a diagnosed schizophrenic with a history of violence and drug abuse was…allowed to roam the streets of Reading as a so-called care in the community patient'. 'My constituents wish to challenge the procedures which allowed Mr Williams to remain at large'. (A Reading MP to the Home Secretary).

'..the fact that Mr Williams was using class A drugs necessitates a review of his release into the community'. (Ms A to trial judge).

Asking if the homicide was avoidable, and who was to blame are understandable questions but they are unanswerable. Mr Williams bears responsibility for the death of Mrs Kazmi. We have, however, tried to address all the issues raised by the families, and other interested parties including ourselves. The explanations are complex and we have identified significant shortcomings, but their earlier remedy would not necessarily have meant that the outcome would have been different.

3 LOCAL PSYCHIATRIC SERVICES

The purpose of this section is to summarise how local psychiatric services were, and are, organised and provided in Berkshire.

There have been many changes within Berkshire's mental health services over the last 10 years; some of these were in response to national initiatives, whilst others have been driven by local needs.

In the year 2000, Berkshire had a population of about 803000 spread across 6 unitary authority areas [1]. It is an urban/rural mix with Reading and Slough being the most densely populated areas.

The Department of Health Mental Health Task Force estimated that, in an average population of 1000 people, one individual will be severely mentally ill and have complex needs requiring integrated and assertive care; a further 5 will have severe illness requiring multi-disciplinary, long-term health and social care. Applying this formula to the adult population of Berkshire it is estimated that about 550 individuals have complex needs; a further 3000 requiring multi-disciplinary care.

These figures are imprecise. Many inter-related factors affect the number requiring care including: social disadvantage, homelessness and poor housing, unemployment and poverty. The 2 most frequently used deprivation measures, Jarman and Townsend scores (which are measures of deprivation based on deprivation factors such as homelessness, poor housing, unemployment, low social status and the effects of poverty) indicate that Reading and Slough have above-average deprivation scores, and Bracknell, Newbury, Windsor, and Maidenhead, below average.

In 1989 Berkshire was divided into 2 health authorities, East and West, with 3 mental health units providing in-patient and community services: Wexham Park and Heatherwood (East Berkshire), and Fair Mile (West Berkshire). Health authorities are charged with commissioning mental health services for local people that are effective and efficient within available resources. They also have a strategic role which includes developing and implementing collaborative strategies with other statutory agencies and voluntary organisations, and meeting national and local priorities. This is done by monitoring the standards of the care provided. In 1992 the 2 health authorities merged to become Berkshire District Health Authority, itself being renamed Berkshire Health Authority in 1996.

Between 1992 and 1993 6 NHS trusts [2] were established across Berkshire; one, the West Berkshire Priority Care Services NHS Trust was charged with providing general community mental health and learning disability services to West Berkshire (and, to Mr Williams, the subject of this inquiry).

A. County-wide strategy. A mental health strategy conference hosted by Berkshire Health Authority in 1996 reached broad agreement about the future direction and configuration of mental health services which had previously developed very differently in the east and west of the county. The strategy was agreed and implemented jointly with both other statutory and voluntary agencies. Part of the plan was that the forensic psychiatric services [3] based at the Wallingford Clinic, Fair Mile Hospital, should provide a county-wide service with local outreach or out-patient services.

The plan was for 3 centres to provide adult acute in-patient beds: Wexham Park Hospital at Slough, Heatherwood Hospital at Ascot, and a new facility (sponsored by the Private Finance Initiative) on the old Prospect Park Hospital site in Reading. A related issue was the closure of Fair Mile Hospital and the re-provision of its general psychiatric services at Prospect Park. The strategy, published in November 1998, was based on 7 service principles:

- an ordinary life;
- the promotion of independence and individual needs;
- local and accessible;
- equity;
- a choice of services;
- the involvement of users;
- the needs of carers.

A number of objectives had to be met to achieve these principles:

- a co-ordinated range of services;
- a multi-disciplinary service;
- a single management structure;
- the re-provision of Fair Mile;
- education - to pursue appropriate consultation and educative programmes to ensure the effective integration of people with mental health problems into local communities;
- users and carers - to develop and encourage local user and carer groups and networks and the formation of multi-agency mental health forums.

B. The National Service Framework (NSF). The National Service Framework for mental health was published in September 1999 and the draft of Berkshire's NSF implementation plan appeared 3 months later; the final plan was agreed in March 2000, with a review in April 2001.

Standard 1

Health and social services should:

- promote mental health for all, working with individuals and communities;
- combat discrimination against individuals and groups with mental health problems, and promote their social inclusion.

Standard 2

Any service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed;

- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if required.

Standard 3

An individual with a common mental health problem should:

- be able to make contact around the clock with the local services necessary to meet their needs and receive adequate care;
- be able to use NHS direct, as it develops, for first-level advice and referral on to specialist help-lines or to local services.

Standard 4

All mental health service users on the Care Programme Approach (CPA) should:

- receive care which optimises engagement, prevents or anticipates crises, and reduces risk;
- have a copy of a written care plan which: includes the action to be taken in a crisis by service users, their carers, and their care co-ordinators; advises the GP how they should respond if the service user needs additional help; is regularly reviewed by the co-ordinator;
- be able to access services 24 hours a day, 365 days a year.

Standard 5

Each service user who is assessed as requiring a period of care away from their home should have:

- timely access to an appropriate hospital bed or alternative bed or place which is: in the least restrictive environment consistent with the need to protect them and the public; as close to home as possible.
- A copy of a written after-care plan agreed on discharge, which sets out the care and rehabilitation to be provided, identifies the care co-ordinator, and specifies the action to be taken in a crisis.

Standard 6

All individuals who provide regular and substantial care for a person on the CPA should:

- have an assessment of their caring, physical and mental health needs, repeated on at least an annual basis;
- have their own written care plan, which is given to them and implemented in discussion with them.

Standard 7

Local health and social care communities should prevent suicides by:

- promoting mental health for all, working with individuals and communities (standard one).
- delivering high quality primary mental health care (standard two);
- ensuring that anyone with a mental health problem can contact local services via the primary care team, a help-line or an A&E department (standard three);
- ensuring that individuals with severe and enduring mental illness have a care plan which meets their specific needs, including access to services round the clock (standard four);
- providing safe hospital accomodation for those that need it (standard five);
- enabling individuals caring for someone with severe mental illness to receive the support which they need to continue to care (standard six).

And in addition to:

- support local prison staff in preventing suicides among prisoners;

- ensuring that staff are competent to assess the risk of suicide among individuals at greatest risk;
- developing local systems for suicide audit to learn lessons and take any necessary action.

The NSF resulted in a need to update the county's mental health strategy, along with those of local authorities and community care providers.

The priorities set out in the current implementation plan include opening local secure beds, creating better 24-hour access to mental health services county-wide, special emphasis on enhanced Care Programme Approach (CPA, and see sections 5 and 11), and developing both supported accomodation and 24-hour staffed community beds.

C. Re-configuration of mental health services. In April 2001 a new mental health and learning disability trust was set up: Berkshire Healthcare NHS Trust with a responsibility for all mental health and learning disability services across Berkshire. West Berkshire Priority Care Services NHS Trust and East Berkshire Learning Disabilities NHS Trust were dissolved, and the mental health units at Wexham Park and Heatherwood Hospitals were transferred to the new Trust.

Other changes have included the establishment of 8 primary care groups [4], 4 of which became primary care trusts [5] in April 2001. They have taken over a commissioning function for the areas they cover.

D. Fair Mile Hospital and its replacement. Fair Mile hospital was established as a Victorian asylum, built in the late 1800s; the fabric of the building has for some time been in very poor condition. Although the hospital provides a service to West Berkshire county boundary re-configuration in the 1960s now places it in Oxfordshire.

The hospital continues to provide an in-patient service for acutely ill adults as well as rehabilitation and continuing care. There were (in mid-2001) 91 acute beds on 4 locality-based admission wards, and 16 intensive care beds. Other services provided from the site include:

- day-care therapies;
- rehabilitation;
- community psychiatric nursing;
- psychology;
- occupational therapy;
- pharmacy services.

The Coley Clinic was a community mental health team (CMHT) base in Reading between 1989 and 1997. The CMHT moved to Prospect House, occupying the 2 upper floors above the day hospital in August 1997. The CMHT consisted of social workers, community psychiatric nurses, an occupational therapist, a community support worker and administration and support staff. Psychotherapeutic services and the therapeutic community were, and still are, sited at Winterbourne House. It is hoped that the Fair Mile Hospital transfer to the Prospect Park site will be completed by 2003. The range of services will include: general adult psychiatry, community mental health teams, an assertive community treatment team, and court diversion.

The 13-bed medium secure unit, the Wallingford Clinic, at Fair Mile Hospital closed in September 1999 (see section 4), and was replaced by a new 30-bed medium secure unit, the Oxford Clinic at Littlemore Hospital, Oxford. Berkshire initially commissioned 14 of these beds, increased by one after the move from Fair Mile. A second new 10-bed medium secure unit on the Littlemore site provides for individuals with learning disabilities combined with mental disorder, and special needs. Berkshire commissions 5 of those beds.

NOTES

1. **Unitary authority:** an organisation which is responsible for all local government services in its area.
2. **NHS trust**: an organisation that provides health care within hospitals and the community and is funded by the NHS.
3. Forensic psychiatry is the application of the principles of general psychiatry to that part of the population which comes into direct contact with legal processes either in criminal or civil actions as a result of mental disorder (see Thornicroft & Szmukler, 2001). Forensic psychiatry is a tertiary service (general practice is the primary level of care; general psychiatry, a secondary service).

   The Royal College of Psychiatrists (2000) described the scope of forensic services as:

   'Forensic services vary considerably in their organisation and degree of integration with generic services. There is a need (for) locally agreed access criteria. These services should include a dedicated in-patient provision for mentally disordered offenders, risk assessment advice to local services and specific treatment provisions for dangerous patients with specific psychopathologies, such as some personality disorders and sexual pathologies'.
4. Primary care group: this is a sub-committee of the health authority. A geographically-based, multi-agency group including GPs, community nurses and social workers that take a lead in improving the health of local people.
5. Primary care trust: a locally-managed free-standing body responsible for commissioning and delivering health care to its local population.

4. THE WALLINGFORD CLINIC

This section covers the establishment and development of forensic services.

In the latter 1980's the Oxford Regional Health Authority (RHA) served the contiguous middle-English counties of Berkshire, Buckinghamshire, Northamptonshire, and Oxfordshire. In comparison with other health authorities Oxford RHA was late in implementing the recommendations of the Committee on Mentally Abnormal Offenders (Home Office and Department of Health and Social Security, 1975) relating to the development of forensic psychiatric services in general and regional secure units in particular. Oxford RHA finally made a decision to establish 2 units: the first to cover the south of the RHA's area of responsibility, at Fair Mile Hospital near the village of Wallingford (see map at 18 D); the second at Milton Keynes, to cover the north.

When it opened in April 1989 the Wallingford clinic was relatively small; it was also an interim unit in that it occupied converted existing buildings pending a decision by the RHA on the type, scale, and sighting of a permanent service. Geographically Fair Mile Hospital is in south Oxfordshire and administratively the 13-bedded unit always served Berkshire (803000 in the year 2000 and 8 designated beds) although a disproportionate number of east Berkshire patients tended to be referred out of county for geographical reasons. It also served most of Oxfordshire (600000 population, and 5 beds).

Dr Henrietta Bullard was appointed as a consultant forensic psychiatrist to establish the Clinic in October 1987. She provided a service to both counties; she was also the regional adviser and lead in forensic psychiatry. The closure of Borocourt Hospital in 1994, which, among other facilities, provided a secure service for patients with learning disabilities, raised the issue of whether a single regional unit could serve both mental health and learning disabilities in different buildings.

A court-based 'Divert' scheme has been operating in Reading for more than a decade, and was extended to east Berkshire in 2001. Its aim is to divert appropriate mentally disordered offenders from the criminal justice system to psychiatric services.

When Dr Robert Ferris joined Dr Bullard in February 1993 as a second consultant forensic psychiatrist it was agreed that they would sectorise with Dr Ferris taking responsibility for Berkshire, and Dr Bullard, Oxfordshire. At about this time a decision had been made to develop 2 units: an expansion of the secure forensic unit at Milton Keynes, and a new-build at Oxford. It was also agreed that Dr Ferris would take the medical lead in the development of the new unit, a programme driven by the existing Oxford services.

Below is represented a ranking of the 6 commonest known sources of referrals to the whole of the forensic service (i.e. requests for assessments at the Clinic's out-patients and elsewhere) for the period from January 1991, until its closure in September 1999. The figures are percentages of all known referrals (of 2 894 referrals, in only 2 224 were the sources of the referrals recorded). (Besides the sources ranked below the other 19% of referral sources include 'social services', and 'social worker' etc).

Table 1: sources of referral as percentages of all referrals.

Source of referral	% of all known referrals. N=2224	Assessed by
Psychiatrist*	23	Occupational therapists, psychologists, & psychiatrists
Solicitor	14	Mostly psychiatrists and psychologists
Police	13	All by CPNs
Prison	12	Psychiatrists
Divert & court	11	Mostly psychiatrists
Probation	8	Mostly psychologists

** includes the following categories: consultant psychiatrist, junior doctor.*

Following its opening the Wallingford Clinic always had a full complement of patients, and, a waiting list.

Details of the last 50 admissions and discharges to, and from, the Wallingford Clinic before its closure in September 1999 are shown below. (The figures are percentages).

Table 2: the Clinic's last 50 admissions and discharges.

	Special Hospital	prison	Non-NHS hospital	community	Oxfordshire NHS hospital	Berkshire NHS hospital
Admitted from	6	42	4	12	16	20
Discharged to	4	10	6	34*	30	16

** 14% to specialist forensic after care and 20% to general psychiatry*

Oxfordshire provided no move-on facilities for its Wallingford Clinic patients, and while Berkshire provided some, they were difficult to access.

Following the discharge of her patients from the Wallingford Clinic Dr Bullard pursued a policy of placing her patients with non-specialised Oxfordshire general psychiatric (generic) services whereas Dr Ferris tended to continue to retain responsibility for his patients, seeing them as out-patients in one of the administrative portacabins at Fair Mile (mostly) or on Thursdays at the probation-based court diversion scheme's offices in Reading. Some of Oxfordshire's maximum security ('Special Hospital') patients have also passed directly through a unique rehabilitation service at Littlemore Hospital.

In addition to his in-patient work Dr Ferris came to have from 12-15 regular out-patients and responsibility for the Reading court diversion scheme. He also visited HMP Bullingdon each week.

The Oxfordshire Mental Healthcare NHS Trust had gone a considerable way in planning a new unit when the Private Financial Initiative (PFI) was introduced. The capital limit on expenditure was such that it was forced to go back to the beginning; it was one of the early schemes and much of the guidance and standard contracts had yet to be produced. A summary of the situation was provided in *The 7th Biennial Report (1995-1997) of the Mental Health Act Commission* regarding a visit in February 1997 to West Berkshire Priority Care Services NHS Trust:

'Repeated postponements of plans for relocation and expansion of the Wallingford Clinic RSU service, the latest being attributed to the complexities of the Private Finance Initiative, are causing problems. Patients from the area who need a secure bed are being accommodated far away, while patients ready to move on have long waits for suitable placements'.

In early September 1999 the Wallingford Clinic transferred to the Oxford Clinic at Littlemore Hospital.

For Mr Williams this meant that until about 2 weeks before the homicide he remained a patient of the West Berkshire Priority Care Services NHS Trust, and at the time of the homicide, of Oxfordshire Mental Healthcare NHS Trust. In effect, he had visited the Wallingford Clinic for the last time on 27th August when his depot injection was administered. His next (unscheduled) depot injection and out-patient visit were to be at the newly-opened Oxford Clinic.

Because of its patients' characteristics all those in-patients discharged from the Clinic should have come under after-care provisions which were introduced for the first time in the 1983 Mental Health Act (see section 5 A and B). These provisions are discussed in the next section.

5. THE FRAMEWORK OF CARE IN THE COMMUNITY

This section outlines both the statutory provisions and government guidelines which underpin care in the community; each have been developed to provide for local needs and these policy documents are also discussed. Finally, as a partner in the management of conditionally discharged patients the role of the Home Office is also covered.

'The CPA can and should be applied to all patients who are accepted by the specialist psychiatric services. The reason for applying the CPA to all patients is simple; it is the only way in which we can hope to ensure that people receive the services they need and that no vulnerable people slip through the net of care' .(*Building Bridges,* 1995 para 1.3.6).

A. Legislation. The 1983 Mental Health Act addresses the issue of after-care.

The relevant section reads (in part):

117. – (1) This section applies to persons who are detained…in pursuance of a hospital order (like Mr Williams)…and then cease to be detained and leave hospital.

(2) It shall be the duty of the…Health Authority and of the local social services authority to provide, in co-operation with relevant voluntary agencies, after-care services…until such a time as (the authorities) are satisfied that the person concerned is no longer in need of such services'.

In addition, section 118 of the 1983 Act charges the Department of Health with producing a *Code of Practice* which appeared first in 1990 and was revised in 1993 and 1999. The *Code* is dealt with below.

B. Guidelines: Department of Health. In 1989 the Department of Health and Social Security (DHSS) issued a circular regarding the discharge of patients from hospital (Health Circular HC(89)5) which states that no patient may be discharged until the doctors have agreed that everything reasonably practicable has been done to organise the care a patient will need in the community. This includes making arrangements for any necessary follow-up, and support in the place to which they are being discharged. Their relatives should also be fully informed about such things as medication, symptoms to watch for, and where to get help if it is needed. Important points must be confirmed in writing. One member of staff caring for that patient should have the responsibility of checking that the necessary action has been taken before the patient leaves hospital. A check-list should provide a permanent record of action taken before discharge. General practitioners should be given all the information they need.

With the intention of ensuring the support of those with mental illness in the community, and thereby minimising the risk of them losing contact with services and maximising the effect of therapeutic intervention, the DHSS issued further guidelines in 1990 which were titled '*Care Programme Approach' (*Health Circular HC(90)23). These guidelines are now known universally as the CPA. The guidelines provide systematic arrangements for assessing the health care needs of patients who can potentially be treated in the community. A keyworker should be appointed for the patient, and that person's role is to keep in close touch with the patient, and to monitor the treatment and help which is given. A particular responsibility of the keyworker is to review the care plan and advise professional colleagues on its modification; every effort should be made to sustain a therapeutic relationship and to be informed as to what is happening.

The issue of the risk which patients may represent after discharge was addressed in *Guidance on Discharge* (Health Service Guidelines HSG(94)27) which was circulated in 1994. It reiterated previous recommendations concerning good practice on discharge and added that any risk to the public or to patients should be minimised as far as possible. The 1994 guidance emphasised the essential elements of an effective care plan:

- the existence of a care plan;
- the allocation of a key worker;
- systematic assessment;
- regular review.

Furthermore, the professionals responsible for making discharge decisions should be satisfied that these conditions are fulfilled before any patient is discharged. Arrangements for discharge and continuing care should be understood and agreed by the patient and everyone else involved including: knowledge of the first care plan review date; information relating to any violence or assessed risk; the name of the key worker and how that person can be contacted should the need arise; what to do if the patient fails to meet agreed requirements and commitments.

There should be a full assessment of risk prior to discharge which involves:

- ensuring the relevant information is available
- conducting a full assessment
- seeking expert help if necessary
- assessing the risk of suicide.

A proper assessment cannot be made if available information is not part of the risk assessment.

The *Report into the Care and Treatment of Christopher Clunis* (Ritchie et al, 1994) highlighted a number of inconsistencies in the application of s.117 after-care and included the recommendation that:

> 'A new form should be designed for use in all s.117 after-care cases, similar to other forms which are presently standardised under the Mental Health Act'.

The Government accepted the principle of this recommendation but were unwilling to make it a statutory requirement.

In February 1995 the Department of Health issued an after-care form designed for use for all patients discharged from psychiatric in-patient treatment. Its use was '**…not mandatory but highly recommended'** as representing good practice.

West Berkshire Priority Care Services NHS Trust and Reading Social Services were required to establish procedures for after-care arrangements with special consideration being given to restricted patients such as Mr Williams. They did so in 1994.

The *Code of Practice* also states that records should be kept of all those patients to whom section 117 could apply and for those for whom arrangements have been made under section 117.

In October 1999, the Department of Health issued a policy booklet *Effective Care Co-ordination in Mental Health Services – Modernising the Care Programme Approach.* It confirmed the Government's commitment to CPA as:

> '…the framework for care co-ordination and resource allocation in mental health (and set out changes to the CPA which) …take account of available evidence and experience and which will make the CPA an even more effective and efficient system of care co-ordination. (The document noted) the essence of effective care co-ordination is sound professional

judgement and practice. The implementation of any care co-ordination process can be no substitute for this. Rather, it is intended to support good professional practice. It is recognised that much work has been invested in the development of CPA procedures and practice across the country. However, research has demonstrated that the effectiveness of implementation and, indeed, commitment to the CPA is variable. It is right, therefore, that a clear policy position on implementation is given and that this builds on the good practice and experience available' .

In February 2001, The Care Programme Approach Association updated its guidance first published in 1998 and issued the *CPA Handbook* which focuses on the role of the care co-ordinator (formally the CPA key worker) as **'…the linchpin of the whole process'.**

In June 2001, the Department of Health issued *An Audit Pack for Monitoring the CPA* which up-dated a document first published in 1996.

i. **Local CPA guidelines.** The Care Programme Approach was to be implemented nationally in 1991 as a measure designed to improve the delivery of services in the community to people with severe mental illness and to ensure that the health and social needs are properly assessed.

West Berkshire Care Programme Approach (CPA) Guidelines 1994 states:

> **' CPA was commenced in West Berkshire during the Spring and Summer of 1993. Training of staff and development of documentation…took place prior to the implementation'**.

The 1994 West Berkshire *Guidelines* also commented:

> **'…there have been areas of concern regarding CPA meetings in that they are not given priority and often have limited time allocated to them in the ward rounds and can take place without the relevant involvement of community staff.**
>
> **….people are given insufficient notice of their required presence at CPA meetings and on occasions the meetings are given low priority by team members'**.

The West Berkshire CPA documentation was developed further with revised versions in 1996 and 1998. A 3-tiered CPA approach was introduced in 1996: standard, full, and supervision register.

- **Standard CPA**. If the patient needs the attention of 1 member of the team, the CPA requirements are simple:
  - the CPA meeting – carried out by 1 or 2 members of the team;
  - **a keyworker** – formally identified and a member of the team ensuring the delivery of care;
  - **a care plan** – which is concise, and indicates the regular, planned interventions.
- **Full CPA**. For people with severe mental illness, whose health and social care needs are complex, such that they require the multi-disciplinary care of 2 or more professionals:
  - the CPA meeting – several members of the team will need to be involved and adequate notice given to all concerned;
  - a key worker – (as above and) the role under the CPA and the responsibilities of a care manager are qualitatively the same. Authorities and professionals are individually responsible for the particular services they provide to the patient or client, but overall responsibility for co-ordinating services remains with the key worker;
  - a care plan – (more complex than above) with interventions from several members of the team.

- Supervision register. This is defined in the March 1998 policy document as follows:

  ' This is a register designed to identify patients who may be at significant or potentially significant risk of committing serious violence or suicide, or of serious self-neglect as a result of severe and enduring mental illness. It aims to ensure that they receive appropriate and effective care, support and supervision by their community mental health team '.

  No criteria are given for the supervision register in terms of meetings, key worker and care plan but it can be assumed that they are at least as stringent as the full CPA. (In effect conditionally discharged patients such as Mr Williams should be managed as if they were on the supervision register).

  It was recommended that case reviews should take place as often as was required according to the changing needs of the patient; at a minimum 6-monthly. The March 1998 policy document alters the hierarchy and refers to the 3 tiers as being minimal, intermediate and full.

- Minimal. This level is appropriate where the input of one professional acting as key worker is sufficient to meet the health and social care needs of the person.
- Intermediate. For people whose health and social needs are less likely to remain stable and would probably require the intervention of health and social services.
- Full. For people with severe and enduring mental illness suffering from severe social dysfunction whose health and social care needs are likely to be highly volatile and who represent the highest level of risk to themselves and/or others. They will need a complex care plan and full disciplinary review. Full CPA will include those who are subject to supervised discharge or who are on the supervision register.
- CPA meeting. The multi-disciplinary team will need to be involved and members will require a minimum of 7 working days notice to ensure maximum attendance at the meeting.
- Key worker. The identified key worker will be a member of the team with the responsibility for co-ordinating and monitoring care, keeping in touch with the patient, and is the contact person for carers and other professionals. He/she ensures that the care plan is delivered and calls for reviews if and when circumstances and needs change. The maximum period between reviews will be 6 months.

  One Home Office witness was asked to describe the Mental Health Unit's expectations of RMO's and social supervisors with regard to these guidelines:

  > 'You will have to accept that the Home Office would expect a fair standard of professionalism from those people who are tasked with supervision in the community. We have already talked about the (s) 117, and that is a statutory requirement. The Home Office has to work on the basis that if it is a statutory requirement, people will comply with it to the best of the standards and their professional quality that is required'.

ii. Collation and distribution of CPA documentation.

All West Berkshire policy documents refer to these matters. The 1996 document states that at CPA meetings the distribution of the forms was to be agreed and the completed originals sent to a named administrator, at the project administration block, Fair Mile Hospital, together with a list of to whom copies were to be sent, including carers and other agencies, subject to the client's agreement. The administrator will then copy and distribute the forms. The 1999 guidance states that CPA documents were to be kept in a central folder.

Mr Dale-Emberton, a social supervisor to Mr Williams, wrote to the panel in these terms:

> 'The setting of periodic reviews was undertaken as part of a multi-disciplinary team and generally arranged at the date of a CPA…the MHA administrator for the Wallingford Clinic conducted the administration'.

(And in separate evidence Mr Dale-Emberton wrote)

> '.The administration for collating the CPA forms was undertaken by (the MHA administrator) . It was my understanding that she would collate the forms and send them to the CPA administrator at Fair Mile Hospital'.

In evidence to the panel Dr Ferris said:

> 'The person who drew up the system…would be the former administrator…She could explain to you better than I how the system works

Dr Ferris secretary told the panel that she did not know who administered CPA at the Clinic.

> '…the key worker/nurse would sort everything out…the CPN would be one of the key people…'

The administrator declined an invitation to meet with the panel. She wrote to say that she had no role in relation to CPA at the Clinic and knew of no documentation concerning Mr Williams.

iii. Audit.

> 'Authorities will need to establish mechanisms to monitor the application of the CPA as a whole and should report progress at regular intervals to authority members' (*Building Bridges,* 1995, para. 1.4.9).

In April 1997 West Berkshire Priority Care Services NHS Trust carried out an audit of CPA use in patients discharged under section 117 between 1st April and 30th September 1996. In the introduction to *Audit of CPA for Patients Discharged Under Section 117 of Mental Health Act 1983* (1997) the following observation was made:

> ' Review of the CPA should take place as often as required according to the changing needs of the patient and at a minimum should take place every 6 months. Discharge from CPA requires that a full review with a multi-disciplinary team should take place. The CPA co-ordinator should be advised in writing of any such discharge from the CPA.'.

Subjects were identified from CPA files kept by the CPA co-ordinator as being those whose CPA dates fell between 1st April and 30th September and where the CPA form showed that the patient was subject to section 117. The audit stated that at Fair Mile all CPA forms were kept by the CPA co-ordinator. (The inquiry panel was told repeatedly by witnesses that the MHA co-ordinator at Fair Mile also acted as CPA co-ordinator).

Ninety CPA forms were identified by these criteria of which 68 (75%) were found on the Protechnic list. (The Protechnic system was a computer package summarising basic patient information). Twenty-two (24%) of the forms failed to show that the patient was subject to section 117 after-care. The entire cohort required a mandatory review of the CPA within 6 months of the CPA date; in 53 (59%) no review form was found.

The audit also noted that most CPA documents contained adequate information. It concluded:

> ' The CPA was set up to organise the management of patients continuing health care and social care needs and it must be fully implemented, documented and reviewed until it is agreed that the patient no longer needs to be subject to after-care under section 117

which requires a complex multi-agency programme of care. All aspects of CPA must be followed and the records of such procedure should be complete and correct.

The implementation of CPA guidelines is discussed further in section 11.

iv. Mental Health Act Commission reports on the CPA at the Wallingford Clinic (1995-9).

The Mental Health Act Commission (MHAC) is a special health authority set up by the Secretary of State for Health. It is independent in the performance of its functions and the advice it offers. Its members include lawyers, nurses, psychologists, social workers, doctors, and lay members. In its functions and duties it is authorised to interview, in private, patients detained in hospital. Members of the Commission visit regularly every hospital where a patient is detained and report on the outcome.

The MHAC visited both Fair Mile Hospital and the Wallingford Clinic. The visits took place on the same day, but were reported separately by the Commission. In its reports between 1995 and 1999 comments were made specifically on the implementation and monitoring of the CPA. The report of the 15th September 1995 visit to the Clinic observed:

> ' Commissioners look forward to seeing the results of the monitoring of the CPA including section 117 after care planning by the newly appointed project nurse'.

West Berkshire Priority Care Services NHS Trust wrote to the Commission on 28th December 1995:

> '…in addition the project nurse will take the role of CPA co-ordinator, (and) the responsibility of developing training programmes for all staff involved in after-care '.

Following a visit the Commissioners noted on 20th February 1997:

> 'There was evidence of after care planning from information in the files. Although sometimes quite detailed, it was recorded in different places in the files and difficult to locate and sometimes only seemed to occur when the patient was identified as ready for discharge or transfer rather than commencing at the time of admission and assessment and then being ongoing, as recommended within the Care Programme Approach. An agreed Care Programme Approach record form for use throughout the Trust, on which basic after care needs and arrangements are intended to be summarised, was available, but it was not found in every file and where it was present it was often left blank or largely uncompleted.

Commissioners advised that basic information about such matters as key workers, responsible authorities and on going needs should be recorded as early as practicable and regardless of whether the expectation was for the ultimate transfer to the community or to another mental health facility'.

The Trust responded on 24th April 1997 as follows:

> 'The comments and criticisms made by the MHAC have been accepted by the consultant forensic psychiatrist. It is recognised that with s.117 and CPA there is a particular need for staff training and it is anticipated that this will be initiated by the CPA co-ordinator later this year'.

The report of the Commissioners' visit of 26th June 1997 returns to this point:

> ' Following the last Commission visit, efforts have been made to make a full, on going record of care planning and discharge planning. Some files contained detailed and informative records although some did not '.

The Trust replied on 18th August 1997 to the Clinic report.

> 'We have followed the Commissioner's advice made on their last visit about CPA patients whose file did not contain detailed and informative records of those who are awaiting such a meeting to take place. We are committed and have pro-actively invested in the CPA directive'.

With reference to the MHAC's visit to Fair Mile Hospital the Trust informed the Commission on 7th October 1997 that the CPA and after-care planning with the Trust was being reviewed which would include the documentation and the Commissioner's comments would be made known to the review group.

An audit of CPA for patients discharged under section 117 MHA 1983 was produced by the clinical audit department, Fair Mile Hospital in April 1997 (see section 5 B iii above) but it is not referred to in any reports from the MHAC or in the Trust's replies.

On 3rd April 1998 the MHAC observed of the Wallingford Clinic:

> 'The Commissioner was pleased to see documentation of CPA meetings and care planning including risk assessment strategies'.

At an unannounced visit by the MHAC to Fair Mile Hospital on 6th August 1998 the following observation was made of s.117, CPA and after-care planning:

> 'Documentation on the yellow forms has improved since the last visit and review meetings are usually taking place monthly. Copies are kept in the MHA administrator's records'.

There were no comments on the operation of the system at the Wallingford Clinic.

A Commission visit on 8th/9th October 1998 commented on the CPA:

> 'There was evidence in the patients' notes that planning meetings are happening, although these are not always recorded on the dedicated documentation. Commissioners advise that it is useful to record the outcome of after care planning meetings on a specific document so that the needs of each patient are clearly identified together with the allocation of responsibility to meet them.
>
> There appeared to be some problems concerning social services in Reading who were unable to attend meetings for want of sufficient notice where patients were discharged without their knowledge. It would be helpful for Commissioners to receive information on the number of after-care planning meetings held in the absence of the community key worker or social worker '.

C. Guidelines: Home Office & Department of Health and Social Security.

In 1987 the Home Office and the Department of Health and Social Security issued a document Supervision and After-care of Conditionally Discharged Restricted Patients. Notes for the Guidance of Supervising Psychiatrists. Recommendations include the following:

- the supervising psychiatrist is responsible for all matters relating to the mental health of the patient, including the regular assessment of the patient's condition, the monitoring of the necessary medication and consideration of action in the event of deterioration in the patient's mental state;
- the frequency and manner of psychiatric supervision and treatment appropriate in any case may be determined by the supervising psychiatrist;
- the supervising psychiatrist should be prepared to be directly involved in the treatment and rehabilitation of the patient and to offer constructive support to the patient's progress in the community;

- close liaison between the supervising psychiatrist and the social supervisor is essential if supervision is to be effective, and this should take the form of regular discussions. Any clinical personnel involved with the patient should be under the general direction of the supervising psychiatrist;
- the Home Office will usually ask a supervising psychiatrist for reports on the patient's progress one month after conditional discharge and every 3 months thereafter.
- In 1987 the Home Office and the Department of Health and Social Security published a similar document *Notes for the Guidance of Social Supervisors.* (It was updated in 1997). The recommendations for good practice include:
- a sound knowledge of the case is essential if the social supervisor is to spot warning signs before dangerous behaviour occurs;
- meetings (with the patient) should take place at least once each week for at least the first month after discharge reducing to once each fortnight and then once each month. These are considered to be minimum periods;
- if, after some time, a social supervisor considers that supervision at monthly intervals is unduly frequent, then he should consider the case for recommending discharge from conditions;
- meetings should usually take place on the patient's home territory but some meetings away from home, perhaps in the supervisor's office, may also prove valuable;
- the social supervisor is asked to report to the Home Office one month after discharge and every 3 months thereafter;
- close liaison with the supervising psychiatrist is essential if supervision is to be effective;
- the social supervisor will usually be the key worker in liaison between those involved in the patient's care and support.

D. The role of the Home Office.

In 1979 at the Central Criminal Court Mr Williams was found to be a mentally disordered offender who had committed an imprisonable offence and was made the subject of a hospital order (to Broadmoor) under section 60 Mental Health Act 1959 (section 37 of the 1983 Act, and see notes to section 1). A restriction order was imposed under section 65 MHA 1959 (now section 41 MHA 1983). The restriction order was made by the Court having heard evidence regarding the nature of the offence, Mr Williams antecedents, and that a restriction order was necessary for the protection of the public from serious harm. At least one of the medical practitioners whose evidence was taken into account must have given oral evidence in court. The effect of the restriction order was to place authority for granting leave, transfer or the discharge of the patient with the Secretary of State or, since 1983 with regard to discharge, a mental health review tribunal. On discharge from hospital conditions can be imposed either by the Secretary of State or the tribunal and usually include psychiatric and social supervision as well as conditions of residence.

Mr Williams was granted a conditional discharge on 3 occasions: in 1984, 1990, and in 1995. This is a tripartite arrangement for the community supervision of conditionally discharged patients between the psychiatrist, social supervisor and the Home Office. (In addition, the patient's agreement is sought to any discharge plan and its conditions).

A patient who has been conditionally discharged from hospital remains liable to be recalled to hospital by the Home Secretary. In the *Notes for Guidance for Supervising Psychiatrists* (1987) the Home Office comments as follows (and see section 12 G):

'The purpose of the formal supervision resulting in conditional discharge is to protect the public from further serious offending by the patient in two ways:

i. by assisting the patient's successful reintegration into the community after what may have been a very long period of detention under conditions of security;

ii by close monitoring of the patient's progress so that, in the event of any deterioration in the patient's mental health or of an increased risk of danger to the public, steps can be taken to assist the patient and protect the public'.

i. The Mental Health Unit.

'The main role of (the Mental Health Unit) in the management of restricted patients is to protect the public from serious harm.

The Unit's task is to scrutinise the proposals relating to restricted patients looking for evidence of thorough risk assessment and risk management '. (*From Mental Health Unit induction papers).*

The Home Office's Mental Health Unit deals with the powers of the Home Secretary in respect of mentally disordered offenders on whom the courts have imposed restriction orders under section 41 Mental Health Act 1983 (see Dent, 1997). Those powers include a consideration of such matters as the circumstances in which a restricted patient is given leave, transferred or discharged from hospital. They also include certain functions in relation to tribunals which consider applications for discharge from restrictions.

The panel was told by a Home Office witness that it was not the Unit's role to **'…police…'** professionals' supervision, or to make clinical judgements, but to look at risk in the broader sense. A Home Office witness told the inquiry panel:

'…we do not second-guess clinicians. We will take a view about what we are being told as we see it, according to the assessment of risk based on the information that is available to us'.

The same Home Office witness was asked if there had been any suggestion that Mr Williams was unmanageable in the community.

'It wasn't satisfactory, that's quite clear. There shouldn't have been gaps between reports. We had sought to bring it to their attention that reports were due, but we didn't have a set period where we say that after so long we do anything.

…We were very unhappy with the way he was being managed. (See comments to section 12 H).

…We don't police professionals.

…We give as much guidance as is reasonable…but the professional integrity and service delivery is a matter for individual professionals involved…there is a line, and in this case we put enough markers up, but I don't know who locally was looking over the shoulders of the people who were involved'.

Sometimes Home Office internal notes reveal a questioning of the psychiatric approach. The following are comments made in response to a request for leave made in June 1995 after Mr Williams' recall to the Clinic (see section 1, note [4]).

Mr Williams suffers from schizophrenia/psychopathic disorder…some unescorted leave would appear to be of benefit. However, I have some doubts as to whether this should be at the RMO's discretion, given that (a ward doctor) at least, was pushing for (conditional discharge) extremely quickly and the latest letter reads as though it is merely an attempt by the doctors to get through the ' tiresome bureaucracy ' asap' .

After a patient is conditionally discharged the Unit monitors the patient's progress and gives consideration to the variation of conditions, recall to hospital or absolute discharge as the circumstances require. Staff at the Unit are:

> '…ready and willing to discuss the case in any restricted patient…with supervisors and there is an out of hours service in the event of an emergency'.

ii Reports to the Home Office.

The *Guidance* documents for psychiatric and social supervisors set out what are called 'post discharge procedures'. The 1997 social supervisors *Guidance* document describes: the manner and frequency of supervision; the disclosure of information; liaison with others involved in patient care; reports to the Home Office; post-discharge contact with the discharging hospital in the event of concern about a patient's condition, and recall. After a period of more frequent reporting the social and psychiatric supervisors are both required to provide quarterly reports to the Home Office with copies being sent to the other supervisor. In the absence of such reports the Home Office will send reminders.

The purpose of reports is to:

> 'Convey sufficient information to enable the Home Office to consider whether the patient may remain in the community or whether, in the patient's own interest or for the protection of the public, steps should be taken to return him to hospital'.

Guidance suggests that reports should include:

> 'A detailed account of the patients current mental condition, including any changes since the previous report and the apparent reasons for these changes. The report should always cover the subject of medication where appropriate. Any signs of deterioration in the patient's mental health or behaviour should be described in detail, with proposals for improving the situation'.

An issue discussed later in this report (at section 12 H) is that of failures to adhere to Home Office G*uidance* on the frequency of both patient contact and the submission of reports. A social work manager told the panel:

> 'I was surprised that in the reports to the Home Office, where it clearly said, 'I haven't seen him…this is pure oversight', they hadn't written back asking why, and are you going to assure us that this doesn't happen again…it reinforces…I don't need to worry if I miss for three or four months. I was surprised really'.

iii. The power of recall.

Article 5(1) of the European Convention on Human Rights provided:

> '…everyone has a right to liberty and security of person. No one should be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law…(i.e.) the lawful detention…of persons of unsound mind'.

(A Home Office witness when asked if things could have been put right earlier).

> 'We've looked at it, and if we are talking about recall, there were no circumstances in any of the reports that were presented to us that could have acted as a trigger for recall'.

Section 42(3) MHA 1983 gives the Home Secretary the power to recall a conditionally discharged patient to hospital. There is no specification as to when recall should take place although the *Notes for Guidance of Supervising Psychiatrists* state that:

'…this would largely depend on the degree of danger the particular patient might present'.

The social supervisors 1997 *Guidance* states:

'…it is not possible to specify all the circumstances in which the Home Secretary may decide to exercise his powers under section 42(3)…but in considering the recall of a patient, he would always have regard to the safety of the public…(and)… a report to the Home Office should always be made in a case in which there appears to be an actual risk to the public;…patient's behaviour or condition suggests the need for a further in-patient treatment in hospital; the patient is charged with or convicted of an offence.

In all cases it seems that admission is necessary to protect the public or the patient from possible harm, the recommendation must have the support of the supervising psychiatrist that the patient be formally recalled to hospital'.

Chapter 28 of the *Code of Practice. Mental Health Act 1983* (1993) contains the following in relation to patients concerned in criminal proceedings:

'28.2 Recall. If a conditionally discharged restricted patient requires hospital admission, it will not always be necessary for the Home Secretary to recall the patient to hospital. For example:

a The patient may be willing to accept treatment informally. In these circumstances, however, care should be taken to ensure that the possibility of the patient being recalled does not render the patient's consent to informal admission invalid by reason of duress.

b In some cases it may be appropriate to consider admitting the patient under Part 11 of the Act as an alternative.

c It may not always be necessary to recall the patient to the same hospital from which he was conditionally discharged. In some cases recall to a hospital with a lesser (or greater) degree of security will be appropriate.

28.3 When recall is being considered this should be discussed between the doctor and the social supervisor'.

The 1999 edition of *Code of Practice Mental Health Act 1983* makes 2 amendments to the above:

(At 28.2 (a) above) '29.2 (a) …In these circumstances, however, care should be taken to ensure that the patient's consent is freely given, if he or she is capable of giving consent. If the patient is incapable of giving consent, it is advisable to consider whether treatment may be given under the common law doctrine of necessity or whether the Home secretary should recall the patient'.

(At 28.3 above) ''When recall is being considered this should be discussed between the doctor, the social supervisor and the Mental Health Unit of the Home Office'.

In March 1998 the Home Office revised its internal *Mental Health Unit Casework Guide.* Section 20 'Problems arising after discharge – recall' reads in part:

i. General

Under section 42 of the 1983 Act a conditionally discharged patient may be recalled to the hospital from which he was discharged or to any other hospital. The statutory power of recall is not dependent on a hospital's agreement to admit a patient but in practice we would always seek to obtain such agreement. When recalled a patient becomes liable to detention as a restricted patient in pursuance of the legal authority which was operative immediately before the conditional discharge. Under section 75 of the 1983 Act the Home

Secretary is obliged to refer the case of a recalled patient to the Mental Health Review Tribunal within one month of the date when the patient is received back into hospital..

20.23 Consideration of recall in any particular case can be complex. Formal recall by warrant is rightly regarded as a last resort, to be effected only where the Home Secretary is satisfied that no other course is consistent with his responsibility for the protection of the public. Any decision to recall a patient, resulting as it must in apprehension and detention after perhaps years in the community, will have a drastic effect on a patient's freedom and rights and will have to be justified before a Tribunal which has the power to discharge the patient again. On the other hand the Home Secretary's overriding responsibility is for the protection of the public and if there are reasonable grounds for believing that recalling a patient is necessary to prevent serious harm to the public then we are justified in doing so.

ii Ministerial involvement

20.25 Any case in which a conditionally discharged patient is charged with a criminal offence should be brought to the attention of a Grade 7 at an early stage so that a decision can be made whether or not to let Ministers know what has happened. Ministers should normally be informed when such a patient is charged either with a serious offence or with a less serious offence which could give rise to adverse public reaction. As to the latter category each case should be considered on its merits (the history of the offender will be relevant), but cases involving less serious offences against children and women might often fall within this category.

iii Factors to be considered

20.26 There will be cases in which problems arise in the community and where recall is the obvious response. Examples are where markedly dangerous behaviour (carrying weapons etc) has been observed or where the patient suffers a serious relapse in his mental disorder. Other cases in which problems arise may be unsuitable for recall, for example where there is anti-social or criminal behaviour which is unconnected with the patient's mental condition. In such cases further detention in hospital might not be appropriate and there may be no alternative but to leave the patient to be dealt with as may prove necessary by the normal processes under the criminal law.

iv Presumption of recall

20.27 It can generally be presumed that the patient should be recalled if there is informed medical opinion that the patient is mentally ill or showing signs that their mental health is deteriorating.

20.28 A recommendation from the supervising psychiatrist is not an absolute prerequisite to recall. He or she may advise, for example, that the patient is disordered but that the disorder is untreatable. There are many different professional opinions on what constitutes effective treatment. Bear in mind, however, that recall to hospital is justified only where is current professional medical evidence that the patient is mentally disordered and requires treatment. It must not be used purely as a means of detaining. This guidance reflects the principle established in the case of Kay v the United Kingdom before the European Court of Human Rights; that nobody should be admitted compulsorily to hospital in the absence of up to date medical evidence of disorder requiring treatment.

20.29 Exceptionally, in an emergency, recall may be ordered in the absence of current medical opinion where there is a risk of immediate and serious harm and where there are grounds to believe that the patient is disordered. Any such action must be followed by immediate professional medical assessment of the recalled patient with a presumption of

immediate discharge if that assessment does not find evidence of disorder which requires treatment in hospital.

v Threshold of recall: degree of risk presented by the patient

20.30 Where the patient has in the past been capable of homicide or serious violence or serious sexual offending, comparatively minor irregularities in behaviour or co-operation would be sufficient grounds to give serious consideration to the question of recall. Conversely, where the perceived degree of risk is less, other courses of action may be appropriate'.

It was held in the legal judgement in the case of Winterwerp v The Netherlands (1979) that for the detention of a person of unsound mind to be lawful:

> 'The individual concerned must be clearly shown to be of unsound mind, i.e. a true mental disorder must be established before a competent authority on the basis of objective medical expertise; the mental disorder must be of a kind or degree warranting compulsory confinement; and the validity of continued confinement depends upon the persistence of such a disorder'.

This matter was the subject of a further consideration in the case of K v United Kingdom (1998). In this case the individual was conditionally discharged by a mental health review tribunal in March 1985. He left hospital in April 1985. In April 1986 he was sentenced to 3 years imprisonment. He remained subject to the conditional discharge. His earliest release date from prison was 24th October 1989. On 1st September 1989 the Home Secretary issued a warrant of recall, stating that as soon as the subject was released from prison he should be taken to a Special Hospital and detained there. The applicant complained of violation of Article 5 (1) of the European Convention on Human Rights, in that the recall warrant represented an illegal deprivation of liberty, because the Home Secretary had not obtained up-to-date medical evidence that he continued to suffer from a mental disorder. It was held by the European Commission of Human Rights that when the Secretary of State recalled the applicant certain minimum conditions of lawfulness were not respected. In particular, there was no up-to-date objective medical expertise showing that the applicant suffered from a true mental disorder, or that his previous psychopathic disorder persisted. This was only confirmed a month after the applicant's recall.

In conclusion: the effect of Winterwerp and K is that in order for a conditionally discharged patient to be lawfully recalled to hospital, there must be: objective medical evidence available prior to recall showing: that the individual suffers from a true mental disorder; the mental disorder must be of a kind or degree warranting compulsory confinement.

6. MR WILLIAMS' PERSONAL AND PSYCHIATRIC HISTORIES

This section summarises: Mr Williams' early life, his migration to the UK, the offence which resulted in his admission to Broadmoor, his re-admission there a year after his discharge, his transfer to the Wallingford Clinic and subsequent rehabilitation. Discharged to the community in 1989, Mr Williams was readmitted to the Clinic in 1995, to be discharged again a year later.

A. Early development. Winston Delorn Williams was born in Kingston, Jamaica on 30th June 1945, the youngest of 5 children [1]. Winston Williams childhood appears to have been unremarkable; his health was good and his development was normal. He was at school between 4 and 15 and was an average scholar; he served 2½ years as an apprentice motor mechanic [2]. Mr Williams father is now dead. Recent information indicates that his mother and siblings live outside the UK.

B. 1964 to 1977. In April 1964 Mr Williams came to England to join a Jamaican female friend who he married and by whom he had a child; the relationship ended in 1968. Soon after his arrival in England Mr Williams found work as a welder, and between late 1964 and early 1970 he had 3 periods of employment as a motor mechanic. In mid-1969 Mr Williams cohabited and a son was born by that relationship. In 1971 he remarried; a son was born in 1970 and a daughter in 1973. He remained in contact with his second wife and his youngest daughter. Until the end of 1978 Mr Williams always lived in north London.

In 1966 Mr Williams was fined after being found guilty of an offence of violence. In late 1972 he was admitted as a detained patient (i.e. involuntarily) to a psychiatric hospital at the instigation of his wife. He was confused, had abnormal religious ideas and was intolerant of his children. A provisional diagnosis of severe mental illness (schizophrenia) was made. He alleged that hospital staff had assaulted him and was discharged after failing to return from home leave. In 1973 he was fined for possessing an offensive weapon (a knife).

In July 1975 Mr Williams was fined after being convicted of offences of violence and possession of an offensive weapon (a knife); in September he was imprisoned for 3 months for non-payment of fines and criminal damage at the house of his estranged second wife's relatives. In September 1976 Mr Williams attacked a man with a knife. His victim was an acquaintance of his wife who had given her and his daughter a lift home. The attack was motivated by the delusional (i.e. false) belief that the man intended to harm his daughter. Mr Williams was found guilty of offences of violence against both the man and the police, and of possession of an offensive weapon. The court made an order for him to be admitted to a psychiatric hospital for treatment of schizophrenia. His wife said at the time that they did not live together because of his violence and jealousy. He left hospital after 5 days and was later said by the psychiatrist who had been responsible for his care to represent '**...a real danger in the community**'.

In April 1977 Mr Williams was sentenced to 9-months imprisonment (suspended) for an offence of violence.

C. Index offence [3]. On 21st December 1978 Mr Williams made what was thought to have been a planned knife attack on a previous employer with the intention of killing him. The victim received serious (i.e. life threatening) injuries as did a paper boy who attempted to intervene. The first victim, who knew of Mr Williams' family and mental health problems, had dismissed him because of his instability with other employees. For Mr Williams' part it was recorded that he believed that his employer was '**…after** (his) **daughter…**', and was involved with his wife in some way; he also believed that his employer's thoughts were broadcast on the radio, and he heard voices; in prison, Mr Williams was found to have abnormal emotional responses and he became mute (the preceding

beliefs and perceptions are all symptoms and signs of schizophrenia). Facing 2 counts of attempted murder Mr Williams pleaded guilty to wounding with intent; the court made orders under sections 60 and 65 MHA 1959 (now ss. 37 and 41 MHA 1983) for his admission to Broadmoor Hospital whose staff had assessed him and agreed to a bed being made available should the court direct his admission there. He was transferred to Broadmoor on 16th July 1979 [4].

D. First admission to Broadmoor Hospital. Having received medication in prison between late 1978 and early 1979 Mr Williams' illness was under control by the time of his admission to Broadmoor Hospital; nevertheless, the diagnosis of schizophrenia was confirmed. An early suggestion that he be transferred to his local psychiatric hospital in north London was not proceeded with following expressions of concern by one victim's MP. Psychological testing showed Mr Williams intelligence to fall into the low average range and in May 1983 he was transferred to a secure rehabilitation unit in Nottinghamshire. Repatriation to Jamaica was explored but adequate treatment and support there were lacking. In January 1984 Mr Williams was considered suitable for transfer from secure conditions, and, with the intention of avoiding placement in London, he was placed on trial leave [5] at a Richmond Fellowship hostel, Brunswick Lodge, in Reading, Berkshire.

Reading appears to have been chosen for a number of reasons: the north London MP's objections to his return to that area; the failure of attempted repatriation; the willingness of the Richmond Fellowship to provide places for patients such as Mr Williams; the availability of an RMO at Broadmoor who could oversee his supervision in the community without burdensome and possibly fruitless attempts to place him with local psychiatric services.

Mr Williams' hospital admissions and his placements following his transfer to Reading are shown below.

Table 3: Mr Williams' hospital placements, hostels & homes.

Location	Dates
Friern Barnet Hospital	September to October 1972
Friern Barnet Hospital	October 1976
Broadmoor Hospital	July 1979 to June 1983
Eastdale Unit, Balderton Hospital	June 1983 to April 1984
Brunswick Lodge hostel, Reading	January to September 1984
Mandela Road, Reading	September 1984 to September 1985
Broadmoor Hospital	September 1985 to December 1989
Wallingford Clinic	December 1989 to November 1990
Basingstoke Rd flat-share, Reading	September 1990* to January 1991
Lyon Square, Reading	January 1991 to November 1994
Wallingford Clinic	November 1994 to October 1995
Lyon Square, Reading	October 1995 to September 1999
Broadmoor Hospital	September 1999

** Mr Williams spent a period on trial leave at Bucknell House before his formal transfer from hospital*

Cannabis use caused difficulties in Mr Williams' management at Brunswick Lodge (see section 7 A) but in April 1984 he was conditionally discharged by a mental health review tribunal. In the community Mr Williams was treated by a psychiatrist who was based at Broadmoor Hospital and supervised by a Reading probation officer. He was difficult to manage and was isolated socially. He left the hostel in September 1984 when he took a bedsit at Mandela Road, Reading. His psychiatrist died in November and no replacement was found; he discontinued his treatment in early 1985, apparently with the knowledge and agreement of Broadmoor staff. At about the same time Mr Williams became known to a family, one of whose members he was later to kill.

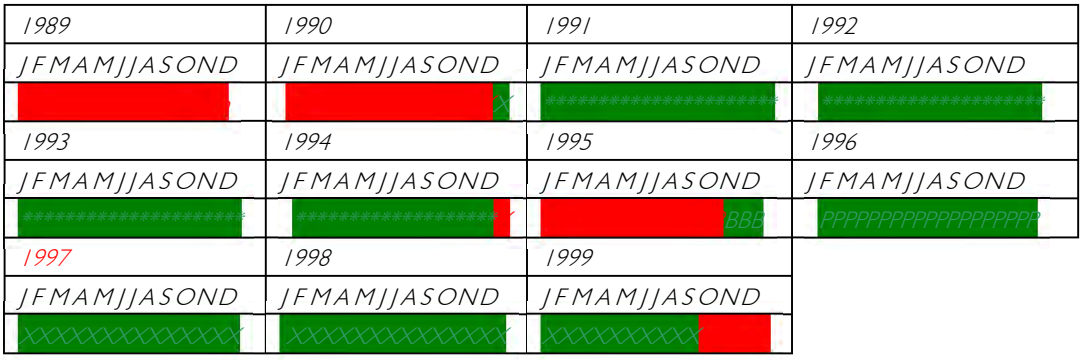
E. Re-admission to Broadmoor. By mid-1985 Mr Williams mental state was clearly deteriorating: he appeared to be affected by drugs, dressed bizarrely (e.g. wearing a cartridge belt with imitation cartridges) and was fatuous in behaviour. In July he visited his wife in London and later, with his young daughter in the car, drove at high speeds, causing accidents; he said that if he was at risk, so was she (see section 12 F). Later, he visited a female friend, appeared in the street naked and then cut his throat in her bath.

The self-inflicted injury could well have resulted in his death but after a period in intensive care he was transferred back to Broadmoor Hospital, recalled (i.e. re-admitted to hospital) by the Secretary of State under the provisions of his conditional discharge (see section 1, note [2]). Mr Williams was re-established on medication; no satisfactory explanation for the suicide attempt was ever found. At a re-admission case conference in December 1985 Mr Williams was noted to be remarkably secretive and to completely lack insight into (i.e. understanding of) his illness; it was said that his delusional jealousy had twice led to serious violence (i.e. in 1976 & 1978).

Mr Williams second stay at Broadmoor was uneventful. Another, again unsuccessful, attempt was made to repatriate him to Jamaica; an approach to transfer him to a general psychiatrist at Fair Mile Hospital also failed because the assessing consultant psychiatrist considered Mr Williams to be still capable of explosive violence and incapable of forming a relationship of trust. (Significantly, perhaps, the same psychiatrist also thought that Mr Williams exhibited a disorder of personality in addition to mental illness). Finally an approach was made to the soon-to-be established medium secure unit and forensic psychiatry service at Fair Mile Hospital, the Wallingford Clinic.

F. Transfer to the Wallingford Clinic.

Table 4: shows Mr Williams' in-patient and out-patient status between 1989 and 1999.



In May 1989 a consultant forensic psychiatrist, Dr Henrietta Bullard, had completed her assessment of Mr Williams' suitability for transfer to the Wallingford Clinic. She concluded that Mr Williams could become dangerous if his illness relapsed but was suitable for treatment in the community if he could be persuaded to take treatment; he minimised the seriousness of his offending and still had fixed delusions regarding the offences of 1976 and 1978. Dr Bullard also negotiated a change from oral to depot medication (long-acting treatment given intra-muscularly). The nursing assessment concurred with the view that he was suitable to transfer on trial leave and he was admitted to the Wallingford Clinic in December 1989 with the agreement of the Secretary of State. (Mr Williams remained on trial leave from Broadmoor Hospital to the Wallingford Clinic until November 1990 when he was formally transferred by the Home Office which acts in these matters on behalf of the Secretary of State). The expectation was for a '…relatively fast' move to accommodation (a friend's house) and work in Reading.

In the event the expected accommodation did not materialise and in January 1990 the Clinic social worker applied for local authority housing (see section 13). As he had been following his transfer to the community in early 1984, Mr Williams was difficult to manage at the Clinic: he was considered to be manipulative and untruthful; his drinking caused management difficulties (see section 7 B); he would not, or could not, form a meaningful treatment alliance. Leave from the Clinic had to be sanctioned beforehand by the Home Office but in practice the issue was a constant source of conflict between Mr Williams and Clinic staff. In May 1990 a mental health review tribunal conditionally discharged Mr Williams from the Clinic to the community, but it deferred implementation until the following conditions were met: arranging suitable psychiatric and social (i.e. social work) supervision; approved accommodation being found; remaining liable to recall to hospital (as happened with his re-admission to Broadmoor following his suicide attempt in 1985).

G. Discharge to Basingstoke Road.

By August 1990 privately rented accommodation had been found for Mr Williams in Reading and the Home Office agreed that he could live there on a trial basis. An after-care plan was drawn up and despite concerns at both Mr Williams' drinking and his working while claiming benefits while on trial leave the tribunal agreed in November that the conditions it had outlined earlier had now been met and he was formally discharged from hospital.

In January 1991 the local authority offered Mr Williams a bedsit in the Tilehurst district of Reading, at Lyon Square on the Dee Park Estate, and he moved in almost immediately. From the beginning he complained at both the frequency with which Wallingford Clinic staff required contact with him, and at the dose of his depot medication. Towards the middle of the year his social supervisor was changed from a Clinic social worker to one based in Reading. At about the same time the Driving Vehicle Licensing Authority (DVLA) refused to renew his licence after he tested positive for cannabinoids (cannabis by-products) in a urine test (see section 12); it was assumed that this would effect Mr Williams' ability to work in the motor trade. By early 1992 he was said to be boasting, untruthfully, both that he had been a patient at Broadmoor after killing his wife's lover, and that he was '…licensed to kill'. In addition, he had a reputation for regularly carrying a knife.

Mr Williams told his psychiatrist in March 1992 that he had spent the previous Christmas with his family in Jamaica; this was in clear breach of what had been said to him, namely that he should seek the agreement of the 3 parties in his community management (his social supervisor, psychiatrist, and the Home Office) before undertaking such a venture. Following his return he complained even more than usually about the side effects of his depot medication, and of the inconvenience of attending the Clinic where it was administered. In April he warned that he would refuse to take any further treatment and in June he was extremely difficult with his social supervisor, who he had not seen for 3 months. In late June he was truculent and rude to his psychiatrist and social worker; he had been charged with evasion of road fund licence duty and had outstanding bills for rent and service charges; he was in full-time work and claiming benefits; he was clearly drinking but denied other substance abuse (as he always did). Mr Williams continued to be confrontational and unpleasant. In the belief that his mental illness was well controlled the dose of his depot was reduced in May 1993 in an attempt to secure more co-operation.

In July 1993 a previous partner gave birth to his son.

Mr Williams missed his appointments with his social supervisor in July, August, and September 1993, complaining that the social worker was too intrusive. A home visit by his supervising psychiatrist in November found the Lyon Square bed-sit dirty and impoverished. There was little change over the following months but in April 1994 Mr Williams made 2 unusual and

unannounced visits to the Wallingford Clinic which prompted a review of his mental state. It was felt that he may be in the early stages of relapse but Mr Williams refused to accept an increase in his medication to the pre-May 1993 level.

In mid-1994 Mr Williams complained of damage to his bed-sit and car and in July he failed to attend for his depot injection (the first actual refusal). In August he attended for his depot treatment but he missed injections in both September and October. Over the ensuing weeks the supervisors learned that Mr Williams had spent several weeks in Jamaica, and New York, and he said that his family supported him in the view that medication was unnecessary. On the 1st November Mr Williams announced that he was well enough to do without medication, and both psychiatric and social work supervision. Acting on the recommendations of the social and psychiatric supervisors the Home Office recalled Mr Williams to Fair Mile hospital on 4th November 1994.

H. Re-admission to the Wallingford Clinic, Fair Mile Hospital.

Although at first there were no obvious signs of a relapse of his mental illness it was reported that, shortly before his recall to hospital Mr Williams had threatened his social supervisor's life (see section 12 A). Initially, he refused to accept medication but his behaviour became more abnormal until early January 1995 when he was medicated forcibly after assaulting a nurse. Re-established on depot medication, Mr Williams case was automatically referred to a mental health review tribunal which met on 8th February; it did not order conditional discharge, however, the tribunal's finding stated:

> '…the tribunal hope that at the first available opportunity the RMO will approach the Home Office to seek the patient's discharge'.

Again the ward staff sought Home Office agreement to a gradual programme of community leave, although for Mr Williams' part he continued to lack insight and viewed himself as a powerless victim. For Clinic staff the issue was the extent to which Mr Williams could be relied on to comply after discharge with plans made, and agreed with him, beforehand.

Dr Rob Ferris had been Mr Williams consultant and supervising psychiatrist since February 1993, replacing Dr Bullard in this role. By August 1995 it was Dr Ferris' view that Mr Williams should be discharged from the Wallingford Clinic and that there was nothing to be gained from keeping him in hospital. At this time Mr Williams was allowed occasional overnight leaves at his flat. However, in September a fellow female patient told staff that Mr Williams had given her cocaine and a urine test on Mr Williams proved positive for that substance. Leave was suspended and an impending tribunal was adjourned. Unlike Dr Ferris, the Home Office was not satisfied that Mr Williams was ready for discharge, not least because he continued not to accept that he had ever been mentally ill and therefore believed that he did not need medication. On the 30th October a mental health tribunal, whose president was a judge, ordered Mr Williams' discharge subject to certain 'conditions' [6]. The reasons for the tribunal's decision were given as follows:

> 'The tribunal are satisfied that the patient is now suffering from mental illness but not of a nature or degree which makes it appropriate for him to be liable to be detained in hospital for medical treatment however it is appropriate for the patient to remain liable to be recalled to hospital.

(The tribunal was satisfied about these reasons because:)

The tribunal accepts the evidence of Dr Ferris, (RMO) that the patient continues to suffer from paranoid schizophrenia which is now being held in remission by appropriate medication. After his conditional discharge in November 1990 the patient appears to have done well living in the community holding down regular employment and complying with the conditions of his discharge until the middle of 1994 when he left the country to attend his father's funeral in Jamaica, and then ceased taking his medications and refused to resume compliance. This led in turn to his recall to hospital and the re-appearance of some florid symptoms of his illness. With the assistance of the medical team at the hospital Mr Williams' condition has again reached stability with appropriate medication. The patient appears to have little real insight as to the nature of his illness or as to the positive effects of medication. It is however the opinion of his RMO and social worker that he does appreciate that failure to comply with medication and the other conditions of a discharge will lead to his further recall, and the tribunal accepts this evidence. In our view the patient's desire not to be recalled yet again to hospital will provide sufficient motivation to ensure his compliance with conditions.

The tribunal has weighed carefully the significance to be attached to the episode of 'crack' taking which led to the adjournment of the hearing of 29 September 1995, whilst it is of course a matter of considerable concern that the patient took this prohibited drug whilst on overnight leave and then lied to his RMO when confronted on the subject, the tribunal is conscious that its function is not a disciplinary one. Whilst there can be no doubt that any sustained abuse of dangerous drugs would be likely to endanger the patient's mental stability, there was no indication that what may have been an isolated incident, did in fact give rise to any signs at all of the patient's mental state being affected. The tribunal accepts the view of the RMO that such risk as there is of further drug abuse can be adequately forestalled by a condition that the patient submit to random drug testing at the RMO's absolute discretion.

The tribunal is therefore of the view that with the safeguards provided by the above conditions this patient no longer requires to be detained in hospital for treatment: such treatment as he undoubtedly still requires can be appropriately provided in the community'.

The conditions attached to the discharge order were [7]:

- to reside at Lyon Square or where directed by his responsible medical officer (Dr Ferris);
- to accept treatment as prescribed by the RMO;
- to attend out-patients and receive visits from the RMO and community psychiatric nurse (CPN);
- to comply with social supervision (by the social worker);
- to submit to and co-operate with random urine testing at the absolute discretion of the RMO.

1 Discharge to Lyon Square.

In the first 5 months following his discharge Mr Williams was seen at outpatients (based in one of 3 portacabins alongside the Wallingford Clinic, one of which was shared by the social and psychiatric supervisors, and the CPN) by a senior registrar (now termed 'specialist registrar') attached to Dr Ferris. For 14 months he was also seen by a CPN, Ms Jackie Lee, usually at Lyon Square, and, until March 1998, social supervision was provided by Mr Dale-Emberton, a social worker attached to the Wallingford Clinic who saw Mr Williams both at the Clinic and visited him at home. (At section 18 F are 4 tables detailing all Mr Williams' contacts with the

after-care team). Both the social supervisor (being the term for the social worker who supervises a conditionally discharged person in the community) and the psychiatrist who provided out-patient treatment and supervision were expected to submit reports regularly to the Home Office which based its contribution to Mr Williams management wholly on the reports it received and held on file.

By the end of 1995 Mr Williams had settled at home and acquired a car. In the first 6 months of 1996 Mr Williams was visited regularly at home by his CPN in addition to his social worker. The accepted view was that he worked part-time at either a garage or vehicle breakers; he had some contact with his daughter; he denied alcohol or other substance use; he was incurring debts with rent and service charges; he saw his social supervisor, although he missed some appointments.

On 24th July 1996 Dr Ferris received a telephone call from Ms A who, it later emerged, was the mother of Ms Katie Kazmi who Mr Williams subsequently killed (see section 12 B). Both social worker and psychiatrist reported to the Home Office in December 1996: the former noted that Mr Williams had several girl friends, did nothing to improve conditions in his flat, had been warned about working and receiving benefits, and was invariably out when the social supervisor called unannounced; the psychiatrist said that he would not accede to Mr Williams request for a reduction in medication until urine testing was established, and that the risk of relapse with substance abuse had been repeatedly pointed out to Mr Williams.

At the end of February 1997 the CPN Ms Jackie Lee withdrew from the case; she had visited him at home on 13 of the 16 months since his discharge from hospital (see section 10 B). Mr Williams faced court summons for non-payment of rent and service charges; in addition, he was failing appointments with his social supervisor.

Later in 1997 Ms B, the mother of Mr Williams youngest child, alleged that he had assaulted her and made threats to kill (see Risk Assessment and Management section 12 D). In February 1998 Mr Williams was charged with an offence relating to stolen goods found in his car. (The charge was dropped in July 1998).

Mr Williams complained repeatedly of burglaries to the Lyon Square bedsit and damage to his property; he sought housing transfer but that was not feasible because of rent arrears for which an eviction warrant was taken out in April 1998. In the same month arrest warrants were discovered for non-payment of fines for 2 non-moving traffic offences. Mr Hayward, a senior social worker based at Reading social services took over the role of social supervisor in March 1998. In June Mr Williams reported that his car had been written-off in an accident. (A statement taken by the police after the homicide alleges that in September 1998 he was found in an unoccupied flat attempting a theft. The police were called and a violent struggle ensued. Charges were not made because the victim refused to give a statement following alleged threats from Mr Williams).

Dr Ferris learned that Mr Williams was driving school transport in September 1998 (see section 12 F ii). As ever, Mr Williams denied abusing illegal drugs and attempts to undertake random urine tests were finally abandoned because of Mr Williams refusal to co-operate with the procedure. In November discussions took place with the DVLA to whom Mr Williams had made a false statement in his licence application. His licence was not renewed in January 1999 and was withdrawn in April after a urine test proved positive for cocaine (see section 6 J).

(A police witness statement taken after the homicide alleges that in late 1998 Mr Williams used his bedsit as a base for selling and using cocaine, and that he habitually carried a knife which he used to threaten people. A second police witness statement refers to a period about 6 months later when, again, Mr Williams was said to always carry a knife. Investigations concluded in early

2001 indicate that between 1st February and 23rd April 1999 Mr Williams worked each week day as a special-needs school bus driver (see section 12 ii), although he could have worked in this capacity for a longer period, quite possibly from the Autumn of 1998 to mid-1999). Mr Williams was convicted of a non-moving traffic offence in May 1999. (In a statement made to the police after the homicide a neighbour of Mr Williams said that by mid-1999 he became depressed and moody; '…**he often talked about losing it and not being in control**').

J **The months before the murder**.

In July, Mr Williams had his last meeting with his social supervisor: he was said to be paying off his rent arrears, to be unemployed, still compliant with medication, and that the risk was unchanged. (The social worker noted that Mr Williams left the appointment driving a mini bus). Dr Ferris last saw Mr Williams in early-August: he was unhappy and forlorn. Mr Williams said that his disability allowance had been withdrawn (in December 1998) and he had no driving licence. Dr Ferris 'phoned the DVLA who confirmed the licence withdrawal, and the reason. Dr Ferris' view was that Mr Williams' cocaine use was not at a level which caused a relapse of his psychiatric symptoms and that forcing urine tests would adversely effect his relationship with his patient (see section 8 D for a fuller account) .

Dr Ferris' dictated a report to the Home Office on the 16th August after an out-patient meeting with Mr Williams 10 days earlier. Mr Hayward did not receive his copy of that report until the day of Mr Williams' arrest, and the Home Office copy was received on 17th September, the day after Ms Kazmi was probably killed.

(A witness statement taken by the police after the homicide alleges that on the day before the killing of Ms Kazmi, Mr Williams met 2 school girls while sharpening his knife on the balcony outside his bedsit (one had previously taken cocaine from Mr Williams, the second had previously taken cannabis from a neighbour and friend of Mr Williams); he chased one girl along the balcony with his knife and threatened: **'If I never get to go out with you, I'm going to cut your throat'**. The girl said that she was very frightened).

NOTES

1 According to the police' trial statements, at the time of his arrest Mr Williams was in possession of a driving licence in the name of Sam Williams, with a date of birth 3rd July 1947. (The DVLA informed the panel that no licence had been issued with these details).

2 The information provided by Mr Williams may not be reliable.

3 By convention, the phrase 'index offence' is the conviction for which the first hospital order (with restrictions on discharge) was made.

4 The Central Criminal Court made orders under sections 60 and 65 Mental Health Act 1959 (sections 37 & 41 Mental Health Act 1983. (The first a hospital (admission) order; the second an order restricting Mr Williams discharge indefinitely). (See section 1).

5 Trial leave is used to test a person's cooperativeness in moving from more to less secure, or controlled, conditions.

6 (See section 1, note 2). At the time of Mr Williams discharge in October 1995 discharge was 'conditional' in the sense that agreed limitations were attached to it. Such conditions were usually: to reside at an agreed address; to accept medication at the direction of the supervising psychiatrist; to accept visits from the social supervisor. The circumstances in which recall can occur are covered in section 5 D iii.

7 (There were 2214 restricted patients like Mr Williams in hospitals in England and Wales in 1995; 140 were conditionally discharged in that year. See *Mentally Disordered Offenders in England and Wales: 2000.* Home Office, 2001)

7 SUBSTANCE USE AND MISUSE

Section 7 outlines Mr Williams' use of alcohol, cannabis, and cocaine.

It is not known whether or not there is a history of abuse of alcohol or drugs (known as substance abuse) in Mr Williams' family. What is clear is that a significant proportion of persons who suffer from severe mental illness are also substance abusers; the combination is termed 'co-morbidity' or 'dual diagnosis'. The proportion of mentally ill persons with co-morbidity is rising, and it both complicates the management of the mental illness and increases substantially the risk of dangerous behaviour (See Marshall, 1998; All Party Parliamentary Drug Misuse Group, 2000).

It is also not known what, if any, contribution substance abuse played in Mr Williams' offences between 1966 and 1978, or, in the early years, to his mental illness; there is no mention of it in the records of Broadmoor and Balderton hospitals covering the period 1979 to 1984. The fact that the information is lacking does not, of course, mean that it did not play a part.

A. Cannabis. Between January and September 1984 Mr Williams lived at Brunswick Lodge in Reading (now re-named Winterbourne House, a centre for psychotherapy) where his use of cannabis caused problems in his management. There were other difficulties: Mr Williams would not engage with medical and social supervision (the latter was, then, provided by a probation officer); he was reluctant to accept medication, and had a reputation for doing as he pleased. In September 1984 he moved to a bedsit in Mandela Road, Reading. Shortly afterwards his medical supervisor from Broadmoor hospital died, and was not replaced, and in early 1985 he discontinued medication. By May Mr Williams was clearly mentally unwell and his probation officer considered that **'…drugs…'** may be contributing to the deterioration in his mental state; after a visit to Mr Williams at work the probation officer was sure that **'…cannabis…'** was responsible for his hostility and aggression; it was also suspected that Mr Williams smoked cannabis while waiting in the probation office for an appointment.

   Substance abuse is not mentioned either in the records covering Mr Williams second 4-year admission to Broadmoor between 1985 and 1989, or in the assessments which resulted in his transfer from Broadmoor to the Wallingford Clinic in December 1989.

B. Alcohol. It is usual for patients in 'medium secure units' such as the Wallingford Clinic to have strictly controlled leave: in the grounds of the unit, then to the local community, then further afield. The leave is at first accompanied, usually by a nurse, and then unaccompanied; it is for limited periods. Leave arrangements are used to test a person's re-integration into the community and each stage must have the agreement of the Home Office. After obtaining unescorted grounds parole Mr Williams was reported as being impatient with what he saw as his slow progress towards discharge. He was also considered untruthful and manipulative. By February 1990 he was allowed escorted community parole and by May 1990 staff had recorded 10 visits to a local pub, in addition to other outings. In late May he was granted unescorted community parole but he became demanding in his requests to leave the unit, and was thought to be untruthful about leave arrangements.

   Mr Williams use of alcohol emerged as an issue in his management at the Wallingford Clinic in mid-1990: he was visiting a pub while purportedly out shopping for a patients' cooking group; while clearly affected by alcohol he denied drinking and he attracted the following comment in the nursing notes: '**A compulsive liar about whereabouts and drinking**'. He was also suspected of bringing cannabis onto the unit.

   Both the Home Office and the Special Hospitals Service Authority (who then managed the maximum security hospitals and had a continuing involvement in Mr Williams' case) were reluctant to agree to community leave while Mr Williams' drinking posed a management

problem for Clinic staff and the tribunal president, a judge, noted in October that the delay in meeting the deferred discharge conditions was a consequence of his use of alcohol. Nevertheless, by mid-November the tribunal members accepted that the conditions attached to Mr Williams' discharge had been satisfied and he left hospital to live at Basingstoke Road, Reading.

Mr Williams' account to those responsible for his treatment and supervision in the community was that he did not use drugs and took alcohol only at weekends. In July 1991 the licensing authority refused to renew his driving licence when a urine test proved positive for cannabis, and in November of the same year he told a visiting community psychiatric nurse that the large amounts of alcohol in his bedsit (now at Lyon Square) were being sold on behalf of a friend. Overall the picture remained the same with Mr Williams admitting moderate social use of alcohol, but denying other drug use. (An assertion not accepted by those who saw him whose suspicions were passed on to the Home Office).

C. Cocaine. As is detailed in the previous section Mr Williams was readmitted to the Wallingford Clinic in November 1994. Substance misuse was not an issue in his management in the early months and it is not mentioned in the tribunal report (which put forward the arguments behind the decision not to discharge Mr Williams) of February 1995. The situation changed in September 1995 following the report of a fellow female patient that she had been given cocaine when Mr Williams took her to his flat. Mr Williams vehemently denied the allegation until his urine tested positive for the drug. An imminent tribunal was adjourned while the situation was assessed. In his account of the incident to Dr Ferris, Mr Williams said that his taking crack cocaine was a one-off incident and Mr Williams agreed to random urine testing which Dr Ferris believed would effectively eliminate the risk of serious substance misuse. A rescheduled tribunal in late October discharged Mr Williams, on this occasion against the advice of the Home Office. (Their reasoning is at section 6 I). In addition to the usual conditions, and after obtaining Mr Williams' agreement, the tribunal stipulated that he submit to and co-operate with random urine testing as directed by Dr Ferris. A Home Office note at this time has proved remarkably prescient:

> 'I'm not sure how effective a condition that he should have regular urine tests could be applied. If he was taking drugs with no apparent mental relapse could he be recalled (to hospital)'

In November 1995 Mr Williams gave a sample of urine and a note of 15th December indicates that it tested negative; a second sample was given in January 1996 and a note of 13th March also indicates a negative result. When Dr Ferris saw Mr Williams in May 1997 he denied substance misuse and although Dr Ferris suspected strongly that he was using cocaine occasionally he decided not to re-institute urine testing on the ground that Mr Williams' mental state was stable. (This last point was emphasised repeatedly over the ensuing 2 years).

On 30th March 1999 Mr Williams had a urine test which was required by the DVLA. The test was taken not by his GP, but at another surgery in Tilehurst. The test was positive for urinary cocaine (section 6 J). The DVLA reported the result to Mr Williams' GP; there is no evidence that the Wallingford Clinic staff were made aware of the situation.

The last visit to Mr Williams' home by a member of the team was on 8th January 1998.

(A police witness statement from a school-girl described the bed-sit at the time of the murder.

> 'There was a little glass table he would cut crack on…towards the end people would put their cigarettes out on the floor, the toilet was derelict and in the kitchen there wasn't any food or anything. He didn't live there – he was not living, he was just existing').

(The issues of suspected drug dealing and urine screening are dealt with at section 12 B).

8. PSYCHIATRIC MANAGEMENT

Mr Williams was first described by a psychiatrist as being dangerous in 1976. His admission to a maximum security hospital, Broadmoor, in 1979 reflected judgements that he was both mentally ill and would present a grave and immediate risk to the community if he were at large. The fact that he remained a conditionally discharged patient from April 1984 (albeit recalled to Broadmoor and the Wallingford Clinic for 48 months in 1985, and again to the Wallingford Clinic for 11 months in 1994) until the murder, is a reflection of the judgement that he continued to be considered a special risk, which required special measures to be contained at an acceptable level.

This section examines Mr Williams' psychiatric management both at the Wallingford Clinic, and in the community after his discharge in October 1995 where the focus is on drug screening. Other aspects of his care in the community are covered in section 12 Risk Assessment and Management.

GENERAL COMMENT

At this stage it is helpful to ask what type of service the Wallingford Clinic should have been providing in the mid to late 1990s. As was mentioned in the introduction it was a relatively small service plagued, perhaps, by planning blight. On the positive side it was part of a recently established national forensic psychiatry service which provided ample opportunity for discussion and debate.

Underpinning all forensic psychiatry developments is the belief that certain mentally disordered individuals can be identified as requiring a specialist service. As with all developments of specialities from generic services, the forensic service tended to be elite: it chose its own client group; it had a relatively higher staff/patient ratio; there was a greater proportion of higher grade. The rationale being that a dedicated team would provide a better service for the targeted group.

Because of the nature of their client group, forensic services should have become a paradigm of good practice. Risk management was their bread and butter; policies and procedures were agreed and implemented rigorously. Relatively small case loads meant that specific issues were commonplace and their management a matter of routine: addressing non-compliance; education on mental illness and its treatments; understanding the contribution made by personality to behaviour; providing specific psychological treatments; working closely as a multi-disciplinary team; having an excellent system of recording information; managing boundaries; establishing a system of audit; dealing with denial; providing a system of professional supervision for all clinical staff.

Forensic psychiatry staff know that more heads are better than one; that good record keeping is essential; that the question 'Where are we going ?' must be asked, and answered, repeatedly; that goals are there to be aspired to, and revised; that team meetings and discussions should be recorded; that there must be a bring-up system; that home visiting is (in)valuable; that seeing relatives and other informants is an essential part of assessing a mental state.

A. Diagnosis. Mr Williams was first diagnosed as suffering from schizophrenia in 1972 and throughout the Wallingford Clinic notes the views were expressed that Mr Williams suffered from schizophrenia (sometimes qualified as paranoid in type) and that the condition could usually be expected to be controlled with a specific drug, at a specific dosage level. For understandable reasons other agencies involved in Mr Williams' care took the Clinic's lead in the matter of diagnosis.

Comment

1. While there was a principle diagnosis of schizophrenia there was no *diagnostic formulation* which, by outlining the unique features of the case in a narrative form, would provide a comprehensive picture of Mr Williams and thereby help determine his management.

   A diagnostic formulation has the following structure:

   - demographic data (e.g. age, occupation);
   - descriptive formulation of the illness;
   - differential diagnosis;
   - aetiology;
   - investigations;
   - treatment;
   - prognosis.

   The Clinic's remarkably limited view of Mr Williams' psychological state was accompanied by a therapeutic minimalism in which only medication appears to have had any place in his out-patient management; social and environmental factors appear to have been largely ignored.

2. There was no differential diagnosis, or ordering of diagnose*s.* (A commonly-used system is to allocate 2 axes: axis 1, comprising clinical disorders, and other conditions which may be the focus of clinical attention; axis 2, personality disorders).
3. A diagnosis of substance abuse was not considered.
4. Mr Williams low average IQ and specific cognitive defects were not considered in his management. (Psychological testing at Broadmoor Hospital in 1980 suggested impairment certainly of visual memory, possibly also of verbal fluency and comprehension, together with a relatively low intelligence quotient. These deficits were thought to be related to brain damage, psychosis, and educational needs). Psychological treatments could have helped ameliorate these specific cognitive defects, by addressing , for example, the lack of insight and/or denial, and the issue of substance abuse.
5. A diagnosis of personality (anti-social or psychopathic) disorder could have been proposed on the basis of the following persistent characteristics: lack of insight and/or denial; avoidant features (evasive, secretive, untruthful, devious); violence (aggression, impulsivity, truculence threats); jealousy (manipulative, exploitative, invasive, arrogant); substance abuse (alcohol, cannabis, cocaine); abnormal sexuality (promiscuity, violence, the use of prostitutes, disinhibition).

   A Home Office internal note of 20th June 1995 refers to a request for leave during Mr Williams recall to the Clinic:

   ' Mr Williams suffers from schizophrenia/psychopathic disorder '.

   This view was not communicated to the supervisors.

6. There was no written summary of the main phenomena (symptoms and signs) which characterise Mr Williams' illness when he was in relapse. If this was not possible as a single profile, a summary of his several relapse profiles should have been prepared.
7. There were no progress or hand-over notes.

B. Medication.

Other than in early 1995, throughout the whole of the period in which Mr Williams was treated at the Wallingford Clinic he was given Fluphenazine Decanoate (also called Modecate). It is a preparation used routinely in the treatment of schizophrenia and it is delivered by deep intra-muscular injection into a gluteal (buttock) muscle in recommended doses of 12.5 to 100 milligrams (mgs) at intervals of 14 to 35 days (British National Formulary). (The recommended dose range is 12.5 to 250 mgs/35 days).

Table 5: Mr Williams' medication 1989 to 1999

Period	Dose and frequency of Modecate injection
December 1989 to May 1993	50mg every 4 weeks
May 1993 to April 1994	37.5 mg every 4 weeks
April 1994	Refused increase to 50mg every 4 weeks
Sept. 1994 to January 1995	Refused all medication
(January 1995)	(Emergency sedation as an in-patient and temporary increase in Modecate dose)
April 1995 to March 1996	50mg every 3 weeks
March 1996 to arrest	50mg every 4 weeks

The most frequently encountered side effects of Modecate are abnormal (and sometimes reduced) physical movements, sedation, and, in men, erectile impotence. Complaints of side effects are common and include the feeling of 'not being oneself '; side effects often restrict the dosage of the drug and cause non-compliance (a refusal to accept the medication either openly, or by subterfuge).

Mr Williams dose of Modecate was one used commonly, at the lower end of the dose range; he did not complain of side effects when he received 50mg Modecate every month, although he did at higher dose levels (see the care plans of 07.08.95 and 01.10.95 at section 10 A). After his discharge from hospital in late 1995 he insisted on receiving his medication from the Clinic rather than at home, claiming that the nurses there were more expert in its administration. (At section 8 D nurses outline their attempts to assess Mr Williams' mental state as an out-patient).

Comment

1. Given the difficulties experienced in many areas of Mr Williams' management his compliance with medication for the 4 years following his discharge in 1995 raises the issue as to why he complied. One possible explanation is that it was a consequence of his recall to hospital following his non-compliance in September 1994. He was known to prefer the depot to be administered by a male, senior nurse, and his preference for Clinic-administered treatment may have been a consequence of his dislike of the 'intrusiveness' of home visits.
2. Mr Williams had no history of relapse when he received a dose of 50mg of Modecate monthly. His lack of insight and life style meant that the only feasible pharmacological treatment as an out-patient was by depot injection.
3. There is a widespread belief in psychiatry that personality changes can occur in individuals who are partially treated for severe mental illness. These changes include difficult-to-manage, uncooperative, and 'psychopathic-like' behaviours, in the absence of evidence of formal mental illness. These features often disappear with increased, or different neuroleptic (anti-psychotic) medication.

C. Medical management 1990 to 1994.

In late September 1990 Mr Williams was granted trial leave to a flat-share in Basingstoke Road, Reading. Technically his supervising psychiatrist remained a Broadmoor consultant although Dr Bullard fulfilled this role during his Wallingford Clinic stay, and took it over formally in November 1990.

Until November 1992 Mr Williams was seen mainly at Fair Mile out-patients by a female senior registrar in forensic psychiatry at the Clinic, who had known Mr Williams as an in-patient. He was also seen by a male senior registrar. Dr Bullard herself, who was supervising these trainee psychiatrists, saw Mr Williams at Clinic out-patients in March 1991. In late 1992 a second male forensic psychiatry senior registrar at the Clinic began seeing Mr Williams in out-patients. It was a time when Mr Williams was questioning his continuing medication and challenging his social worker Mr Jarvis; he was also missing appointments and putting pressure on the senior registrar to discontinue treatment. Mr Williams' complaints of side effects from his depot medication and his lack of co-operation generally led to the Modecate dose-reduction in May 1993.

Following his arrival at the Wallingford Clinic, Dr Ferris took over as the new 'Berkshire' consultant, and as Mr Williams' psychiatric supervisor, in February 1993. On 19th May 1994 he met Mr Williams for the first time. The senior registrar continued to be Mr Williams' psychiatrist and it was he and Mr Jarvis who dealt with the non-compliance and recall to the Clinic in late 1994 (see section 6 H).

Comment

1. It is possible that the reduced dose of Modecate which Dr Ferris sanctioned in 1993-4 was sub-therapeutic (the lowest agreed dosage in the 1990-1999 period, see table 5 above) and this 'under treatment' may have contributed to both the episode of non-compliance and relapse after admission.

D. Third conditional discharge.

'The two most important elements in effective supervision are the development of a close relationship with the patient and the maintenance of good liaison with the social supervisor. However often the supervising psychiatrist decides he needs to see the patient, he should see him in a situation in which he can detect deterioration in the patient's mental health or behaviour at an early stage'. (*Notes for the Guidance of Supervising Psychiatrists* (1987) Home Office).

> ' His release in October 1995 was supposed to be conditional on random urine tests to keep track of his drug abuse.
>
> Mr Williams use of crack should have been identified by the supervising psychiatrists'. (A Reading MP to Home Secretary 24.05.00).

In the period immediately after Mr Williams' discharge from hospital in late October 1995 he was seen in out-patients by a senior registrar who was supervised by Dr Ferris. Unlike her predecessor, who saw Mr Williams between 1992 and 1994, she was a senior registrar in *general* psychiatric training. She was attached to the Clinic for 6 months, and in a part-time capacity from the Oxford training scheme. She told the panel that when she saw Mr Williams in out-patients it was her first clinical contact with him; she had attended both his second tribunal and ward rounds but had not been at his pre-discharge meeting; he was both her first forensic out-patient, and restricted patient. She saw Mr Williams on 7 occasions over a period of 6 months, 3 times in the first month of his discharge. On one occasion there was in excess of 6 weeks between their meetings (15.12.95-02.02.96).

She did not visit Mr Williams' home.

In accordance with the conditions attached to his discharge there is a note that Mr Williams gave a urine sample on 8th November to the CPN, Ms Lee, and on 15th December that the result was negative. He gave a second sample to Ms Lee on 18th January, and that is reported also as negative on 13th March. The senior registrar told the panel that, whilst her recollection could be influenced by current practice, she believed that the nurses who gave Mr Williams his depot injection were testing his urine with a testing kit; the nurses we spoke to had no knowledge of this arrangement. The negative urine test reports mentioned earlier (December 1995 and March 1996) are recorded as hand-written entries in the clinical notes.

The senior registrar was asked by the panel how she would have responded if she had learned that someone like Mr Williams was using cocaine.

> 'I would be concerned…that the therapeutic relationship with the patient was breaking down if someone was taking drugs…I wouldn't necessarily make the assumption that they were going to become unwell because they were using a substance, but it would concern me that the relationship, which is very important in maintaining somebody in the community, may have broken down'.

After the senior registrar's departure Dr Ferris saw Mr Williams, first in out-patients at the Wallingford Clinic in May 1996. Dr Ferris told the panel that when they met he had the lever arch files containing Mr Williams' notes. He did not make entries in the clinical notes but wrote short entries on an A4 pad which was kept in his office, or he dictated a report which acted also as a record. In July 1996 Dr Ferris received a telephone call (see section 12 B) which made allegations of cocaine use (and dealing) and faking urine tests. Dr Ferris spoke to a case worker at the Home Office about the allegations and they were in agreement that it was a matter of (Dr Ferris') clinical judgement as to the extent to which the tests were a necessary part of his treatment. Two days after receiving the 'phone call Dr Ferris saw Mr Williams and there is a typed record of the meeting.

> 'I explained to him why the so-called 'random' testing we had been carrying out was not really random and therefore could not be effective. I also told him that my concerns were whether he was taking cocaine and the possible effects on his mental health, rather than with whether he was supplying cocaine to other people as that was a criminal matter essentially between him and the police.
>
> I re-iterated statements previously made at the tribunal that in my opinion, depending on the amount he was taking, his cocaine would probably increase the chance of a relapse of his illness, even if he remained compliant (as he does) with medication.
>
> (And later.) I explained that in order to continue the testing which I felt I had to do, particularly in the light of the information I had received, it would have to be tightened up and made truly random. We therefore discussed and agreed the following:
>
> 1. We would send him a letter (as he does not have a 'phone) every now and then advising him that we needed to meet him at his home the following day at times specified in the letter, in order for him to provide a urine sample.
> 2. That we would try and avoid writing to him asking to meet him on days that he was at work i.e. Mondays and Wednesdays.
> 3. That when he was tested a male nurse would need to be present with him when his sample was produced in order to prevent sample-switching or tampering.

4. That we would not harass him or make his life a misery by seeking to test him with undue frequency. I told him that I thought about once a month would be fair and he did not disagree with this'.

It was 9 weeks before Dr Ferris saw Mr Williams again.

A clinical biochemistry report from the Royal Berkshire and Battle Hospitals NHS Trust refers to a sample taken on 6th September 1996:

'…a very low level of cannabinoid metabolites. No cocaine metabolites detected'.

A second biochemistry report of a sample taken on 27th September showed no evidence of illicit drug use. Dr Ferris' note of their meeting on 30th September includes the comment that Mr Williams was told that he must present himself for a urine test on the day after receiving notification, not after a delay of 3-4 days as occurred recently. (Thereby not allowing time for drug break-down products to clear from the urine). Dr Ferris wrote a note of 30th September out-patient contact:

'Overall, there are no indications of any serious problems or new concerns. The fact that he has five girl friends does raise questions about whether possible dealing in cocaine may have some unpleasant connection with his sexual relationships, as suggested by the mother of a woman back in July. He said that he had no further contact with her and no further problems and I have not heard anything from her. He clearly has been smoking cannabis (a positive urine test on 6th September) and in future I plan to let him know that if he wishes any reduction in the dosage of medication he will have to show a complete abstinence from both cannabis and cocaine for a prolonged period. The random urine tests (which have to be truly random) clearly must continue. In the meantime the care-plan remains in place and I will see him again in six weeks time'.

The urine test taken on 27th September 1996 was the last taken under the aegis of the Clinic.

Ms Lee's evidence to the panel provides a description of events surrounding urine testing. (Ms Lee was a CPN involved with Mr Williams and her responses have been re-ordered to produce a narrative).

Q: Can you recall any discussions about how frequently the urine should be tested?'

A: 'I think it was something that was discussed in the CPA. I can't remember a timescale but I was asked periodically to do a urine sample…there was no timescale…'

Q: ' without the person's compliance…it (urine testing) is a charade?'

A: 'Yes. But you have to see whether it is going to work out or not, and until the 'phone call…as far as we were aware Winston was complying. If that 'phone call hadn't happened we wouldn't have been aware…'

Q: 'Random sampling doesn't seem to have happened'.

A: '(I would write saying I will be there tomorrow) I would then go along and he wouldn't be there – or he may well be there and I couldn't gain access to the front of his flat…I couldn't gain access to the front door because of the intercom system…The next time I saw him he came back with the thing about the post…going missing'. (The landing which gave access to Mr Williams' and other bed-sits had an access door locked so as to provide some security).

Q: 'What was the impact of the' 'phone call…?'

A: 'The main thing for me was the fact that potentially Winston had been getting round the drug tests, so the discussions were how to make the drug tests more foolproof. If I remember rightly, that is when we started the letters and that is when I made the

'phone call to the Post Office and subsequently to visit the neighbourhood centre below the flat'.

Q: What about putting water in his sample?

A: As a female I would not go into the bathroom with him while he was doing the sample, so it is possible and also proven. I mentioned the day I went looking around the flat; he went out for a pint of milk and I went into the bathroom and hidden amongst all his stuff was a Lucozade bottle with a urine sample that I presumed he hadn't done, but it was in case I asked him for a sample.

That is when Dr Ferris, Richard (Dale-Emberton) and I had a discussion of making it more random of sending a letter for him to receive one morning to say I would be there the next day. Then he beat that by saying that there was a problem with the post. I 'phoned the Post Office because he said it had been reported and that the Reading post office knew there was a problem on Lyon Square, to which they replied no, no there wasn't.

…To get to the balcony (and Mr Williams' bed sit) there was a locked entry. Our next suggestion was that I would go and put a note through the door to say that I would be there the next day for a sample, but I couldn't gain entry. I would only be able to gain entry if Winston was in…he'd say he wasn't there and he hadn't got the message. The last thing was about a male nurse going with me and standing in the bathroom with him while he did the sample. At one stage we were arranging for him to come to the clinic on a Saturday morning'.

'I went (to the neighbourhood centre underneath the flats in Lyon Square) to see whether they had the master key to get onto the landing where Winston lived…to put a note through Winston's door so that I knew he had received the note'.

Q: when (finding the Lucozade bottle) might that have been?'

A: 'After the (Ms A's) 'phone call…That is what alerted me. Dr Ferris informed me of this (the allegation that Mr Williams substituted urine), and the next time I asked Winston if he would go out and get a bottle of milk'.

Dr Ferris next saw Mr Williams on 10th December, 10 weeks after their last meeting. He reported to the Home Office:

'I have repeatedly pointed out to Mr Williams the importance of abstaining from cocaine and the potential risk of a relapse of his illness being caused by repeated consumption.

…The urine testing has led to some tension between Mr Williams and ourselves as supervisors, particularly with his CPN, Jackie Lee who writes the letters to him.

…He has not however co-operated fully with random urine testing though in my opinion it probably has the continuing effect of significantly reducing the amount of substance abuse'.

On 26th February 1997 (see section 11) a CPA review meeting was held, attended by Mr Dale-Emberton, Ms Jackie Lee, and Dr Ferris; Mr Williams was not present. Dr Ferris recorded:

'JL seeing him fortnightly. No urine tests since November '96 (in fact September 1996). RD-E decreased visit, seeing him monthly…Mr Williams comes here Fridays for injection…Paying children in the street to produce urine sample...JL will write to GP…Mental state OK – med fine…3 to 4 girlfriends; more time with one…bathroom was filthy…working 2/7…Mon and Wed. Can't sample.

Needs→soc supervision one monthly…JL withdraws; debt free, rent paid; driving licence. 6 weekly with RF'.

Dr Ferris next saw Mr Williams on 30th May 1997, more than 24 weeks since their last meeting in December 1996.

After 3 requests from the Home Office Dr Ferris wrote a report on 28th July 1997 which referred to a meeting 3 days earlier with Mr Williams:

' It transpired that for one reason and another he had given no urine samples for random testing since about September 1996 (at which time cannabis metabolites showed up). After considerable discussion we agreed that the random urine tests would not be re-instituted, even at reduced frequency. My main reason for deciding this was that Mr Williams had remained well for eight months without any signs of relapse, whilst not undergoing urine testing. In other words, he was remaining well whether or not he continued to use cocaine or cannabis occasionally, which I strongly suspect that he may do'.

After seeing Mr Williams on 19th September 1997 Dr Ferris wrote to Mr Williams' GP:

'Mr Williams progress in psychiatric supervision is entirely satisfactory at present and I have no major concerns about him'.

Dr Ferris' file note of his meeting with Mr Williams states that he is now seeing Mr Williams 2-monthly; Mr Williams is seeking re-housing and has some contact with his daughter. He continued:

'He told me he continues to have relationships with the same three girl-friends, none of whom knows of the existence of the other two. These are sexual relationships about which he is obviously pleased.

We also discussed absolute discharge and he told me he might apply for a tribunal next year (I did not tell him that I would not support an absolute discharge but this is so)'.

As planned Dr Ferris next saw Mr Williams about 2 months later, coincidentally shortly after the allegations of assault and threats to kill were made against a woman (see section 12 D). Dr Ferris wrote to the Home Office outlining the conclusions reached by Mr Dale-Emberton and himself that there were not grounds to recommend recall. Dr Ferris continued:

'Having said all this, my impression was that Mr Williams is probably lying about the incident …if the allegation is true it is worrying that such an incident has occurred in the context of compliance with supervision and medication. The situation perhaps illustrates the limits to what supervision can achieve'.

A month later Dr Ferris saw Mr Williams again and reported to the Home Office: Mr Williams' mental state continued to be stable and the suggestion had been made that the allegations were false.

The next meeting between Mr Williams and Dr Ferris was more than 21 weeks later. On 1st May 1998; Mr Hayward took over from Mr Dale-Emberton as social supervisor. Dr Ferris wrote to the Home Office after receiving 3 requests for a report (16.02.98, 18 03.98, 23.04.98):

' Mr Williams is now seen by me at two-monthly intervals and was due to have one further appointment between December and the present time. However, due I believe to an oversight on my part he was not sent an appointment in February and therefore I did not see him'.

Dr Ferris saw Mr Williams 20 weeks later; again the Home Office issued 3 requests for a report (07.05.98, 05.08.98, 11.09.98). He wrote to the Home Office on 24th September:

' In addition to my contacts with him his mental state is monitored by monthly contact with the Wallingford Clinic staff…who administer his depot injections and know him well '.

The panel interviewed 2 members of the nursing staff, one of whom had considerable out-patient contact with Mr Williams. The nurses said that the arrangement with Mr Williams was unique: no other out-patient received his/her depot at the Clinic. Because the panel saw no nursing notes made at the time the depot was administered (they were said to have been lost in the move from the Clinic) it was put to one witness that no mental state assessment notes were made other than a record of the depot administration; in reply it was said that the assumption was a reasonable one. The second nurse said that depot-contact with Mr Williams would be for a couple of minutes. In answer to a question about accessing Mr Williams' mental state the nurse replied:

A 'It's very difficult, especially with him, because you don't know what's going on inside…

Q: Do you really think you were assessing his mental state when you saw him in the Clinic?'

A: Not for a couple of minutes, no. Usually he goes to the portacabin after he has his depot, and we make sure that he goes there'.

Q: So they were doing it?'

A: 'They should have been. As an out-patient either the social worker or Rob Ferris should be seeing him'.

Q: But you would see him for a couple of minutes?'

A: Yes. He was always in a rush to go…'

On 22nd September Mr Hayward wrote to Dr Ferris:

' (I am) concerned at Mr Williams' lack of response to the growing crisis relating to his non-payment of rent arrears'.

In his report to the Home Office of 24th September 1998 Dr Ferris informed the Mental Health Unit that Mr Williams was driving a school bus. In the Home Office notes concerning the report of Mr Williams driving is a comment that the Home Secretary wanted to know whether Mr Williams' employers were aware of his history and if not, what the plans were for both informing them and re-introducing random urine testing (see section 6 I).

In November and December 1998, and January 1999 Dr Ferris saw Mr Williams at monthly intervals. In November with Mr Hayward, when the issue of driving a school bus was discussed; in December, when the focus was on the driving/urine testing options, and on 22nd December Dr Ferris reported to the Home Office. The handwritten notes for the January meeting read, in part:

'…Bus, only two hours per day, £60 per week…see(s) soc(ial) work(er) every 3/52'.

The Mental Health Unit notes of this period (07.01.99) reveal continuing concern and prescience:

' Will give up job rather than submit to tests. (Which raises concern about his use of drugs). The idea of a conditionally discharged restricted patient with a history of drug abuse, real or suspected, driving schoolchildren is not one which conjures up a reassuring picture.

Concern raised at welfare of the children and bad press coverage if anything goes wrong. Dr Ferris to confirm resignation from job '.

(On 21st January 1999 Mr Williams' driving licence expired. It was not renewed).

Dr Ferris' hand-written notes for the 19th March 1999 Clinic out-patient meeting read in full:

'2 letters → one for disability living allowance'.

In February 1999 Mr Williams continued in his role as a special needs school transport driver, now to a single community resource, a job which he continued until at least 23rd April; on 2nd April his driving licence was revoked because of his cocaine use.

Comment

1. Mr Williams' discharge in 1995 followed his second recall to hospital. In the first 6 months after his discharge there should not have been a period in excess of 6 weeks when he was not seen by his supervising psychiatrist.
2. The female senior registrar was not prepared adequately to take on Mr Williams' supervision: she had little clinical knowledge of the case and was relatively inexperienced. She played no part in the pre-discharge planning.
3. Dr Ferris' notes and reports in 1996 make several important points:
   - substance misuse increases the risk of relapse;
   - risk increases with the amount of misuse;
   - urine testing limits misuse. (The female senior registrar also made this point in her evidence to the panel);
   - urine testing must continue;
   - that the structure of care provided by conditional discharge was necessary to protect the public from serious harm.

   Dr Ferris' notes suggest an agreement, albeit never one put into practice: long-term validated drug-free urines will be traded for a reduction in medication. It should be remembered that in 1993/4 Mr Williams became non-compliant and relapsed when his medication was reduced below the level on which he was stabilised after his 1995 discharge from the Clinic. While it could be viewed as prudent to increase Mr Williams' depot medication because of his cocaine use, the reverse is not true.

   At the CPA meeting on 22nd October 1996 Dr Ferris is reported as saying:

   > …there would be a severe risk of relapse from Winston taking illicit drugs.

   The panel expected to find extra vigilance on the part of the multi-disciplinary team in the light of: the probable misuse, the amount of misuse being unknown and therefore the degree of increased risk being not quantifiable, and the (later) accepted fact that the testing plan had been abandoned. None was discernable.
4. Urine testing was unplanned and unstructured. From the beginning its *frequency* was unclear. It seems that Ms Lee mainly *administered* the testing process; the very necessary suggestion that a male nurse be involved did not happen. It is also unclear who *owned* (was responsible for) the testing, although it was clearly at Dr Ferris' absolute discretion. Testing was not established successfully at any of the suggested *locations*: the Clinic, at Mr Williams' home, or at his GP's surgery. In the end, a safe guard which **'…must continue'** was quickly abandoned.
5. Dr Ferris was Mr Williams' RMO and supervising psychiatrist from 1994 and he saw him with his senior registrar in May of that year. Following Mr Williams' discharge in late October 1995 his first direct contact with Mr Williams in out-patients was in June 1996. In early 1997 Dr Ferris did not see Mr Williams for a period of more than 24 weeks during which time: the professional most involved with Mr Williams, CPN Ms Lee withdrew from the case; the social supervisor Mr Dale-Emberton increased the period of time between his contacts; it became clear that urine testing was not possible.
6. Dr Ferris' assurances to the panel that the nurses were monitoring Mr Williams' mental state when he received his monthly injection was not confirmed by the nursing staff. They told the

panel that they believed that the RMO and social supervisor were undertaking this task at their out-patient portacabin meetings after the depot administration. In fact only 7 of the RMO's 24 out-patient Clinic contacts with Mr Williams occurred on the day he received his depot; for the social supervisor, 6 of 39.

7. Throughout Dr Ferris' out-patient management of Mr Williams there is no evidence that he:

   sought independent information (from individuals other than members of the MDT) to help establish the reliability of Mr Williams' account of his life, habits, and mental state; sought to involve family, carers or neighbours in his community management;

   staggered contact with the social supervisor, thereby maximising cover;

   planned any sustained increase in contact after significant events (e.g. the

   CPN's withdrawal, Ms A's 'phone call, the assault allegations, the failure to establish a urine-testing programme).

8. Dr Ferris did not see Mr Williams at his home. (Although he had visited once during a period of increased concern but Mr Williams was out (see section 12 D)).
9. Mr Williams depended on being sent an appointment. Dr Ferris had no call-up system and for relatively long periods there was no contact. The length of time between some contacts was unplanned and could have involved considerable risk (2 periods of 5 months, 2 of 4 months).
10. Dr Ferris' contact with Mr Williams was irregular, and infrequent. The case management lacked direction and any psychiatric/psychotherapeutic context.
11. From what we know about lack of information on both the social supervisors behalf, and mutually between the RMO and social supervisors about each other's contact and practice, we conclude that structured communication did not occur.
12. Dr Ferris was the only psychiatrist who saw Mr Williams from June 1996 onwards. There are no records updating Dr Bullard (who stood in as consultant in Dr Ferris' absence) of Mr Williams' case and her evidence to the panel did not lead us to believe that she had an up-to-date knowledge of him.

E. Last contacts.

In May 1999 the Home Office wrote to Dr Ferris.

> 'We note from your last report, dated 22 December 1998, and a report recently received from Mr Hayward, that Mr Williams remains mentally well but continues to refuse to submit to random urine tests, despite being required to do so by he conditions of his discharge.
>
> It is clear that Mr Williams does not require recall and it would therefore be inappropriate for us to send him a warning letter about the drug screening threatening recall if he does not comply'.

(A neighbour and acquaintance of Mr Williams was interviewed by the police after the homicide.

> 'Shortly before I went to prison (28th July 1999) I noticed Winston's behaviour had got worse. He was depressed and moody and I had to take him to Fair Mile on a couple of occasions to get his medication. He often talked about 'losing it' and not being in control').

Dr Ferris saw Mr Williams next on 6th August. Mr Williams said that there were problems with his driving licence. When Dr Ferris later contacted the DVLA he learned, for the first time, of the failed urine test in late March and the subsequent withdrawal of his licence. (Although it had not been renewed on 21st January 1999). Dr Ferris dictated a report to the Home Office on 16th August; it was received at the Home Office on 17th September (see section 6 J). (The

Home Office made 5 requests for reports to Dr Ferris in 1999, the last being marked 'urgent'). A Home Office witness told the panel with regard to late reports:

> 'A letter from the Home Office normally has quite a strong effect, especially if its written saying, you're due to report or we haven't had your report, your report is due and you get another one. Most people who have professional pride respond to that' .

And the Home Office's response to the report?

> '…we didn't get (the report) until 17th September, where we find that he is still using a van. I am not trying to teach my grandmother to suck eggs, but the sort of things we look at is, where is he lying, where is the breakdown in the relationship where they don't have a grip on the truth? When we see something like that, and there has been positive testing for cocaine yet again, our detective work tends to put things together saying, how much can you believe of what you are being told? '

Mr Hayward received his copy of the report on 20th September when he learned for the first time that Mr Williams did not have a current driving licence. He told the panel:

> '…if the homicide hadn't occurred, I have no doubt that would have prompted a crisis meeting with myself and Dr Ferris, and indeed Winston Williams, within a very short period of time indeed'.

The report is worth quoting in full here although it deals with issues also covered in other sections. (The supra-text numbers refer to the comments which follow the report).

> 'The following is a progress report on the psychiatric supervision of the above conditionally discharged patient. I have the most recent social supervisor's report [1] by Mr Hayward on March 31st, 1999. The last letter from me was dated December 22nd, 1998, addressed to (the case worker) which mainly concerned the question of Mr Williams driving children to school in a van [2], his then employer having been sub-contracted the job by social services [3].
>
> Mr Williams gave up that job after being given a choice by me between doing so or agreeing to have random urine tests to detect possible cocaine misuse [4].
>
> Mr Williams has continued to attend the Wallingford Clinic monthly for his Fluphenazine Decanoate intra-muscular injections (50mg) . He therefore has regular contact with nursing staff who know him well and can help monitor his mental state and progress [5]. He prefers this arrangement to being visited by a CPN [6] as he values the injection giving expertise (as he perceives it) of the senior Wallingford Clinic nursing staff. Mr Williams and I are supposed [7] to meet at six to eight weekly intervals but again a gap of about three months passed recently between appointments [8]. This has been as much my fault as his [9] though it is clear that Mr Williams will never initiate an appointment with me and only responds when an appointment time and date are sent to him.
>
> I saw him last week [10]. He seemed unhappy and rather forlorn. He said that this was because his Disability Living Allowance had been reduced or withdrawn, significantly lowering his income. This was in spite of a letter I wrote on March 25th, 1999 offering (qualified) support to the continuation of the DLA. I also wrote to the Housing Officer at Reading Borough Council at the same time supporting Mr Williams' request to move to alternative council accommodation. He told me that this letter had been helpful in qualifying him for a significant number of points and therefore moving his name up the waiting list for re-housing. However, he is still in the same flat at present and unsure of when he will move. Although he continues to be unhappy about his accommodation he did not describe any particular incidents recently (for example fire setting in the stair well by local boys (sic)).

Mr Williams went on to tell me that he had not had his ordinary licence renewed in April 1999. He said he did not know the reason for this [11] and had been told that 'his doctor' (i.e. me) would tell him. After explaining that I was unaware of the reason and, indeed, puzzled by this news in the light of lengthy conversations I had with the DVLA last year (see previous correspondence), I telephoned the drivers medical group of the DVLA in Swansea. They informed me that the reason his licence had been withheld was that a urine test by them around April/May was positive for cocaine metabolites [12]. This of course confirms continuing cocaine misuse by Mr Williams [13]. He was present in the office when I made the 'phone call and I immediately confronted him with this information. He made no attempt to deny the obvious facts and we then had a discussion about the choices facing him We agreed that these were first, he continues to misuse cocaine and gives up any idea of having a driving licence. Second he agrees to random testing of his urine, gives up cocaine, and then uses a series of two or three negative results to support a re-application for an ordinary driver's licence in April 2000 or thereabouts. After briefly hinting that he would be happy to co-operate with urine testing if he knew the dates in advance and then seeing that I would not agree to this, he stated frankly that he would like to go away and deliberate about these choices, getting back to me if he opted for random urine testing [14].

So far as cocaine use is concerned my attitude remains that the misuse is clearly not at a level causing any recrudescence of psychiatric symptoms. The symptoms of his illness seem well controlled by the maintenance of anti-psychotic medication [15] and although it would clearly be preferable if Mr Williams refrained from any cocaine misuse, the practical difficulties in getting him to co-operate with our attempts at random urine testing in the past were so great that, in the absence of any evidence that his substance misuse is bringing about a relapse of his illness, I would prefer to leave things as they are [16]. I am not sure how Mr Williams funds his substance misuse and it is theoretically possible that he may be dealing [17]. Again, I have no evidence of this or indeed of any ongoing criminal activity [18].

Mr Williams reported his life in other areas to be stable. He is not employed and, unable to drive [19] spends much of his time in or around the home. He continues to have some contact with his daughter and ex-wife. He also described continuing relationships with three 'girl friends' [20, 21].

On mental state examination although morose and unhappy, he did not appear clinically depressed. His mood was reactive and he was able to smile ruefully [22] on occasions. As mentioned, there was no evidence of any active signs or symptoms of schizophrenia or psychosis.

In conclusion Mr Williams continues to co-operate with treatment and psychiatric supervision [23]. The signs and symptoms of his mental illness are apparently well controlled by the maintenance anti-psychotic medication with which he remains fully compliant. He is presently unemployed and had lost his driver's licence because of recurring substance misuse. He is unhappy about this and also a reduction in his income from benefits and allowances, as well as delays in being re-housed by Reading Borough Council. He continues to have contact with his extended family and there do not appear to have been any major life events or changes in his circumstances. The previous concern about his driving children to school in a van is no longer relevant [24].

Mr Williams may elect to undergo random urine testing to check for continuing cocaine misuse but I doubt this. As explained I do not feel it is justified in present circumstances trying to force this on him. I plan to continue to see him at six weekly intervals [25] and to continue liasing from time to time with his social supervisor Mr Hayward [26].

Comment (referring to the supra-text numbers added to the report above).

1. Dr Ferris believed (mistakenly) that Mr Hayward had not reported to the Home Office for more than 4 months which is well outside the *Guidelines.* He did not check with Mr Hayward or comment on this omission. Furthermore he did not mention his own 6-month delay in providing a report.
2. Mr Hayward's report of 31st March was not his most recent. Mr Hayward reported to the Home Office on 7th July and sent a copy to the Wallingford Clinic where it was stamped 'Received 12th July 1999'. Dr Ferris had not seen this second report and he was unaware of Mr Hayward seeing Mr Williams driving. The fact that an important letter was at the Clinic for more than 3 weeks, unseen by Dr Ferris, raises questions about communication (both oral and in writing), and management.

   Had Dr Ferris been aware of Mr Hayward's report he would have known that Mr Williams was driving, probably school transport, and while disqualified. This would have provided a completely different context to the meeting, which, in the light of what Mr Hayward knew and Dr Ferris should have known, was based seemingly on Dr Ferris' accepting the lies which Mr Williams told him.

   Mr Hayward's report of 7th July opens with information on Mr Williams' desire to move to north London. The report continues:

   > ' I should point out that I believe Mr Williams was subject to a fine relating to a non-moving traffic offence committed last year but which only came to court in May 1999 (see enclosed press cutting: '12th May 1999 – Reading Magistrates' Court – fined £200 with £30 costs and £37.50 back duty for keeping a vehicle on the road without an excise licence on 25th June 1988'.). When I asked Mr Williams about this, he denied all knowledge of any such offence. In addition, when he left the appointment on 30th June, he was driving a medium sized mini bus with perhaps eight or nine seats. There was no sign indicating it was for children. It is for these reasons that I suspect that Mr Williams is not being completely open and honest with me about what is happening in his life at present, but when I challenged him about this, he has denied it (sic)'.

   A Home Office witness told the inquiry of his response when he read, following the homicide, that Mr Williams was still driving:

   > 'What the hell was he doing in a van when allegedly he had given up his licence and supposedly was no longer involved?'

   It is clear that Mr Williams was lying repeatedly to both his social supervisor and RMO, and that communication between the two was poor. We can only conclude that Mr Williams felt able to tell different lies to his supervisors in the knowledge that they would go unchallenged.
3. In evidence the panel heard that it was the Department of Education and Community Services which out-sourced transport services on behalf of Reading Borough Council.
4. We understood that it was the Home Office which had been portrayed as having issued the ultimatum. Thus in his letter to the Home Office of 22nd December 1998 Dr Ferris wrote:

   > 'I found it very necessary to cast the Home Office in the role of 'the bad' in order to minimise the damage to my satisfactory supervisory relationship with Winston'.

   The fact that Dr Ferris believed that he had a satisfactory supervisory relationship raises important issues of judgement.
5. Notes of the Clinic contact are lost. We have no evidence that there was a regular feed-back of Clinic appraisals (which were at best perfunctory).

6. Following the late 1995 discharge the CPN's home visits had never been with the intention of administering medication.
7. The word 'suppose' indicates an expectance, and the remainder of the sentence is an important recognition of the necessity for regular, if infrequent, meetings.
8. This is inaccurate: Dr Ferris had not seen Mr Williams between 19th March and 6th August, a period of 20 weeks. Taking Dr Ferris' own outer limit of 8 weeks between appointments, 7, of a total of 16, fell outside his limit.
9. We cannot understand in what sense Mr Williams could have been at fault, the agreement being that it was Dr Ferris who initiated contact.
10. The report to the Home Office is the only record of the meeting which took place on 6th August, was dictated as a report on 16thAugust, and was not typed until16th September. It was received by both Mr Hayward and the Home Office on the 17th, which was probably the day after the homicide.
11. Mr Williams was being untruthful. His licence was not renewed on 21st January 1999, and withdrawn in April following the positive cocaine test.
12. Although told by the DVLA that it was not customary practice, we find it very difficult to understand why the DVLA did not also inform Dr Ferris, who certified the licence application and had spoken extensively to their medical adviser, of the urine test result in April 1999.
13. Had Dr Ferris contacted Mr Hayward by 'phone to give him the information on Mr Williams disqualification he would have learned of Mr Williams' driving and it would have provided a completely different context to the subsequent discussion. Mr Hayward did not learn of the positive cocaine test until he read Dr Ferris' report on the 20th September.
14. There was no choice: note Dr Ferris' earlier comment that Mr Williams never initiates contact.
15. The comment that cocaine use **'…is…'** not bringing about a relapse was at best based on limited information, but the issue surely was 'will it'? At the CPA meeting in October 1996 Dr Ferris is reported as believing: **'…there would be a severe risk of relapse from Winston taking drugs'.** Furthermore, Dr Ferris' confidence in Mr Williams' mental stability should be judged in the light of the knowledge that over a period of 19 weeks Mr Williams had been seen once by his psychiatrist, and once by his social supervisor. It was later to be Dr Bullard's view that Mr Williams relapsed despite continuing to receive medication, and so it was not a dependable point.
16. Dr Ferris gives no *balanced* assessment of risk, merely re-iterating reassuring judgements. He had no knowledge of the extent of Mr Williams cocaine use, nor did he seek to assess it, and he could not therefore, with confidence, make any comments on risk.
17. In 1996 Dr Ferris was given information in a telephone call, which he said at the time he accepted, that Mr Williams was dealing in drugs. Mr Dale-Emberton, his social supervisor at the time, was asked if Mr Williams may be supplying drugs:

    'We were always wondering how he managed the big Jaguar car. He had all these girlfriends and some expensive clothes. It didn't add up with his income, and with his record we would be thinking, what's the drug situation with him…We suspected it but we couldn't prove it. Rob (Ferris), Jackie Lee (CPN) and I would challenge him, but we didn't have any evidence to take it further'.

18. This is not an objective view. It is not *theoretically possible* but *most likely* that Mr Williams was involved in criminal activity. Even on the basis of limited information the only reasonable assumption which Dr Ferris could have made was that Mr Williams was funding his cocaine use

from other than his benefits and 'therapeutic earnings'. Dr Ferris did not *put himself in the position* of having adequate, and reliable information on which to make a judgement of risk.

19. 'Unable to drive' is both inaccurate and gratuitously reassuring. Mr Williams was able to drive, and did; he was probably employed as a driver for almost a year, until the summer of 1999.
20. Despite having been diagnosed as pathologically jealous no-one sought to contact Mr Williams' 'girl friends'.
21. The picture painted of Mr Williams' home life is largely inaccurate. He was living in squalor, using and dealing in drugs, driving without a licence, and becoming increasingly unstable.
22. The use of the word 'rueful' is significant given the content of the interview. It suggests that Mr Williams showed remorse, or repentance, and evoked pity.
23. This is misleading. The psychiatric supervision amounted to a one hour (at best) contact (in which Mr Williams repeatedly deceived Dr Ferris) over a period of 20 weeks.
24. This is an unsupportable judgement. Mr Williams continued to drive after losing his licence, and drove children.
25. Use of the word 'continue' is misleading. Dr Ferris penultimate appointment with Mr Williams was 19 weeks previously.
26. Dr Ferris is known to have last liased formally with Mr Hayward about Mr Williams in November 1998. The evidence points to them being largely ignorant of each other's contact and being reliant on copies of Home Office reports as a basis of communication.

F. Expert evidence.

In summary, Dr Michael Farrell, the panel's expert witness on substance abuse, told the inquiry that typically crack cocaine induces feelings of euphoria and stimulation which last 10 to 15 minutes. It is used by the young adult population, mostly episodically, costing about £60 per gram, with a consumption of about 2 grams at each session. Others take large amounts of the drug, often in binges; sometimes its effects are extremely destructive socially, and it is particularly addictive; increased criminal activity is commonly encountered. There are increasing reports of cocaine use in people with chronic mental illnesses in inner city areas.

Cocaine can induce paranoid psychoses if taken in large enough amounts and in the vulnerable, like Mr Williams, it can predispose to a relapse of their underlying mental disorder. If someone has an aggressive predisposition, cocaine facilitates their violence. After using the drug there can be a substantial mood change with associated suicidal behaviour.

If drug use is considered a critical matter in terms of risk, monitoring has to be put in place. Testing has to be random in that the test is taken within 24 hours of the request and the sample has to be passed in the presence of a scrutinizer who ensures that it is a fresh sample.

The panel received conflicting evidence on local substance abuse services: on the one hand they heard evidence that a broad range of services was then available in west Berkshire;

> 'The Neutral Zone was set up in 1990 providing a needle exchange service. In 1993 it became part of West Berkshire Priority Care Services NHS Trust and started to treat substance abusers'.

Dr Ferris' view is that at the time the local NHS service in west Berkshire confined itself exclusively to problems of alcohol misuse and dependence.

Comment

1. Much of the 'un-understandable' in Mr Williams' history becomes understandable in the knowledge of his substance use: his working-while-claiming-benefit, debts, and (in some ways) extravagant life style; his status as the frequent 'victim' of burglaries and damage to his property; his dangerous driving; his singular evasiveness and lack of concern for others.
2. A commonly held view is that substance *use* becomes *abuse* in one or more of the following circumstances:
   - when it interferes with normal day-to-day functioning and responsibilities;
   - when it recurrently exposes the user to risk;
   - when its use is accompanied by legal problems;
   - when its use continues despite the above.
   - Mr Williams management at the Wallingford Clinic was certainly affected adversely by his drinking; for example, his lying made it difficult to form a relationship of shared trust. His cocaine use exposed him to: risk of physical harm, psychological stress, and a relapse of his mental illness. His debts brought both court action for non-payment of fines and the threat of eviction.
3. Mr Williams' untruthfulness made any exploration of his substance abuse difficult. Later, the adverse consequences of cocaine use were explained to him but this was done in the context of complex semantics: he was told that cocaine use would increase the risk of his illness relapsing while the Home Office was assured repeatedly that cocaine use was not being accompanied by evidence of relapse; the Home Office considered threatening to recall him if he did not submit to urine tests while in truth it did not have this power without evidence of relapse (see section 12 G). Furthermore some of those responsible for his supervision believed, mistakenly, that substance abuse without evidence of mental deterioration was grounds for recall.
4. The assertion that Mr Williams substance abuse was not accompanied by a deterioration in his mental state was both simplistic and misleading. The abuse itself was largely denied (in the psychological sense); its extent unknown. Given Mr Williams' economic circumstances, his personality, record of violence, and severe mental illness, it was *likely* to expose him to severe social hardship and interpersonal conflict, to greatly increase the risk of violence both with and without a relapse of his illness.
5. While Mr Williams was unlikely to have co-operated with referral to a specialist substance abuse team such a service could have given Mr Williams' supervisors an *informed* opinion on the likely extent of substance abuse, and of its possible effects. Furthermore, such a specialist service might have supervised and undertaken the urine testing programme.
6. The supervising professionals had evidence that Mr Williams cocaine use involved others, putting them at risk. Dr Ferris' view that the allegation that Mr Williams was dealing in cocaine was essentially a matter for the police was extremely limited. His cocaine use was linked inextricably with his severe mental illness; it should have had a significant effect on his risk management; it involved child care issues. Should there not have been an attempt to liase with the child protection team which was mentioned by Ms A, or, after informing Mr Williams of the proposed disclosure, to discuss the allegations with the police on the basis that issues of potentially serious harm were involved?
7. Supervisors have an absolute professional responsibility to provide full and objective reports to both colleagues in health and social services and to the Home Office.

G. Psychiatric notes.

Medical records (nursing and psychiatric) were kept in a variety of locations:

1. a buff document wallet
2. a second buff document wallet
3. a half-flap buff document wallet
4. the Protechnic system
5. diaries entries
6. hand-written notes.

The contents of 1-3 above were either held in place through two punched holes, or contained in clear plastic sleeves, or loosely inserted; in 2 and 3 above there were also dividers.

1 above contained a number of named dividers: legal documents, case conferences, correspondence, laboratory results, social work, psychology, occupational therapy, nursing notes, prescription cards.

The Protechnic recording system reflects patient contacts. It depends on information being fed in to a computerised system which records it under the appropriate headings (1-25).

Names were entered in one of two diaries: one held by Dr Ferris which covered the period from May 1996 until July 1997; a second held by the secretary (May 1996 to August 1999). Dr Ferris' diary contained entries relating to maters other than out patient appointments, and that of the secretary referred to contacts with other clinicians.

Lastly, there was a ruled pad of hand written notes which acted as an *aide memoire* to Dr Ferris on some of his out patient contacts.

The senior registrar's clinical notes were not a continuation of earlier entries in the Clinic file but were written on distinctive forms which are used in prison hospitals [1]; she was unable to explain this anomaly.

Of the four urine screening tests referred to in the clinical notes 2 are accompanied by pathology forms.

Comment

1. We cannot overemphasise the difficulties experienced by the inquiry panel both in obtaining a complete set of records and understanding the form in which they existed originally (i.e. at the time of the homicide). These problems contributed to the complexity and duration of the inquiry.
2. In 1-3 above there was no discernable method which distinguished between the different systems.
3. In 1 above the dividers did not contain only what was named, and what was named was found other than in the confines of the divider. The same was true of the plastic sleeves: while some contained completed forms (e.g. nursing progress sheets, community parole), these forms were also found elsewhere and in other cases the sleeves contained a miscellany. No attempt had been made to: archive material in an orderly fashion; place important material in positions of prominence; cull duplicates; append discernable names to many entries.
4. In practice only three Protechnic headings were used: 'Staff' (usually Dr Ferris), 'date seen', and 'Activity' (out patient contact). The system was not used to record failed appointments, or contacts with other members of the clinical team. Additionally, not all consultant contacts were recorded on the system. It follows that the system was not used in a reliable way.
5. Taking the wallets individually there was no evidence of chronological ordering; wallet 1 covered the period 1989-1996, wallet 2 1989-1999, and wallet 3 1994-5. Neither was there

evidence of a system based on discipline (e.g. nursing, occupational therapy), form of recording (e.g. forms, hand-written notes), or purpose (e.g. prescription cards, copy correspondence, reports).

6. Clinical notes act not only as an *aide memoire* but also as a form of communication. Their organisation is central to the effective management of psychiatric patients, by facilitating communication and ordering the many processes which underlie case management. In this case there was little evidence of the application of any system to the recording and storing of information, a fact which must raise issues regarding communication and the processes of case management.
7. The female senior registrar's unusual out-patient notes entries raises the issues of what information she had when she saw Mr Williams.

   'I think those were the continuation sheets available to me in the Wallingford Clinic, and I do remember thinking that I felt uncomfortable with the idea of the term inmates, but they were called inmates'.

8. Dr Ferris' hand-written notes were not incorporated into the clinical file; neither were they seen by the Internal Inquiry.

NOTE

1. The forms are headed: MEDICAL IN CONFIDENCE.

   Continuous Medical Record.

   These pages are intended to provide a continuous medical record passing from one sentence to another. The Medical officer at each establishment through which the inmate passes should record details of each consultation. Both medical and nursing staff should record any salient medical features or occurrences.

9 SOCIAL SUPERVISION.

Mr Williams was subject to 3 periods of conditional discharge totalling nearly 9½ years between April 1984 and the death of Ms Katie Kazmi in September 1999. This section examines the involvement of the social workers who supervised Mr Williams in the community. It also comments on some broader aspects of social work practice.

'There is a certain level of supervision which should be maintained if possible changes in a patient's mental state or behaviour are quickly to be spotted. It is recommended that meetings should take place at least once a week for at least the first month after discharge reducing to once each fortnight and then once each month as the social supervisor judges appropriate. These are to be considered minimum periods. Sometimes the Home Office will request more frequent meetings to take place. Generally, individual supervisors will consider more frequent meetings appropriate, particularly for the initial period of the first year during which the patient settles down to life in the community. Meetings should usually take place on the patient's home territory but some meetings away from the home, perhaps in the supervisor's office, may also prove valuable. If, after some time, a social supervisor considers that supervision at monthly intervals is unduly frequent, then he should consider the case for recommending discharge from conditions …' *(*para. 44*, Notes for the Guidance of Social Supervisors*, (1997) Home Office, (unchanged from 1987 version)).

A. First conditional discharge: April 1984 - September 1985 (1 year and 6 months).

In January 1984, after 4 ½ years in hospital, Mr Williams was placed on trial leave at Brunswick Lodge, a Richmond Fellowship hostel in Reading, Berkshire and conditionally discharged by a mental health review tribunal in April 1984. He was supervised by a Reading probation officer. Mr Williams was found to be difficult to manage and socially isolated. He left the hostel in September 1984 and moved to a bedsit in Mandela Road, Reading where he lived until being readmitted to Broadmoor Hospital in September 1985.

B. Second conditional discharge: November 1990 - November 1994 (4 years).

(i) Social Supervisor: Ms Carol Frost (November 1990 – July 1991).

In May 1990 a mental health review tribunal conditionally discharged Mr Williams from the Wallingford Clinic, but it deferred discharge until certain conditions were met. By August 1990 privately rented accommodation had been found for Mr Williams in Reading and the Home Office agreed that he could live there on a trial basis and he was conditionally discharged from hospital in November 1990.

He was supervised by Ms Frost, a senior social work practitioner, from the Wallingford Clinic. In a letter to the mental health tribunal office in July 1990 she commented:

> 'I do not think supervision will be that easy as I do believe Mr Williams can be devious and manipulative.'

On her first visit to the bedsit in September 1990 after he was granted trial leave from the Clinic she noted:

> 'Mr Williams is pleased with the bedsit and thinks that he will be happy. However, he has put pornographic pictures on the wall and I suggested that they might not be appropriate but Mr Williams enjoys them on the wall, for this reason I decided not to visit the bedsit again.'

The care plan was changed to him being seen fortnightly at Bucknell House, a base of the Reading community mental health team.

In January 1991 the local authority offered Mr Williams a bedsit in Reading's Tilehurst district, on the Dee Road estate at Lyon Square, and he moved in almost immediately. In

the 9 months after leaving the Wallingford Clinic, Ms Frost saw Mr Williams on 11 occasions, mostly at Bucknell House or on infrequent home visits when she was accompanied by a colleague.

Comment

1. The inquiry panel was unable to contact Ms Frost. We note that she made no home visits between 6th September 1990 and 14th February 1991 because of the pornography. She did however see him regularly at Bucknell House during this period.

   An alternative arrangement which would have allowed home visiting to continue would have been for the case to have been transferred to a male worker.

(ii) Social Supervisor: Mr Keith Jarvis (July 1991 – November 1994).

Ms Frost left the Wallingford Clinic in July 1991 and arranged for Mr Keith Jarvis, based in the Reading community mental health team to take over supervision. She had suggested that a black male worker should take over from her. Mr Jarvis qualified as a social worker in 1983 and was also an approved social worker; he had acted as a social supervisor on one previous occasion. On the handover visit with Ms Frost in July 1991, Mr Jarvis noted:

> 'It seems as if he has been drinking and smoking dope, has pornography pictures on the floor and tape and TV…This should be a very interesting type of case.'

Mr Jarvis told the panel of the first interview with Mr Williams:

> "He didn't particularly like me very much, being black, straight away we didn't hit it off. After we had a chat,…he felt it was the worst thing that had happened to him because he felt the white people would be much more liberal to his way of thinking. As a West Indian myself, he felt that we were going to have lots of problems because I could then put pressures on him and expect that whatever he says I will understand. Therefore he thought I would be really a pain."

In his first report to the Home Office in September 1991 Mr Jarvis wrote:

> "He did mention also that seeing him once a month is too often and this is curtailing his job prospects. I pointed out to him that I will be seeing him in the evenings at 7 o'clock so this should not stop him having a job during the day … Mr Williams continues to complain about everything and can be difficult but shows no sign of his illness re-emerging. I feel it is rather Mr Williams' difficult personality re-emerging. There may also be some difficulties with Mr Williams having at this present time, a black social supervisor, and therefore finds it difficult to be at ease or is trying to pull the wool over my eyes."

Ms Anne Emmons, area manager, Reading social services, who reviewed the case file following the homicide told the panel that of the social supervisor's, she considered that Mr Jarvis had been:

> '…the most proactive because he was the one going round to the house, he was the one who was following him up. I am sure Mr Williams would take the view that Keith was harassing him, but he was the one who was following him up and was very assertive in that role and his own life was threatened.'

Dr Ferris said in evidence:

> "There are particular aspects of his relationship with Keith Jarvis that are perhaps relevant in understanding why there were difficulties there. Keith Jarvis is a very different character to some of the other social supervisors, and the point has been made that he may have had a better 'handle' on the world or subculture in which Mr Williams lived in Reading than other people did. Winston may have known that and, being a secretive

person, that put him off. He felt Keith Jarvis riding him hard and knowing more about him than he felt comfortable with, possibly."

Mr Jarvis remained the social supervisor for the next 40 months. He considered it essential to see him at home and mostly visited Lyon Square in the early evening. Of 27 recorded contacts, 18 were home visits to Lyon Square. Mr Jarvis told the panel:

'I felt I needed to see him in his home to see what was happening in his home, because seeing him away from home you never knew what Winston was up to.'

Home visits were never easy. Mr Jarvis told the panel that visits would usually last between 30 and 60 minutes. He described Mr Williams as:

'…a chap who was always fed up with me, pushing me out. Spending an hour was very anxious for him. His phone was always ringing, he was always making deals, so you couldn't do a 10-minute or 15-minute interview because he was on the phone.'

Mr Jarvis said he was well supported and said of his line manager, Mr Hayward:

'If my back is to the wall he is the man I want beside me because he is really a person who would look after the team.'

In his 'Closing Summary' Mr Jarvis refers to Mr Williams having made **'…several threats towards my life'** in the garage when he was being recalled to hospital. He told the inquiry panel that Mr Williams **'…was going to knife me or run me over'** and he took the threats **'…very seriously'.** (The threats to Mr Jarvis are discussed at section 12 A)

Comment

1. Mr Jarvis' approach to supervising Mr Williams was positive and commendable.
2. The importance of seeing Mr Williams at home was fully appreciated.
3. The following events were not recorded in social services' files:
   - some visits or the outcome following letters to Mr Williams arranging to visit;
   - some contact with family members;
   - some calls to and from the Home Office.
4. Some individual entries following home visits were brief, e.g.

   'No change'

   'He still gets monthly visits and is still on Home Office section'

   'He is still in his flat.'

   Sometimes there was a fuller account in the subsequent report to the Home Office but no reference to this in the contact sheets.
5. The following were not completed and although some may not have been required by the social services department at the time current practice would recognise their importance:
   - on-going summaries of involvement;
   - a review of the care plan first formulated following discharge in 1990; formal reviews despite Mr Williams' after-care being subject to the provisions of s.117 Mental Health Act 1983.
   - risk assessments.
6. Mr Hayward took full advantage of the opportunity afforded for line managers' comments to be included in the reports to the Home Office.
7. Taking into account that Mr Jarvis supervised Mr Williams for over 3 years, the half page headed 'Closing Summary' dated 18th November 1994 simply describes the situation at the time (following recall) and does not summarise his input over the years.

8. The break-down in the supervisory relationship could have been related to Mr Williams being under-medicated. (He became non-compliant and eventually relapsed).

C. Third conditional discharge: October 1995 to September 1999 (3 years and 11 months).

(i) Social Supervisor: Mr Dale-Emberton (October 1995 - March 1998).

Social supervision was, until March 1998, provided by Mr Dale-Emberton, an experienced social worker attached to the Wallingford Clinic. Mr Dale-Emberton trained as a probation officer; he became an approved social worker in 1985. He established the forensic social work service for Berkshire social services department (SSD) at the Borocourt Hospital, a secure unit for patients who suffered from mental impairment or severe personality disorder which closed in 1991. He worked as a senior social work practitioner, employed by Berkshire County Council, for the forensic psychiatry service at Fair Mile Hospital from 1991 until he left in March 1998. In view of his considerable experience in forensic psychiatry he was seen as a local resource. He had received training in the supervision of conditionally discharged patients and was experienced in the role.

He undertook approximately 70 ASW assessments a year resulting from his involvement with the Reading Divert scheme as well as contributing one day each month to the ASW duty rota.

Mr Dale-Emberton told the panel that whilst working at the Wallingford Clinic he probably had a caseload of no more than 25 but this was a **'…heavy workload'** as they were really **'…high risk'**. He described Mr Williams as a **'…worrying case'.**

He had first become involved with Mr Williams at the end of 1994 as there was a forthcoming mental health review tribunal following Mr Williams' recall; his social work student wrote the social circumstances report.

Mr Dale-Emberton was assertive in stressing the need for regular contact with himself as social supervisor. There is evidence that he was endeavouring to impose limits. In an early letter to Mr Williams he wrote: **'…don't forget I am here to help if I can',** however, in June 1997 he wrote:

> "I received the message you left yesterday only an hour before our arranged appointment. This is not satisfactory to me and therefore a very serious matter for you due to the conditions to which you are subject. I should remind you that I will not tolerate former social supervisors experiences of you missing appointments, as this will eventually lead to your being recalled … I am sure that you do not want a situation to develop where our relationship deteriorates …"

Mr Dale-Emberton illustrated clearly the difficulty he experienced in seeing Mr Williams at Lyon Square. He described to the panel how:

> "It was difficult to try and get access. I would have an appointment and he wouldn't be there, so I would maybe go and see another patient or do something else and go back later on at night and try to raise him. Always in the back of my mind is, is he trying it on or what is happening?" .

Nonetheless, Mr Dale-Emberton managed to maintain regular contact with Mr Williams with 31 successful contacts taking place over 29 months, half of these taking place at Mr Williams' home in Lyon Square.

Mr Dale-Emberton told us that interviews lasted an average of 30 minutes. In the light of what he believed to be Mr Williams' limited intellectual ability Mr Dale-Emberton gave him a 'Community Care Card' detailing the next appointment.

Mr Dale-Emberton described there being **'…quite a comprehensive package of supervision and monitoring'** following Mr Williams conditional discharge from the Wallingford Clinic in October 1995. For the next 14 months Mr Williams was not only seen by Mr Dale-Emberton and Dr Ferris but he was also seen, usually at home, by a community psychiatric nurse, Ms Jackie Lee (see section 8 B).

Mr Dale-Emberton arranged with Ms Lee, CPN, for her to visit more frequently whilst he was on leave.

Mr Dale-Emberton was asked about Mr Williams' rent arrears and the threat of eviction.

> '…I was completely shocked (when hearing about these matters) because I didn't realise that until I got the records the other day. That was really a shock to me because it was a frequent issue for me to make sure that he was keeping his rent up-to-date…he misled me'

In their evidence to the panel both Mr Dale-Emberton and Dr Ferris spoke highly of each other's professionalism and their close working relationship. Mr Dale-Emberton believed that Dr Ferris was seeing Mr Williams every 4 – 6 weeks. (In fact, in the 15 month period ending in March 1998 when Mr Dale-Emberton left the Wallingford Clinic, Dr Ferris had seen Mr Williams on 5 occasions).

Mr Dale-Emberton told the panel that he was supervised by Mr Hayward monthly at the Wallingford Clinic and that he found his style of supervision **'…very enabling and useful'.** Mr Dale-Emberton added that he:

> '… always valued his supervision, support and advice, and although I was very much aware of his excessive workload, he never stinted in giving his time and an opportunity for reflection on cases that caused concern.'

Mr Dale-Emberton told the inquiry panel that Mr Hayward tried to ensure that no worker supervised more than 3 conditionally discharged patients at any one time otherwise the worker **'…would become overburdened.'**

Comment

1. Mr Dale-Emberton saw Mr Williams relatively frequently, and often at home. He complied with Home Office reporting expectations. However, his lack of appreciation of the frequency and context of his fellow supervisor, Dr Ferris' contact suggests that their management was not part of a joint plan.
2. Mr Dale-Emberton failed to see either of Mr Williams relatives in the context of social supervision, and he also failed to attempt to cultivate a supportive and informative relationship with Mr Williams neighbours and female friends.
3. While it was assumed that he took over the role of key worker following Ms Lee's departure in February 1997, CPA procedures were effectively abandoned.
4. On learning more about Mr Williams during his panel interview Mr Dale-Emberton said:

   'The role of social supervision is very limited … but I didn't realise the extent of his dangerousness with the reports you have told me.'
5. Mr Dale-Emberton also questioned whether he had been unduly reassured by the fact that Mr Williams was accepting the depot medication.

6. The file contained no:
   - up-to-date or reviewed care plan (see section 5 B i);
   - risk assessment (despite the social services department procedures on *Risk Assessment and Management* dated June 1997 which emphasise that **'…the department expects a risk assessment to occur in every case.'**)

(ii) Social Supervisor: Mr Hayward (April 1998 – September 1999).

Mr Hayward qualified as a social worker in 1979 and specialised in mental health practice. He joined the Reading community mental health team in 1990 as principal social worker and in subsequent years his job title changed to care manager co-ordinator and senior care manager (mental health). He had previously supervised one conditionally discharged patient but had extensive experience of working with 'high risk' clients. He attended a one day course in supervising conditionally discharged patients run by Berkshire Social Services in 1996/7 but questioned its usefulness when he met the inquiry panel.

Mr Hayward supervised Ms Frost between November 1990 and June 1991 and as line manager he had also seen, and commented on, Mr Jarvis' reports to the Home Office. He had also been Mr Dale-Emberton's supervisor from his appointment as Mr Williams' social worker from December 1994, and as his social supervisor from October 1995, in which capacity he saw copies of, and had the opportunity to comment on, his reports to the Home Office. Although he had not met Mr Williams, he was familiar with the case. For example, in 1992, Mr Hayward commented as line manager on the social supervisor's report to the Home Office that **'…it appears that Mr Williams is not the easiest person to supervise'.** In a subsequent report to the Home Office later that year, he added, again, as line manager that:

'… given the nature of the index offences and the reluctance that Mr Williams has shown to keep two appointments made by Mr Jarvis which have been outside the latter's normal working hours in order to suit Mr Williams, the correct decision was made to inform Mr Williams' employer of his background as stated in paragraph 38 of *Notes for the Guidance of Social Supervisors.* This decision was not taken lightly.'

On another report, Mr Hayward had added the need for **'…careful monitoring'** of Mr Williams. He had also supported the recall of Mr Williams to the Wallingford Clinic in November 1994.

In May 1997 Mr Hayward was responsible for managing the equivalent of 8.5 full-time staff, as well as holding a client caseload. That month, after discussion with Mr Hayward, Ms Gill Handley, service manager, Reading Borough Council concluded that Mr Hayward had difficulty in prioritising his workload. It was agreed that the majority of his cases should be either closed or handed over. This decision was reviewed 4 months later when Mr Hayward said that Ms Handley's:

> '… initial insistence – made very clear to me – that I reduced my caseload dramatically in September 1997, wasn't that possible. It became apparent that that aim was not going to be achieved because of the level of vacancies that we had within the CMHT as a whole subsequently for the best part of, though not quite, a year thereafter'.

In October 1997, Mr Hayward wrote to Ms Handley outlining his serious concerns about the staffing situation in his team. He was concerned that:

> 'The pressure on team members would increase to an unacceptable level … I would not be prepared to manage the CMHT in these circumstances and would have to consider my position as senior care manager and as an employee of the social services

> department for which I have worked for over 11 years (and concluded)… if the new Reading unitary authority is serious about giving mental health a high priority, then now is a good time to begin. I am sure that the new authority would not wish to begin life with a well-publicised 'mental health tragedy' on its hands, yet I fear the chances of this occurring will increase unless action is taken to address the current situation in the CMHT'

Asked by the panel about Mr Hayward's letter Ms Handley said that she was:

> '… a great believer in defensive practice. I am amazed if somebody doesn't want to push the responsibility up to their managers. If you feel there is something risky the first thing I would want to do is to tell my manager so that there is a shared responsibility.'

In December 1997, Mr Hayward, anticipating the possible departure of Mr Dale-Emberton, expressed further concern in a memo to Ms Handley:

'No decision has been made in relation to the future of social work input to the forensic service from April 1998. Richard Dale-Emberton has shown a high degree of professionalism and commitment to this service over several years and it should not be imagined that this can be replaced by 2 people going on 6 days training between now and March 1998'.

In September 1998 Mr Hayward wrote to Ms Handley a memo for their forthcoming meeting in which he told her that:

> '…the effects of the staffing position on the CMHT as a team and on the individuals within it has been a cumulative one, rather than dramatic … staff morale is at a very low level'.

He outlined serious concerns about the pressures outside his control in the Reading community mental team. He described how:

> '… (at an) operational level people rush from one crisis to another, attempting to support severely ill individuals in the community with variable input from medical colleagues, some of whom are reluctant participants in the Care Programme Approach, despite this being health-led, at least in theory. In such a climate, people may act without considering carefully enough the consequences of their actions, clients may be put at risk, unnecessary tragedies may occur. I believe such a climate exists in the CMHT at present.'

Ms Handley replied on 15th October 1998. She had in the meantime met with Mr Hayward where they had also discussed the increased number of referrals to the team needing assessment for possible use of the Mental Health Act. It was agreed that there needed to be 2 people on duty at all times which would impact on the team's ability to respond to work of lesser priority.

Mr Hayward provided the following information to the panel:

> 'My caseload numbered 23 in November 1998, 47 in June 1999, and 43 in October 1999.
>
> Between April 1998 and March 1999, I undertook 78 items of statutory work under the Mental Health Act, including assessments, tribunal reports and guardianship applications.
>
> Fifty-three items of similar work were undertaken between April and September 1999.
>
> The reason for the increase in my caseload related to the actual decrease in social service staff levels during this period. The forensic post (full time), occupied by Richard Dale-Emberton, remained vacant subsequent to his departure in April 1998, the point at which I took over the role of social supervisor in respect of Winston Williams. One

other full-time social work post was vacant for 9 months between December 1998 and September 1999. A further full-time senior social work post had been vacant for at least 2 years and was only filled in September 1999'.

By November 1998, Mr Hayward was managing the equivalent of 14.6 full-time staff, in the Reading community mental health team, (2 posts were vacant), and a full time community support worker.

In February 1999 Ms Handley discussed the cases held in Mr Hayward's name. These included those in the community being seen by Mr Hayward and others in residential placements requiring 6-monthly reviews. Whilst he had limited involvement with these latter clients, it was reiterated by Ms Handley that he should have no more than 5 complex cases.

By August 1999 Mr Hayward had, in addition to Mr Williams, 6 clients (one client like Mr Williams who was conditionally discharged who he saw every 3 weeks either at home or out-patients; one client seen fortnightly and the remaining 4 were either in hospital or residential care where Mr Hayward visited approximately monthly).

At about this time, Mr Hayward had discussions with Gill Handley about his taking on a different job. At the time of Mr Williams arrest Mr Hayward had been appointed to a new post, senior forensic social work practitioner, employed by Reading and jointly funded by and covering the unitary authorities of West Berkshire, Reading and Wokingham, which he took up in October 1999. He described the move as:

'The cumulative effect of attempting to manage a team with shortages of staff at times during the latter period, plus the case work responsibilities that I felt I had to take on in the absence of other people, gradually wore me down. I had had enough …'

Mr Hayward considered that this new post would provide him with:

'More time to devote to a number of cases … I saw Winston Williams' case as one that I would take with me to my new post, and therefore be able to get back on track and visit, perhaps to re-establish contact at 6 to 8-week levels.'

Returning to a time 18-months earlier, in January 1998, Mr Dale-Emberton discussed with Mr Hayward the advisability of Mr Williams having a male worker when he left. Mr Hayward was away when Mr Dale-Emberton presented to the Reading community mental health team the cases of 4 conditionally discharged patients (2 in the community – including Mr Williams, and 2 in hospital) in need of re-allocation. Mr Dale-Emberton told the panel that he:

'… would have preferred to have a handover to a colleague. There was a general reluctance throughout Berkshire to take my patients on … They felt untrained to do it. They didn't feel able or confident enough to take any patients on, because of the Darren Carr Inquiry (relating to the investigation of an earlier homicide in Berkshire by a mentally disordered person) and other worrying developments '.

In the event, Mr Hayward reluctantly took on all 4 conditionally discharged patients himself. A measure of the input required for these cases can be gained from the Internal Inquiry report (see section 15 A) which found that Mr Williams was '**… by no means the most difficult patient on the caseload of Mr Hayward or Dr Ferris during 1998 and 1999.'**

Mr Hayward had been unable to attend the planned handover visit arranged by Mr Dale-Emberton for 6th March 1998 as he was on duty as an approved social worker (ASW) and had to undertake 2 Mental Health Act assessments. Mr Dale-Emberton told the Inquiry panel that in Mr Hayward's absence he saw Mr Williams at the Wallingford Clinic on his

own but did not record the contact. No other arrangement was made for Mr Hayward to meet Mr Williams before Mr Dale-Emberton left at the end of March 1998.

Mr Williams had been out of hospital for 2½ years and his situation was viewed as being stable. When Mr Hayward took on the role of social supervisor in March 1998, he was: **'…hopeful at that stage that we would be able to appoint somebody to that kind of post to whom I could transfer this case.'** At this time Mr Hayward had 7 forensic clients (including Mr Williams). In supervision with his manager, Ms Gill Handley, in April 1998, she recorded that they: **'Agreed it would be difficult for Mike to hand over these cases until we get a senior forensic worker in post.'**

In an attempt to limit his work, Mr Hayward had reduced acting as a duty ASW to twice a month and only stood-in if people were off sick. Bearing in mind that he was a senior care manager (team manager), the inquiry panel asked whether he had still wanted to be an ASW, or whether that was a requirement of the job or a response to staffing issues. He replied that:

> 'The answer to all those questions is 'Yes'. That is, 'Yes', I did want to remain an ASW; 'Yes', it had been a requirement of the job that those supervising ASWs should continue to be so. My job title changed several times between 1990 and 1999, and certainly as care manager co-ordinator, it was made very clear that those of us across Berkshire who were in that role should remain ASWs and I had no problem with that at all. It was also a response to staffing shortages'.

It is important to note that although Mr Hayward had known of Mr Williams since 1990, he met him for the first time on 1st May 1998 at the Wallingford Clinic. His first report to the Home Office was written later that month, which, as with all 5 reports he produced, was copied to Dr Ferris. He informed the Home Office that he had taken over from Mr Dale-Emberton and that he had intended to: **'…maintain contact with Mr Williams every 6 to 8 weeks'.**

Mr Hayward told the inquiry panel that the purpose of his meetings with Mr Williams was **'…a continuation of the work already started'.** However, from the onset he decided, in the light of his other commitments, to significantly reduce the frequency of contact. (Mr Dale Emberton had been seeing Mr Williams monthly).

Mr Hayward acted as the social supervisor to Mr Williams from the beginning of April 1998, when Mr Dale-Emberton left, to the time of the homicide in September 1999 (18 months), The Home Office guidance suggests a minimum of monthly visits; Mr Hayward saw Mr Williams on 7 occasions. He told the panel that he wanted to see him every 6 weeks but this was only achieved on 3 occasions (see appendix F section 18).

Mr Hayward had no contact with Mr Williams between 20th November 1998 and 30th March 1999 (just over 18 weeks, and covering a period when Mr Hayward took 2 weeks compassionate leave following the death of a close relative). The next (and final) occasion on which Mr Hayward saw Mr Williams before the homicide was on 30th June 1999 (a gap of just over 13 weeks). Mr Hayward said that he was about to arrange to see Mr Williams when he learned of his arrest on 20th September (a gap of nearly 12 weeks). (See section 18, appendix F).

Home Office G*uidance* stresses the importance of home visits by the social supervisor, Mr Hayward did not see Mr Williams at home or made any attempt to do so. He was aware that the last home visit by a professional had been by Mr Dale-Emberton in January 1998. Mr Hayward told the panel that:

> 'In relation to the meetings I accept that there was no pressing reason for not having seen him at home. I cannot explain the reason for not seeing him at home except to acknowledge that it was more convenient to see him at Bucknell House. I am aware of the advantages of seeing a patient at home: it would afford the opportunity to pick up any clues to a patient's behaviour and it would allow the supervisor to check the veracity of information. If there was chaos and disorder in the home environment this may be reflected in other areas of the patient's life. Visiting a patient at home can be an effective way of assessing risk.'

Mr Hayward saw Mr Williams initially at the Wallingford Clinic and then at Bucknell House which he described as: 'A neutral venue, not where my office was but where I had access to interview rooms, which wasn't the case at the Wallingford Clinic.'

Dr Ferris told the panel that he had been aware that Mr Dale-Emberton had been frequently seeing Mr Williams at home and his expectation was that Mr Hayward: **'…would have visited him at home at least some of the time, and not that he never saw him at home.'**

Mr Hayward told the inquiry panel that he felt confident in having Dr Ferris acting as psychiatric supervisor to Mr Williams. Dr Ferris told the inquiry panel that, as with Mr Dale-Emberton, he '…**related well'** to Mr Hayward and thought he was **'…a good and hard-working competent colleague'.**

After telling the panel of his expectation of home visits by the social supervisor, Dr Ferris said he assumed that Mr Hayward would have been seeing Mr Williams **'…either at monthly or 2-monthly intervals.'** When told that Mr Hayward had seen Mr Williams on 7 occasions Dr Ferris said **'I would have thought he was seeing him more often than that'.** For his part, Mr Hayward believed that Dr Ferris **'…would be seeing him every 2 to 3 months'** although told us that he was aware that there was one occasion that Dr Ferris had not seen Mr Williams for **'…perhaps 4 to 5 months'.** Mr Hayward told the inquiry panel that he had a close working relationship with Dr Ferris who he saw each fortnight at Divert meetings:

> ' … I think that if we had a more distant working relationship then we would have been more formal about recording discussions on our cases.'

Mr Hayward was asked about Ms A's telephone call:

> 'I'm pretty sure that I didn't know about it at the time and I only learned of the details subsequently…'(i. e. after the homicide).

At the time of Mr Williams' arrest on suspicion of murder on 20th September 1999, Mr Hayward had seen him twice in 1999 (the last occasion being 30th June 1999). Mr Hayward told the panel that he was about to arrange to see Mr Williams as he was due to report to the Home Office when he heard of his arrest. Mr Hayward said:

> 'I recognised that it was 2½ months since I had last seen him and I was planning to arrange an appointment in the latter part of that week or early the next week.'

Mr Hayward did not receive a copy of the report from Dr Ferris to the Home Office until the day of Mr Williams' arrest (20th September 1999). He stated in the light of the content of that report, particularly when he learnt for the first time that Mr Williams did not have a current driving licence when he had last seen him driving,

> '…'if (the homicide hadn't occurred) I have no doubt that would have prompted a crisis meeting with myself, and Dr Ferris, and indeed Winston Williams, within a very short period of time indeed.'

In the 18 month period that Mr Hayward acted as social supervisor to Mr Williams he was senior care manager (team manager). He also conducted 94 mental health assessments,

wrote 21 social circumstances reports for mental health review tribunals, applied for 3 people to be brought into guardianship, and was involved in a further 10 pieces of statutory and related work.

Ms Handley told the inquiry that she was **'…pretty horrified'** when she saw the file for the first time following the homicide as Mr Hayward was:

> '…known and respected as a practitioner who had a lot of experience with forensic clients and it wouldn't have crossed my mind that he wasn't complying with Home Office guidelines.'

She considered that what Mr Hayward was:

> 'Doing as a practitioner was very much respected and, as far as I understand, was good practice. What he wasn't coping with was his management responsibility.'

Ms Emmons said she was:

> '…surprised at the level of contact in this case. I had always the view that Mike was a really good social worker, and certainly in files that I had seen of his cases in the past, the content was always good.' (When asked why this had not happened in Mr Williams care, Ms Emmons speculated) '…he had been in the community for a long time, wasn't producing major problems, it was just trying to follow him up to come for appointments and on occasion he might come for help. He was clearly asking for no help, so was it seen as a very low priority case in those terms? I think people had forgotten about the original reason why he was put on an order'.

The last Care Programme Approach review had been held on 14th July 1997, 8 months before Mr Hayward took over supervising Mr Williams. There were no attempts to arrange a review before Mr Dale-Emberton left, and no reminder system in place.

Mr Dale Emberton wrote to the panel about these matters:

> 'I was very much concerned to involve the new social worker/social supervisor in the CPA process together with Dr Ferris and the forensic services manager, as well as lobbying Anne Emmons and Gill Handley, and other members of the new unitary authorities for a new specialist social worker. I had met with members of the County Council Social Services Committee and the director of social services. Mike Hayward had repeatedly tried to allocate (Mr Williams) to members of his team and his line managers were well aware of him being overburdened. The delay in organising a CPA before I left the department was caused by lack of a social worker'. (And later, a different point) Mike Hayward's inability to allocate (Mr Williams) to other social workers was because of their fear of being named and blamed when a tragedy occurs'.

Comment

1. Mr Hayward's pressure of work was appropriately brought to senior management's attention. They in turn were concerned whether he was managing adequately. Management needed to satisfy themselves that there were adequate resources and that he had responded appropriately to their directions.
2. The panel believe that Mr Hayward had a heavy workload. Other social workers were reluctant to take on Mr Williams, and what was, perhaps, a temporary arrangement , became permanent. In relation to this point Mr Dale-Emberton wrote to the panel:

   > 'There was no formal handover between social workers because there was no social worker to hand over to. The crucial reasons for such an important issue, and very much linked to the eventual tragedy, is the fact that this was repeatedly brought to the notice and acknowledged by higher management…'

3. Mr Hayward failed to comply with the Home Office *Guidance* for social supervisors which recommends a minimum of monthly contact. On average, Mr Williams was seen every 10 weeks.
4. The panel took the view that Mr Hayward did not consider Mr Williams to be a serious risk: we understand that he managed a second restricted patient wholly within Home Office *Guidelines.*
5. Mr Hayward failed to record any details of his interviews with Mr Williams in the social services 'contact sheets' apart from the date of the contact. The only information relating to some of his contact with Mr William is found in the subsequent report to the Home Office.
6. Mr Hayward made no attempt to visit Mr Williams at home - the last home visit prior to the homicide had been by Mr Dale-Emberton in January 1998. The absence of a home visit for 20 months before the homicide was a major breach of the Home Office guide for social supervisors which recommends that:

   'Meetings should usually take place on the patient's home territory but some meetings away from the home, perhaps in the supervisor's office, may also prove valuable.'
7. Mr Hayward undertook no specific risk assessment on Mr Williams despite the social services department procedures on *Risk Assessment and Management* dated June 1997 stating that **'…the department expects a risk assessment to occur in every case'.**

   Ms Handley told the Inquiry panel that the absence of a risk assessment:

   '… struck her particularly, given that we were working over a number of months and Mike had been heavily involved in getting staff to put risk assessments on all their client' files, but certainly the high profile ones.'
8. The panel found no evidence of discussions about whether the supervisors should have held joint interviews and whether they should stagger their contact with Mr Williams.
9. In the areas of benefits and housing he failed to take a lead.
10. There was good compliance with completing reports on time to the Home Office (see section 12 H).

D. Social Work Notes

Mr Dale-Emberton saw the case files for the first time since leaving the Wallingford Clinic in March 1998 when interviewed by the panel in January 2001. He told us that:

'The social work files bore little resemblance to my record keeping and had clearly been cannibalised. The vital information that was missing from the social work files included the entire primary so called 'CRIS' forms. These would have given full information of all contacts, the first sheet displaying Winston Williams' status as person subject to ss.37/41 and the Home Office reference number and contact person. Level of dangerousness and risk would have been displayed. The other parts of the CRIS forms missing were the six monthly reviews and the transfer summary. There was a tracking and monitoring process within Berkshire Social Services at the time of my employment. I am absolutely sure that the transfer summary would have contained an expressed need for firm, clearly defined boundaries and regular contact with the next social supervisor. I would have included the continued need for regular liaison with Dr Ferris, the psychiatric supervisor. The transfer summary would have included completed sections on early warning symptoms and risk management. The transfer summary would have been completed by my last supervision session on 23rd March '.

Mr Hayward could not recall seeing either a transfer summary or periodic reviews of Mr Dale-Emberton's involvement when he took over the file although he did not believe that the lack of a transfer summary hindered his management of the case.

Ms Emmons told the Inquiry of the process by which she secured the social services file in September 1999 and that:

> 'What you have is what I had, and I was assured that I had all the files. If there are bits missing, they certainly weren't on the file at the time. If they were missing, they can't have been on the file at the time the file was handed over to Mike (Hayward) , because I cannot believe that Mike would have taken anything off the file '.

Mr Hayward told the Inquiry panel that Ms Handley called him and asked him to put the files in better order. He said:

> 'To my mind they were in fairly good order in terms of structure in that my colleagues and I could find our way around them without any difficulty at all. However, I did go along there – and this may have been a week after the homicide – and made what I considered to be some fairly minor modifications. I took some papers out of one part and put them in another part for ease of access, and clearly labelled the contents of each because there wasn't a label between the two files. They were not strictly chronological.'

Comment

1. All entries in the social services notes were typed which we considered greatly assisted anyone reading them. Mr Jarvis told the panel:

   > 'I had a Dictaphone in the car. In those days they had enough clerical staff … as I came out, I would use the Dictaphone … and hand it in the next day to be typed.' (With a turnaround time of about 2 weeks).

   When asked about the current system Mr Jarvis said it was:

   > 'Terrible. We have one person on today coping with forty people, answering the phone and whatever it is … It's not typed any more its hand-written, because they say they can't get the people to do typing.'

2. Mr Dale-Emberton said that some information was missing from the file:

   Client Record Information System (CRIS) forms recording regular reviews and change (e.g. of risk); a CRIS form relating to case transfer; some CPA forms. Furthermore, the notes were not in the order which he left them.

10. NURSING CARE.

Taking as a starting point Mr Williams' re-admission to the Wallingford Clinic in 1994, this section looks at the nursing contribution to his management as both an in-patient and an out-patient. The section shows the interventions which were made to help Mr Williams make a successful integration into the community.

A. In-patient care 1994-1995.

The nursing notes contain a number of forms for completion. The disposition of these forms is discussed in comment 6 at the end of this section.

1. The first form considered here is 'Care plan A' which is headed with Mr Williams' name and that of his key nurse. The form has 3 columns, the headings to which changed during Mr Williams' in-patient stay from 'Problem, Action, Goal/rationale' to 'Need, Issue, Aim/purpose'.
2. Secondly, there is 'Care plan sheet B' which records an evaluation, the date of that evaluation, and the date of the next evaluation.
3. Thirdly, are notes headed 'Short-term objectives' and 'Long-term objectives'; these are either as completed forms or written freely on blank sheets.
4. Fourthly, there are forms headed 'Nurse's summary for clinical team meeting to take place on: (date)', and, below, 'Feedback from clinical team meeting'.
5. These last forms appear to have been completed as summaries of the fifth form 'Nursing notes' which were completed on a daily basis, often with 3 separate entries.
6. Lastly, are running typed notes of clinical team meetings (CTM). Below are represented samples of 'Care plan A', all the typed clinical team meeting notes, and one 'Care plan sheet B'.

   The Care Programme Approach Association (2001) has repeated that care plans should:

   - identify the interventions and anticipated outcomes;
   - record all the actions necessary to achieve the agreed goals;
   - include the reasons in the event of a disagreement;
   - give an estimate of the timescale in which goals will be achieved or reviewed;
   - detail the contributions of the agencies involved;
   - have the date of the next planned review;
   - include crisis and contingency arrangements;
   - include arrangements for mental health care, including medication and other relevant interventions).

   The forms represented below give a useful description of Mr Williams management at the Wallingford Clinic following his admission in 1994. They outline his mental state on admission; the response to his assault on a nurse; his gradual rehabilitation; education relating to treatment compliance and substance abuse; the pressure to secure his discharge from hospital; the responses to his cocaine use; setting up his community care.

	Problem	Action	Goal/rationale
07.12.94 Care plan A	1. Whilst on the unit Winston has expressed a reluctance to participate or attend any therapeutic groups.	1. Staff to encourage Winston to attend groups on a daily basis. Key worker/co-worker to spend time with Winston allowing for ventilation of feelings and anxieties he may have. Staff to offer positive reinforcement in the form of praise and support; acknowledge his willingness to participate in groups.	1. As Winston attends groups regularly, a review of the past few days could result in a more comprehensive programme of care.
	2. Winston has been accepted on the unit as a day patient, from 9AM to 5PM, 5 days a week. He spends the rest of the time on Grazeley ward. Potential problem: risk of absconding.	2. Staff escort to and from Grazeley/Wallingford Clinic, at least 2 nurse escorts.	2. Minimise risk of absconding

	Problems	Key nurse action
04.01.95 CTM	1. Winston's behaviour has deteriorated over the past week and a half and it is now felt by most people that he is exhibiting signs of a psychotic illness in that he is inaccessible, distractible, preoccupied and behaving in a bizarre fashion.	1. (The senior registrar) has prescribed Acuphase, Droperidol and depot injection to be given if Winston's behaviour becomes unmanageable but not until then. We feel that Winston is refusing representation at his tribunal we should try and obtain some representation for him and let the tribunal decide whether or not he requires detention and treatment in hospital as he is so adamantly opposed to it. This was balanced against the risks of leaving him untreated. It was felt that as he is in a safe and contained environment at present we can reasonably observe and monitor his mental state on a daily basis and that treatment can be instituted rapidly if there is a sudden deterioration in his mental health.

	Problem	Action	Goal/rationale
12.01.95 Care plan A	1. He is still completely denying the attack (10.01.95) on a member of staff, and still refusing intermittently his oral medication. Denies any symptoms of mental illness. In my opinion he still presents a risk to staff and patients in his present frame of mind. 2. As Winston remains unpredictable all staff should bear in mind that the attack on a member of staff occurred in the male bathroom and no other staff/patients were in the vicinity.	1. It has been decided (see medical notes – 12.01.95) to administer Acuphase over the next 2-3 days if he refuses oral medication. His regular medication is now (a) Serenace 10mgs QDS (omit if drowsy) (b) depot 50mgs Modecate weekly. 2. Staff should not compromise their safety and should always get another member of staff if they have to go into his bedroom or other areas of the unit such as the toilet/bathroom and so on.	1. To stabilise his mental state. 1(a). To promote awareness of his condition and encourage interaction. 1(b). The medium/longer term view is, obviously, to help him participate in the day-to-day activities of the unit. 2. To minimise/eliminate risks of physical violence.

	Problem	Action	Goal/rationale
20.01.95 Care plan A	1. Although he currently shows no hostility to staff and is a lot more stable in mood he still denies mental illness. He maintains there is no reason whatsoever why he should be here. He still refuses to participate in ward based activities. 2. He has now apologised to the member of staff he attacked. But he cannot, or finds it difficult to say why he did it. 3. Winston made a serious suicide attempt in 1985 (see medical notes).	1. He is now accepting, albeit reluctantly, his depot medication. We can only remind/explain to him the circumstances leading to his recall and that if he genuinely does want to get out, he will have to be more rational and co-operative. 2. Staff to be aware of dangerousness especially if showing signs of acute ill health. 3. Mental state and whereabouts to be monitored at all times.	1. We can only hope that in due course he is going to become more aware of his mental health condition/circumstances and be more responsive to nursing/medical intervention. 2. To minimise risks of physical attacks. 3. To minimise/ eliminate risks of self-harm.

	Problem	Key nurse action
30.01.95 CTM	1. Current medication: Fluphenazine 75mgs IM one week. No oral meds. (Dr Ferris) was updated with the situation with Winston. There was a long discussion about his mental state and the illness/anger debate. He is still refusing to participate in OT, to let anybody go to his home or take part in a lengthy conversation about his mental state. His tribunal is 08.02.95. (The senior registrar) has done a report. He is refusing to have a solicitor for his tribunal despite our efforts to persuade him otherwise. He has however agreed to see the second opinion doctor. 2. Winston says he is over-medicated and we agree.	1. Continue to try to engage Winston and encourage him to have legal representation. We need to be aware that Winston is a suicide risk, particularly if the tribunal doesn't go in his favour. 2. Reduce medication to Modecate 100mgs fortnightly.

	Problem	Key nurse action
20.02.95 CTM	1. Mental state. No evidence of psychosis or depression. No behavioural problems. Accepts medication but probably doesn't accept that he has ever been. 2. Requests escorted community parole. 3. Recent tribunal.	1. Gradually reduce dose of depot initially to 75mgs Fluphenazine fortnightly. 2. (A ward doctor) to write to C3 (the Home Office). 3. Not discharged from his section.

	Problem	Key nurse action
13.03.95 CTM	1. Mental state. Remains well. No evidence of psychosis. No behavioural problems. 2. We anticipate that he will be fit for conditional discharge in about 6 weeks. 3. Lack of a social worker. 4. Ground parole. 5. Wife wishes to speak with a doctor.	1. Reduce Fluphenazine to 50mgs fortnightly. 2. (The senior registrar) to write to C3 to expedite this. 3. RD-E will see him. 4. Increase to 1 hour/day. 5. RF to see her. She seems to have concerns about the risks of mental illness developing in their daughter.

	Problem	Key nurse action
03.04.95 CTM	1. Mental state. Euthymic. No evidence of psychosis, no aggressive behaviour. Attending work therapy. 2. Parole. 3. Wife has asked for a copy of the recent letter to C3.	Fluphenazine 50mgs 3-weekly for the next 6 months. No reduction in frequency during his period of adjustment back in the community. 2. Has been granted 6 escorted community leaves. 3. (A nurse) to help him make an application to see his medical records.

	Need/issue	Action	Aim/purpose
07.04.95 Care plan A	1. Although Winston's mental state appears stable, he is still not willing to converse in depth about his mental health problems.	1. Staff should spend at least ½ hr. about 3-4 times a week with Winston gradually giving him the opportunity to explore his feelings. 1(a). Encourage Winston to approach staff whenever he needs to talk about any problems he may have. 1(b). Ideally a specified nurse i.e. key nurse should facilitate counselling sessions.	1. To minimise the risk of relapse.
	2. Winston has now been granted unescorted ground parole and escorted community parole. 2(a) He has also started working at the work therapy department 4 days per week.	2. Make Winston aware of rules and policy of both paroles. He should be aware of the extent and limitations of community parole. Monitor for mental state and social skills whilst on escorted community parole.	2. To enable Winston to improve his confidence whilst out in the community as well as to increase his motivation to seek employment and enhance working skills.

	Problem	Key nurse action
24.04.95 CTM	1. Mental state. Remains well although disappointed that he is not being discharged.	1. No change in medication i.e. 50mgs Fluphenazine 3-weekly. 2. C3 contacted re our desire to discharge him.

	Problem	Key nurse action
15.05.95 CTM	1. Discharge plans.	1. Section 117 meeting held today. Discharge plan is: a) Medication – Fluphenazine 50mgs IM 3-weekly for at least 6 months. He will attend the clinic and the staff will record his mental state. b) Non-compliance – i) will be initially rung at work. ii) if no response within 2 days a letter will be sent to him. iii) if no reply within a week a CPN will visit him to give the depot. iv) if he is not available, CPN will leave a note warning him that the Home Office will be informed within 14 days of his non-compliance unless he attends the Clinic for his treatment. c) Supervision – social supervision by RD-E, medical supervision by RF/senior registrar. First OPD 1 month.

	Problem	Key nurse action
05.06.95 CTM	1. Discharge plan. C3 have not yet agreed to Winston's discharge because of conflicting recommendations between (a ward doctor) and Richard Dale-Emberton's reports.	1. RD-E and RF to write supplementary reports for C3.
	2. Attitude to supervision after discharge.	2. Continue to help Winston understand the need for regular supervision and medication after discharge.
	3. Repairs needed to flat.	3. Winston to carry out these repairs himself prior to discharge on day leaves.

	Problem	Key nurse action
17.07.95 CTM	1. Lack of insight into illness remains. 2. Continuing bi-lateral shoulder pain. 3. Need to plan for discharge.	1. Likely to be a long-term problem but he is amenable to treatment. 2. Continuing daily physiotherapy is considered to be suitable for a degree of light work. 3. RF to write to Home Office to request un-escorted overnight leave at RMO's discretion.

	Problem	Key nurse action
07.08.95 CTM	1. Complaining of shoulder pain. 2. Requesting reduced medication. 3. ? fluctuating mental state. However mental state examination revealed rational discussion with reasonable insight.	1. Rob Ferris to write to Home Office regarding his conditional discharge and over-night leave. 2. Medication to be reviewed. Will probably be reduced after discharge. (See table at section 8 B).

	Problem	Action	Goal/rationale
28.08.95 Care plan sheet A	1. Winston still complains about his shoulder pains. He has asked me if he could be referred to Battle hospital. 2. Winston has 2 overnight leaves. To continue with overnight leave. 3. MHRT to be held on 29.09.95. 4. Has complained of difficulties reading & watching TV. 5. Expenses (meals) for overnight leave.	1. To see medical staff. 2. To seek HO permission for more overnight stays. 3. HO has requested a medical report. 4. DSS contacted for eye consultation & payments for glasses. 5. DSS contacted for extra payments.	1. It makes sense to refer him to Battle. If he still has the pain when discharged Battle will be the nearest place for him to attend. 2. As part of the preparation for eventual discharge. 3. To keep pressing HO for discharge. 4. To see optician in Wallingford. 5. Designed for sensible budgeting.

	Problem	Key nurse action
30.08.95 CTM	1. Requesting 2 over-night leaves. 2. Complaining of pain in his left shoulder.	1. … to write to Home Office requesting over-night leave at RMO's discretion. 2. Referral to physiotherapist at Battle Hospital after discussing with the physio. who was looking after him before.

	Problem	Key nurse action
18.09.95 CTM	1. Patient from another ward alleged that she and Winston took illicit drugs over the weekend. 2. Winston has a mental health review tribunal on 24th September 1995. Meanwhile his mental state remains improved. He also claims to have improved with his shoulders.	1. Urine samples taken from Winston. We will await the result of this sample before confronting him.

	Need/issue	Action	Aim/purpose
01.10.95 Care plan sheet A	1. Winston admitted to taking crack cocaine when he was on overnight leave. He said he did it only once and took only a small amount. He claimed that the depot was affecting his sex life and that he took the drug to improve his sexual performance and prove his virility. He also said it did not work. Some of his assertions were unrealistic. He compared himself to his dad who fathered a child at 72. He also compared himself to when he was a young man.	1. Subsequently his MHRT was postponed to October 30th. 2. All unescorted parole was cancelled from 29.09.95. 3. To be seen by Dr Ferris, (a ward doctor) and key worker.	1. To give time to Dr Ferris to send a supplementary report to the Home Office. Dr Ferris will be recommending discharge and one of the recommendations will be random drug testing. 2. Winston became very emotional and appeared to be very low in mood when he learned that he was not going to be discharged. To allow him time to calm/settle down. 3. To reassure Winston that we are still working towards his discharge. To relieve his anxieties. To get all the facts.

	Problem	Key nurse action
09.10.95 CTM	1. He was not discharged from the last tribunal because his urine tested positive for crack cocaine. 2. Complaining of medication-related sexual dysfunction which is attributed to his Fluphenazine depot.	1. Need to regularly check his urine for the presence of drugs. 2. (A nurse) to explore with him these sexual problems and assess its relationship with this medication. The adjourned tribunal is on October 30th.

	Need/issue	Action	Aim/purpose
16.10.95 Care plan sheet A	1. Winston admitted to taking crack cocaine whist on overnight leave and the urine test proved positive.	1(a) MHRT was postponed until 30.10.95. 1(b) HO has cancelled all leave arrangements. 1(c)One to one sessions with key worker.	1(a) To enable Dr Ferris to send supplementary report to the Home Office. 1(b) Leave arrangements had already been cancelled by key worker as a precautionary measure, also in view of Winston's low mood and past history of self-harm. 1(c) regular session with key worker to reinforce to Winston the dangers/risks of relapse if drug taking becomes a habit.
	2. The MHRT to be held on 30.10.95	2. CPA/117 to be held on 27.10.95	2. Discharge plans/supervision to be fully explained again to Winston.

Evaluation	Date	Next evaluation	Signature
1(a) Dr Ferris' supplementary report has been sent to the Home Office (see medical notes).	19.10.95	30.10.95	Signature
1(b) Over the past week Winston has been observed to be more relaxed in manner/mood than of late. Mental state appears stable.	19.10.95	30.10.95	Signature
1(c) Key worker has continued to reinforce to Winston the need for supervision in the community, the reasons why he should not take/misuse drugs and the continued need for anti-psychotic medication (depot).	19.10.95	30.10.95	Signature

	Problem	Key nurse action
30.10.95 CTM	1. In view of the fact that his urine tested positive for cocaine, his mental health review tribunal was postponed until today. He is hoping to be discharged.	1. Provisional discharge package: i) medication to continue under close supervision ii) Dr Ferris/CPN input iii) social supervision with Richard Dale-Emberton, initially once weekly iv) medication supervision from (ward doctor) v) urine tests to be done vi) work therapy to be optional as he is complaining of right shoulder pain.

A report headed 'Nursing summary on Winston Williams, treatment and discharge plans' is reproduced below. It was prepared for the tribunal planned for 29th September, which was subsequently adjourned. (An annotation at the end of the summary: **'Depot – 3/52 on Friday 3rd of Nov 1995'** suggests that it was also used for the re-convened 30th October tribunal).

Introduction

Mr Winston Williams was recalled to hospital and admitted to Grazeley Ward on 11.11.94. He was subsequently transferred to the Wallingford Clinic on 23.12.94. The main reasons for his recall were that he refused to attend for his depot injection and was also becoming increasingly hostile towards his social worker and stopped seeing him altogether.

Initially, he was resistive to all nursing and medical interventions. He exhibited signs of a psychotic illness in that he was inaccessible, distractible, preoccupied and behaved in a bizarre fashion. This culminated in a physical attack towards a member of he nursing staff in January 1995. As a result of this totally unprovoked attack, and the fact that Winston was still acutely paranoid, he was acuphased (meaning, given an injection of the major tranquilliser Acuphase) and started on Modecate 75mgs weekly.

Over the next few weeks he became a lot more amenable and started participating in OT activities. He was granted ground parole and attended work therapy.

Current care and treatment

Winston appears to be well stabilised on his present regime of medication – Fluphenazine 50mgs three weekly. He now has unlimited ground parole, and overnight leave to his flat once weekly. He attends work therapy on a regular basis and participates in ward based activities.

We continue to help Winston understand the need for regular supervision and medication after discharge.

Discharge plans

A section 117 meeting was held on 15.05.95. Discharge plan is:-

A) Medication – Fluphenazine 50 mgs IM three weekly for at least six months. He will attend the Clinic for this and staff will record his mental state.

B) Non-compliance – (i) If at work, he will be initially rung at work; (ii) If no response within two days, a letter will be sent to him; (iii) If no reply within a week, the CPN will

visit him to give the depot; (iv) If he is not available, the CPN to leave a note warning him that the Home Office will be informed within 14 days of his non-compliance, unless he attends the Clinic for his treatment.

C) Supervision – social supervision by Richard Dale-Emberton, medical supervision by Dr R Ferris/senior registrar.

To see RD-E once weekly for the first month following discharge.

To see Dr Ferris once a month.

(Signature)

Key worker

25.09.95

Comment

1. The care plans of 24.04.95 and 28.08.95 record the goal of pressurising the Home Office to agree to Mr Williams' discharge. This was recognised by the Home Office and interpreted as undue haste.
2. The care plan of 01.10.95 is the first to note Mr Williams' cocaine use; the information came from another patient. The Home Office responded promptly by withdrawing Mr Williams' leave. Subsequent care plans summarise staff's attempts to counsel Mr Williams.
3. The way in which staff dealt with their knowledge of cocaine use appears to have been to accept Mr Williams' account of it being a one-off event (prompted by his complaint of medication-induced impotence). This may explain both why he was not referred for specialist substance abuse assessment, and why, 6 weeks later, he (a twice-recalled restricted patient, with no insight into his illness, and a marked trait of untruthfulness) was recommended by his RMO for conditional discharge.
4. While the report mentions 'Non-compliance' the actions recommended refer only to medication; non-compliance with medication is one part of risk management, all others are ignored. Furthermore, this section is a replica of the CTM notes of 15.05.95; they have not been amended since the subsequent cocaine use came to light.
5. The MHRT nursing report is remarkable for what it does not mention: Mr Williams' cocaine use. While this is covered in Dr Ferris' psychiatric report the nurse key worker fails to report Mr Williams' repeated lying when challenged on the subject.

   This omission diminishes the potentially valuable contribution which nursing staff can make to MHRT proceedings.
6. When received by the inquiry panel the only nursing notes which were in sequence were the daily nursing notes and the typed running clinical team meeting notes. Care plans A and B were often separated, as were the short-term and long-term objectives documents. Many forms were undated, and brought together as short runs of similar forms. As a general statement the nursing notes were of good standard, but the chaotic way in which they were *received* by the panel made it difficult to do them justice.
7. All local practice should take into account *The CPA Handbook* (The CPA Association 2001).

B. Out-patient care 1995-1999.

Immediately following Mr Williams conditional discharge in late-October 1995 a ward nurse acted as his CPN. From mid-November 1995 until late-January 1997 Ms Jackie Lee acted in that capacity, having first met him during his 1989 to 1990 admission to the Clinic. She made 22 contacts over this 14-month period, all but 3 at Mr Williams' home.

> ' He realised that it had to be done; maybe it was under sufferance but he did accept our visits and was polite and courteous when I was there'.

She told the panel that she saw herself as key worker under the CPA (see section 11 A) although she believed that the role was shared between herself, and the psychiatric and social supervisors. When her involvement ceased she believed that the key worker role was passed to Mr Dale-Emberton.

The panel asked why she withdrew from the case?

> '…we had a CPA meeting and the three of us felt that it was the right thing to do'.
>
> …It was time to reduce the visits and he needed an RMO and a supervisor, so I stepped down'.

Questioned in regard to her role of key worker.

> ' I took on the role of key worker until, I think, February 1997 when it was felt that my services were no longer needed, so I dropped out of looking after Winston and handed it over to Richard'.

Ms Lee told the inquiry:

> 'We had a very good working relationship, and all being sited together in one portacabin – my office was opposite Rob's and just down the corridor from Richard's – we had quite a lot of informal meetings'.

Mr Dale-Emberton said of communication at the Wallingford Clinic.

> 'We were in the same building and we would share coffee together. I would know when Jackie was visiting or when Winston was coming in for an injection…That informal information-gathering is completely invaluable in my experience'.

Nurses continued to have some contact with Mr Williams when he attended the Clinic each month for depot medication and their notes were made confirming that an injection had been given and summarising his mental state. Nurses comments on their assessment of Mr Williams mental state are at section 8 B.

Comment

1 It is difficult to understand why Ms Lee withdrew from the case; she was a key figure in Mr Williams early management, in relative terms she had a good relationship with him, and visited his home, frequently, and regularly. Only one CPA meeting was held after her departure and it is remarkable that when she left arrangements were not put in hand to provide further care of a similar quality.

2 Some of the hand-written contact notes which Ms Lee made are lost and have not therefore been considered by the panel.

> ' I would hand-write my visits for that day at the end of each day. I had my own unwritten rule that I would write up each entry within 24 hours. These would go to…my secretary , she would type them and I would get a copy the next day'.

3 The picture Ms Lee painted of Mr Williams in her evidence is in marked contrast to that reflected later.

'Well-dressed, he looked after himself, clean, a friendly, person. He would invite you in, would ask you to have a drink when you walked in, would go off and buy a pint of milk if he didn't have any – made you feel welcome when you went in. All conversation was normal…no paranoid ideas or thoughts… '

If Mr Williams home had been visited in the 20 months before the homicide (the panel has seen police photographs of the bedsit) they may well have been struck by the change in home circumstances, which in turn would have raised issues of why it occurred.

4. While the record of pharmacological treatment given to Mr Williams has been seen, the notes which the nurses made at the time when Mr Williams received his depot as an out-patient are lost (as have other patients) and have not been considered by the panel.
5. Community psychiatric nurses have a major role in the management of conditionally discharged restricted patients. Only in the most exceptional situation (for example, where absolute discharge was anticipated), would they not be involved in care planning.

11 IMPLEMENTATION OF GUIDELINES

Given the local guidance existing at the time, and against which his care should be judged section 11 examines the way in which the Care Programme Approach was implemented in Mr Williams' case

Health and local authorities have a statutory duty under section 117 to provide after-care services for all patients (in all categories of mental disorder) who have been detained in hospital …To fulfil this duty authorities will need to ensure that the CPA, and care management if needed, is fully implemented for mentally ill patients who have been detained…' (*Building Bridges,* 1995, para. 1.4.9).

In 1994 Berkshire Social Services, Oxfordshire Social Services, and West Berkshire Priority Care Services NHS Trust issued *Guidelines* on the CPA. (see section 5 B i). Appendix 1 of the Guidelines contains the following 'Action Chart'.

ACTIVITY	TIMING	PEOPLE INVOLVED	MEETING CO-ORDINATOR	PURPOSE
1. Initial meeting	Within one week of identification as fitting CPA criteria	Patient, (carer) and all available professionals involved in care	Named nurse	Identify prospective key worker and make initial plans
2. Pre-discharge programme meeting	Pre-discharge	Patient, (carer) key worker, representatives of all involved and key reps. from community disciplines and agencies	Consultant psychiatrist	(a) To establish workable community care programme (b) Agree review process (c) Identify unmet needs
3. Discharge agreement	On discharge	Patient, named nurse	Named nurse	Ensure patient has copy of care programme
4. Care review meeting	To accord with agreed date identified at stage 2, but no later than 6 months after discharge	Patient, (carer), key worker, and any other professional directly involved.	Key worker	Review provision of CPA and any subsequent reviews arrangements (b) Ensure contact has been maintained (c) Negotiate the long-term objectives with patient (d) Review and agree with patient if CPA needs to continue.

Below is the care plan form completed at the time Mr Williams was discharged.

Front Note: all written insertions on the form are in **bold** type

CARE PROGRAMME	
West Berkshire Priority Care Service NHS Trust	
Oxfordshire Social Services & Berkshire Social Services	
REVIEW/DISCHARGE DATE: **31-10-95** NAME: **WINSTON WILLIAMS** ADDRESS: **(number) Lyon Square** **Dee Road Estate Tilehurst** **Reading RG3 4DA** TELEPHONE NO: CARER'S NAME: **name of daughter inserted** ADDRESS: TELEPHONE NUMBER: **number inserted**	G.P.: **name of GP inserted** G.P's address: **Address inserted** TELEPHONE NUMBER: **number inserted** SOCIAL WORKER: **Richard Dale-Emberton** **Fair Mile Hospital** WARD: Case notes no.
CRISIS CONTACT: (Address) **Wallingford Clinic** **Staff nurse/manager** **Fair Mile Hospital** CRISIS CONTACT (Out of hours) TELEPHONE NO: **number inserted** CRISIS CONTACT (Office hours) TELEPHONE NUMBER: **number inserted**	RMO **Dr Ferris** **Consultant Forensic Psychiatrist** **Fair Mile Hospital** TELEPHONE NO: **number inserted** DESIGNATION:
COMMENTS BY CLIENT: YES/NO **Mr Williams' signature** (added on 08.11.95) Signature.....	COMMENTS BY CARER: YES/NO Signature **ward nurse's name inserted**
Date of Next Review:	Time & Place

Back

NEEDS IDENTIFIED	ACTION TO BE TAKEN	BY WHOM	ARRANGEMENTS
1. Medication to maintain mental health	**Mr Williams to visit each Friday for nurse to administer depot medication. Depot 2/52**	**Mr Williams and nursing staff**	**Next due 24.11.95**
2. Finance	(Ward doctor) **to be asked to complete Med 10 form and discharge letter to GP and DSS**	**Key nurse/registrar**	**Winston Williams to sign on at DSS and GP**
3. Supervision	**Weekly sessions with SSW and CPN alternating between office and hospital visits. Psychiatric supervision**	**R Dale-Emberton (Ward nurse)** (Ward doctor) **Fair Mile**	
4. Monitoring of drug abuse	**Random urine tests at 2-3 weekly intervals. Daily attendance at Battle Hospital OP for physiotherapy for painful shoulder**	**CPN**	
5. Occupation			
Unmet needs:		Reasons:	

We, representing our respective Authorities, confirm that these plans are agreed. Also we confirm that the patient and where appropriate the carer have been involved and consulted regarding the Care Programme, and agrees to any involvement specified above.

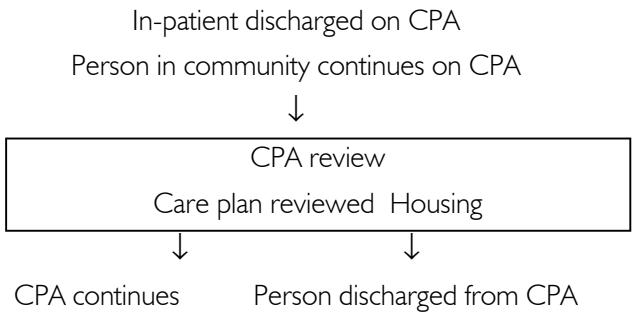
Signed **Ward nurse's signature** **Dr Ferris' signature** **Richard Dale-Emberton's signature**
Key Worker Consultant Social worker

Date:

Name:

The pre-discharge meeting on 31.10.95 was attended by Mr Dale-Emberton, a social work student, and a nurse. At section 18, appendix F are 4 tables which summarise the subsequent contact between Mr Williams and the clinical team between his discharge from hospital in late October 1995 and his arrest for the murder of Ms Kazmi in September 1999. In addition to recording all contacts with social workers, psychiatrists and nurses the tables show the dates on which Mr Williams received depot medication, when urine tests results were received, and when his case was discussed at a clinical meeting.

Berkshire Social Services, Oxfordshire Social Services, and West Berkshire Priority Care Services NHS Trust revised their *Guidelines* in 1996 to include the supervision register (see section 5 B i). The 1996 up-date contains an 'Order of Process' (represented, in part, below).



A second CPA meeting was held on 22nd February 1996. The contact sheet (social work) notes of the meeting are the only record available to the inquiry.

26.2.96. CPA Dr Ferris, RMO, Jackie Lee, CPN, and R D-E, SSW

SW and CPN visits discussed and agreed that the function would now be best served by RDE visiting monthly, these to be organised to allow his visits for his medication to the Wallingford Clinic monthly, to have 2 weekly contact.

Drugs monitoring checks can be taken by asking him to come to the Clinic on Saturdays. Therefore ask him to come to the Clinic any days bar Monday and Wednesday. Urine can be stored in fridge over weekend.

No other needs identified except to continue to monitor mental state and dangerousness, and continue with HO reports. RDE/SSW.

A third CPA meeting was held on 24th July 1996.

CPA MEETING ON WINSTON WILLIAMS

24.07.96

Present: Rob Ferris, Richard Dale-Emberton, Jackie Lee

Identified needs for CPA

1.Medication. Winston is now taking 50mgs Depixol every four weeks. This is still given by the Wallingford Clinic staff.

2. Finance. Winston is in receipts of all his benefits - £74.05 weekly, also £38 therapeutic earnings.

3. Supervision. Winston sees Richard every two weeks, Jackie monthly, Rob every six weeks.

4. Monitoring for. Drug abuse – random tests to continue.

5. Occupation. Winston works two days a week, he still attends physio once a week.

Next review: Wednesday 23rd October 1996 at 11AM.

Jackie Lee

Forensic CPN

A fourth CPA meeting was held on 22nd October 1996.

NURSING CONTACT

WINSTON WILLIAMS

22.10.96

CPA held on 22.10.96

Present: Dr Ferris, Richard Dale-Emberton, Jackie Lee, Ann

Following a long discussion, the team emphasised the unreliability of Winston's self-report.

Dr Ferris felt there would be a severe risk of relapse from Winston taking illicit drugs. Winston at present is not complying with random urine tests, tests to continue, to include a test on Saturday morning.

No evidence of mental state deterioration.

Contact to remain: Richard every 2 weeks

Jackie once a month

Rob every six weeks

Injection at clinic once a month

Next CPA, 9AM on Wednesday 5th February 1997.

Jackie Lee

Forensic CPN

The fifth CPA meeting is reported in a joint form (Berkshire and Oxfordshire County Council Social Services and West Berkshire Priority Care Service NHS Trust) completed and signed by (only) Mr Dale–Emberton and dated 26.02.97. Present were Ms Lee, Dr Ferris, and Mr Dale-Emberton. The first page gives the names and addresses of Mr Williams, Mr Dale-Emberton, (GP), Dr Ferris, and the Home Office. The second page records:

CARE PLAN

NEEDS IDENTIFIED

i. Regular medication to improve mental health - Monthly injection by Mr Williams visits to the Wallingford Clinic
ii. Periodic review re. Above - Dr Ferris & Richard Dale-Emberton
iii. Social supervision by monthly contact by - Richard Dale-Emberton - home visits or office meeting
iv. Home Office reports re. Risk - Dr Ferris and R Dale-Emberton
v. Periodic urine tests for crack cocaine and cannabis - Clinic staff and R Dale-Emberton

The last CPA meeting was held on 14th July 1997.

CONTACT SHEET WINSTON WILLIAMS
Date: 14.7.97. CPA meeting with Dr Ferris and RDE
Worker: Richard Dale-Emberton
Agreed to lengthen periods of contact to 2 monthly.
Medication to continue at present levels administered by Clinic staff, therefore no CPN.
Drugs testing to cease. RDE/SSW

In addition to the 5 post-discharge meetings outlined above, other meetings are recorded. On 12th November 1997 Mr Williams met with Dr Ferris and Mr Dale-Emberton to discuss the allegations of assault and threats to kill (see section 12 D). There are brief notes which indicate that Mr Williams case was mentioned at the community focus /management team meetings on 8th October 1996 (present: Dr Ferris and Jackie Lee) and 18th November 1997 (Dr Ferris and Mr Dale-Emberton). Lastly, Dr Ferris and Mr Hayward met Mr Williams together on 20th November 1998 to discuss his driving school transport.

Although Mr Williams' last CPA meeting was held in July 1997 he was not discharged from the CPA. Local guidance, produced in 1996 required:

> 'DISCHARGE FROM THE CPA. This is agreed at the CPA review meeting or at any time in the CPA process…(it requires)…a full review with the multi-disciplinary team and the client and carer…'

In March 1998 West Berkshire Priority Care Services NHS Trust produced a *Policy on the CPA.* The final part of its 'Order of Process' followed that of the 1996 document (see section 5 B i). At the time Mr Williams should have remained subject to CPA processes and the policy provided guidelines for completing the CPA form, and the care plan. The care plan would have required consideration of the following matters: needs identified with action taken and by whom; unmet needs and reasons; subject to s.117 and/or the supervision register and/or supervised discharge; risk assessment completed; recognition of relapse and any concerns about safety, comments by patient/client and carer/next of kin; distribution of CPA forms.

The CPA co-ordinator told the inquiry panel that she took over responsibility for the Wallingford Clinic in 1996. (The guidance for CPA collation is at section 5 B ii). She was asked to respond to the fact that no CPA meeting was held in Mr Williams' case for almost 2 years before the homicide.

> 'As CPA co-ordinator I would be appalled to hear that that hadn't happened'.
>
> Q: We don't know how common that would be in relation to other patients leaving the Wallingford Clinic. At the moment we don't know whether Mr Williams was an isolated instance'.
>
> A: 'I couldn't tell you. I don't know. I have had a few copies of CPA forms that have been done within the Wallingford Clinic. I have also had a couple of forms for patients who have been on supervised discharge and came to the Wallingford Clinic from other places. Hand on heart, I would say that I have had about 5 CPA forms (in respect of 5 different patients) from the Wallingford Clinic over the period of time'.

A. Key worker.

Ms Jackie Lee (CPN) was the key worker from December 1995 until February 1997 when it was decided that she would withdraw from the case. She told the inquiry:

> 'I took on the role of key worker until, I think, February 1997 when it was felt that my services were no longer needed, so I dropped out of looking after Winston and handed it over to Richard.
>
> The way Richard Dale-Emberton, Rob (Ferris) and myself worked was that we shared the key worker role between the three of us, so that it wasn't just one person that was key worker to everybody'.

In his evidence Mr Dale-Emberton said that he could not remember why he, as social supervisor, should not have taken key worker responsibility from the beginning (section 11).

Mr Hayward considered that when he became social supervisor in March 1998 it was his responsibility to ensure that there were regular reviews, and planning, (within section 117 and CPA guidelines), and that review meetings should have taken place in Mr Williams' presence, and sometimes at his home, and that a family member should have been invited. His written evidence contained the following:

> 'Mr Williams was subject to the CPA and there was an expectation that there would be three key elements to his care planning: a care plan, a key worker, and regular review of his case. I regarded myself as sharing the key worker role with Dr Ferris. As there was no formal care plan there was no designated key worker'.

Comment

The following are general statements relating to Mr Williams management in relation to section 117 Mental Health Act, and Departmental and Home Office *Guidelines* as to good practice. Some of the matters are discussed under the headings 'Psychiatric management' and 'Social work supervision' (sections 8 & 9), 'Risk assessment and management (section 12).

1. The form dated 31st October 1995 has the following omissions: time and place of next meeting; action to be taken in the event of non-compliance; a full assessment of risk; detail and frequency of psychiatric supervision.
2. The 1989 DofH guidelines on discharge recommended that relatives are informed of relevant matters, both verbally and in writing. No relative was contacted regarding Mr Williams' after-care. Professionals had no knowledge of the true relationship between Mr Williams and his relatives, nor did they seek to develop a constructive relationship with them.
3. Mr Williams was not at the pre-discharge meeting. He signed the care programme form on 8th November, having been discharged from hospital on 30th October. (A CPN visited Mr Williams at home on 8th when, presumably, the form was signed). There is no record that the discharge and continuing care plans were discussed with, and agreed by, Mr Williams before his discharge. Dr Ferris told the panel:

   > '…around the mid-nineties, certainly it is true that we were not routinely inviting patients to attend those meetings in the way that we have come to in the late nineties and do now'.

4. Mr Williams was not present at any of the 'CPA' meetings; neither were members of his family or 'significant others' (e.g. a representative from housing). This meant that issues such as medication and its side effects, relapse indicators, and risk had no application outside the clinical team. In 1973 a report, in many ways a precursor of developments in forensic psychiatry, recommended with regard to the family:

> '…the members of the rehabilitation team should whenever possible establish friendly communication with them'. (Home Office and Department of Health and Social Security, 1973).

Furthermore, whilst local 1998 CPA guidance recommends that:

> 'Where a key individual does not attend a CPA meeting, the meeting should consider proceeding without them, a plan drawn up and communicated as fully as possible and necessary in the circumstances (sic)'.
>
> …it is doubtful if the meetings should have continued in the absence of so many individuals central to the CPA process.

5. The 'CPA' meetings were held at 3 months, 8 months, 11 months, 16 months, and 21 months after discharge. No CPA meetings at all were held in the 22 months before the homicide.
6. CPA guidelines were not followed in that: reviews were not held at the suggested frequency, and were discontinued entirely in July 1997. Mr Williams' restricted-patient status meant that he should have been subject to after-care under s.117 MHA 1983 within the CPA process. CPA should not have fallen into abeyance.
7. Whether or not CPA meetings took place at the Clinic the relevant documentation rarely found its way to the CPA co-ordinator, and, in Mr Williams' case, none did.
8. The key worker assigned in the pre-discharge 117/CPA meeting saw Mr Williams twice in November 1995. Guidelines indicate that the key worker should be an identified individual who can form a sustained relationship with the patient by monitoring treatment, modifying the care plan, forming a therapeutic relationship, and systematically assessing and regularly reviewing care. The 'sharing' of key worker responsibility mentioned by one witness was unconventional and led to a confusion of roles and responsibilities. While CPA was implemented in the period immediately following discharge, Mr Dale-Emberton should, but failed to, subsume the role of key worker after Ms Lee's departure. Mr Hayward also failed in this capacity.
9. A registrar is recorded as being identified as the psychiatric supervisor (care programme form 31.10.95). The panel have no information to indicate that the nominated registrar ever saw Mr Williams after discharge, a role assumed temporarily by the female senior registrar who was not present at the CPA meeting .
10. It is unclear if Mr Williams agreed to the care plan; he certainly did not adhere to it. The care plan was limited in scope, ignoring some important aspects of Mr Williams behaviour (e.g. substance abuse); it was out of date almost immediately after his discharge; it was not reviewed. There was no plan of how to manage non-cooperation with the plan or detail of relapse indicators.
11. The CPA meeting of 24th July 1996 was attended by Dr Ferris, Ms Jackie Lee, CPN and Mr Dale-Emberton. It was recorded that Mr Dale-Emberton was seeing Mr Williams every 2 weeks and there was no mention of this changing. In fact, in recent months, Mr Dale – Emberton saw Mr Williams on 5th March and 7th June. After the meeting and in the light of the warning 'phone call Mr Dale-Emberton saw Mr Williams on 30th August and 27th September. At the CPA meeting on 22nd October, attended by Mr Dale-Emberton, it was recorded that his contact with Mr Williams was to remain at every 2 weeks. Mr Dale-Emberton next saw Mr Williams on 8th November, 3rd December, 17th January, and 7th February. At a further CPA meeting on 26th February 1997 it was decided that monthly social supervisor contact would suffice.

The 'phone call appears to have been received following the CPA meeting on 24th July. It is not referred to in subsequent CPA meetings and the important issues it raised were not brought up in the subsequent CPA processes.

12. Mr Williams' later management as an out-patient was lacking in initiative, assertion, and any sense of it being a dynamic process with planned goals. On many occasions he appears to have been seen in response to a crisis, or to requests (often repeated) for reports from the Home Office. The management was unsystematic and reactive.
13. There was no formal handover between social workers.
14. In the last 18 months effective communication between members of the multi-disciplinary team was minimal, and often by the means of correspondence exchange. It failed to include Mr Williams, his family and significant others. What communication there was between the psychiatric supervisor and the Home Office often presented an incomplete and sanitised view of Mr Williams and his behaviour. It appears that informal 'corridor' chats replaced formal, recorded reviews.
15. It seems that Mr Williams eventually succeeded in excluding professionals from his home, and it follows that they did not put themselves in the position of knowing what went on there. Neither Dr Ferris or Mr Hayward ever saw Mr Williams at home. This represents a significant failure to use a potentially invaluable source of information.

12 RISK ASSESSMENT & MANAGEMENT

This section is the heart of the report. Mr Williams remained conditionally discharged because the partners in his community care were not satisfied that he was an acceptable risk in the absence of the supervisory structure which conditional discharge could impose. In that there were never any no-risk options with Mr Williams his management centred on an awareness of the risks and taking measures to minimise them, and if they could not be reduced to an acceptable minimum while he remained in the community, recommending his recall to hospital.

Central to these considerations are recurring questions about what could reasonably have been known, and what reasonably could not, and, when there was any conflict of interests, whether or not risk management favoured public safety.

Mr Williams notes contain many general statements about risk. Thus, in 1985, following the unsuccessful suicide attempt, his Broadmoor RMO wrote to the Home Office: '…(It is) fortunate (he) cut his throat, it could easily have been someone else'. And in 1989, when Mr Williams was assessed by a general psychiatrist for admission to Fair Mile Hospital (see section 6 F):

> 'My intuition was that Mr Williams was still capable of explosive violence. I felt it unlikely that I would ever be able to build any relationship of trust with him, and that without this, I was unlikely to predict what was going to happen next and unlikely to secure his compliance in continuing necessary medication…I am sorry I feel unable to become responsible for this man on any out-patient or day patient basis'.

Dr Bullard was the consultant forensic psychiatrist responsible for Mr Williams' acceptance by the Wallingford Clinic in 1989. Her assessment report, which contains a basic outline of risk assessment and management, argued that the relapse in 1985 was related directly to a discontinuance of medication:

> 'There is no doubt he becomes dangerous when his illness relapses'.

But under certain circumstances, she argued, his risk was reduced to an acceptable level.

> 'He does respond to psychiatric treatment and if he is prepared to co-operate with the administration of a regular depot injection and has regular community psychiatric nursing, psychiatric and social work supervision, he could be managed in the community. From his records his relapse was gradual and there were indications before he tried to kill himself that his mental state was deteriorating. Psychiatric supervision would involve his immediate admission to hospital if there was evidence that his illness had relapsed'.

There is only one (albeit basic) structured, and specific, risk assessment and that is contained in a relapse recognition appraisal made in a discharge and after-care plan of September 1990.

> 'Relapse recognition. Becoming withdrawn, isolated, behaving oddly and not co-operating with follow-up.
>
> Contingency plans. Increased input CPN, SW, psychiatrist; readmission; Home Office recall'.

Risk assessments do not always predict dangerousness, thus Dr Ferris wrote to the Home Office in August 1995, after Mr Williams' recall to the Wallingford Clinic:

> 'It is my view that Mr Williams should be discharged from hospital as soon as possible and that he can be discharged without any undue risk to the public…There is nothing to be gained by keeping him in hospital…He should be conditionally discharged as soon as possible'.

In other instances risk assessments vary with time, and the context in which they were made. For example, at a CPA meeting in October 1996 Dr Ferris' view is recorded as: 'Dr Ferris felt there would be a severe risk of relapse from Winston taking illicit drugs'. In contrast, on the subject of urine testing, Dr Ferris wrote to the Home Office in these terms in July 1997:

'After considerable discussion (with Mr Williams) we agreed that random urine tests would not be re-instituted, even at reduced frequency. My main reason for deciding this was Mr Williams had remained well for eight months without any sign of relapse, whilst not undergoing urine testing. In other words, he was remaining well whether or not he continued to use cocaine or cannabis occasionally, which I strongly suspect that he may do'.

Mr Dale-Emberton, Mr Williams' social worker during the 1994-5 admission and social supervisor until March 1998 was asked about the warning signs and symptoms to look for in Mr Williams' case, and if the risk assessment and management plan was recorded in the social work file?

'No, it wasn't. For a start I would be looking for his sense of suspiciousness in his co-operation. Any abnormal beliefs that were around, if he started talking about being burgled or had been a victim from neighbours or anything like that. His ability to care for himself'.

With regard to the relapse indicators identified by Mr Dale-Emberton, he said in answer to a question about Mr Williams' flat.

' His flat was pretty appalling, and I was concerned whether he was looking after himself properly.

Often the door was quite damaged. He was always saying that somebody had tried to get in or he was waiting for the council to repair it…The bed was often quite dirty and unmade and clothes were heaped to one side. It smelt; it wasn't the best of places, but this is not unusual'

The only written evidence that risk was considered following Mr Williams discharge from hospital in late 1995 is contained in the supervising psychiatrists' and social supervisors' reports to the Home Office. Here the line taken is to infer that because Mr Williams is receiving his medication, and there is no evident deterioration in his mental state, all is well. Sometimes, adverse factors (e.g. Mr Williams' general uncooperativeness, and his substance abuse) are countered with reassuring comments.

'At the present time Mr Williams appears very well and there is no evidence of a deterioration in his mental state' (Psychiatrist to Home Office, November 1995)

'Relationships with me are friendly and accepting. Adjusting to living in the community without difficulty (Social worker to Home Office, December 1995).

'Friendly and conforming. Popular with former patients of the service' (Social worker to Home Office, March 1996).

(After the telephone call alleging cocaine use) 'He denies taking crack and said that the person making the allegations (whoever it was) must bear him malice for some reason…Mr Williams has cooperated fully with psychiatric supervision and with medication. There has been no evidence of a deterioration in his mental state…I must emphasise that even if he has been taking cocaine, there is no evidence it has affected his mental state' (Psychiatrist to Home Office, August 1996).

'The allegation from a disapproving and protective mother…is clearly of concern, not only because it is illegal (crack) but also the consequences, i.e. drug effects and social networking.

There are no known factors to indicate a relapse in Mr Williams' mental state and/or dangerousness to others and this is supported by (the), nurse manager, Wallingford Clinic, who has known Mr Williams for some years, both as an in-patient and when living in the community, returning to the Wallingford Clinic for advice and support' (Social worker to Home Office, August 1996).

'There is a degree of concern from professionals about the attitude of ambivalence on Mr Williams' part, primarily linked with an interventionist model of supervision related to possible drug abuse. At present this is being monitored and balanced with his experience of being recalled, a factor of great importance to Mr Williams. There has been no evidence of a regression in his mental state and/or risk towards others '(Social worker to Home Office, December 1996).

(After the assault and threats to kill allegations) '…both supervisors agree that there are insufficient grounds to justify Mr Williams' immediate recall to hospital. There was no evidence of a deterioration in his mental state arising from any acute recurrence of his mental illness. (He denied recent drug abuse). He has been complying with medication and there is no indication of any life stress or other change in circumstances that might be expected to contribute to his becoming unwell' (Psychiatrist to Home Office, November 1997)

Comment

1. While risk appraisal is a fundamental part of all psychiatry, the 1990s saw forensic psychiatrists assume the role of risk management specialists; moving from intuitive clinicians to clinical and actuarial assessors working to highly structured protocols.
2. At its simplest, risk assessment involves 2 stages: the context in which risk increases, and the symptoms and signs which indicate that risk. For its part, risk management relates to the interventions which contain, or reduce risk.
3. Nowhere in the clinical notes which relate to Mr Williams is there an analysis over time of the context in which his illness relapsed, and of the differing symptoms and signs of those relapses. (In 1972 delusional ideas, religiosity, and irritability; in 1976 jealousy and violence; in 1978 jealousy and other delusional ideas; In 1985 isolation, uncommunicativeness, belligerence, and a serious suicide attempt; in 1994/5 suspiciousness, irritability, violence and, possibly, auditory hallucinations).
4. The September 1990 after-care plan contains the only, and most basic, risk management outline. When it was conceived Mr Williams had had 4 known episodes of severe mental illness, all happening in different contexts and with differing presentations. None are reflected in the after-care plan. Furthermore, the contingency plans mentioned in the document were not activated post-1995 when risk increased.
5. Following Mr Williams' discharge in October 1995 there is a notable shift from objective balanced risk assessment to adopting a position of not only minimising what risk there is to reassuring, on that partial basis, that all is well.
6. Looking at the pattern of Mr Williams illness over time it is clear that dangerous behaviour itself can be the first that *professionals* know about his relapse. It follows that in the absence of pointers to all-not-being-well any management plan must include both unremitting vigilance and wherever possible the cultivation of a net of 'informants' who would be the people most likely to be the first to witness any relapse.

A The threats to Keith Jarvis.

Mr Keith Jarvis was asked by the inquiry panel about the situation in 1994 when Mr Williams was refusing to accept medication.

> 'I went to his work place and he was very threatening. I asked the proprietor who saw me there and he gave us a room to sit down with Winston in the waiting room, and he went absolutely ape, he was really angry that I kept coming to the work place to see him…Then he starts threatening me for the first time in the time I've known him with violence.
>
> This was calculated…what he was going to do.
>
> He said he was going to kill me.
>
> He said he was going to knife me or run me over. When I went to see him next time he was going to attack me.
>
> (I took the threat) very seriously. As he said, he had nothing to lose'.

A Home Office witness was asked if the social supervisor Mr Jarvis had informed the case worker of both the refusal to continue medication and of the threats to kill? Mr Jarvis' file note was read and the witness invited to comment on their response.

> 'I saw Winston at the garage in Wokingham…I have informed (a case worker), C3 Division Home Office, of what Mr Williams said'.
>
> 'Telecom Keith Jarvis, social worker. Mr Jarvis tracked Mr Williams down to his place of work… Mr Williams spent one week in New York and 2 weeks in Jamaica. He has been convinced by his relatives that he does not need to take medication and he is adamant that he will no longer do so. He is prepared to see (senior registrar). He states that if attempts are made to admit him to hospital he will leave the country for good.
>
> The latest developments are worrying. Mr Williams has an extensive history of violence. His index offence was a particularly brutal attack on 2 persons. His previous CD in the community broke down following his refusal to take medication. He subsequently attempted to take his own life by cutting his throat. I think that recall will be a distinct possibility if he continues to refuse medication and/or exhibits bizarre behaviour.
>
> …There is nothing after that, there is no mention of threats to kill. I knew (the case worker) before he left, and if there had been any mention of that he would have put it down.'

Mr Dale-Emberton did not mention the threats to Keith Jarvis either in his 1995 tribunal report or its addendum. He was asked what his view of the threat was, and, twice, why the threats had not played a part at all in the ongoing risk assessment or the risk management.

> 'It was very real.
>
> Again, during the threat he wasn't conforming to medication or compliant; he was definitely not complying with the conditions of his discharge. The splitting that went on between Keith Jarvis and (the senior registrar) was around, and I guess I was determined not to let that happen with our relationship with Dr Ferris and Jackie Lee and the nurses.
>
> What I am trying to say is that although we didn't have a relationship, it wasn't an antagonistic relationship that he had with Keith Jarvis'

Later Mr Dale-Emberton said:

> 'I wasn't really aware of the threat to Keith (Jarvis) until I had seen the recent files…When I took the case over we had a job to find the case file…'

Mr Hayward recalled the threats; he was acting as Mr Jarvis' line manager at the time. He could not remember any action being taken as a result, other than Mr Jarvis being taken from the case. He accepted that no records existed of action subsequent to the threats. He continued:

'I would agree, with hindsight, that more attention should have been paid to the threat that he made against Keith during the admission process, and certainly during the discharge planning process, including the report's addendum to the tribunal'

Comment

1. Threats to kill such as those made by Mr Williams to Mr Jarvis are usually taken very seriously by mental health professionals. We found no evidence that the threats played any part in Mr Williams management after his discharge in October 1995. Mr Dale-Emberton worked at the Wallingford Clinic and he was Mr Williams' social worker during his inpatient stay in 1994-5, and later the social supervisor. Mr Dale-Emberton did not know of the threats. That they should have been forgotten or ignored raises serious issues of failures in communication and the adequacy of risk management.

B. A warning telephone call

'…before the murder the psychiatrists treating the defendant were aware that he was taking cocaine. The cocaine must have combined with mental illness to create a danger to the public.

The fact that (Ms A) reported her fears to Fair Mile Hospital is disturbing'. (The trial judge in his report to the Lord Chief Justice at the end of the trial, 24.05.00).

On 24th July 1996 Dr Ferris received a telephone call from a woman (Ms A) who made a number of serious allegations concerning Mr Williams:

- that over a 2-year period he had given cocaine to her 2 daughters inducing states of dependence (one daughter was subsequently killed by Mr Williams; the second was then a mother and this led to the involvement of a local child protection team and a named worker);
- that she suspected that sex was a surrogate payment for drugs;
- that he boasted of beating urine tests by giving urine other than his own or diluting the sample;
- that she was afraid that if the source of the allegations was revealed she may be harmed.

Ms A's present recollection of events is as follows.

- She spoke to Dr Ferris who would not listen to her complaint because she refused to give her name and other details.
- She decided to provide this information, and made a second call later that day in which her allegations were made. Dr Ferris said that he would contact her to let her know that Mr Williams was aware of the complaint.
- Dr Ferris did not telephone back. No-one contacted her again in relation to these matters.
- Dr Ferris' file note records the agreement that he would contact Ms A if he found it necessary to divulge her name. He did not do so. It was Dr Ferris' opinion that the allegations were truthful and he saw the need to re-introduce urine testing. When confronted, Mr Williams said that the allegations were false and that his accuser bore him malice. Dr Ferris wrote to the Home Office on 7th August 1996.

  'I explained to him again my opinion that his taking 'crack' was likely to increase the risk of his becoming ill again, even if he is complying with anti-psychotic medication…The only difficulty that has arisen concerns information given to me, which indicates a likelihood that Mr Williams has been taking 'crack' cocaine. The testing we were carrying out was not really fool proof. The procedure has now been revised so that it should (in

> future be) much more difficult for him to persist with abusing cocaine to any significant extent. I must emphasise that even if he has been taking cocaine, there is no evidence that it has adversely affected his mental state'.

Mr Dale-Emberton was asked about the call which he referred to in his report to the Home Office.

> 'If I remember rightly, I went round to visit them, but I don't think its recorded…I went round to check with the family how they felt and they said, no, there's no problem, he's not going mentally ill or anything like that'.
>
> We should have followed it up with a meeting with her (the caller) and investigated it further. I don't quite know why we didn't'.

He wrote to the Home Office on 1st August 1996:

> 'According to Mr Williams he has 2 women friends and is much more content in the improvement in his sexual prowess, brought about he believes in the slight reduction in medication. Of note, however, is a complaint from one of the women's mother to Dr Ferris, RMO, alleging that he is supplying illegal drugs in the form of crack. Dr Ferris is in the process of dealing with this allegation together with Jackie Lee, CPN, of this service…The allegation from a disapproving and protective mother of one of Mr Williams' women friends is clearly of concern, not only because it is illegal (crack) but also the consequences, i.e. drug effects and social networking. Risk evaluation is currently being pursued by Dr Ferris, RMO, and Jackie Lee, CPN, and will take the form of urine tests calculated to coincide with times Mr Williams will least expect to be tested'.

It was agreed between all parties, although reluctantly on Mr Williams' part, that urine testing would be re-introduced and the procedure tightened to make it more difficult to both anticipate when the test would be done and interfere with the sample. Notes indicate that in the event there were 2 further urine tests, both taken in September 1996: the first revealed a low level of cannabis break-down products; the second was negative but for evidence of a commonly-used preparation for pain relief. In November Dr Ferris wrote to the vehicle licensing authority that Mr Williams: '…slight cannabis and cocaine use (was) being restricted by random urine testing'. (see section 8 D).

Dr Ferris' note of his meeting with Mr Williams on 30th September 1996 reads, in part:

> 'The fact that he has five girl friends does raise questions about whether possible dealings in cocaine may have some unpleasant connection with his sexual relationships, as suggested by the mother of a woman back in July. He said he had no further contact with her and I have not heard anything from her'.

Until his arrest on the charge of murder Mr Williams avoided further urine tests by a combination of subterfuge and making professionals feel that insistence on the provision would prejudice his co-operation with medical treatment (the monthly depot injections) and contact with his psychiatrist and social worker. It was believed broadly that Mr Williams was untruthful in his denials of substance abuse and, again, emphasis was placed on his seemingly stable mental state. From about mid-1997 Mr Williams' refusal to agree to urine tests ceased to be an issue in his management, although in early 1999 his driving license was withdrawn because a urine test taken at a surgery in Tilehurst on 30th March 1999 (not Mr Williams' own GP) was positive for cocaine.

Mr Hayward wrote in his third written statement to the panel:

'The information about (the caller's) daughter, as communicated to Rob Ferris, was not known to me. I have checked the records and I did not identify any formal communication between Rob Ferris and Richard Dale-Emberton about this matter'.

(Information taken from police statements after the homicide allege that Mr Williams:

- occasionally spent several hundred pounds buying cocaine;
- encouraged cocaine use, and later drug-dependency, in 2 young women from about 1993 and that he attempted to rape one of these women ;
- attempted, in the context of cocaine use and while armed with a knife, to rape a second woman;
- gave drugs to teenage girls;
- requested or demanded sexual intercourse in surrogate payment for drugs.

Blood samples taken after Ms Kazmi' s death, and Mr Williams' arrest, revealed high abuse dose (or doses) of cocaine in her sample and the presence of cocaine metabolites in his).

Comment

1. The warning telephone call followed the fellow-patient's report that Mr Williams had given her cocaine whilst on leave from the Clinic, and was to be followed, in 1999, by the DVLA-instigated positive cocaine testing. Everything in the call had a resonance in what the clinical team already knew about Mr Williams: his known alcohol and cannabis misuse, his violence, mental illness, and other related factors.
2. In the knowledge that Ms A was unlikely to contact the police Dr Ferris made the decision not to notify them of the caller's allegations himself. Dr Ferris' view that the allegation of drug dealing was not a matter for psychiatric and social supervisors but for the police is dealt with in section 12 B. It raises the issue of how the police were to obtain information on which to act. The Home Office view was unequivocal:

   'I wouldn't have thought it necessary to remind somebody who is extremely professional that criminal activity should be reported to the police. Or that the allegation should at least be made (known) to the police'.
3. Dr Ferris and the MHRT recognised that cocaine use greatly increased the risk of relapse and that urine testing must take place. When it became clear that urine testing was not possible nothing was put in place to redress the increased risk which that knowledge brought. In practice clinicians seem to have progressively distanced themselves from an objective assessment of risk in favour of denial and mutual reassurance.
4. No contact was made with the named child protection team worker mentioned in the telephone call.
5. Ms A's recollection was that no-one contacted her after she spoke to Dr Ferris. This is contrary to Mr Dale-Emberton's recollection (unrecorded at the time) that he visited, and Dr Ferris', that the onus was on her to contact him. It also appears from Dr Ferris' note of the 30th September meeting that the caller's identity was known to Mr Williams. The panel do not know how Mr Williams may have come by this information but it raises issues of Ms A's safety.
6. Mr Dale–Emberton told the panel that when he heard of the warning phone call he took the matter **'…very, very seriously'.** The detailed report from Dr Ferris of the call was not copied to Mr Dale-Emberton although Dr Ferris informed Mr Dale- Emberton of the call. There is no mention of the call in any of Mr Dale-Emberton's subsequent contact sheets. There is no reference to the call in the records which Mr Hayward kept of his supervision sessions with Mr Dale-Emberton. Mr Hayward, who later took over the role of social supervisor told the inquiry panel that he had only heard of the call after the homicide.

C. The issue of pathological jealousy.

Mr Williams re-admission case conference was held on 12th December 1985. In the case conference report the consultant forensic psychiatrist who chaired the meeting refers to Mr Williams' 1976 conviction for unlawful and malicious wounding, actual bodily harm, assault on the police and possession of an offensive weapon (a knife), and which resulted in an order for admission to Friern Barnet psychiatric hospital.

> 'The 1976 offence occurred because he believed the victim was molesting his wife or perhaps having an affair with her and the Broadmoor offence (in 1978) also occurred because he believed the victim was having an affair with her'.

Writing from the Wallingford Clinic in December 1994 the senior registrar also referred to the 1978 conviction:

> 'Mr Williams had developed delusional beliefs that his former employer was having an affair with his wife and was showing an interest in his daughter as well'.

Returning to the Broadmoor consultant psychiatrist's conclusion in December 1985.

> 'His delusional jealousy has in the past twice led to serious violence and he is extremely sexually active. I can therefore see history repeating itself in future relationships'.

Dr Bullard refers to this matter in her Wallingford Clinic admission assessment report of May 1989.

> 'He was rather guarded when describing the belief that his wife was having an affair with the victim. This belief must be regarded as a paranoid delusion as it does seem very fixed'.

Mr Dale-Emberton was asked about the issue of delusional jealousy and if he had seen any of Mr Williams' female partners.

> 'I didn't see any evidence of that that I can recall'. (He went on to say that he had seen the woman who later made the accusation of assault and threats to kill and Mr Williams daughter when they visited the Wallingford clinic when Mr Williams was an in-patient).

Mr Hayward was asked about jealousy. (He did not see any of Mr Williams female friends).

> 'It was something that I was aware of in relation to the offence that took place in the late 1970s and the circumstances around that. It was something that I had under consideration, and should any signs or symptoms arise, that would trigger the recalling in my own mind. It is also correct to say that I don't recall having any conversations with Dr Ferris or other people about the issue of pathological jealousy in the ongoing management of Winston Williams'.

Dr Ferris too did not see any of Mr Williams female friends. He was asked if he was satisfied that the necessary importance had been attached to the issue of jealousy after the 1995 discharge.

> '…we didn't overlook or neglect it completely. Maybe we could have done more, but he never spoke about his connections or relationships with any woman in a way that indicated that any of those relationships were important to him'.

Comment

1. The issue of jealousy holds a place of great importance in forensic psychiatry. It is termed pathological (or morbid) jealousy when it exists without evidence of psychosis, and delusional jealousy when it accompanies other symptoms and signs of severe mental illness. It is important because: it can lead to serious harm; it has a tendency to recur in future relationships; its re-emergence can be the first sign of psychotic relapse; sufferers are notoriously secretive and

difficult to manage. Furthermore, clinicians may have a responsibility to warn partners of the risk they face.

2. We have no evidence that the matter played any significant part in Mr Williams management following his discharge from the Wallingford Clinic in 1995. Mr Dale-Emberton did not know about the condition; no-one saw any of Mr Williams girl friends because his pathological jealousy made it important to monitor his relationships. These observations lead to 3 conclusions: some professionals had an inadequate knowledge of the case; communication was poor; risk management was risky.

   Mr Dale-Emberton wrote to the panel about a matter which is not referred to in the case notes:

   > 'The only woman friend he mentioned by her first name was said to have just left a probation hostel. When I tried to get some contact with her or with the probation hostel (Mr Williams) informed me that their relationship had just ended and her clothes being removed from the flat evidenced this'.

D. The allegation of assault and threats to kill.

On 31st October 1997 Mr Hayward, senior care manager, Reading community mental health team, took a call regarding Mr Williams. Afterwards he wrote a memorandum to Mr Dale-Emberton who was then the social supervisor.

> This is to inform you that (Ms B), who I believe to be Mr Williams' ex-partner and mother of their child, took an overdose on 25.10.97 and was admitted to RBH. She was seen by (a social worker) who was covering the liaison psychiatry service on 27.10.97 and although he was unable to get a clear picture of the immediate events surrounding her taking the tablets, which she did while resident at (a) refuge, she told him that she left her flat about 6 weeks ago due to Mr Williams kicking at her door at 3 a.m. and behaving in an abusive way towards her. She alleged that he had beaten her up one week before this incident for reasons unknown to her and that he had also cut her arms. She showed (a social worker) some superficial cuts but it was not clear whether these were self-inflicted or by Mr Williams.
>
> (Ms B) has returned to (the) refuge and although she was offered assistance by the social work department at the RBH, at the time of the assessment she declined this. However, it has since been learned that she has a boy friend who is living with her at her flat but that he works long hours and may be unable to offer the protection from Mr Williams that she feels she requires at the moment. She is undecided whether to return to Reading or not.
>
> The child is safe and (is) currently living with foster parents'.

Mr Dale-Emberton, who said in evidence to the panel that he was '…greatly concerned' by the allegations visited Mr Williams' home on both 31st October and 3rd November: he was not in. On the second visit Mr Dale-Emberton left a note for Mr Williams together with an appointment to attend Fair Mile on 7th November, which Mr Williams also failed to keep. On the 8th Mr Dale-Emberton took a call from the refuge. His notes read:

> 'Mr Williams harassing (Ms B) for past few months for access to son. Mr Williams pulled up next to her when she was walking home in the early hours. Abusive and cut her arms with a bottle which he took from his car and broke; her boy friend found her at home removing glass from her arm. Declined option of court injunction (In his letter of 10th to the Home Office, Mr Dale-Emberton said she wouldn't press charges for fear of retaliation).
>
> Contact with police, refuge and Child Protection Team'.

Mr Williams failed to attend a second appointment with Mr Dale-Emberton on 10th November. On 11th November Dr Ferris and Mr Dale-Emberton attempted to see Mr Williams at his home. He was out; a neighbour was asked if he had noticed any change in Mr Williams' behaviour or demeanour. He said he had not. Mr Dale-Emberton tried to meet with Ms B at the refuge but she declined contact.

On 12th November Mr Williams was seen at the Clinic by Dr Ferris and Mr Dale-Emberton, his 2 supervisors. Mr Williams said that he had had no contact with Ms B or their son for more than a year.

> 'In conclusion both supervisors agree that there are insufficient grounds to justify Mr Williams immediate recall to hospital. There was no evidence of a deterioration in his mental state arising from a recurrence of his mental illness. (He denied recent drug abuse)….Having said all this, my impression was that Mr Williams is probably lying about the incident…' (Dr Ferris to Home Office, 12th November 1997).

On 18th November Mr Dale-Emberton wrote to the Home Office:

> '…Thames Valley Family Protection Unit pointed out chronological inconsistencies in (Ms B's) account and their belief that her arm wounds were self-inflicted'.

After receiving the reports and following discussions with the supervisors the Home Office amended the conditions of discharge on 8th December to include the clause:

> 'You shall not seek to approach, contact or communicate with…and their son, unless through the offices of a legal representative'.

In the Home Office file a note of 28th December 1997 reads: '…we will, of course, need to keep a close eye on all this'. The next report provided by Dr Ferris was dated 17th April 1998, Mr Dale-Emberton having sent one on 29th February.

Comment

1. The inquiry panel failed to trace Ms B.
2. There was a suggestion that Mr Williams spent a lot of time tracing the woman who made the allegation and the Home Office raised the issue of 'stalking' and asked for a risk assessment. In the context of pathological jealousy the whole matter takes on a much more sinister prospect. Dr Ferris' risk assessment concludes with the comment that he does not believe Mr Williams' denial of the allegations. Nevertheless, both he and Mr Dale-Emberton failed to interview Ms B and (perhaps as a consequence) did not recommend recall.
3. While Dr Ferris saw Mr Williams in November 1997, as a result of the allegations, and again in December, he did not do so again until May 1998. This raises questions about the quality of psychiatric monitoring in such a complex case, particularly where the RMO believes that the allegations of assault and threats to kill were true.
4. Mr Dale-Emberton responded promptly to the allegation. He tried, unsuccessfully, to see Mr Williams at home both on his own and with Dr Ferris, and Mr Williams failed office interviews. He phoned the Home Office and later wrote to the case worker:

   > '…in summary we have received convincing evidence of an assault plus threats to kill, but have had no opportunity to date to assess Mr Williams due to his failure to keep appointments'.

   Mr Williams was seen on 12th November and contact with his by Mr Dale-Emberton was increased from 2-monthly to fortnightly until early January 1998.

E. Use of knives.

A Broadmoor Hospital social worker referred in a report to a telephone conversation she had with the woman Mr Williams visited on the day of his suicide attempt in July 1985. A copy of the report is contained in the Reading social work file.

> ' She was a customer at the garage where Mr Williams worked and he gave her special service. She was a community district nurse. On the day of the attempted suicide he visited his wife and took his 12-year old daughter out for the day. She was extremely frightened because he drove very fast and had two accidents, failing to stop after each. In addition, he attempted to break into a garage with a knife. Mr Williams said that if anything happened to him it would also happen to his daughter'.

Mr Jarvis was asked if he was aware that Mr Williams carried a knife. He answered: 'Yes'. Asked to elaborate he said:

> 'Carol Frost (social supervisor 1990-1) told me before that he sometimes carries a knife in his socks. When I went in his flat a couple of times, before I walked in the door I asked if he had any weapons, and he always smiled and said no. So I said, pull your socks down, which he did on 2 or 3 occasions, and there was no knife there, but I understood that he used to go round with a knife'.

One of the women who alleged that Mr Williams raped her said that he did so while armed and in section 6 G & J there are references to 2 police witness statements alleging that Mr Williams always carried a knife; later in the same section the young female reports Mr Williams sharpening a knife and chasing her with it on the day before the murder. A panel-witness was asked if Mr Williams carried a weapon. She told the inquiry panel:

> 'Yes, he was a knife carrier. He was a known knife carrier.
>
> 'All the time?'
>
> 'All the time. He used to get out a little knife at one of my friend's houses and he would sit there and laugh and pick his fingernails out. 'I killer man, I killer man, me, chuck him up and chop him up. Me, I killer man, I am. I'm a killer man'. Because he would want my friend to feel scared – and she did sit there and feel intimidated. He could intimidate people with his knives, that is exactly what he did'.

Dr Ferris said that he was unaware that Mr Williams carried a knife.

Comment

1. Unsurprisingly, perhaps, carrying weapons carries a high weighting in risk assessment schedules.
2. Dr Ferris was Mr Williams' RMO from mid-1993, working for about 18 months with Mr Jarvis who was, at the time, acting as social supervisor. That Mr Williams' knife-carrying was not an issue in Mr Williams' post-1995 supervision reflects significantly on Dr Ferris' ongoing care, and on communication between, and amongst, professional groups.

F. Driving and the DVLA.

Mr Williams left school in Jamaica at the age of 15 and spent 2½ years as an apprentice motor mechanic. He came to England at the age of 17, in 1964 and began working in a garage later that year. Information regarding motor vehicles features regularly in his notes. The DVLA informed the inquiry panel that Mr Williams held a driving licence from at least 9th March 1983 but were unable to provide any earlier information.

(Following Mr Williams' arrest for the murder of Ms Kazmi he was interviewed by the police (22.09.99). The police statement begins by noting that Mr Williams' driving licence was in the

name Sam Williams (the DVLA have no record of this), and gave a date of birth of 03.07.47 whereas his passport was in the name of Winston Delorn Williams, with a date of birth of 30.06.45).

During the index offence in December 1978 he rammed the car of one of his victims.

Just prior to cutting his throat in September 1985, an incident which led to his re-admission to Broadmoor Hospital, he had taken his daughter, then aged 12, out for the day. He apparently drove at high speed, and was involved in 2 accidents but failed to stop. (See section 6 E which discusses the incident).

On 11th March 1990 Mr Williams, while on trial leave to the Wallingford Clinic from Broadmoor Hospital, completed a medical form authorising disclosure of his medical history so he could regain a driving licence. Dr Bullard's senior registrar wrote to the DVLA in March 1990, whilst Mr Williams was still not able to leave hospital without a nurse escort, in support of Mr Williams' application for a driving licence..

On discharge he was working several days each week as a motor mechanic. In January 1991 Mr Williams told his social supervisor that he had changed his Renault to a BMW, losing £700 on the deal and later that year that he had applied to British Rail to be a train driver.

i First licence refusal.

The DVLA wrote to Mr Williams' GP in July 1991 that Mr Williams had a urine test which had proved positive for cannabinoids and that he was to be refused to have a driving licence. The DVLA advised that Mr Williams could re-apply in 6 months time if the drug abuse was controlled and subsequent urine analysis showed no abnormal substances.

Mr Williams informed his social supervisor later in July that he had lost his job as a mechanic although the following month the social supervisor records:

> 'He has a part time job for a garage but says he cannot do much without his driving licence'.

The DVLA wrote to Dr Bullard in October 1991 requesting a medical report in view of:

> '…his psychiatric condition and more recently because of an episode of abuse of cannabis'.

Dr Bullard's registrar wrote to the DVLA later in October stating that Mr Williams was not now abusing drugs, and, following a discussion with Dr Bullard recommended that Mr Williams should have his licence returned. The DVLA returned Mr Williams' licence in November 1991 but it had to be renewed annually.

In June 1992 Mr Williams told his then social supervisor, Mr Jarvis, that he was working 6 days each week in a garage while claiming income support and that he had recently been fined £300 for non-payment of road fund tax. Mr Jarvis informed the Home Office. Later that year the Home Office was informed that Mr Williams was working 3 days each week, and that his car had been stolen. In his report of February 1993 to the Home Office Mr Jarvis noted:

> 'I have had another discussion at our meeting about signing on for income support while he is enjoying full-time employment as a motor mechanic. He said he will take a chance until he is caught. His employer knows that he is claiming unemployment benefit and therefore pays him a low wage but allows him time to go and sign on'.

In August 1993, Mr Jarvis informed the Home Office in his quarterly report:

> 'Mr Williams has had his car broken into yet again'.

In April 1994, Mr Jarvis, again in a report to the Home Office noted that Mr Williams:

> '…is still working at the garage and is also signing on but he seems to think that the job with the garage is getting scarcer these days and cannot cope with the money or the hours his employer wants him to work'.

In his next report in August 1994, he observed:

> ' Mr Williams also showed me his new car, which has a sophisticated burglar alarm, also, he said, £1 600 worth of…stereo equipment…I asked where he got it from and he said he got it "…on the cheap'.

In November 1995, following his discharge from the Wallingford Clinic, he told his community psychiatric nurse that he had saved £700 and was about to buy a car. The following month, Mr Dale-Emberton recorded following a home visit:

> '(Mr Williams) paid £1 000 for a car from a local woman who previously owed him compensation. She smashed his car when borrowing it when Mr Williams was in hospital'.

In early 1996 Mr Dale-Emberton challenged Mr Williams about non-payment of road fund tax after he noticed that he had a beer mat for a tax disc. In June 1996 Mr Williams was driving a VW Golf and had resumed working part-time at a breaker's yard. By September the car was sold and he was driving a Ford diesel pick up belonging to a former employer.

Mr Williams told his CPN in December 1996 that he had bought a Jaguar for £4000 which would cost £700 to insure. Presumably referring to the same car Mr Williams told his social supervisor in January 1997 that he had bought a Jaguar 3.5 for, he said, £5000. When asked by his social supervisor he strongly denied that it had been purchased from '…the proceeds from drug dealing or other illegal means'. Two months later Mr Williams told Mr Dale-Emberton that his car had a fuel pump problem which would cost approximately £400 to repair; he just smiled when the social supervisor asked where he would find the money. In the same interview Mr Williams asked for help in obtaining his driving licence which had been withdrawn on medical grounds (the reasons for which are unclear). A letter from Mr Dale-Emberton to the Home Office at this time concluded:

> 'Mr Williams' ability to purchase and run an expensive car and his proclaimed status of having a number of girl friends, leaves cause for concern in the light of evidence of his past association with drugs, however, I believe these possible deviant activities are not linked with mental illness'.

Mr Williams' driving licence was renewed by the DVLA for 2 years from 22nd January 1997.

Mr Williams informed his social supervisor in April 1997 that his car

was **'…now repaired, insured and MOT'd'** but the following month he reported to both supervisors that his Jaguar needed repair as it had blown up while he was driving at 130 mph on the M4.

In early 1998 Mr Williams had 2 outstanding arrest warrants for a failure to display a tax disc and parking violations. In June 1998 Mr Hayward wrote to Dr Ferris:

> 'Mr Williams was recently involved in a road traffic accident which resulted in the car he was driving being written off. He told me that it was not his fault, that he was waiting to turn right and not moving when his car was hit from behind. He is awaiting payment from his insurance company and with this he will buy another car which he said would make getting to the Wallingford Clinic and other places much easier than had been the case since the accident about five weeks ago. He did not sustain any physical injury because of this'.

ii Driving school transport.

Mr Williams saw Dr Ferris on 18th September 1998. His hand-written notes record (and see section 6 I):

> 'Bus driving job – 2 months ago…private bus hire firm. Up at 6.30; then to school at 9.00am. Escort –like a nurse. Nine kids each morning; 7 stops, several different places. No radio – pick up at 3.15pm. Wokingham breaker's yard too hard. Knew a bloke; said

> he had a vacancy, said start tomorrow. (Name of car firm): 50 to 60 cars. Twenty mini buses; licence covers him…Licence renewal due this year'.

Dr Ferris had seen Mr Williams once that year (1st May) and a report was outstanding to the Home Office (due 17th July). He informed the Home Office in his report of 24th September 1998 that Mr Williams had recently commenced driving school transport.

> 'Hearing of this change in employment, I have considered the risks that might attach to his driving a mini van in this way. Firstly, there is no reason, taking into consideration Mr Williams' past history, to think that the risk of re-offending (presently low) is in any way focussed on or directed towards children. Secondly, the dosage and type of medication he is being prescribed, together with the absence of any side effects, does not mean that he is unfit to drive a motor vehicle or at increased risk of a road traffic accident. However, I note that in a letter to me of June 15th 1998 Mr Hayward mentions a recent road traffic accident in which Mr Williams was involved which resulted in the car he was driving being written off. His account to Mr Hayward was that this accident was not his fault, that he was waiting to turn right and not moving when his car was hit from behind. He sustained no significant physical injury.
>
> It seems to me that if there is any increased risk arising from Mr Williams' work as a driver of a mini van containing school children, it relates to his past history of substance abuse, including cannabis and (on one documented occasion) cocaine. Mr Williams insists that he is not continuing to use illicit substances but he is an unreliable informant. As I have stated before, when giving reasons for pursuing the random drug testing, the only thing that can be said with certainty is that Mr Williams is not using any illicit substances to the point where they have induced a relapse of his schizophrenic illness. In my opinion, if he was using cannabis or cocaine regularly or extensively then his mental state would be unlikely to show its present stability, despite treatment with regular anti-psychotic medication. I intend to discuss this further with the DVLA and Mr Williams' social supervisor but to take no other action in the interim'.

The Home Office's reply to Dr Ferris was dated 30th September:

> 'The Home Secretary is concerned about Mr Williams' current employment. The Home Secretary should be grateful to know whether Mr Williams' employers are aware of Mr Williams' history and if not wishes to know what plans are in hand for informing them.' ' Additionally, the Home Secretary is concerned about Mr Williams' history of drug abuse and his unreliability of self-reporting. In the light of this the Home Office would be grateful to know what plans are in hand for the re-introduction of random drug testing. A reply outside of the normal reporting cycle would be appreciated'.

On 12th October Mr Hayward saw Mr Williams and although there is no record of this meeting it is referred to in his subsequent report to the Home Office.

> 'He told me that he had presented his driving licence to his employers and informed them that he was seeing a doctor and myself on a regular basis'.

Also on 12th October Dr Ferris rang a medical adviser to the DVLA and discussed the driving issues *without revealing Mr Williams' name*. A week later Dr Ferris rang the Home Office case worker and in his record of their conversation noted:

> '…I would not have expected Winston to have given his employers details of his previous history and that he had defaulted on a recent appointment with Mike Hayward who had been going to discuss the whole matter with him. I explained that my understanding of the DVLA regulations, particularly in the light of new legislation which came in within the last year, was that if Winston's details (specifically his history of hospital admission within the past

3 years and the history of one episode at least of cocaine use in the same period) were known to the DVLA he could not retain a licence allowing him to continue to drive a school bus. If he were in a situation where three years had passed since his last admission and since the last definite evidence of drug abuse, then it might be tenable to have him continue driving provided he agreed to a strict programme of random drug testing designed to ensure that he was abstaining from these drugs in the community. However, because of the DVLA regulations this situation does not arise.

Therefore, in short, Winston cannot be allowed to continue in this job and this needs to be explained to him as soon as possible to give him the opportunity to resign and find other work, rather than have us give his details to the DVLA and therefore cause him to lose his job through losing his licence., or have us contact his employer directly and give details of his past history and/or convictions, probably leading his employer to terminate his employment at that point'.

On 4th November, Dr Ferris wrote to Mr Williams asking to see him on 13th November. The meeting was re-arranged for the 20th and Dr Ferris wrote to the Home Office after a joint meeting with Mr Hayward and Mr Williams. The main issues centred on Mr Williams' driving licence renewal and on his employment driving school transport.

'Essentially, the position is that if Winston is driving a mini bus with 8 or more children in it then he needs to apply for a PSV (public service vehicle) licence, to obtain which he will need to sit a bus driver's exam. Before he sits the exam then his application will be processed by a traffic commissioner who has the discretion to call him in for interview, having reviewed the medical information about his past history, and past offences. It is now 3 years since his last admission to hospital (discharge October 1995) and more than 3 years since the episode of cocaine abuse (September 1995) was documented. He has no convictions for drug related offences and no convictions for offences against children. His last violent offence (the end of a series of violent offences) was 20 years ago in 1978. However, he has spent 11 of the past 20 years in hospital and 9 out in the community.

Winston says that at present he is not driving a mini bus but a Shogun in which he picks up 6 children, plus the escort (a woman) who travels with him. He said that he had been driving the 8 seater mini bus but his boss had lost the contract, though he might be getting it back in future.

From my discussions with (a doctor) at the DVLA, it is my understanding that if he is driving a Shogun and collecting no more than 6 children, even if it is for money (which is clearly the case) then he does not require a PSV licence and from the DVLA's point of view they are happy to renew his current licence when it falls due for renewal in December.

…Winston informed me that he has shown his licence to his employer and mentioned to him that he came out to the clinic for monthly injections of Modecate, but had not given him any details about his past history of admissions to hospital or criminal offending.

…After lengthy discussion with (the Home Office case worker) we agreed that it would only be reasonable to allow Winston to continue to do the job that he is doing now…if he would agree to resume random urine testing aimed at ensuring (as far as possible) that he was not continuing to use cocaine or other illicit drugs….When I suggested to Winston that the outcome of my discussions with the DVLA and the Home Office might be that he could only continue in the job if he were to agree to resume the drug testing, his initial response was to say rather unhappily 'Well I'll chuck the job then'.

Dr Ferris went on to say that the issue of providing more information to the employer had been left for further consideration by the Home Office. Dr Ferris concluded:

'The upshot of all this was the following:

1 Winston needs to be given another appointment for about a fortnight's time, rather than waiting 6 to 8 weeks. When I see him at that appointment I will give him the choice of continuing with the job and resuming the drug tests or resigning.

2 After that appointment I will get back in touch with (the Home Office case worker) who will let me know what conclusions the Home Office have reached about contacting his employer and who will also be able if asked at that point to write a letter taking the 'bad guy' role *vis-à-vis* the drug tests if that looks likely to help maintain my satisfactory relationship with Winston.

3 Depending on what Winston decides to do when given the drug test ultimatum, we will need to decide whether he then goes on to apply to the DVLA for a PSV licence or simply renews his ordinary licence, that renewal falling due next month'.

On 3rd November 1998 Mr Williams completed a *Driving Licence Expiry Reminder and Application Form* (received by the DVLA on 9th November) in the 'General Health Declaration' part he ticked 'No' to the boxes 'Any severe psychiatric illness or mental disorder?' and 'Have you in the past 3 years been dependent on or misused illicit drugs or chemical substances?'. In addition Mr Williams completed a form 'M1: About your medical condition' in which he also ticked 'No' to the box 'Have you misused drugs or other chemical substances which have not been prescribed?' Copies of these applications were in Mr Williams' clinic notes along with a copy-letter informing him that he would need an '…authenticator who can authenticate your application/documents'. With these papers is a further page requiring certification that the documents were authentic copies of the originals and that a photograph was of Mr Williams. It was signed by Dr Ferris when he saw Mr Williams at the Wallingford Clinic on 22nd December.

Dr Ferris wrote again to the Home Office commenting that Mr Williams refused random urine tests and had said, angrily, that he would give up his job; he continued:

'My plan is to see him again in 6 weeks and confirm with him then that he had resigned. If his replies at this meeting seem convincing then my feeling is that we will probably need to take no further action (i.e. we do not need to independently verify this) but if you feel otherwise then perhaps you would let me know'.

The Home Office case worker made a file note on receiving the report:

'Whilst giving up a socially useful job is to be regretted, the fact that he refuses drug tests must lead to continuing concern about his abuse of drugs. Whilst strictly not a 'mental health' issue, the idea of a conditionally discharged restricted patient with a history of drug abuse, real or suspected, driving school children is not one which conjures up a reassuring picture. Winston Williams has been stable for some time and is without doubt one of our more able patients'.

The Home Office reply (of 16th January 1999) informed Dr Ferris that a further report was expected before 22nd March. It continued:

'The Home Secretary is content to proceed as you suggest in relation to verification of Mr Williams' resignation from his job. It would be appreciated if you could contact the Home Office on this matter whenever possible'.

Dr Ferris saw Mr Williams next on 22nd January when in notes he recorded:

'Driving declared £70 week. Undeclared. Transport from friend. Employer…Thinking about couriering – post haste. Sold his vehicle on the motorway, DLA letter one month ago – threatening withdrawal. Says boss offered him a job driving stuff instead – 'Doctor told me

he doesn't want me driving children'. Bus only 2 hours per day. £60 per week…Walk distance / gets giddy. My sights are blurred (sic) '.

Dr Ferris next reported to the Home Office in September 1999. He informed the home office that:

'Mr Williams gave up his job after being given a choice by me between doing so or agreeing to have random urine tests to detect possible cocaine misuse'.

The inquiry panel heard evidence from the head of Learning Support in the Educational Services Directorate of RBC. Following the homicide it had come to her attention that Mr Williams had provided school transport to a pupil referral unit. The centre to which Mr Williams drove children had a number of concerns about pupils arriving late and so, on 1st February 1999 they monitored the situation, continuing until 23rd April. She continued:

'What I believe was happening was that Mr Williams was being used at (a transport firm) to fulfil his contract for some of these pupils outside the terms of a contractual arrangement, so it was an informal arrangement. Certainly when I interviewed…he was adamant that he had not used Mr Williams'.

The witness, and the police were satisfied that Mr Williams had been working for a transport firm and, from October 1998 after receivership proceedings, for the re-named transport firm. The witness said that she learned that Mr Williams:

'…had spent some time in Broadmoor, that he was under licence and had been involved injuring a 13-year old boy. On all of those levels quite clearly there was no way in which he could be agreed as a suitable person to be involved in home/school transport. Had there been any kind of checking he would have failed'.

A police witness statement taken after the homicide refers to this period:

'I know that he picked up children from (a named school and the single pupil referral unit). Since attending…one of the teachers told me that Winston used to take children from (the referral unit) and they used to complain about him smoking spliffs'.

And a witness told the inquiry panel:

'A little boy had to wake him at the traffic lights because he was asleep, obviously because he had been on the binge the night before. He wouldn't have had an early night, he would have been doing the stuff. Why was he asleep at the steering wheel? Under the influence of drugs again'.

iii Second licence refusal.

On 10th January the DVLA wrote to Dr Ferris and asked him to complete a medical questionnaire. Dr Ferris was unaware that Mr Williams' driving licence, which had been renewed by the DVLA for 2 years from 22nd January 1997, expired on 21st January 1999 unless renewed before that date. Mr Williams' licence was not renewed; he continued to drive.

Dr Ferris completed the form on 15th February 1999 when he informed the DVLA that Mr Williams was receiving treatment for schizophrenia and had tested positive for cocaine in 1995.

An entry in Mr Williams GP's notes of 8th March reads: 'Drives mini buses. Medical tomorrow'. On 12th April the DVLA advised Mr Williams GP, that his licence has been withdrawn because of a positive urine test for cocaine following a sample taken at Tilehurst Village Surgery on 30th March. On 30th June Mr Williams was seen by Mr Hayward his social supervisor:

'…driving a medium-sized mini bus with perhaps 8 or more seats. There was no sign indicating it was for children'.

In his report of 7th July Mr Hayward informed the Home Office that he had seen Mr Williams driving and copied the letter to Dr Ferris. Dr Ferris saw Mr Williams next on 6th August but had not read Mr Hayward's report. Mr Williams informed him of the positive test for cocaine earlier in the year and that the DVLA had not renewed his licence. Dr Ferris later contacted the DVLA whilst Mr Williams was still with him who confirmed what Mr Williams had said. In a subsequent report to the Home Office he wrote:

> 'He made no attempt to deny the obvious facts and we then had a discussion about the choices facing him. We agree that these were, first, he continues to misuse cocaine and gives up any idea of having a driving licence. Second, he agrees to random testing of his urine, gives up cocaine, and then uses a series of 2 or 3 negative results to support a re-application for an ordinary driver's licence in April 2000 or thereabouts. After briefly hinting that he would be happy to co-operate with urine testing if he knew the dates in advance and then seeing that I would not agree to this, he stated frankly that he would like to go and deliberate about these choices, getting back to me if he opted for random testing…The previous concern about his driving children to school in a van is no longer relevant'.

Comments

1. It was only after the homicide that it came to light that Mr Williams had been driving children to and from school between January and, at least, April 1999 without a licence.
2. The DVLA advised the panel that Mr Williams had no driving convictions or endorsements.
3. Employers not only condoned Mr Williams continuing to work while claiming benefit (and receive payment in excess of the 'therapeutic earnings' limit) but took advantage of the situation by paying him at a lower rate. His social and psychiatric supervisors informed the Home Office which made no comment.
4. Mr Williams ordinary driving licence allowed him to drive transport with a maximum of 16 passenger seats provided it was not 'for hire or reward' (which it was). As from January 1988 the entitlement to drive a vehicle with up to 16 passenger seats not for hire or reward became subject to special application which involves meeting higher medical standards.
5. Since April 2000 RBC have taken direct responsibility for arranging home/school transport and have introduced a number of changes to police checks, contracts and other measures aimed at enhancing the safety of children using home/school transport.

G. Recall to hospital.

Section 5 D iii dealt with the framework of recall to hospital, which is in many senses the central purpose of supervision as a conditionally discharged person. Mr Williams was twice recalled to secure hospitals, in 1985 to Broadmoor after cutting his throat, and in 1994 to the Wallingford Clinic when he became non-compliant with treatment and supervision, subsequently relapsing.

The senior registrar mentioned the subject of recall in response to a question about urine testing.

Q: 'Did you at the time remember thinking that urine tests were important or significant?'

A: 'I felt that they were important in that they would hopefully be discouraging Mr Williams from using drugs if he knew he was likely to be tested, and that he would likely be recalled to hospital should he fail to meet the conditions of the discharge'.

Q: 'Did you understand that he could be recalled for failing to meet the conditions?'

A: 'Yes'.

Q: 'In the absence of a deterioration in his mental state?'

A: 'Yes'

Dr Ferris was asked what his understanding was about the circumstances in which the Home Office could order Mr Williams recall to hospital.

'I'm not sure about this, but I believe there may have been a change relating to case law developments that related in turn to European Court decisions. That more limited the powers of the Home Office in that, whereas before non co-operation even in the absence of other difficulties, such as signs of relapse or anti-social behaviour, could justify a recall. I was told…that their powers of recall had been limited (and) there needed to be some signs of relapse or deterioration before recall could be justified. I am not sure about that.

Because I was uncertain about whether there had been a change, I would have assumed that the non-compliance he had shown in 1994, they could have recalled him in a similar way in 1999 had that occurred'.

In the context of recall Dr Bullard was asked about her understanding of the situation which existed before the homicide.

'Prior to Winston Williams committing this offence, if he had been my patient and he were taking cocaine, and I couldn't find any change in his mental state, I still wouldn't be happy about supervising him in the community. The Home Office could have recalled him – they don't have to give reasons. He doesn't have to have a deteriorating mental state; his behaviour can deteriorate, that's all that matters'.

Mr Hayward's understanding of the circumstances in which Mr Williams could be recalled was also sought. He was asked by the inquiry panel about recall as a response to Mr Williams' driving school transport.

'They might have been able to recall him on that basis as and when that came to light.

In the absence of evidence of deteriorating mental health, could solely offending behaviour justify recall?

'I would like to think that they would have given that some very serious consideration'.

Comments

1. Understanding the circumstances in which a patient can be recalled to hospital is an essential requirement of the supervisors roles. That the supervisors in this case had different criteria for recall may in part be explained by the fact that there was a change in case law concerning recall midway through the last period of conditional discharge.
2. Local Authority Circular (LAC(93)9) Recall of Mentally Disordered Patients Subject to Home Office Restrictions on Discharge fails to mention the criteria for recall.

H. The Home Office and the supervisors.

The Home Office depends on supervisors' reports and the information held on file to make judgements about the use of its powers. *Guidelines* indicates that separate reports will be submitted by the supervisors, at least quarterly. The Home Office operates a bring forward system to ensure that targeted files are reviewed monthly. A Home Office witness told the panel that there was no Unit-wide agreement as to the procedure to be adopted in cases of late reporting by supervisors. The general approach was:

'…you chased three times (i.e. monthly for 3 months) , after which you write a letter of complaint, probably to the chief executive or line manager.'

The same witness said that infrequent reporting was of concern to the Home Office and that there was a case for letters of complaint being sent sooner.

After receiving the supervisors' reports regarding the 'phone call in July 1996 the Home Office records note the allegations in their file and add that the matter was being investigated by the supervising psychiatrist and CPN. A further comment reads '…no other concerns…please acknowledge report and bring forward for next date'. The Mental Health Unit case worker for this period told the panel that he felt there was little more that the Home Office could say than to request a further report in 3 months time.

'We could perhaps have added a paragraph, we look forward to hearing reports about the drug testing, but it is not for us to monitor the professionalism or professional standards of the local care team'.

And with regard to that part of the warning 'phone call which alleged criminal activities the case worker did not feel that it was necessary to:

'…remind someone who was extremely professional that criminal activity should be reported to the police…an allegation of that criminal activity should go to the police…It's always been standard procedure…if they commit an offence…they should stand trial'.

Following the allegations of assault and threats to kill in October 1997 the Home Office file noted:

'…(the RMO expressed the view)…that if this is a result of a deterioration in Mr Williams' mental state, it may well be the case that (he) is back on crack again'.

(And further, recording the case worker's view)…recent developments in this case…have turned out to be eerily familiar'.

After the incident the Home Office files record

(28.11.97)'…we will, of course, need to keep a close eye on all this'.

Following his report of the alleged incident the supervising psychiatrist did not report to the Home Office for 5 months, with a subsequent report again, 5 months later.

On 22nd April 1999 the Home Office file note reads:

'…the annual review is overdue but I would prefer to submit with some recent reports especially given the tone of Dr Ferris' last one (dated 22.12.98). Please chase Dr's report. Thanks.

The Home Office annual review was made on 4th May without an up-to-date supervising psychiatrist's report. It was noted that: there was no suggestion of relapse; Mr Williams' attitude to supervision left a lot to be desired; there was concern about the failure to establish urine testing. However, it was felt that there was little which could be done. After requesting an urgent report on 5th August the Home Office heard from Dr Ferris on 20th September.

The following tables summarise reporting to the Home Office.

Table 6: Dr Ferris' reporting to the Home Office

Report due	Date of report to Home Office
	24th November 1995*
	23rd February 1996*
23rd May 1996	7th August 1996
26th October 1996	10th December 1996
10th March 1997	28th July 1997
28th October 1997	Letters 12th November & 11th December 1997
12th February 1998	17th April 1998
17th July 1998	24th September 1998
24th December 1998	22nd December 1998
22nd March 1999	16th September 1999 (dictated 17th August 1999)

** These reports were written by the female senior registrar*

Table 7: Mr Dale-Emberton reporting to the Home Office

Report due	Date of report to Home Office
Conditionally discharged by MHRT on 30th October 1995 and returned to Lyon Sq. the following day	4th December 1995
4th March 1996	19th March 1996
25th June 1996	1st August 1996
1st November 1996	2nd December 1996
2nd March 1997	17th March 1998
17th June 1997	15th July 1997
15th October 1997	Letters on 11th and 18th November 1997 to Home Office following allegation of assault
18th February 1998	26th February 1998

Table 8: Mr Hayward reporting to the Home Office

Report due	Date of report to Home Office
26th May 1998	29th May 1998
29th August 1998	6th August 1998
6th November 1998	23rd November 1998
23rd February 1999	31st March 1999 (not received by the Home Office until 28th April 1999)
31st June 1999	7th July 1999
7th October 1999	

In his last report to the Home Office dated 7th July 1999 Mr Hayward notes that when he saw Mr Williams on 30th June, Mr Williams told him that he was:

> '…not currently employed in any capacity, that he is taking things quite easily. He has no immediate plans to seek employment …'

Later in the report, under the heading of 'Risk', Mr Hayward adds that when Mr Williams left the appointment, he was: "… driving a medium-sized mini bus with perhaps 8 or 9 seats.'

The Home Office reply to Mr Hayward dated 14th July asked '…if you would let me know your conclusions in due course.' Mr Hayward told the Inquiry panel that he thought Mr Williams had given up taking children to school but:

> "…was still working, perhaps driving adults. I recall that thought very clearly. I was aware that Dr Ferris was due to see him between what turned out to be the last appointment prior to the homicide and my next one. Dr Ferris had a copy of my report with my further concerns and anxieties."

Mr Hayward relied on the fact that he had copied his report to the Home Office to Dr Ferris. He had no discussion about Mr Williams with Dr Ferris and Dr Ferris did not read the report. Until after the homicide Mr Hayward had no further contact with either Mr Williams or the Home Office.

Comment

1. The Home Office may have been reassured by the proposals outlined by the supervisors following Ms A's 'phone call. However, the re-introduction of urine testing did not occur and there is no evidence that further consideration was given to finding ways of reinforcing public protection. The case worker did not contact the supervisors at a later date seeking further information regarding the 'phone call.

   The allegation of supplying cocaine was not reported to the police: the Home Office considered the suggestion too self-evident to be worth making; the supervisors thought the matter was not for them but the caller; the caller had concerns for her safety.

2. After the allegations of assault and threats to kill in October 1997 the Home Office made no additional attempts to secure early, and prompt reporting from the supervising psychiatrist. In evidence a Home Office witness expressed concern at the way in which the case was supervised; there is no casework note confirming this and the view was not passed to the supervisors themselves.

3. On 4th March 1998 the Home Office notes recorded that Mr Williams had been granted conditional bail for handling stolen goods and was further remanded until 31st March. On the 18th March a standard report-reminder was sent to Dr Ferris without any reference being made to criminal proceedings. Too frequently the Home Office acknowledgement of a report was in the form of a standard letter.

   The Home Office sometimes received contradictory information as to the frequency of contact. For example, in 1998 Dr Ferris saw Mr Williams in May and September. Following the second meeting he wrote to the Home Office that he:

   > '…continued to see Mr Williams at approximately 2 monthly intervals. I saw him in May and then again on 18th September 1998 '.

   Mr Hayward made no attempt to visit Mr Williams at home. The absence of a home visit for 20 months before the homicide was a major breach of the Home Office guide for social supervisors which recommended that:

   > 'Meetings should usually take place on the patient's home territory but some meetings away from the home, perhaps in the supervisor's office, may also prove valuable'.

4. Neither of the supervisors were aware that the Home Office undertook annual reviews. (Although in Mr Williams' case it appears that one was undertaken, in May 1999).

5. The Home Office held no internal inquiry following the homicide. Since 1996 four conditionally discharged restricted patients have been the subjects of independent inquiries (Jason Mitchell 1996, Richard Stoker 1996, Luke Warm Luke 1998, Richard Gray 2001). Because many of this inquiry panel's recommendations relating to the Home Office mirror those in the Luke Warm Luke case the Home Office was asked to indicate what consideration had been given to that report. The reply was:

   > 'To conduct a historical review of what was our response to its (the Luke Warm Luke report) recommendations, however, would involve considerable investment of our resources which might better be employed in the management of restricted patients'.

   A Mental Health Unit case work team head who gave evidence to the panel was invited to comment on those sections of the first draft of this report which may contain some criticism of the Unit (as were all witnesses to the inquiry). He replied:

   'I am afraid that I am unable to comment at this stage as we should prefer to see all the recommendations, or a draft management summary of the report, in order to put the

comments you have forwarded in some context. In isolation I believe any comments we make and which the panel take on board may be misleading'.

6. Although it is evident from the Home Office file that they have a bring forward system to ensure that certain files are reviewed monthly, they appear to be powerless to ensure that supervisors provide reports or at all. In any event they were generally reassured by the information provided in each report.

I. Police

i. Home Office liaison.

Although the police do not have a supervisory function in relation to a conditionally discharged patient, they are notified formally by the Home Office of changes in circumstances. A letter was sent to the chief constable of Thames Valley Police on 15th November 1995 (see section 18 appendix E i).

Upon receipt of the notice, the information is put on to the intelligence computer either at headquarters or it is passed to the local police for input by a civilian worker. A record of convictions is also held on the police national computer.

At the same time as the notice is sent to the chief constable a letter was also sent to both the psychiatric and social supervisors notifying them of the details of the discharge and Mr Williams. In the letter to the social supervisor considerably more detail is given about the circumstances of the index offence (see appendices E ii & iii).

The local community police officer did not have details of Mr Williams generally, his mental disorder and past offending were unknown to him. He had not seen the Home Office letter to the chief constable, and commented when asked to read it:

> 'That tells you nothing whatsoever about Mr Williams, does it?'
>
> (He continued) 'No (I have not received any information about Winston Williams or his mental illness) on the morning I came on duty I heard about what had happened in relation to Katie Kazmi, and I was then rooting around to find things about Winston Williams, who was he, what sort of a person was he. I felt it was wrong that I did not know and in some respect should have made some enquiries to find out, but I do not have anything to…work from to ask questions'.

The police national computer recorded that Mr Williams had been conditionally discharged from Broadmoor Hospital but not the Wallingford Clinic. From 1998, it also recorded that he was suffering from schizophrenia.

Comment

1. The Home Office notification to the chief constable concludes with the following:

   'It is important that this information is held in confidence. If you think that anyone else needs to know, you should seek advice from this division'. (See section 18, appendix E i).

   The suggestion is inappropriate and should be replaced with advice in keeping with current risk management practices.

2. A Home Office witness informed the panel that in London the notification procedure has been altered following discussion with the Metropolitan Police and the information is now provided direct to the force intelligence officer. This does not appear to have happened elsewhere in the country.

3. The notification to the local police force by the Home Office is inadequate to enable a proper risk assessment to be carried out by the local police force. It is deficient in the following areas.

It failed, until 1998, to describe the nature of the mental disorder.

It did not provide any contact names and addresses in the event about concern of the individual's mental health or offending behaviour.

It did not fully describe the index offence or other antecedents such as other offences which may be relevant.

It was inappropriately targeted. Details should be direct to the local police force directly responsible for the area in which the patient lives as well as being included on the police national computer;

The introduction of the inter-agency strategy and protocol for the provision and management of dangerous offenders within the community provides an opportunity for further risk assessment and public protection. It is however dependent upon the nature and quality of the actual referrals to the service for its implementation.

Consideration should be given for the involvement of the community beat officer in CPA and other review meetings for the care and treatment of people like Mr Williams

4. The panel heard criticism both about the length of time which elapsed between Ms Kazmi's disappearance and the discovery of her body, and learned that this matter was referred to the Police Complaints Authority. Panel members know that limited information regarding Mr Williams was available on the police national computer, although they have not been able to discover when this was accessed by local police. The panel does not believe that it is within its remit to take the matter further.

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ii. Public protection.

In the months after the murder the question was frequently raised as to how someone with Mr Williams' background could be allowed to roam the streets with impunity. The issue of what was known by the police, is dealt with above. Save for the warning telephone call with allegations about possible drug use and prostitution, and a complaint of domestic violence in February 1998, there were no reports or complaints by members of the public to either the police or those involved with the treatment, care and supervision of Mr Williams. However, what was not known was the extent of his drug use or his involvement with prostitution which only came to light in witness statements following the killing.

Until 1st May 1999 there was no inter-agency strategy or sharing of information and monitoring of dangerous offenders within the community in the Berkshire area. With effect from that date a protocol was implemented. It was known as *The Supervision and Monitoring of Potentially Dangerous People (PDP) in the Community; Inter-Agency Strategy and Protocol.* Those individuals whose antecedents and personal circumstances pose a danger to others were to be the subject of formal inter-agency strategy. The lead agencies are Berkshire Probation Service and Thames Valley Police but involve other key agencies depending on the background of the individual.

The *Protocol* provides for management panels to meet on a regular basis with members of three agencies: probation, police, and social services attending every meeting and other key workers from relevant agencies, as circumstances of the individuals dictate (e.g. general psychiatric or specialist forensic services).

The purpose of the risk management panel is to:

- share information;
- jointly assess risk and its implications for known or potential victims and the wider public;

- devise strategic plans to manage, reduce, and contain an individual's risk and dangerousness;
- contribute to a supervision plan if the PDP is currently under Berkshire Probation Service supervision;
- agree on the frequency of panel reviews how effectiveness will be assessed;
- agree how much the offender is to be told and by whom;
- agree on action concerning any third party issues e.g. victim or potential victim;
- agree and document the role of each respective agency/individual in the management of the case;
- agree media strategy.

This scheme was in operation whilst Mr Williams was living in the community but his details were not referred to that body for consideration and in evidence to the panel professionals said that he did not stand out as someone who they would refer.

Comment

1. Had the social supervisor put himself in a situation where he had adequate information on Mr Williams' social circumstances the judgement of both supervisors may have been that his case should be referred to the PDP panel. (Although for Mr Hayward's part he was at the time not aware that guidelines had been developed as to the nature of the mental health forensic cases that should be referred to the panel).

13. HOUSING

This section gives some details of Mr Williams' accomodation during the 1990s. It also looks at problems experienced with his rent account and the involvement of the clinical team and Reading Borough Council Housing Department in connection with that. His requests for alternative housing, and income derived from employment and welfare benefits are also discussed.

> *'…*housing plays a crucial role in outcome for mentally ill people. Health and social services should ensure that they make housing authorities and providers aware of the mental condition and the level of support which they are likely to need if they are to remain in the community'. (Berkshire Healthcare NHS Trust and Social Service Department (2001) *Care Programme Approach, chapter 16).*

In 1990 Reading Borough Council (RBC) had responsibility for housing homeless persons in its area. When Mr Williams was accepted for housing RBC was provided with the following information in a letter from a social worker in January 1990:

> ' He is currently under sections 37/41 of the Mental Health Act 1983 and would be vulnerable to stress which affects his mental health. (He) needs a permanent base when he leaves hospital as he will be prone to stress. However, he is on a restriction order of the Mental Health Act; after care, overseen by joint health and social services will be very comprehensive, therefore Mr Williams will be followed up and will be in constant contact with support services '.

The housing file was marked 'Ex Broadmoor and Fair Mile patient'.

In November 1990 Mr Williams was conditionally discharged from the Wallingford Clinic. An application made to RBC for housing as a homeless person was accepted and after a short period of living in private rented accommodation, Mr Williams took up tenancy on the Dee Park Estate at Lyon Square in Reading in January 1991. This was a first floor bedsit in a block originally built for single people in employment and without vulnerabilities. The inquiry panel were informed by the housing needs manager from RBC that the profile of the block changed throughout the 1990s in that it came to accommodate greater numbers of more vulnerable persons. Since 1995-6 procedures had been changed and the housing department would now seek to ensure a spread throughout the Borough so that : support services were not overloaded and those with similar vulnerabilities are not housed in close proximity. The allocation of tenancies in Lyon Square are now scrutinised closely before a placement is made.

Mr Dale-Emberton considered that the flat in Lyon Square was:

> '…an appropriate place to go. He had his life skills to do it if he chose to, he could cook, care for himself. He had the ability to manage money although he chose not to pay the bills. He survived in a low sort of standard'.

However, conditions deteriorated and Mr Dale-Emberton found the Lyon Square bedsit **'…pretty appalling'.** He said that he told Mr Williams, who was seeking a housing transfer that:

> '…nobody is going to offer you another place if you keep this like a pig sty, and he did improve it. It was a question of standards; he could do it if he wanted '.

The panel was informed by a number of witnesses that Mr Williams paid little attention to the state of his accommodation. His flat was often in an unsanitary state and although he had self-care skills latterly he failed to cook for himself.

There were 2 main themes during Mr Williams' tenancy of Lyon Square: rent arrears and his requests to move.

A. Rent arrears. Between November 1991 and February 1992 the social services contact sheet records no concerns about Mr Williams' financial position. On 6th February 1992 Mr Keith Jarvis recorded:

> ' I had a look at his gas and electricity bills, they had been paid regularly '.

The first Notice of Seeking Possession for rent arrears was served on Mr Williams in January 1993 and at about the same time he submitted an application for transfer of housing. A suspended possession order was made for rent arrears in February 1994. None of these matters were notified to social services by housing. The panel was told that since 1999 the rents section notifies social services when a warrant for possession is applied for.

Following his second discharge from the Wallingford Clinic a letter was sent to Mr Williams from the housing department on 28th July 1996 advising him that he had breached the suspended possession order made in 1994. (In July 1996 both Dr Ferris and Mr Dale-Emberton had contact with Mr Williams because of the warning telephone call). There is no record in psychiatric, social work, or CPN notes of any awareness of the suspended possession order. In fact on 1st August 1996 Mr Dale-Emberton wrote to the Home Office:

> 'He assures me that his former rent arrears are nearly repaid and that he is currently saving to tax his car'.

The bulk of Mr Williams rent was met from housing benefit although he was personally responsible for a small charge to cover communal heating (£1/week when he took over the tenancy, £6.51 by 1999); he did not agree with this arrangement. On 30th August 1996 a letter was sent from the rent section at RBC advising Mr Williams that his housing benefit had expired in May of that year, had not been reinstated and an application for a warrant to evict was to be applied for if payment was not received in 7 days; again, social services were not informed that this had happened. Throughout his tenancy he was in arrears of rent; he raised the matter with Dr Ferris at the end of September and as a result a letter was written to the housing benefit department in support of both Mr Williams' own statement and the reinstatement of housing benefit. A copy of the letter is in the social services file. The benefit was reinstated and back-dated. Mr Dale-Emberton was asked about rent arrears at the time he was handing the case over to Mr Hayward.

> 'Yes, I was completely shocked because I didn't realise that until I got the records the other day. That was really a shock to me because it was a frequent issue for me to make sure that he was keeping his rent up-to-date. I was surprised because I had contacted the housing department and they knew who I was if they had a problem. I was most shocked when I saw Mike's entry because I thought it was being paid regularly, so he misled me'.

On 21st April 1998 a telephone call was made from RBC to Dr Ferris' secretary advising her that Mr Williams was due to be evicted from his home the next day for non-payment of rent. Several letters had been sent to Mr Williams without reply. The new social supervisor Mr Hayward was informed of the situation and the eviction was cancelled on the basis that social services would be responsible for ensuring that rent arrears were paid. (At the time of his arrest the arrears were £745.61).

Mr Hayward was asked about his involvement with Mr Williams' arrears in the time he acted as social supervisor.

Q: 'Did you have contact with housing in that 18 months?

A: Not in terms of a transfer, but in terms of attempting to initially prevent possible eviction and to broker an agreement between Mr Williams and the housing department concerning the arrears and paying those off on a regular basis. It was something he needed to do, and was something I recall stressing to him on every occasion that we met, and also in my reports to

the Home Office. I think I wrote to Dr Ferris on one occasion saying, the next time you see Mr Williams please stress the importance of him continuing with the payments, for without he will not achieve his aim of moving to be nearer to his daughter and family, which he says he wants to do.

Q: Did you believe at the time that he was paying his arrears?

A: I recall that initially he did not do so, and that subsequently – I think on the second contact with him – I stressed the essential nature of doing that. I don't recall having any further contact with the housing department rent arrears section, believing that if there had been problems, and having made a direct contact with them by 'phone and by letter, I would have been informed straight away. Initially they didn't know that I was involved, hence the call to Dr Ferris' secretary. Subsequently they had my name and knew of my involvement.

Q: So, no contact with the housing department may mean that the arrears are being cleared or it may mean that he is paying the current rent, but we don't know which. You were limited in what you could draw from that.

A: Yes.

Q: If he hadn't been paying any rent and the arrears were becoming worse, were you confident that they would contact you?

A: Yes. On the basis that in similar situations – not with Mr Williams – that was the practice, and it is even more so now.

Q: Looking at it now, do you believe that he was doing anything about clearing the arrears?

A: I don't know. The housing needs manager who gave evidence to the panel referred to these matters.

'Mr Hayward stepped in and said that he would supervise and make sure that a payment for arrears was made, and we didn't receive any payments from that.

(A note on the housing file reads:

' Eviction has been put off. According to Mike Hayward this chap has a Home Office restriction order on him and Mike has agreed to supervise him and report his address. Mike will try to arrange for payment of arrears').

Q: You say that after April 1998 no money was received?

A: According to this (the rent and housing files) no further payments were received'.

Mr Hayward was asked why in his report to the Home Office of 7th July 1999 he had said that Mr Williams was paying his rent arrears off at £8/week when this was not the case? Should he not have contacted housing?

'Absolutely. I assumed that they would be letting me know if there was a problem. When I checked up that he was paying off his rent arrears, I assumed that they would have got back to me. On reflection, you could say that maybe we should have been far more active in involving them because this is an indicator that he isn't conforming to what is required of him'.

On 7th September 1998 Mr Hayward wrote to Mr Williams after hearing from the rent section of RBC that he had not paid any arrears.

'I urge you to begin to pay this amount on a regular basis…evicting you from your housing…is only suspended…THIS IS NOT A MATTER OF CHOICE…it is something you have to do'.

Comment.

1. For the period 1990 to 1999, the housing department did not have any information about the nature of Mr Williams' offending and substance abuse which would be valuable for 3 reasons: the protection of staff; to ensure that the prospective tenant is not allocated accommodation in close proximity to the victim; the protection of other vulnerable tenants. What information it had was never up-dated in line with events (for example, Mr Williams admission to the Clinic in 1994/5); guidelines (the CPA); changing practice (the 1989 assurance that Mr Williams was in 'constant' contact with professionals was never modified).
2. When Mr Williams was re-admitted to the Wallingford Clinic in 1994 there is no evidence that consideration was given to the appropriateness of Lyon Square remaining his home.
3. There is no evidence of a risk assessment having been completed.
4. No joint meetings took place between housing and the mental health teams.
5. The housing department did not inform social services of the deteriorating situation in 1998, only informing them of impending eviction one day beforehand.
6. In April 1998 the social supervisor assured RBC that Mr Williams would clear his rent arrears. This did not happen.
7. The panel agrees with the recommendations contained in Berkshire Healthcare NHS Trust and Social Service Department's *The Care Programme Approach Policy* which deals with the sharing of information in the interests of public safety. Housing needs should be identified and considered at the initial CPA assessment and care planning meetings.

   1 The panel supports the proposal 5.33 in *Reforming the Mental Health Act* that:

   > '…there be a new duty covering the disclosure of information about a patient suffering from mental disorder between health and social services and other agencies (e.g. housing and criminal justice)'.

   The panel notes that such a duty will be framed so that such information is exchanged only in certain circumstances and provided certain conditions are met, for example, if disclosure is necessary in the best interests of the patient or to prevent a significant risk of harm to others.

B. Housing transfer.

The first application for transfer was submitted by Mr Williams on 28th January 1993; support for the application was sent by Mr Dale-Emberton to RBC on 22nd September. On 1st January 1999 Mr Williams completed a second application and as a result he was placed on the transfer list for the over 50s. On 24th March Dr Ferris wrote in support of the application and this evidence of emotional instability, together with Mr Williams agreement to a move anywhere, meant that he was placed fairly high on the transfer list, despite rent arrears.

Comment.

1. Although Mr Williams sought transfer initially to be near his family, and later to be able to accommodate them as visitors their views on these plans were not sought.

14. IN CUSTODY

Reading Social Service Department and Wallingford Clinic staff examined Mr Williams after his arrest on a charge of murder. This section looks at their assessments and the decisions made after discussions with the Home Office and the medical director of Broadmoor Hospital.

A. An appropriate adult.

Mr Williams was arrested at Reading police station on Monday 20th September at approximately 13.00 hours. At 14.30 an approved social worker (ASW) received a call from a nurse on the learning disability team saying that the police had contacted their service requesting an appropriate adult[1] to be present when Mr Williams was re-read his rights. It had already been established that Mr Williams was known to Mr Mike Hayward although with a different date of birth. The ASW spoke to Mr Hayward and it was agreed that she would attend as an appropriate adult. The ASW saw Mr Williams at 15.15 and she found him calm and rational, although reluctant to talk at length. Mr Williams was re-read his rights having refused a solicitor until he saw his ex-wife and daughter. It was agreed that a mental health assessment would be undertaken.

The ASW again contacted Mr Hayward who informed her that he had spoken to: the Home Office, the Wallingford Clinic, and social services' senior management. The ASW also ascertained that if necessary Mr Williams could be detained under a civil section of the Mental Health Act (i.e. as would any person admitted formally to hospital).

B. The forensic medical examiner.

Mr Williams was allowed to speak to his ex-wife on the telephone and then agreed to see a solicitor who he knew. A forensic medical examiner (FME), attended to examine Mr Williams and concluded that he was fit to be both detained and interviewed. The police national computer indicated that Mr Williams had been discharged from Broadmoor, and a police officer spoke to the director of medical services at that hospital. A decision was made to proceed with a mental health assessment .

The forensic consultant psychiatrist, Dr Bullard, was not available when the call was received at the Wallingford Clinic concerning the arrest. (Dr Bullard was standing in for Dr Ferris who was on leave). A specialist registrar in forensic psychiatry took the call. He was an experienced trainee, who had completed many mental health assessments in police stations.

C. First mental health assessment.

The first assessment took place at 15.20 on Tuesday 21st September. Present were: Mr Williams, a social worker, Mr Hayward (the social supervisor), the ASW as appropriate adult, and the specialist registrar. With the exception of what Mr Hayward told him, the specialist registrar had no knowledge of Mr Williams, his remit was clear - to assess Mr Williams' fitness to be interviewed. The specialist registrar and the other assessors agreed that Mr Williams was fit to be interviewed. In addition to denying any involvement in the alleged offence Mr Williams admitted no symptoms which would indicate a relapse of his illness; no signs of mental disorder were found. The consensus was that Mr Williams did not require admission to hospital; he was fit both to be interviewed and remanded in custody to prison if charged. The specialist registrar informed Broadmoor's director of medical services of these views and that a place at Broadmoor would not be needed.

D. Dr Bullard.

Returning to the Wallingford Clinic the specialist registrar met Dr Bullard at about 17.45. The specialist registrar reported his consultant's views as:

> '…when he's really well he's quite charming …(her) thoughts were, irritable, difficult rapport, he has a body in his room for 3 days, he has to be psychotic…anyone who sits around with a body in his room for three days has to be mad .

Although the specialist registrar knew that Dr Bullard had not examined Mr Williams for several years, and that he had himself considered Mr Williams' irritability as possibly a consequence of cocaine withdrawal he did not feel that he could challenge Dr Bullard's view. Dr Bullard telephoned the director of medical services at Broadmoor who again agreed to a bed being available at that hospital, if needed .

Dr Bullard was asked by the panel about the propriety of overriding others' judgements, and if she knew of Mr Williams' cocaine use.

> ' My feeling is that is why I'm a consultant, because I have, or am supposed to have, good judgement about things and can set things up and make this happen.
>
> Mr Hayward isn't qualified to say whether somebody is mentally ill or not.
>
> No, I don't think I knew about his cocaine use'.

The specialist registrar believed there was a second, quite important reason for Dr Bullard's advice:

> '…rather than being a Wallingford Clinic patient he becomes a Broadmoor patient '.

And of the subsequent mental health assessment?

> 'The second interviews were prejudged by the decision to remove him'.

At about 18.30 Mr Williams was interviewed by the police in the presence of a solicitor, and the ASW as appropriate adult. Acting on legal advice Mr Williams answered mostly '**No**' or '**No comment'.**

On the morning of 22nd the Home Office informed the Wallingford Clinic that a second mental health assessment was required in view of the seeming disagreements. A second specialist registrar first learned of the case at a supervision meeting on the morning of Wednesday 22nd September. He was asked to see Mr Williams because the Home Office required:

> '…clear evidence of a deterioration (of mental state) or a clear statement to enable them to lawfully recall a patient. ..I was acting as a proxy for Dr Bullard, and certainly her view was not equivocal'.

E. Second mental health assessment.

At about 12.00 on 22nd Mr Williams was interviewed by the police for the second time: his replies were mostly 'No comment'.

The second mental health assessment was undertaken at 17.00 by the second specialist registrar and Ms Jackie Lee (a forensic community nurse who knew Mr Williams well (see section 10 B). The psychiatrist's assessment summary reads:

> '…Jackie Lee found Mr Williams to be different from his normal self. I found Mr Williams to be a man who appeared anxious, perplexed, pre-occupied, and appeared to be experiencing hallucinations.
>
> In the context of his history and recent events, I think that the only reasonable conclusion to be made is that he is experiencing a relapse of his psychotic illness'.
>
> The second specialist registrar did not consider whether or not cocaine use was affecting Mr Williams' mental state at the time of his interview.

On the basis of the advice given the Home Office issued a recall direction on behalf of the Secretary of State and Mr Williams was re-admitted to a high security hospital at 21.30 from Reading police station. On 23rd Dr Bullard wrote to the Home Office:

'…In my experience it is only patients who suffer from psychotic illnesses or organic dementias who cohabit with dead bodies. I do not think that the fact that Mr Williams presents as 'normal' means that this is the case. Our knowledge of the patient, his illness, his co-morbid drug use and the circumstances of the finding of a body suggest that at the very least Mr Williams should have the opportunity of an assessment in a secure hospital. I do not think that his remand in custody would provide sufficient protection for other inmates or staff in the prison system where his condition would be likely to deteriorate and where there would be a risk of unprovoked assaults on staff and inmates'.

Mr Williams was formally interviewed by the police regarding the death of Ms Kazmi at a high security hospital on 16th November 1999.

Comment

1. The fitness-for-interview assessment on the afternoon of 21st appears to have been undertaken thoroughly.
2. The first specialist registrar discussed his findings with his consultant, Dr Bullard, and her views had a determining influence on the subsequent outcome.
3. Although Dr Bullard had knowledge of Mr Williams she had not examined him recently or received a précis of his mental state and social circumstances. She believed that Mr Williams was in relapse, and that he should be recalled to Broadmoor. The first judgement was, at best, based on limited information; the second was seemingly motivated by a wish to distance the WC from unwelcome publicity.
4. The outcome of the second assessment was from a psychiatric view **'…prejudged…'** and the second specialist registrar saw himself as **'…proxy…'** for Dr Bullard whose opinion was clear and unshakeable.
5. Dr Bullard's judgement was not informed, and she overrode the principle of multi-disciplinary working.
6. Dr Bullard's position made it difficult to consider the appropriateness of: admission to hospital for assessment under the Mental Health Act 1983; a remand in custody. The contribution which substance abuse made to his clinical presentation was not considered, nor was the longer-term influence which recall may have on the issue of criminal responsibility.
7. Dr Bullard's 'insistence' that Mr Williams' behaviour in killing Ms Kazmi must have been driven by mental illness is both an example of a circular argument (he must have been ill because he killed; he killed because he was ill), and a reversal of earlier assurances by his psychiatrist and social supervisors, namely, that his anti-social behaviour was not a reflection of a relapse of his disorder.

NOTE

1. Where the arrested person is considered by the police to be mentally disordered or mentally handicapped, the police must request the attendance of an 'appropriate adult' who might be 'a relative, guardian, or other person responsible for his care or custody; someone who has experience of dealing with mentally disordered or mentally handicapped people but who is not a police officer or employed by the police (such as an approved social worker as defined by the Mental Health Act 1983 or a specialist social worker); or failing either of the above, some other responsible adult aged 18 or over who is not a police officer or employed by the police'. (Code C, para. 1.7b, Police and Criminal Evidence Act 1984, Codes of Practice, revised 1995).

The role of the appropriate adult is 'first, to advise the person being questioned and to observe whether the interview is being conducted properly and fairly, and secondly, to facilitate communication with the person being interviewed'. (Code C, para. 11.16, Police and Criminal Evidence Act 1084, Codes of Practice, revised1995).

15. RESPONSES TO HOMICIDE

An Internal Inquiry was set up by Oxfordshire Mental Healthcare Trust which had just taken over the management of forensic services for Berkshire and Oxfordshire. This section describes the process of the Internal Inquiry which considered the supervision of Mr Williams by staff from health and social services and reports their recommendations. It also considers the responses to its recommendations by other agencies.

A INTERNAL INQUIRY.

'If a violent incident occurs, it is important not only to respond to the immediate needs of the patient and others involved, but in serious cases also to learn lessons for the future. In this event action by local management must include an immediate investigation to identify and rectify possible shortcomings in operational procedures (our emphasis), with particular reference to the Care Programme Approach'. (Para. 33, *Guidance on the Discharge of Mentally Disordered People and their Continuing Care in the Community,* Department of Health, May 1994).

At the beginning of September 1999, just over 2 weeks before the homicide, all of the forensic service, providing for both in-patients and those in the community were transferred from West Berkshire Priority Care Services NHS Trust to Oxfordshire Mental Healthcare Trust (OMHT). Ms Janet Godden, who had been non-executive director, OMHT since 1997 was asked to lead the Internal Inquiry[1] by the Trust's chief executive, Ms Julie Waldron. Ms Godden told the panel that a decision was taken to have as a member an external consultant forensic psychiatrist, from Three Bridges Secure Unit, Southall, Middlesex who had acted in a similar capacity in the *Inquiry into the Care and Treatment of Darren Carr* (Berkshire Health Authority, April 1997); he was approached and agreed to act. Ms Godden understood that the external psychiatrist had been proposed by Dr Ferris to act both as an independent adviser and a support for himself.

Ms Godden told the panel that she saw the role of the Internal Inquiry as being:

> '…to find out what had happened rather than to make judgements about it, which I knew from the onset would be the role of the (independent inquiry)' .

In a letter to the independent inquiry Ms Godden made clear her view that the Internal Inquiry's format was of round table discussions as opposed to a panel taking evidence. Furthermore, it had been her intention that Mr Hayward would participate (like Dr Ferris) but:

> '…Ms Handley told me over the telephone that she would prefer to attend the Internal Inquiry herself, rather than allow Mr Hayward to come'.

The Internal Inquiry heard from Dr Ferris, Mr Roger Winter, general manager, (mental health) West Berkshire Priority Care Services NHS Trust, and Ms Gill Handley, social services manager. Ms Handley told the Inquiry panel that she had completed an internal management review of the files for Reading Borough Council which she shared with the Internal Inquiry. She described how she was:

> '…invited to come along and it was all people around the table, including Dr Ferris. It didn't bother me, but I was left in the position of having to criticise his practice with him sitting in front of me, because I can remember exactly what his response was. The findings from that were very much toned down, certainly from my report and I made some comments on that and never really saw it again after that until the published one, which I got much later on.'

A draft version of the report was considered by the OMHT on 3rd November 1999. The final report was clearly laid out and promptly completed. Criticisms of psychiatric and social supervision were limited and had an emphasis on social work practice. It was sent by Ms Waldron to Berkshire Health Authority on 11th November 1999, when she sought a decision on the report's distribution.

The report made a number of important recommendations and the action taken was reported to the inquiry panel by Ms Waldron. (Both are reproduced below).

i. Recommendations of the Internal Inquiry (November 1999).

1. Care plan monitoring.

   The Care Programme Approach should be fully implemented in all cases. Regular recorded multi-agency meetings should be held perhaps as often as three-monthly, which is the rule in some trusts for section 37/41 patients. The patient, and where appropriate his carer, should be present for at least part of the meeting. The review should consider all elements of the care plan, with the aim of ensuring that social and environmental factors affecting the patient's well being are not overlooked. Changes in key worker should be formally recorded. It would be hoped that such reviews of the care of restricted patients could allow scope for considerations of positive rehabilitation issues, rather than concentration on statutory reporting. They would also enable medical and social staff new to a case to understand its background and special features, and facilitate the patient's acceptance of new care staff.

   Action taken: the CPA is now fully implemented in all cases and, for forensic community out-patients, whether subject to a restriction order or not, the CPA meetings take place at 3-monthly intervals with the patient, and where appropriate his or her carer, who is invited on all occasions.

2. Home visiting.

   This is a statutory requirement on social supervisors, in recognition of the inherent danger of potentially violent patients living entirely alone, often in low-cost accommodation and perhaps with anti-social neighbours. Home visiting allows conditions to be assessed which may reflect the patient's mental state and social functioning. This requirement should therefore always be adhered to. Furthermore it is recommended that patients with a history of violence should normally be visited by 2 people.

   Action taken: this is a matter for social supervisors and their line managers but it happens in all cases where social workers, whether or not acting as social supervisors for restricted patients, are seeing Oxford Clinic/forensic community patients. The recommendation that patients with a history of violence should normally be visited by 2 people has not been fully implemented. The majority of the service's patients have a history of violence and it is not always practical to have visits by two people as a matter of routine. Often, patients are visited by a CPN and social worker turnabout (alternating weeks or fortnights).

3. Frequency of supervision.

   It is recommended that Home Office guidelines on supervision and after-care should also be strictly adhered to. For restricted patients these guidelines require at least monthly meetings with the social supervisor and a minimum of quarterly meetings with the psychiatric supervisor., in order to meet the requirement, which should be complied with, of quarterly reporting to the Home Office. In addition it is recommended that CPN involvement should be maintained for restricted patients.

Action taken: the guidelines regarding the frequency of contact between conditionally discharged restricted out-patients and their psychiatric and social supervisors are strictly adhered to in all cases. For the West Berkshire team, monthly meetings are held involving the medical staff, social worker, and CPN, to review all out-patients who are in regular contact with the team. The aim of this meeting is to ensure that all patients are being seen and appointments sent regularly or to share information about why this is not happening (e.g. poor compliance), as well as to review CPA compliance.

4. Revised protocols with Thames Valley Police (TVP).

   It is realised that supervision in the community for patients using illegal drugs and/or with a record of violence would benefit from a fuller sharing of information with the police authority. This could be done either through the use of 'Potentially Dangerous People' panels which exist in some authorities, or by increased reporting in specific cases. TVP are in agreement with this view.

   Action taken: the West Berkshire team have held meetings with police officers from the area intelligence team based in Reading. It has been agreed that rather than working through the 'potentially dangerous people' panel, we will hold regular quarterly meetings with the officers from the area intelligence team. We will also provide them with written summaries containing brief information (including names) and a risk assessment in summary form, relating to all the forensic community out-patients in regular contact with our service. Also, in some special cases, we have had police attend a CPA review meeting for Oxford Clinic in-patients.. This liaison arrangement will soon be extended to the Newbury area intelligence team (thereby covering all of the West Berkshire sector). Consultants covering the East Berkshire sector and Oxfordshire are considering appropriate arrangements for their liaison with the police.

5. Improved record keeping.

   Additional training may be useful for support staff responsible for the maintenance of medical records; reminder systems of overdue supervision appointments or CPA reviews may need tightening and electronic records could help here. Psychiatric and social supervisors should be reminded of the importance of keeping file notes of telephone calls with partners from other agencies, including the Home Office. Where certain records have to be kept separately, a photocopy should be placed on the main file. In the case of restricted patients consideration may be given to carrying out a quarterly reconcile of electronic records of contact and file reports.

   Action taken: as above, monthly meetings of the out-patient team serve to operate as reminder systems of overdue supervision appointments and/or CPA reviews. We will introduce a quarterly reconcile of electronic records of contact and file reports in relation to restricted patients.

6. Contact with carers.

   The lack of the input of a family carer should not be under-estimated, although it is acknowledged that undue burdens cannot be placed on family members living at a distance, or who have no regular links with the patient. Consideration should be given to the possibility of telephone contact with the named carer before care plan review.

   Action taken: we are trying to place an emphasis on involving carers wherever possible through contact with social workers or social supervisors, in relation to care plan reviews of both in-patients and out-patients.

7. Issues of ethnicity.

It would be good practice for patients from ethnic minority cultures to be offered periodic support from a care worker from their own culture. (It was not felt, however, that issues of race were central to the case under review, nor is there any suggestion of staff insensitivity to these issues).

Action taken: we have not so far taken any action in relation to this last recommendation but it is under active consideration by the management team from the forensic service. The management team will be discussing how to implement it before the end of the financial year.

Mr Roger Winter told the inquiry panel:

> '…that (his) Trust made no formal response to the recommendations in the Internal (Inquiry) report. The Trust only received a draft copy…it was looked at in the context of work going on…it has not been formally considered'.

The Home Office were informed by Berkshire Health Authority on 24th May 2000 that the report of the Internal Inquiry was completed in November 1999 and:

> '…shared with the South East Regional Office (SERO) of the NHS Executive. In liaison with SERO, we felt that there were sufficient flaws in the care given to Mr Williams to warrant an inquiry, i.e. there are lessons to learn from this incident which should be made public. SERO agreed that an inquiry would be necessary'.

The following day a detailed briefing note was sent to the junior Home Office minister which repeated that an Internal Inquiry had been undertaken. However, a copy of the Internal Inquiry report was never requested by the Home Office. A senior Home Office civil servant at the Mental Health Unit updated the Home Secretary in July 2000 that the membership of the independent inquiry panel was being finalised. He recommended:

> '…(that) until the independent inquiry (panel) submits its report it is not possible to comment on what may have gone wrong with Mr Williams and the supervision to which he was subject'.

The civil servant told the inquiry panel that he was not aware that there had been an Internal Inquiry until we interviewed him in February 2001. Even if the Home Office had obtained the Internal Inquiry report and used it to inform the Home Secretary, key elements may not have been clear without further contact with the supervisors (e.g. that the last home visit was 18 months before the homicide; the true frequency of contact). The Mental Health Unit witness reviewed the Home Office file following the homicide and told the panel that:

> '…as I read the circumstances, the response was appropriate in the light of the information that we were getting. Clearly, there was not satisfaction with the delays in the reports but when the reports came – until the last one, which would have raised concerns about the van and also the cocaine again – they had been fairly soothing, albeit they drew attention to pointers of concern. There was no request by the RMO for…Home Office involvement…The way the Home Office responded, it was appropriate given that this was not an easy person to handle'.

Comments

1. 1994 DofH *Guidance* imposes a responsibility to hold an immediate investigation **'...to identify and rectify possible shortcomings in operational procedures…'.** The Internal Inquiry would have known that the independent inquiry panel could only be appointed after the conviction of the accused, and that it would then be about 2 years before a report appeared. Given the nature of the case, were round table discussions, in the absence of one of the 2 professional supervisors closely involved in the case, appropriate?
2. The individuals who participated in the Internal Inquiry were uncertain of their status: whether as members, 'participants' (being the term used in the Internal Inquiry report), or witnesses.
3. The Internal Inquiry report was produced promptly and we support all its recommendations.
4. Panel members believe that the social and psychiatric supervisors roles and responsibilities in the case were both shared and different. Whilst the intention had been that both would be present in round-table discussions to establish what had happened (i.e. how the Internal Inquiry perceived its role), in the event only the psychiatrist was present. (Because the social supervisor's manager stated that she should attend rather than the senior social worker who had acted as supervisor).

   The social worker faced disciplinary proceedings. Several witnesses put to the panel the point that this was inequitable to both parties. To the psychiatric supervisor on the ground that he shared (at least) responsibility for the case management, while his partner in that process was disciplined for his contribution to the management of the case. How could the social supervisor be disciplined without raising doubts about the psychiatric management? To the social supervisor who was excluded by his manager from the Internal Inquiry process.
5. Although the Home Office knew of the Internal Inquiry report's existence, no copy was requested by the case worker or his line manager. And, as has been mentioned in section 12 H, the Home Office undertook no internal objective review of the facts of the case to see if there were any matters which needed immediate rectification).
6. That West Berkshire Priority Care Services NHS Trust did not formally consider the Internal Inquiry report is difficult to believe, but the independent panel heard that the final report was not sent to the Trust, and it was not requested. The CPA co-ordinator did not even know that an Internal Inquiry had taken place. She said:

   'As the CPA co-ordinator, I would have expected that if there were issues around CPA and we hadn't complied…I would like to have been told where I had fallen down in my job'.

B. Developments in Reading Social Services Department.

Ms Emmons told the panel that the conclusions of an internal social services investigation, confirmed later by the findings of the Internal Inquiry, led to disciplinary action having been taken against Mr Hayward. The internal investigation also led to an action which is summarised below. (The plan was sent to the panel on 12.07.01, and updated on 21.01.02).

1. We have produced a new approach to case recording system with a clear set of standards for case recording and file management. During supervision, practitioners must produce case files for review by their supervisor against those jointly agreed standards. This applies to staff from both Reading Borough Council and Berkshire Healthcare NHS Trust who are subject to the process. From this the team manager produces a monitoring report to the respective locality manager on a quarterly basis.
2. The line of supervision has now changed within our teams. The senior social worker with forensic lead in the community mental health team gives supervision and support to staff

with forensic cases and undertakes a quarterly review of all forensic cases, with particular focus on those service users subject to ss. 37/41 (MHA 1983). The review examines case files, reports to the Home Office and overall practice of the social supervisors. A quarterly report is produced for the team manager and locality manager.

3 The community mental health team now holds monthly ASW meetings and time is set aside in these meetings to discuss issues of practice and provide peer support and advice on the management of complex and difficult cases. This has been specifically audited since December 2001 and is ongoing.

4 Stronger community links with other agencies in the Borough have been established. The development of a protocol between community mental health team and housing department was introduced in February 2001. In addition key members from the community mental health team including senior practitioners attend regular community liaison meetings. These are held at the Advice Shop on the Dee Park estate where the homicide took place. These meetings provide an opportunity for all agencies and professionals working in the area to meet and discuss relevant issues. The community mental health team is looking to work with other teams to establish similar forums in other parts of Reading.

5. The community mental health team has now implemented a Patch Based model. This involves team members covering specific areas of Reading and is intended to further advance the relationship-building process between agencies and the communities they serve. Accomodation is currently being reviewed in an effort to determine whether or not a number of physical bases can be developed and sustained within Reading.

6 Reading community mental health team staff who are social supervisors have linked up with colleagues in Oxfordshire to establish a social supervisors' forum which meets quarterly. The meetings cover issues of practice, legislation and discussion of cases. The meetings are also the basis for further training in the area of social supervision duties. These meetings have been specifically audited since December 2001.

7. As a result of the revised Department of Health guidance regarding the Care Programme Approach a full review of the local CPA policy has been undertaken. A revised policy has been issued, underpinned by mandatory training sessions for staff. There is a continuing programme of training. In addition this new policy has an integral risk assessment which is now applied across the board.

8. The Medium Secure Unit Liaison Unit meeting has been re-established. This is designed to bring together all parties across Oxfordshire, Berkshire, and Buckinghamshire who have an interest in secure provision.

9. The lead forensic worker attends the Reading Potentially Dangerous People Risk Management Panel. This is an ongoing forum and offers a local monitoring system of known people within our services and ensures that there is a regular review and updating of issues when they emerge. This facilitates planned action and a far more proactive approach to our tasks than the historical approach.

10. The lead forensic worker, the team manager and the locality manager routinely attend the Thames Valley Mentally Disordered Forum quarterly in order to promote links with other agencies and receive updates on regional developments. This maintains an awareness of future intentions and ensures that planning is a widely owned process.

11. Reading community mental health team has participated in a regional Department of Health project looking at the development of risk assessment tools and competencies for workers and employing agencies. This work is ongoing and forms part of our continuous review of our services and practices.

16. RECOMMENDATIONS AND ACTIONS

In section 15 the immediate organisational responses to the homicide were outlined. This section covers the feed-back process, begun when the first draft of the independent panel's report was available. It identifies what has been done, what is being done, and what is required to be done.

In December 2001 the first draft of this report was completed. In accordance with both what had been said to witnesses and usual practice individuals who had given evidence to the independent inquiry were circulated in early January 2002 with those parts of the draft report when the report contained comments which could be construed as being critical of their practice. Others were sent those parts of the report which required facts to be checked. Replies were sought by late January 2002. Home Office Mental Health Unit staff did not reply.

All responses were considered by the panel: errors of fact were corrected; comments and judgements which were challenged were re-considered and the text altered where it was deemed appropriate. The latter sections of the report generated comments and recommendations and these are listed below. They are brought together under headings which indicate to which agency they are directed. There are duplications because recommendations apply to more than one agency. The previous sections of this report contain comments which are pointers to good professional practice: they are not repeated below.

That there are relatively few recommendations reflects the fact that there are national guidelines and protocols in existence (albeit sometimes dated) for the supervision of conditionally discharged restricted patients.

A. Department of Health

1. The Department of Health and the Home Office in conjunction with the relevant professional bodies should formulate guidelines for the testing for substance misuse with restricted patients.
2. The DofH and The Home Office should prepare a model information leaflet for the use of professionals (including housing), family and carers who are involved with conditionally discharged patients. The leaflet should explain the patient's legal status and contain the names and contact information for both supervisors and those others involved in the care plan. It should request that the supervisors are contacted if there are any concerns about risks to the patient or others. The leaflet should be revised where necessary at the annual review.
3. All agencies should review their current policies and procedures in the light of this report.

B. Driver and Vehicle Licensing Authority

1. The parts of this report relating to driving should be formally considered by the DVLA and Reading Borough Council Learning Support Service so as to consider any necessary improvements to these services.
2. The trusts' risk management policy should require consideration of whether:
   - the individual is a driver with access to a car;
   - driving for that individual would give rise to a significant risk;
   - the risk is such that advice is given not to drive;
   - carers and significant others should be informed of the advice;
   - any other steps should be taken to reduce the risk, including an exchange of information with the DVLA.

C. Health Authorities/ Primary Care Trusts

1. Trusts and social services should ensure that there are both qualitative and quantitative audits of the implementation of local CPA guidance.
2. The trusts should consider the desirability of including in CPA documentation a note of the advice given to the patient on driving.
3. The trusts' risk management policy should require consideration of whether:
   - the individual is a driver with access to a car;
   - driving for that individual would give rise to a significant risk;
   - the risk is such that advice is given not to drive
   - carers and significant others should be informed of the advice
   - any other steps should be taken to reduce the risk, including an exchange of information with the DVLA.
4. All agencies should review their current policies and procedures in the light of this report and in accordance with clinical governance policies.
5. The Health Authorities or their successors should indicate to the relevant bodies their intention to review the progress of this report's recommendations, initially at 6-months. The inquiry panel members should be included in this review.

D. Home Office

1. Restricted patients should be seen by a consultant psychiatrist acting as psychiatric supervisor. If seen by a specialist registrar there should be regular, recorded consultant supervision.
2. There is a confusion in *Guidelines for Psychiatric Supervisors* in the use of the terms 'consultant' and 'supervising psychiatrist'. These should be clarified, particularly with regard to specialist registrars.
3. All parties should understand the context in which conditions are attached to restricted patients' discharge by tribunals, or are added to by the Home Office. The Home Office should issue guidance on the standing of conditions when there may be no sanctions in the event of breach.
4. The Home Office and the DofH in conjunction with the relevant professional bodies should formulate guidelines for the testing for substance misuse with restricted patients.
5. The Home Office should take urgent action to ensure that current supervisors have a clear understanding of the grounds for recall. Furthermore, the Home Office should establish a system of informing supervisors of changes in the law relating to conditionally discharged patients, and of the implications.
6. Home Office *Guidelines* should be brought up-to-date urgently. There should be a single document in a form where supplements and amendments can be easily inserted.
7. In emphasising the Mental Health Unit's supervisory role with restricted patients the Home Office should underline the requirement that information it is sent is comprehensive and objective, and, by implication, sometimes , unfavourable.
8. The Home Office response to supervisors' reports should reflect the reports' contents rather than merely acknowledging their receipt.
9. The Home Office should require that supervisors' reports contain information on: the frequency and venue of meetings; home and work circumstances; the views of the care team other than the supervisors.

(*Home Office continued)*

10. The Home Office should require supervisors to undertake an annual case review, with a particular emphasis on long-term goals. Reports of these meetings should be considered by the Home Office at its annual review, together with that year's CPA and case-conference records.
11. The Home Office should establish a system of notifying the appropriate director of either clinical services or social services where reports are late.
12. The Home Office should ensure that the chief constable's letter contains a summary of the index offence (c.f. the social supervisor's) and a précis of other convictions, and direct that: the information is copied to both the police national computer and local force intelligence; such information should only be inputted or deleted under the supervision of the force mental health police liaison officer.
13. In its review of *Guidance* the Home Office should include the recommendation that all conditionally discharged patients are considered by Potentially Dangerous Persons Panels.
13. The Home Office and the DofH should prepare a model information leaflet for the use of professionals (including housing), family and carers who are involved with conditionally discharged patients. The leaflet should explain the patient's legal status and contain the names and contact information for both supervisors and those others involved in the care plan. It should request that the supervisors are contacted if there are any concerns about risks to the patient or others. The leaflet should be revised where necessary at the annual review.
14. All agencies should review their current policies and procedures in the light of this report.

E. Reading Borough Council Housing and Learning Support.

1. The parts of this report relating to driving should be formally considered by the RBC Learning Support Service and the DVLA so as to consider any necessary improvements to these services.
2. A local protocol should exist between joint mental health services and housing agencies (at a senior level) to facilitate the CPA and local service provision processes.
3. Social services should ensure that housing providers are aware of the importance of giving early notification of any management problems or rent arrears.
4. Where restricted patients are recalled to hospital social services should ensure that there is a joint assessment of the continuing housing needs including consideration of the appropriateness of the previous placement.

F. Social services

1. All parties should understand the context in which conditions are attached to restricted patients' discharge by tribunals, or are added to by the Home Office. The Home Office should issue guidance on the standing of conditions when there may be no sanctions in the event of breach.
2. Social services and trusts and should review the standard of recording, and consider adopting a system of unified records.

(Social services continued)

3. Social services and the trusts should have an untoward incident policy which should include the requirements:
   - all documents are sequestered by senior management;
   - a replica of the originals should be collated which acts as a master copy for any further duplication..
4. Social services and trusts should establish a system of random audit to ensure that Home Office *Guidelines* are followed.
5. Social services and trusts should ensure that there are both qualitative and quantitative audits of the implementation of local CPA guidance.
6. Tertiary services should follow local CMHT models for the integration of records.
7. Social services and trusts should ensure that there is an adequate administrative support system for CMHTs.
8. Social services and trusts should consider the desirability of including in CPA documentation a note of the advice given to the patient on driving.
9. Social services' and the trusts' risk management policy should require consideration of whether:
   - the individual is a driver with access to a car;
   - driving for that individual would give rise to a significant risk;
   - the risk is such that advice is given not to drive
   - carers and significant others should be informed of the advice
   - any other steps should be taken to reduce the risk, including an exchange of information with the DVLA.
10. Where restricted patients are recalled to hospital social services should ensure that there is a joint assessment of the continuing housing needs including consideration of the appropriateness of the previous placement.
11. A local protocol should exist between joint mental health services and housing agencies (at a senior level) to facilitate the CPA and local service provision processes.
12. Social services should ensure that housing providers are aware of the importance of giving early notification of any management problems or rent arrears.
13. Trusts should ensure that there are policies on, and staff training in, the subject of appropriate disclosure of confidential information.
14. In order that adequate care can be maintained the trusts and social services should ensure that hand-over procedures are developed to enable all staff to be fully acquainted with the patient's history and care plans. Hand-overs should not be merely oral.
15. All agencies should review their current policies and procedures in the light of this report, and in accordance with clinical governance and performance management policies.

G. West Berkshire Priority Care Services NHS Trust (now BHT) and Oxfordshire Mental Healthcare NHS Trust

1. Restricted patients should be seen by a consultant psychiatrist acting as psychiatric supervisor. If seen by a specialist registrar there should be regular, recorded consultant supervision.
2. All parties should understand the context in which conditions are attached to restricted patients' discharge by tribunals, or are added by the Home Office. The Home Office should issue guidance on the standing of the conditions when there may be no sanctions in the event of breach.
3. The involvement of nurses in monitoring the mental state of an out-patient should only occur in the context of a full CPA process, with a clear and achievable purpose, full recording and recorded evidence of regular feed-back to the MDT.
4. The trusts should issue a policy statement in regard to the role of forensic CPNs in generic teams.
5. The trusts should ensure that CPA documentation contains a section referring to dual diagnosis. Where appropriate reasons should be given why a decision was made **not** to refer the patient for a specialist substance abuse assessment.
6. Trusts and social services should review the standard of recording, and consider adopting a system of unified records.
7. The trusts should take urgent action to review clinical files and establish a universal system highlighting, and regularly reviewing: a basic chronology; a risk management plan including relapse profile; a care plan and clinical reviews.
8. The trusts and social services should have an untoward incident policy which should include the requirements:
   - all documents are sequestered by senior management;
   - a replica of the originals should be collated which acts as a master copy for any further duplication..
9. Trusts and social services should establish a system of random audit to ensure that Home Office *Guidelines* are followed.
10. Trusts and social services should ensure that there are both qualitative and quantitative audits of the implementation of local CPA guidance.
11. Tertiary services should follow local CMHT models for the integration of records.
12. Trusts should ensure that there is an adequate administrative support system for CMHTs.
13. The trusts should consider the desirability of including in CPA documentation a note of the advice given to the patient on driving.
14. The trusts' risk management policy should require consideration of whether:
    - the individual is a driver with access to a car;
    - driving for that individual would give rise to a significant risk;
    - the risk is such that advice is given not to drive
    - carers and significant others should be informed of the advice
    - any other steps should be taken to reduce the risk, including an exchange of information with the DVLA.
15. Trusts and social services should ensure that there are policies on, and staff training in, the

(BHT & OMHT continued)

subject of appropriate disclosure of confidential information.

16. In order that adequate care can be maintained the trusts and social services should ensure that hand-over procedures are developed to enable all staff to be fully acquainted with the patient's history and care plans. Hand-overs should not be merely oral.

17. All agencies should review their current policies and procedures in the light of this report, and in accordance with clinical governance and performance policies.

H. Preliminary responses

In early December 2001 panel members met separately with representatives of the main organisations which have an interest in the independent inquiry's findings: Berkshire Health Authority, Berkshire Healthcare NHS Trust, Reading Borough Council Social Services and Housing, and Oxfordshire Mental Healthcare NHS Trust. The Home Office declined an invitation to meet with the panel. The main findings of the panel were communicated verbally and invitees asked to respond in writing to 7 main points. (Two additional points were put to social services). The areas covered are given below together with the responses. The responses have been summarised and both arranged and colour-coded according to what has been done (green), what is in the process of being done (grey), and what is to be done (red).

1. The trusts' generic services should also have responsibility for the forensic service in the following areas: clinical governance, CPA co-ordination, and clinical audit.

Oxfordshire Mental Healthcare NHS Trust.

(Green) The forensic service is one of our clinical services managed as part of the directorate for specialist services. The service director and directorate management team ensure that the arrangements in place for clinical governance and clinical audit are robust and subject to on-going review. In turn the forensic services operates audit and clinical governance forums which feed into the directorate and Trust structures.

In addition to this the service director for specialist services is the nominated service director on the Trust's clinical improvement committee which directs and oversees clinical; governance issues under the leadership of the medical director.

The Trust has recently introduced a revised CPA policy and procedure as a joint initiative with Oxford Social Services. A CPA co-ordinator has been appointed.

CPA remains fully implemented for all patients seen by the forensic services (whether) they are in-patients or out-patients. The CPA review meetings take place at 3-monthly intervals, or more frequently if necessary, and the patient and, where appropriate, their carer are invited on all occasions. However, as we provide services for both Oxfordshire and Berkshire patients, we use the CPA policy and procedure relevant to the patient's county of origin. Our clinical teams are county-based so this does not cause confusion in the implementation of CPA.

(Red) All staff will receive training in these new (CPA) procedures.

Berkshire Health Authority.

(Green) BHA is clear that each NHS trust should have one set of clinical governance/audit plans and CPA procedures which apply to all services equally (including forensic services). These plans and procedures must be regularly reviewed by the Trust Board in terms of level of compliance and all breaches reported to Primary Care Trusts (PCT)/ the Health Authority during service level reviews. OMHT supplied a clinical governance plan to SERO NHS Executive in October 2001 stating this is now the case.

Berkshire Healthcare NHS Trust.

(Green) All services whether provided directly or sub-contracted come within the remit of the Trust's clinical governance process. The clinical governance committee is a sub-committee of the board and is chaired by the chair of the Trust. The group meets quarterly and produces an annual report and reports to the board on an as required basis. The forensic services are included in these arrangements. .

(Grey) The Trust is currently working with OMHT to design a joint programme of audit of these services.

The CPA group in the Trust are developing an agreed process for implementing and monitoring CPA across Berkshire. This is due to be completed by April 2002 and will report to the Trust board in May.

(Red) Part of this process will include the introduction of a single comprehensive record for all Berkshire patients using the forensic services based at Oxford.

The 2002/3 clinical audit programme for the Trust will include the forensic services provided by Oxfordshire to Berkshire patients.

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2. Standards of recording.

Oxfordshire Mental Healthcare NHS Trust.

(Green) The Reading/West Berkshire team holds monthly meetings involving all medical staff (psychiatrists and specialist registrars), the CPN(s) and social workers to review all out-patients who are in regular contact with the team. The aim of these meetings is to ensure that patients are being seen, that appointments are sent regularly, that CPA compliance is reviewed or to share information about why this is not happening and agree appropriate action.

Psychiatric and social supervisors have been reminded of the importance of keeping file notes of telephone calls with partners from other agencies, including the Home Office. The Trust also provides written summaries for high risk patients who are managed in the community by the forensic service.

(Red) The CPA training referred to above emphasises the need to maintain high standards of record keeping and will be subject to regular audit

Berkshire Health Authority.

(Green) OMHT now has a policy and procedure for CPA and has reported 100% compliance for 2001

Berkshire Healthcare NHS Trust.

(Green) Training to improve the standard of record keeping has been introduced across the Trust. The quality of patients' records is regularly audited as part of the clinical audit programme.

(Grey) A standard format for record keeping is being introduced across the Trust, with a risk assessment and most recent care programme and management plan located at the front of the notes. This is being audited by the CPA group as part of the clinical audit programme. This will be in place across the Trust by summer of 2002.

Reading Borough Council.

(Green) Integrated record keeping is a principle in our development and we now have a newly developed system in the CMHT. This integrates health and social service records on our clients.

(Grey) We are currently establishing protocols for information sharing particularly with our housing colleagues and other relevant agencies.

3. Policy on psychiatric supervision.

Oxfordshire Mental Healthcare NHS Trust.

(Green) The guidelines regarding the frequency of contact between conditionally discharged restricted out-patients and their psychiatric and social supervisors are strictly adhered to. The monthly meetings of the clinical team act as a monitoring and review mechanism to ensure that this happens.

Berkshire Health Authority.

(Green) Guidelines regarding frequency of contact with conditionally discharged restricted patients are now strictly adhered to. Contact with the supervisor happens at least monthly and contact with the psychiatric supervisor happens at least every 3 months. BHA's good practice recommendation and the Home Office advice is that at least one of these visits must be carried out at the patient's home

(Grey) OMHT are working BHA's good practice recommendations and Home Office advice into their supervision procedures currently.

Berkshire Healthcare NHS Trust.

(Grey) By the autumn 2002 all staff will have a personal development plan and receive regular supervision that is monitored and audited. All consultants in the Trust will be in receipt of an appraisal by April 2002 in line with national policy.

4. Role of forensic CPNs.

Oxfordshire Mental Healthcare NHS Trust.

(Green) CPNs and/or social work contacts often take place weekly/fortnightly. Although CPN involvement is maintained for the majority of patients the forensic service use their discretion to determine whether CPN involvement is necessary and clinically appropriate.

Berkshire Health Authority.

CPN and/or social work contacts often take place weekly/fortnightly.

(Grey) It is BHA's view that the information from such contact needs to be quickly fed back to the other professionals and formally placed on the patient file. BHA have asked OMHT to review the role and information available from the CPN or social worker contacts in the light of good practice in multi-disciplinary working.

Berkshire Healthcare NHS Trust.

(Red) The Trust need to have a debate about this to decide whether they designate a nurse within each team or equip each of the nurses with the necessary expertise within the CMHTs. Patients under a conditional discharge should be allocated a key worker but there needs to be greater clarity regarding the CMHTs' involvement with these patients.

Slough social services have funded a forensic support team, social worker and CPN to provide additional support to those deemed forensic. This works alongside the Oxfordshire forensic team. There are forensic CPNs, one in each location, who work from Oxford but are responsible for patients in east and west Berkshire.

5. Forensic community base.

Oxfordshire Mental Healthcare NHS Trust.

(Grey) Plans are currently in progress to establish a forensic community base at the Coley Clinic in Reading to enable more of a locality focus. A project plan has been agreed and a budget allocated.

Berkshire Health Authority.

(Red) In liaison with Berkshire Healthcare NHS Trust (BHT) early plans are being put together to locate and manage forensic services more locally. Initial plans look at developing a forensic community safety team in Reading and in Slough based around the existing court-diversion community teams there already. The plans would see the community forensic resources in OMHT switch over to provide a more local service.

West Berkshire Priority Care Services NHS Trust.

(Red) Discussions are taking place with (OMHT) regarding setting up forensic bases in Reading and Slough by the end of the year.

Reading Borough Council.

(Red) A forensic community base is not a concept which has been extensively considered locally. Discussions have however conceded the value. We would be happy to subscribe to a model which sought to centralise and concentrate this expertise. The local services have operated as an adjunct to the CMHT for some time now and we would be happy to enhance the approach and focus resources around this model.

6. Substance misuse; co-working and training.

Oxfordshire Mental Healthcare NHS Trust.

(Red) The location of forensic community resources at a local base in Reading will enhance the opportunities for liaison with Berkshire substance abuse service. We recognise the ever-increasing need for psychiatric and substance abuse services to work together to deal with the multiple and complex needs of our patients.

Berkshire Health Authority.

(Grey) BHT are developing substance misuse co-workers in each CMHT and there is full access for CMHT staff to take part in substance misuse training.

(Red) BHT runs substance misuse services in Berkshire, consequently with the changes indicated in 5 above, there will be a greater opportunity for better liaison.

Berkshire Healthcare NHS Trust.

(Grey) Work is being undertaken with local drug action teams to ensure that the work of adult mental health and forensic services are integrated with and informed by the substance misuse services.

Reading Borough Council.

(Red) Substance misuse services are acknowledged as an area in need of more integration with generic services. We have just agreed to appoint a post to the CMHT with exactly this brief in mind. We are hoping that this post will address some of the service deficits and problems identified.

7. Untoward incident policy and consideration of disciplinary action.

Oxfordshire Mental Healthcare NHS Trust.

(Green) This Trust has completely revised its serious untoward incident policy and procedure following a pilot. Training is being rolled out to ensure staff understand their responsibilities. On-call arrangements, including a directors' on call rota, support the implementation of the policy.

The trust has an established disciplinary and policy procedure. We also work to other national policies and guidelines which are relevant.

(Red) The trust expects learning from mistakes to happen both for individuals and the whole organisation. Where appropriate disciplinary action will be taken but this may not be justified in all cases. We believe this fairly reflects Government policy as well as our local policies and procedures.

Berkshire Health Authority.

(Green) BHA requires that the SERO untoward incident policy is applied in all cases. NHS trusts (including both OMHT and BHT) have now developed policies which comply with the guidance. Consideration of disciplinary action is the responsibility of the employing body and as such BHA (having satisfied itself that adequate disciplinary policies exist) must leave this in the hands of the trust/social services for action.

Berkshire Healthcare NHS Trust.

(Grey) A new policy has been developed and will be implemented in March 2002. All line managers will receive training on the use of the policy and this will then be cascaded across the organisation. A review of the effectiveness of the policy will take place at the end of 2002.

Reading Borough Council.

(Green) We do not have an untoward incident policy but all incidents are reviewed and audited to determine the need for policy and or organisational change. This is an integral part of practice. The decision to embark on disciplinary action or not would be taken on the merit of each case and in accordance with prevailing evidence. This accepts that a service outcome cannot be universally interpreted independently of the causative factors. It is the analysis of the latter which would influence the decision to take action and not a service outcome in isolation.

8. Managers' caseload

Reading Borough Council.

(Green) The managers' caseload does not now exist as we have re-structured our services. We now have a joint management post which essentially carries no caseload. If any casework is carried out it is on the basis of modelling good practice with no enduring expectation.

9. Management and supervision of social workers in tertiary services

Reading Borough Council.

(Green) Management and supervision of social workers in tertiary services is now firmly rooted in generic services. The line of all workers has been reviewed and a line of organisational accountability has been defined in addition to professional accountability. This ensures that good solid professional advice is available even where the line manager is of another profession and or agency.

All progress is relative to Spring 2002. Reviews of progress will now occur annually until all recommendations are completed.

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Legal cases

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Winterwerp v Netherlands 1979 2EHRR 387

18. APPENDICES

Appendix A - Abbreviations

ASW approved social worker	MHAC Mental Health Act Commission
BHT Berkshire Healthcare NHS Trust	NHS national health service
C3 previously, Mental Health Unit of Home Office	NSF National Service Framework
CD conditional discharge	OMHT Oxfordshire Mental Healthcare Trust
CPA care programme approach	OT occupational therapy
CMHT community mental health team	PCT primary care trust
CPN community psychiatric nurse	PDP Potentially dangerous person(s)
CRIS Client record information system	RBC Reading Borough Council
CTM clinical team meeting	RD-E Mr Richard Dale-Emberton, social worker
DHSS Department of Health & Social Security	RF Dr Robert Ferris
DofH Department of Health	RMO responsible medical officer
DVLA Driver and Vehicle Licensing Authority	RSU regional secure unit
FME forensic medical examiner (police surgeon)	s(s) section(s) (of MHA 1983)
HO Home Office	SERO South East Regional Office
MDT multi-disciplinary team	SSD social services' department
MHA Mental Health Act 1983	SSW senior social worker
	TVP Thames Valley Police

Appendix B.

The Independent Mental Health Inquiry into the Care and Treatment

Received by Winston Williams

Terms of Reference

General remit	To examine the relevant circumstances surrounding the treatment and care of Mr Winston Williams by the mental health services and from the criminal justice and social services.
	To consider other matters as the public interest shall require, which might arise during the course of the inquiry.
Treatment and care	The appropriateness of his treatment, care and supervision in respect of:
	his actual and assessed health and social support needs;
	his actual and assessed risk of potential harm to himself and others;
	his history of prescribed medication and compliance with it;
	his previous psychiatric history and treatment;
	his previous forensic history;
	the documentation recorded relating to the above.

Compliance	The extent to which Mr Williams' care corresponded to statutory obligations, particularly the Mental Health Act 1983 and relevant other guidance from the Home Office and Department of Health (Care Programme Approach (HC(90)23/LASSL(90)11); Supervision Registers (HSG(94)5); Discharge Guidance (HSG(94)27); and local operational policies.
Care plans	The extent to which care plans were effectively drawn up with Mr Williams, and how these plans were implemented.
Joint working	To examine the process and style of the collaboration between all of the agencies, including the police and Home Office, involved in the care of Mr Williams and the provision of services to him and his family.
Training	To examine any issues of in-service training that arise in relation to those caring or providing services to Mr Williams and to consider the adequacy of the risk management and training of all staff involved in Mr Williams' care and supervision.
Report	To prepare a report and to make recommendations to Berkshire Health Authority (or to Thames Valley Health Authority if reporting after April '02).

Appendix C.

Specimen letter to witnesses from Ms Lynda Winchcombe, inquiry manager.

Re: Mr Winston Williams

An inquiry has been set up by Berkshire Health Authority to examine the care and treatment given to Mr Williams prior to the death of Ms Katie Kazmi.

I have been appointed as manager of the inquiry and am writing to you on behalf of the inquiry panel. The panel members are Ms Geraldine Johns, solicitor (chair), Dr Paul Bowden, consultant forensic psychiatrist, and Mr Dave Shepperd, a former senior social services' manager.

Copies of the terms of reference set for the inquiry, and of the procedure to be adopted are attached for your information.

Mr Williams has given his authorisation to the panel having access to his health and social care records relating to the care he received by all the agencies with which he has been in contact. An initial examination of these records, indicated that you have relevant evidence to contribute to the inquiry.

The inquiry hearings will be private and a transcript of the information provided by you recorded. This will be sent to you following the meeting for verification as to the accuracy of the information given to the panel.

(Details of proposed time of meeting and venue). The panel would like to discuss with you your involvement with Mr Williams and the role you undertook in relation to his care and treatment. (Sometimes specific questions/issues are put here together with a request for a written statement).

Written documentation relating to the above would be helpful to have prior to the meeting. I would like this sent to me by (date) at the above address.

Please confirm that you are available to attend the inquiry at the allocated time. If this is not convenient then I will arrange another time more suitable to you.

Appendix D Map

Appendix E

E i. Home Office to Chief Constable, Thames Valley Police 15 November 1995

Notification of movement of mental patients subject to section 41 of the Mental health Act 1983

(Bold type as in original)

The person named below, a patient subject to the provisions of section 41 of the Mental health Act 1983, was conditionally discharged by the direction of the Mental Health Review Tribunal for the Oxford and East Anglia Regional Health Authority, with effect from 31 October 1995, and is currently residing at (number) Lyons (sic) Square, Tilehurst, Reading.

Name: Winston Delorn Williams

Date of birth: 03 July 1947

CRO number: (number inserted)

Offence which led to hospital admission: wounding with intent to do grievous bodily harm.

This information is given so that you may know of the situation: it is not suggested that any special action on the part of the police is called for. You will be aware that persons who are or have been under treatment for mental disorder may be unusually vulnerable to stress, and no doubt you will consider the possible need for discretion should it become necessary to undertake any inquiries with regard to this person.

It is important that this information is held in confidence. If you think that anyone else needs to know, you should seek advice from this division.

Mental Health Unit

E ii. Home Office to social worker Mr Dale-Emberton 15 November 95

Winston Delorn Williams

As you will be aware, the Mental Health Review Tribunal for the Oxford and East Anglia Regional Health Authority considered the above-named patient's case on 30 October 1995 and exercised their powers under section 73(2) / 74(2) of the Mental Health act 1983 to direct his conditional discharge. The tribunal considered that the patient's discharge should be subject to the following conditions:

1. The patient shall reside at (number) Lyons Square, Tilehurst, Reading or such address in England and Wales as shall be approved by his Responsible Medical Officer, his Successors or Deputies.
2. The patient shall accept medication as prescribed by his Responsible Medical Officer, his Successors or Deputies.
3. The patient shall attend at out-patient clinics and/or shall receive visits at his home from his Responsible Medical Officer, his Community Psychiatric Nurse, their Successors or Deputies, as directed by his Responsible Medical Officer..
4. The patient shall comply with Social Supervision from his Social Supervisor.
5. The patient shall submit to and co-operate with random urine testing for illicit drug taking, at the absolute discretion of his Responsible Medical Officer, his Successors or Deputies.

Under Section 73(4) and (5) of the 1983 Act the responsibility for monitoring the patient's progress in the community rests with the Home Secretary, who has the power, at any time, to vary the conditions attaching to the patient's discharge, to recall the patient to hospital, to allow formal conditions to lapse or to direct that the restriction order to which the patient is subjected should be terminated.

I enclose a copy of the Notes for the Guidance of Social Supervisors which explains the background to the Home Secretary's powers in this respect and the purpose of formal supervision. We would be most grateful if you would let us have reports on the patient's progress initially one month after discharge and then at quarterly intervals thereafter, sending copies to the Supervising Psychiatrist on each occasion. Suggested contents for a report are outlined in paragraph 52 of the enclosed notes.

As you will see from Section 7 of the enclosed notes you should have received detailed information of the patient's personal and medical history from his responsible medical officer at the Wallingford Clinic, Fair Mile Hospital. If this is not the case information should be requested from the discharging hospital.

You will also wish to be aware that the circumstances of Mr Williams's admission to hospital are as follows:-

On 21 June 1979 at the Central Criminal Court, Mr Williams was convicted of wounding with intent to do grievous bodily harm (2 counts).

He was reported to be suffering from mental illness and the Court made an order under section 60 of the Mental Health Act 1959 authorising his detention in Broadmoor Hospital, together with an order under section 65 of the Act, making him subject to the special restrictions set out in that section for an unlimited period. By virtue of paragraph 3 of schedule 5 to the Mental Health Act 1983, the patient is now detained as if he were subject to an order under sections 37 and 41 of the 1983 Act.

It was reported that the circumstances of the offences were that on 21 December 1978 Mr do not hesitate to contact the Home Office at once if you are concerned about any aspect of the case or if you require any further information.

C3 Division

E iii. Home Office to Dr R J Ferris 15 November 1995

Winston Delorn Williams

As you will be aware, the Mental Health Review Tribunal for the Oxford and East Anglia Regional Health Authority considered the above-named patient's case on 30 October 1995 and exercised their powers under section 73(2) / 74(2) of the Mental Health act 1983 to direct his conditional discharge. The tribunal considered that the patient's discharge should be subject to the following conditions:

1. The patient shall reside at (number) Lyons Square, Tilehurst, Reading or such address in England and Wales as shall be approved by his Responsible Medical Officer, his Successors or Deputies.
2. The patient shall accept medication as prescribed by his Responsible Medical Officer, his Successors or Deputies.
3. The patient shall attend at out-patient clinics and/or shall receive visits at his home from his Responsible Medical Officer, his Community Psychiatric Nurse, their Successors or Deputies, as directed by his Responsible Medical Officer..
4. The patient shall comply with Social Supervision from his Social Supervisor.
5. The patient shall submit to and co-operate with random urine testing for illicit drug taking, at the absolute discretion of his Responsible Medical Officer, his Successors or Deputies.

Under section 73(4) and (5) of the 1983 Act the responsibility for monitoring the patient's progress in the community rests with the Home Secretary, who has the power, at any time, to vary the conditions attaching to the patient's discharge, to recall the patient to hospital, to

allow formal conditions to lapse or to direct that the restriction order to which the patient is subjected should be terminated.

I enclose a copy of the Notes for the Guidance of Supervising Psychiatrists which explains the background to the Home Secretary's powers in this respect and the purpose of formal supervision. We would be most grateful if you would let us have reports on the patient's progress initially one month after discharge and then at quarterly intervals thereafter, sending copies to the supervising officer on each occasion. Suggested contents for a report are outlined in paragraph 41 of the enclosed notes.

As you will see from section 6 of the enclosed notes you should have received detailed information about the patient's history. If you have not done so this could be requested from the discharging hospital.

Please do not hesitate to contact the Home Office at once if you are concerned about Mr Williams's mental state or behaviour or if you require any further information.

C3 Division

E iv. Home Office to Mr Williams 15 November 1995

As you know the Mental Health Review Tribunal have directed your conditional discharge from the Wallingford Clinic, Fair Mile Hospital.

The conditions agreed by the Tribunal include a requirement, on your part, to submit to supervision by Dr Ferris and Mr Dale-Emberton, a social worker.

Dr Ferris and Mr Dale-Emberton, appointed to supervise you will explain the obligations this imposes on you, and you will be notified if necessary of any alteration in the conditions specified. Such alteration would be necessary if for instance you were to move from one area to another.

As a conditionally discharged restricted patient you have the right under section 75(2) of the Act to apply to a Mental Health Review Tribunal for the area for which you reside. You may make an application first in the year beginning twelve months after your conditional discharge, and then in any subsequent period of two years. The Tribunal has power to vary any of the conditions to which you are then subject, or to direct that the restrictions should cease to have effect, which would mean that you would no longer be subject to supervision or liable to be recalled to hospital.

Legal aid is available for the purpose of making an application, and the Tribunal office or your supervising social worker or probation officer will tell you how to find a solicitor or other help if you ask them.

C3 Division

Appendix F: Contact with and between professionals

Meetings: the first row shows the dates and membership of the nine meetings (CPA, management, and informal) at which Mr Williams was discussed.

Urine: the second row shows the dates of the five urine tests and their results.

Social worker contact: the third row shows the dates of meetings, who was present, and their venue.

Psychiatrist contact: the forth row shows dates and venue of meetings, and who was present.

CPN contact: the fifth row shows dates and venue of meetings, and who was present.

Depot: the sixth row shows dates of depot injections.

November 1995 to December 1996

	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1 Meetings				26/CPA					24/CPA 24**			8/CF/MTM 22/CPA		
2 Urine tests		15/Neg			13/Neg						6/Pos 27/Neg			
3 Social worker contact	3/O 10/O 17/H 27/?	1/H 8/H	26/H	9/H 16/O 29/?	5/H			7/O		30/O	27/H		8/H	3/H
4Psychiatrist contact	10/O 19/O 27/O	15/O		2/O	1/O 26/O		10/O	14/O	26/O		30/O			10/O
5 CPN contact	8/H 15/H 22/H 30/H	7/H 18/H	4/H 18/H	6/H 22/H	13/H 28/H	11/H	7/H 21/H	27/H	24/O 25/H	22/H		23/O	22/H	20/H 30/O
6 Depot	3, 24	15	5, 26	16	8	5	31	29	26	23	20	12	15	13

The numbers in the cells refer to the date of the month on which meetings took place. It does not include failed appointments.

(Neg=negative, Pos=positive, O=office meeting, H=home meeting, CF/MTM = community focus/management team meeting

RF=Dr Ferris, R D-E=Richard Dale-Emberton, MH=Mr Hayward).

Ward CPN CPN Ms Jackie Lee SW Mr Dale-Emberton Female senior registrar Dr Rob Ferris SW Mr Hayward

** on 24th July Dr Ferris received the warning 'phone call

January to December 1997

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1 Meetings		26/CPA					14/CPA			31**	12/RF, RDE 18/CF/MTM	
2 Urine												
3 Social worker contact	17/H	7/O	7/O	18/H	23/O		1/O 15/H		5/H		12/O 14/O	5/O 24/H
4 Psychiatrist contact					30/O		25/O		19/O		12/O	9/O
5 CPN contact	30											
6 Depot	10	7	7	4	2, 30	27	25	19	22	19	14	9

** on 31st October the team heard of the assault and threats to kill allegations

January 1998 to December 1998

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
1 Meetings											20/RF** MH	
2 Urine												
3 Social worker contact	8/H	6/O	6/O		1/O	10/O		5/O		12/O	20/O	
4 Psychiatrist contact					1/O				18/O		20/O	22/O
5 CPN												
6 Depot	11	6	6	5	1, 29	26	24	20	25	23	20	18

* A urine test taken at the request of the DVLA was reported on 2nd April 1999 as being positive for cocaine.

** The meetings on 20th November were in response to Mr Williams' driving school transport

January 1999 to September 1999

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept
1 Meeting									
2 Urine tests			30/Pos*						
3 Social worker contact			30/O			30/O			
4 Psychiatrist contact	22/O		19/O					6/O	
5 CPN									
6 Depot	15	12	11	9	7	4	2, 30	27	

* The urine test was taken at the request of the DVLA

Further copies of this report are available from the executive office or mental health lead at Thames Valley Health Authority.