Independent inquiry into the care and treatment of Peter Bryan and Richard Loudwell

A report for NHS London

September 2009
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1. Executive summary


1.2 No single individual, whether patient or member of staff, was responsible for the death of Richard Loudwell. There were in our view deficiencies in many aspects of the care provided to both Richard Loudwell and Peter Bryan and shortcomings at every level within the Trust. It was the combination of these shortcomings that led to Richard Loudwell’s death.

Peter Bryan

1.3 Peter Bryan had been in Broadmoor for just ten days. He had been arrested after killing Brian Cherry in East London on 17 February 2004. That killing had been particularly gruesome, Peter Bryan had dismembered and was preparing to cannibalise Brian Cherry’s body when found by police. In 1993 Peter Bryan had killed a young woman following which he had been detained in Rampton High Secure Hospital for a number of years before being discharged into the community. A separate inquiry has investigated the circumstances leading up to the killing of Brian Cherry.

Richard Loudwell

1.4 Richard Loudwell was 59 years of age. On 2 December 2002 he killed Joan Smythe, an 82 year old lady living on her own. His victim had been subjected to a serious sexual assault. Richard Loudwell had been detained in HMP Belmarsh before being transferred to Broadmoor on 15 January 2004, some three months prior to the assault which led to his death. A separate inquiry has investigated the circumstances leading up to the killing of Joan Smythe.

Broadmoor Hospital

1.5 Broadmoor Hospital is a high secure hospital and part of the West London Mental Health NHS Trust. Patients may only be admitted to Broadmoor if they have a recognised
ment disorder and if no lesser degree of security will provide a reasonable safeguard to the public.

Luton Ward

1.6 At the time of the assault on Richard Loudwell Broadmoor had a single admission ward, Luton Ward, where nearly all new patients would spend at least three months being assessed. After assessment they would move to other parts of the hospital, to a different hospital, to prison or be released into the community. On 25 April 2004 there were 19 patients living on Luton Ward.

The attack on Richard Loudwell

1.7 The attack took place in the ward dining room. This is a side room found off the main day room of the ward. Its doors were open but visibility into the dining room was restricted for anyone standing in the dayroom.

1.8 There were nine staff on duty. Three were on a meal break in another room (the ICA room) off the dayroom, the door to which was shut. Three staff were observing the two corridors on which patients’ own rooms were located. The remaining three staff were in the ward office with the door shut.

1.9 At the time of the assault there were up to ten patients in the day area of the ward with no staff physically present. The nearest staff were in the ward office. Staff could see out of the ward office into the dayroom but could not see into the dining room.

1.10 At the time of the assault it is probable that only Richard Loudwell and Peter Bryan were in the dining room. They were out of sight of staff. Staff did not know which patients, if any, were in the dining room.

1.11 Peter Bryan assaulted Richard Loudwell by strangling him with a trouser cord. He then banged Richard Loudwell’s head repeatedly against the floor. The assault was sustained and took place over several minutes.

1.12 Staff were unaware of the assault until those in the ICA room on a meal break heard a banging noise and came to investigate.
1.13 Patients in the dayroom may have been able to see the assault or may at least have been aware that it was taking place. The behaviour of some patients before and after the assault suggests that they might have been aware that an attack was taking place or about to take place but it is unlikely that any patient anticipated the severity of what happened.

1.14 Some staff had noticed a change in atmosphere on the ward prior to the attack but no change was made to the monitoring arrangements.

1.15 Peter Bryan had intended to kill Richard Loudwell for some time before the attack and had been waiting for a suitable opportunity.

Richard Loudwell at HMP Belmarsh

1.16 Richard Loudwell was arrested on 2 December 2002 and spent four days in police custody. On 6 December 2002 he was transferred to HMP Elmley. On 12 December 2002 he arrived at HMP Belmarsh. He remained there until 15 January 2004 when he was transferred to Broadmoor.

1.17 Between December 2002 and March 2003 Richard Loudwell’s behaviour at Belmarsh was disruptive. From April 2003 to August 2003 he was quieter, withdrawn and interacted little with others. From about September 2003 until January 2004 his spirits appear to have lifted and he was thought to be behaving appropriately.

1.18 Richard Loudwell remained in the Health Care Centre throughout his time at Belmarsh.

1.19 Throughout his stay at HMP Belmarsh Richard Loudwell was considered unsuitable to share accommodation with other prisoners. On 5 January 2003 an attempt to allow him on to a six bedded ward in association to watch television led to him being threatened after his index offence became known. On 23 March 2003 an intelligence report noted that three prisoners were planning to assault him on his return from exercise. On 28 April 2003 a teacher reported that prisoners in her class had threatened that they would kill Richard Loudwell if he came to the ward.
Richard Loudwell was seen regularly by RMO1 at HMP Belmarsh or by one of the other psychiatrists. The plan for his management was to secure his admission either to a medium or high secure unit for a full multi-disciplinary assessment.

We have no criticism of the standard of care provided to Richard Loudwell at Belmarsh.

Richard Loudwell’s admission to Broadmoor

Richard Loudwell was assessed by Consultant Psychiatrist 3, consultant forensic psychiatrist, in January 2003 on the instructions of his solicitors. She recommended that he be considered for admission to a high secure hospital.

On 21 March 2003 Richard Loudwell was assessed by Consultant Psychiatrist 4, consultant forensic psychiatrist from Broadmoor, again on the instructions of his solicitors. He tried unsuccessfully to refer Richard Loudwell to a medium secure unit in Kent. He then recommended an assessment by Broadmoor.

On 28 May 2003 Specialist Registrar 2, specialist registrar from Broadmoor, assessed Richard Loudwell as requiring medium rather than maximum security.

On 31 July 2003 the Broadmoor Admissions Panel refused Richard Loudwell a bed on the basis that he was more appropriately looked after in conditions of medium security.

Attempts were then made to find a medium secure bed. When these attempts failed a second application was made to Broadmoor and on 20 November 2003 the admissions panel offered him a bed. Shortly afterwards a medium secure unit did offer a bed but this was not accepted in the light of the offer of a place from Broadmoor. There is some evidence that the Home Office Mental Health Unit insisted that Richard Loudwell go to Broadmoor.

In our view Richard Loudwell did satisfy the criteria for admission to Broadmoor. He was suffering from a recognised mental disorder, he was liable to be detained under the Mental Health Act 1983 and we accept that he presented so great a risk that it was reasonable to conclude that he could only be housed in conditions of maximum security.
Richard Loudwell at Broadmoor

Assessment

1.28 The purpose of Richard Loudwell’s admission to Broadmoor was for a multi-disciplinary assessment. His RMO (responsible medical officer) was RMO3, consultant forensic psychiatrist. At the time of the attack by Peter Bryan the assessment was incomplete but the work that had been done was thorough and of a high standard.

Pre-admission nursing assessment

1.29 A pre-admission nursing assessment was prepared by Nurse Consultant 1. This was of little practical value to staff at Broadmoor. In particular it failed to identify the risk that Richard Loudwell was at from other patients. The management of this risk should have been planned. The pre-admission nursing assessment was a missed opportunity to prepare for some of the difficulties that he would encounter on Luton Ward.

Disclosure of index offence

1.30 Richard Loudwell disclosed his index offence to other patients within hours of arriving on the ward. Staff were ill-prepared to deal with this disclosure.

Observation

1.31 Richard Loudwell was on a regime of constant observation for his first week on Luton Ward. Despite this he was attacked on several occasions without staff noticing. He had water and ash thrown over him. He was also subjected to spitting and verbal abuse. Observations were not carried out to an appropriate standard and nor were adequate records of observations maintained.

Care planning

1.32 All patients in Broadmoor are supposed to be nursed according to a care plan. For Richard Loudwell’s first seven days there was no care plan in place to address the risk of harm from other patients.
1.33 On 22 January 2004 a care plan was devised but this was poorly written and largely ignored by staff. It required Richard Loudwell to be kept in view of staff at all times. This was inconsistent with him being kept on a general level of observation, which required observation only every 15 minutes. The care plan did not give sufficient importance to the need to protect Richard Loudwell from harassment and bullying.

**Bullying**

1.34 Throughout Richard Loudwell’s three months on Luton Ward he was subjected to varying degrees of physical and verbal abuse from his peers. The threat of abuse never receded. Some perpetrators of abuse left the ward but others arrived.

1.35 Contrary to the views of some staff (including the RMO, ward manager and some of the team leaders and senior members of the nursing team) and to the findings of the Critical Incident Review in May 2004, there was no reduction in the level of bullying of Richard Loudwell in the days or weeks prior to the attack in April 2004.

1.36 Richard Loudwell did interact more with his peers in April 2004 but the abuse which he suffered did not reduce.

1.37 On 14 April 2004 Richard Loudwell complained to the duty social worker of verbal and physical bullying by other patients. On the same day he telephoned the Mental Health Act Commission to complain of bullying. On 21 April 2004 he told his primary nurse, Primary Nurse 3, that he was being subjected to physical abuse by a particular patient (not Peter Bryan). On 22 April 2004 Richard Loudwell was seen by a Mental Health Act Commissioner who had come to Broadmoor specifically to see him. Richard Loudwell complained of physical abuse and the issue was raised with the duty team leader by the commissioner. No changes were made to the way Richard Loudwell was cared for on the ward. This was three days prior to the attack by Peter Bryan.

1.38 At the time of the attack on 25 April 2004 Richard Loudwell was being subjected to physical assaults by at least one other patient. This was known by some staff and this risk alone justified him being placed on continuous observations. His observation levels were not increased. Instead his complaints of physical abuse were ignored by staff, including his primary nurse who believed that the allegations of physical abuse by Richard Loudwell were false.
Richard Loudwell made the task of protecting him more difficult by deliberately ignoring advice given to him by staff for his own safety. Staff knew that he would not comply with advice, in particular advice to avoid putting himself in danger. This only increased the need to keep him under greater observation but his observation levels were not increased.

Bullying was not treated sufficiently seriously by any member of the clinical team nor was it given the priority it merited in Richard Loudwell’s case.

**Link between bullying and the attack**

There is a link between the failure to address the bullying of Richard Loudwell and the attack by Peter Bryan on him on 25 April 2004. If the bullying had been taken sufficiently seriously it is unlikely that Peter Bryan would have had the opportunity to mount a sustained attack on Richard Loudwell in the dining room without being observed by staff.

**Risk assessment**

A detailed risk assessment was prepared for Richard Loudwell by his RMO, RMO3. This document was prepared at the time of Richard Loudwell’s admission case conference which was held on 30 March 2004. The risk assessment correctly identified the likely risk of physical assault of Richard Loudwell by his peers. The document was not seen by the ward manager and may not have been in Richard Loudwell’s ward case notes.

**Richard Loudwell’s relationship with his primary nurse**

The relationship between Richard Loudwell and his primary nurse was poor. The person who should have known him better than anyone did not take his complaints of bullying sufficiently seriously and failed to take proper account of the significant risk of serious physical assault of Richard Loudwell in April 2004.
Richard Loudwell’s relationship with other ward staff

1.44 The tone for staff’s dealings with Richard Loudwell was set by the ward manager, Ward Manager 1, who failed to ensure that Richard Loudwell was provided with the respect, care and treatment that he was entitled to on Luton Ward.

Assessment of Richard Loudwell

1.45 The process of assessment of Richard Loudwell was incomplete at the time of his death. An admission case conference was held on 30 March 2004 with input from an array of professionals including two consultant psychiatrists, a neuropsychiatrist, a social worker, an occupational therapist, a clinical psychologist and a senior member of the nursing team.

1.46 The case conference concluded that Richard Loudwell’s case was highly complex and unusual and that the diagnoses still required further investigation and treatment. The possible diagnoses included Asperger’s Syndrome, depression and dementia all underpinned by poor physical health including non-insulin dependent diabetes and high blood pressure.

Peter Bryan at HMP Belmarsh

1.47 Peter Bryan was arrested on 17 February 2004 at Brian Cherry’s flat in East London. He had surrendered peacefully to the police and was charged with murder. Later in a police cell he told police “I ate his brains with butter. It was really nice.”

1.48 This was Peter Bryan’s second homicide. Both involved victims known to him and the use of a hammer. The second homicide involved substantial violence and cannibalism. There was no obvious explanation for either killing at the time of Peter Bryan’s arrest in February 2004 and no indication or information to explain why he had acted in this way. He could therefore only be regarded as highly dangerous.

1.49 On 19 February 2004 Peter Bryan was remanded to HMP Pentonville where he stayed for a short time until his transfer to HMP Belmarsh on 23 February 2004.
1.50 Peter Bryan was involved in a number of incidents while at Belmarsh: on 8 March 2004 he punched an officer and was placed on a 3-man unlock (he could only be let out of his cell escorted by three prison staff). On 12 March 2004 a noose was found in his cell. On 19 March 2004 he was recorded as saying that he wanted to hit the officer he had previously punched. This led to his level of unlock being increased to 4, meaning that an escort of four staff in protective equipment plus a senior officer would be required to escort him out of his cell. On 20 March 2004 he assaulted a member of staff on returning from the shower. On 23 March 2004 he set fire to his cell.

1.51 Peter Bryan clearly presented the prison service with a difficult challenge because of his risk level and behaviour. Within the limits of psychiatric care available in a category A prison, the discipline and medical staff in general acted appropriately.

Peter Bryan at Broadmoor

1.52 Peter Bryan was referred to Broadmoor by RMO1 from Belmarsh by letter of 23 March 2004 for an urgent assessment. His RMO at Broadmoor was RMO2, consultant forensic psychiatrist.

Pre-admission assessments

1.53 RMO2 visited Peter Bryan at Belmarsh on 2 April 2004 when he interviewed him through the cell hatch having been advised by staff that it was too dangerous to go into the cell.

1.54 On 7 April 2004 a pre-admission social work report concluded that Peter Bryan presented a grave risk to others and required a thorough risk assessment. The social worker explained to the inquiry that in her view Peter Bryan presented as an extremely high risk compared to other Broadmoor patients.

1.55 On 9 April 2004 ward manager Ward Manager 1 and Primary Nurse 9 visited Peter Bryan at Belmarsh to carry out a pre-admission nursing assessment. The assessment took about 10 minutes, again through the cell hatch. No written report was produced.
Admission examination

1.56 Peter Bryan arrived at Broadmoor on Thursday 15 April 2004. There is no record of his case having been discussed at a clinical team meeting prior to his arrival, perhaps because these meetings were held on Mondays and the previous Monday had been Easter Monday, a bank holiday.

Seclusion

1.57 Peter Bryan was placed directly into seclusion and given medication. It was unusual to place a patient directly into seclusion on admission. The reason for doing so according to RMO2 was to establish him on medication. The reason for doing so according to Ward Manager 1 was because of his index offence and violent behaviour in Belmarsh.

1.58 Peter Bryan remained in seclusion until 19 April 2004. He went directly on to the ward on general observations i.e. it was a requirement that he should be seen by staff about every 15 minutes.

1.59 When Peter Bryan was released from seclusion he presented no management difficulties. Other patients and staff found him to be likeable and compliant.

1.60 RMO2 believed at the time that Peter Bryan’s case was straightforward and that if he was compliant with his medication he would not be dangerous. In hindsight he accepted that clearly he had been wrong.

1.61 In hindsight members of the nursing staff felt that Peter Bryan should have been placed on a higher level of observation following his release from seclusion. Ward Manager 1 said that even if this had happened Peter Bryan was so compliant with management that the level of observations would have been reduced before the attack on 25 April 2004.

Mental state examination

1.62 RMO2 instructed his SHO (senior house officer) to carry out a mental state examination of Peter Bryan. This was not done. By the time of the assault on Richard Loudwell no doctor had carried out a mental state examination of Peter Bryan.
1.63 There was no medical contact with Peter Bryan in the week between his release from seclusion on 19 April 2004 and the attack on Richard Loudwell on 25 April 2004.

Care plan

1.64 An admission care plan was prepared for Peter Bryan. This identified his unpredictability but addressed only in broad terms what measures were required to monitor changes in his mood and behaviour. In particular the plan failed to emphasise the need to engage Peter Bryan in order to find out more about his thought processes and to elicit warning signs in relation to dangerous behaviour.

1.65 The care plan was modified when Peter Bryan was released from seclusion. The revised care plan made no provision for the observation of Peter Bryan to ensure that he was safe and that he did not present a danger to other patients or to staff.

The error in approach with Peter Bryan

1.66 The understandable desire to allow the least restrictive regime compatible with safety was allowed to outweigh the risks involved in caring for highly dangerous patients who were properly regarded as unpredictable. In our view a high level of observation was required for any patient about whom so little was known as in the case of Peter Bryan.

1.67 We refer to the assessment carried out by the OT department prior to admission. They correctly identified Peter Bryan as highly dangerous. Nursing and medical staff ought to have recognised that notwithstanding Peter Bryan’s good behaviour and undoubted charm he should have been treated as very dangerous until proved otherwise.

Risk assessment

1.68 No risk assessment of Peter Bryan was carried out by the clinical team prior to the attack on Richard Loudwell. Had a risk assessment been carried out properly then it is likely that Peter Bryan would have been recognised as highly dangerous. This was the conclusion reached in the occupational therapy department’s pre-admission assessment based solely on his medical notes.
Luton Ward - observation

1.69 The West London Mental Health Trust's observation policy that was in force at the time Richard Loudwell was attacked was from 2001.

1.70 At the time that Richard Loudwell was on Luton Ward in 2004 general observations (patients to be seen by staff every 15 minutes) were carried out in such a way that staff did not know the location of all patients. That was in breach of the Trust’s policy.

1.71 It was not appropriate that patients on Luton Ward were allowed to be out of sight of staff whilst in association.

1.72 Had there been a requirement for patients to be kept in sight of staff whilst in association it is unlikely that any assault on Richard Loudwell by Peter Bryan would have been prolonged and it is less likely that he would have received fatal injuries.

1.73 The initial period of seven days continuous observation of Richard Loudwell between 15 and 22 January 2004 was carried out half-heartedly and not in accordance with the Trust’s policy.

1.74 Increased supportive observation of Richard Loudwell carried out in accordance with the Trust’s policy from the time of his arrival on Luton Ward would have offered a real opportunity to address the issues of bullying and the risk of physical assault facing Richard Loudwell.

1.75 The 2001 policy was flawed in failing to make explicit the requirements for increasing and reducing observation levels.

1.76 The 2001 policy, despite its flaws, should have provided an adequate basis for effective observation of Richard Loudwell. The fact that so much of the observation of Richard Loudwell in his first week and subsequently, was defective was to a large extent due to a failure of staff to follow the Trust’s observation policy.

1.77 The sort of engagement required by the subsequent 2005 policy, had it been provided, would have made a significant difference to Richard Loudwell’s life on Luton Ward. By making him less isolated, it would have reduced his vulnerability.
1.78 Following his release from seclusion it would have been sensible to place Peter Bryan on a regime of continuous supportive observations followed by intermittent supportive observations before any decision to place him on general observations.

1.79 As a minimum, once Richard Loudwell had complained of bullying on 14 April 2004 he should have been placed on intermittent supportive observations. Had this been accompanied by an appropriate care plan and detailed recording of observations the risk of physical assault would have been greatly reduced.

**Luton Ward - management**

1.80 There is a long-standing history of generic concerns in and around Luton Ward. Some of these concerns may apply to other parts of the hospital as suggested by the Mental Health Act Commission (MHAC). All impacted on the level and standard of care available to Richard Loudwell.

1.81 The staff/patient ratio was such that staff often found it difficult to find time for meaningful engagement with patients, to the extent that they were inclined to engage at all.

1.82 **Ward Manager 1** was brought in in an attempt to make the ward more effective. He was experienced, confident and capable of firm leadership. He succeeded in the difficult and substantial task of improving the organization of the nursing staff. However problems arose from a failure by management, particularly at service manager level, to supervise him more pro-actively. As a result higher management remained largely unaware of the extent of problems on the ward.

1.83 A culture persisted on Luton Ward in which active engagement with patients was not given a sufficiently high priority. The norm was reactive observation rather than engagement with the result that patients were left too much to their own devices.

1.84 There was a lack of purpose and motivation amongst at least some nursing staff. In part this was due to the reactive nature of the nursing regime followed and a lack of definition around the purpose of assessment.
1.85 Morale was not high on Luton Ward in early 2004. Poor morale manifested itself at a ward awayday held in January 2004.

1.86 There was a conspicuous failure of management to follow up and address concerns about Luton Ward whether emanating from ward staff, consultants or the Mental Health Act Commission. The consequence was that there was no real change in the period we have reviewed.

1.87 There have been improvements on the ward since the death of Richard Loudwell. Patient numbers have been reduced to 12 or less, from 19. Under a new ward manager, Ward Manager 2, there was evidence of a more proactive nursing culture on the ward. Improvements have also been made to the accommodation on the ward. However our visits to the ward suggest that patients are still left to their own devices a great deal and that there remains a need to improve the availability of therapeutic activity.

1.88 We have seen evidence of strong criticism of the culture and operation on Luton Ward from at least 2001. This criticism was well founded and we are not satisfied that the Commission’s concerns were adequately addressed. The MHAC records and reports provide a valuable means of auditing the management’s efforts to raise standards. We are concerned that recent changes to the MHAC’s arrangements may have reduced the number of commissioners available to Broadmoor and accordingly reduced its ability to monitor the hospital.

**Security and risk assessment**

1.89 Security has to be an integral part of all activity in a high secure hospital. We agree with the former director of security, Alistair McNicol that a failure to maintain standards in terms of high secure policies, procedures and observation will lead to incidents such as the attack on Richard Loudwell.

1.90 Security advice from outside the ward will only be effective if it is sought, respected, listened to and applied. Such advice should be accepted as an integral part of the day to day working of the ward.
1.91 The role of the security liaison nurse on Luton Ward was not treated as sufficiently important by the rest of the clinical team. The security liaison nurse was not included sufficiently in patient reviews.

1.92 The role of security liaison nurse in individual risk assessment was not sufficiently emphasized.

1.93 Insufficient attention had been paid to the identification of unsafe practices and uses of the building. It should have been part of the security liaison nurse’s job to draw attention to the unsafe use of the dining room.

1.94 There was inadequate exchange of information between the security department and the ward about individual patients. Critical incident forms should have been completed and submitted to the security department in respect of each incident of reported harassment of Richard Loudwell. The only such form in fact submitted related to the last fatal assault. Reports of previous incidents would have highlighted to the security department the level of risk to which Richard Loudwell was exposed.

1.95 The requirements of the Tilt directive on high risk patients were not implemented in full. Patients who were objectively high risk were not registered as such because of a belief that Broadmoor could handle such patients. Only patients thought to present an exceptional risk by Broadmoor standards were designated high risk. We consider that this practice led to complacency and a lack of vigilance.

1.96 The requirements of the Tilt directive regarding the protection of vulnerable patients as part of risk assessment were not given the same priority as those regarding patients who were dangerous to others. Vulnerable patients should be given the same priority in risk assessment.

1.97 The security department and security issues were too often marginalized and seen as peripheral to the therapeutic business of the hospital.

Support for families

1.98 There were shortcomings in the support offered to Richard Loudwell’s family following the attack by Peter Bryan and after Richard Loudwell’s death. Whilst we
recognise that the circumstances in which the hospital found itself were exceptional we believe that greater support should have been provided by the hospital to the family.

1.99 The hospital’s senior management now accept that with hindsight early engagement and communication with the Loudwell family would have been beneficial. It is unfortunate that the Loudwell family were put in a position where they had to write to the Trust on 19 May 2004 expressing their surprise that no one had been in touch with them since the assault to offer any explanation for what had happened.

1.100Courtesy required a swift reply to that letter but no reply was sent for nearly three weeks, by which time Richard Loudwell had died. We find this failure even to send a swift acknowledgment deplorable.

1.101The chief executive finally wrote to the Loudwell family on 11 June 2004. The letter contained no apology for what had happened to Richard Loudwell and described the incident as regrettable. No apology or explanation was given for the delay in responding to the family’s letter. In our view even the sketchiest of details of the attack would have pointed to the conclusion that Richard Loudwell and his family had been badly let down by the hospital and that an apology was appropriate. We were disappointed that none was offered.

1.102 We were even more concerned that when the chief executive gave evidence to the inquiry in June 2006 he still at that stage did not appear to accept that there had been a collective failure on the part of Broadmoor which had led to Richard Loudwell’s death.

1.103The handling of vital communication of information to family, colleagues and agencies was left to the initiative of a conscientious social worker and the RMO who did their best in difficult circumstances but without any adequate guidance or help at a time of considerable anxiety and stress for both of them.

1.104 RMO3 spoke with the Loudwell family by telephone and visited his patient Richard Loudwell in hospital. He felt that he was discouraged by senior management from meeting with the family and from expressing any regret or responsibility on behalf of the Trust for what had happened.
1.105 We think that it will almost always be appropriate after an incident as serious as this for the responsible medical officer to make prompt contact with the patient’s close family and provide as much information and support as possible. Where for any reason information has to be withheld, the family should normally be told why.

**Incident Investigation**

1.106 The Trust complied with its untoward investigation policy in that it recognised the assault on Richard Loudwell was a serious untoward incident, the reporting requirements were complied with and a Serious Untoward Incident Inquiry commissioned. This was reasonably postponed until the completion of the criminal investigation and subsequent prosecution.

1.107 There was a critical incident review (CIR) in May 2004. This was not a substitute for the SUI nor was it intended to be. There were significant omissions in the list of those invited to take part in the CIR, in particular Service Director 3, who attended anyway and Security Liaison Nurse 1, who did not.

1.108 The CIR failed to identify the key fact that at the time of the assault on Richard Loudwell no member of staff was in the dining room or the dayroom.

1.109 The CIR accepted too readily a ‘received’ view that the bullying of Richard Loudwell had diminished prior to the assault and failed to take sufficient care to review the many entries in his nursing and clinical notes which suggested the opposite was true.

1.110 The CIR made a number of sensible recommendations but was wrong to recommend that the dining room be reopened subject only to twice hourly environmental checks.

1.111 The CIR was followed by a ‘table top’ review in September 2004. Arrangements for the table top review were such that ward staff were justifiably concerned that they were being excluded from the process. The recommendations of the table top review were nevertheless largely sensible.

1.112 An interim root cause analysis was subsequently carried out but appeared to have reached no additional conclusions about the incident. It too failed to identify the key fact that no member of staff was in the dayroom or dining room at the time of the assault.
1.113 The SUI, chaired by Professor Kennard, was a useful exercise and produced a helpful report but did not address the underlying issue of how this incident could have happened without being witnessed by staff.

Hospital management

1.114 The evidence tends to suggest that a weakness in the structure and performance of management at all levels may have contributed to a context which permitted the deficient performance in Luton Ward at the time of the attack on Richard Loudwell.

1.115 Generally, and in the case of Richard Loudwell in particular, there are indications that the standard of performance of Luton Ward was deteriorating in the period leading up to the attack. There was:

- no effective anti-bullying policy
- a failure to ensure safe observation practice
- a failure to ensure that appropriate care plans were recorded and implemented in a commonly understood way
- a failure to engage proactively with patients
- a failure to respond effectively and promptly to concerns raised by the MHAC
- a failure effectively to integrate security policy and practice into the operation of Luton Ward
- a failure to respond to staff concerns about the ward.

1.116 We consider that in allowing this situation to arise there is evidence of the following deficiencies in the management of Broadmoor:

- higher management appears to have known little of the difficulties being experienced in Luton Ward at the time
- after the appointment of Ward Manager 1 as ward manager the ward appears to have been managed internally in some isolation from the management structure and without a sufficient degree of external management supervision and support. This is of particular concern because the ward manager was not the selection panel’s first choice and had been appointed against the wishes of the ward RMO, RMO2
the ward was run under the shadow of an impending change of structure with no apparent strategy for managing the effect on the ward of waiting for the change

- there was tension between the clinical and non-clinical management of the ward which led to a lack of integration of these two functions
- management, clinical governance and audit processes were not sufficiently robust to detect issues concerning the performance on the ward of key workers.

1.117 No particular manager or level of management is responsible for the weaknesses we identify in relation to the attack on Richard Loudwell, and the issues arising from it. We see a collective failure in the organisation at virtually all levels to address legitimate concerns about the standard of service provided at ward level. These were either not communicated or were not addressed if they were.

1.118 The evidence suggests that this organisation has been unable to detect such problems, or to effect appropriate change when it has known about such matters. This situation requires a self-critical analysis, not the pillorying of individuals. The failure of the organisation to absorb and implement the conclusions of the W/L report in 1997 and the Appleby Report in 1999 cannot be repeated.

1.119 There is a lack of leadership at most levels of management and little common purpose within the hospital to deliver a first class service to patients and the public.

1.120 Broadmoor should be a leader and an example of excellence in forensic in-patient care in the same way it is a leader in the forensic assessment of patients. We are concerned to find in the areas examined in our inquiry that the management has apparently failed for a number of years and through a number of changes to deliver this standard with any degree of consistency.
2. Introduction

Status and terms of reference

2.1 The terms of reference of this inquiry are set out in appendix A.

2.2 This inquiry is constituted under section 84 of the National Health Service Act 1977. By reason of the transitional provisions of the Inquiries Act 2005 the inquiry continues to be governed by the 1977 Act, in spite of the repeal of this provision.

2.3 What follows constitutes the final report of this inquiry to the commissioning authority, NHS London.

The death of Richard Loudwell and public concern

2.4 On 15 March 2005 Peter Bryan was given two concurrent sentences of life imprisonment having pleaded guilty to two offences of manslaughter by reason of diminished responsibility. These offences were the killing of Brian Cherry on 17 February 2004 and the attack on Richard Loudwell on 25 April 2004. In March 1994 he was convicted of manslaughter by reason of diminished responsibility of a woman in March 1993. For this offence an order was made under sections 37 to 41 of the Mental Health Act 1983. At the time of the second killing Peter Bryan was still subject to that order and was in the community under supervision. At the time of the assault leading to Richard Loudwell’s death, Peter Bryan was charged with murder and on remand in Broadmoor where his mental state was to be assessed in order that a report could be made to the court. Peter Bryan committed the assault in a place not under observation at a time when no member of staff knew the whereabouts either of perpetrator or victim.

2.5 These events gave rise to understandable concern. At Peter Bryan’s sentencing hearing on 15 March 2005 the prosecution made the following remarks, which need to be borne in mind in the present inquiry:

“The last two killings have taken place in the two-month period when on each occasion the defendant was under the care of the Mental Health Act regime, which regime, say the Crown, has manifestly failed to protect the public, and in this case
reveals a chilling insight into the minds (sic) and actions of a man who has literally developed an appetite for killing.”

“The circumstances of this defendant’s offending, his mental condition, the inability of experts to detect when he is at his most dangerous, and his settled desire to cannibalise his victims, all combine to make him so uniquely dangerous that the court will wish to consider whether the determinate period of the life sentence should be a whole life sentence…”

“That there was a significant failure in the mental health regime in recognising the danger the defendant presented is plain. Even more startling is the fact that such a capacity for failure within the regime would be compounded in just nine weeks’ time in circumstances where that failure could justifiably be described as breathtaking.”

The setting up of three inquiries


2.7 Shortly after the trial of Peter Bryan the then North West London Strategic Health Authority (whose functions have been taken over by NHS London) announced that there would be an inquiry into the care and treatment of Peter Bryan and Richard Loudwell in Broadmoor.

2.8 At the same time the then North East London Strategic Health Authority acting on behalf of Newham Primary Care Trust and Newham Social Services announced an inquiry into the care and treatment of Peter Bryan in the community in relation to the events leading up to the death of Brian Cherry. This inquiry is chaired by Jane Mishcon.

2.9 The Harbour inquiry published its report in March 2006.

2.10 We have liaised with both other inquiries in order to avoid duplication and we take account of the findings, in draft and final as appropriate, in our work. It follows that
anyone who wants a full picture of the care and treatment of these two patients should read all three reports. In particular, reference should be made to the reports of both the other inquiries for full details of the background of both patients before their admission to Broadmoor.

2.11 We wish to express our appreciation for the assistance we have received from the chairs of both inquiries.

The panel and advisers

2.12 On 29 April 2005 Robert Francis QC was appointed as Chair of this inquiry.

2.13 The other members appointed were:

- Dr John Baird, consultant forensic psychiatrist at Leverndale Hospital, Glasgow.
- Granville Daniels, then executive director of nursing at Nottinghamshire Healthcare NHS Trust.

2.14 Short biographies of the panel members appear at appendix B.

2.15 On 7 February 2007 Dr Baird resigned from the panel for personal reasons. We had by then considered most of the documentary evidence we had obtained and completed our interviews with all invited witnesses. With the agreement of the Strategic Health Authority, we decided to proceed with the inquiry without appointing a replacement for Dr Baird.

2.16 The expertise and specialist advice in forensic psychiatry he would have brought to the inquiry was provided instead by Dr Adrian Grounds, university senior lecturer in forensic psychiatry at the Institute of Criminology, Cambridge. Dr Grounds was consulted fully about the content of this report, in a capacity analogous to an expert assessor and has made a most valuable contribution to our deliberations. Dr Grounds had access to all of the written material before the inquiry including transcripts of all the witness evidence. While Dr Grounds agrees with our findings and recommendations, the responsibility for its content is ours.
2.17 We would like to record our gratitude both to Dr Baird, whose wisdom and input during the evidence-gathering stage was of great benefit to us, and to Dr Grounds without whom it would not have been possible to complete our task with the benefit of a profound psychiatric perspective.

2.18 John de Bono was appointed as counsel to the inquiry with the role of not only advising us on legal and procedural matters, but also in undertaking the principal examination of witnesses and in undertaking research and drafting at our instruction. We wish to record our thanks to him for his energy, dedication and skill in the help he gave us.

2.19 We have been supported throughout by the secretarial and administrative services of Verita and in particular of Derek Mechen. Without his skilled, diplomatic and efficient help and advice this inquiry would have taken longer and been less effective. We thank him.

Powers of the inquiry

2.20 The Secretary of State granted us statutory powers under section 84 of the National Health Service Act 1977, enabling us to take evidence on oath, to summon witnesses and to order the production of documents if necessary.

2.21 It is a tribute to the cooperation we have received from everyone we approached that the only time we had to exercise our statutory powers was in relation to the production of the records of patients other than Peter Bryan and Richard Loudwell.

Procedure

2.22 We adopted an inquisitorial procedure. We have sought out such documentation, statements and met witnesses as we considered helpful to the fulfilment of our terms of reference. We did not consider that this process would be assisted by hearings attended by interested parties and their representatives, but we have throughout sought to ensure that those most closely affected have had the opportunity to put their points of view and to offer comment on potential criticisms.
2.23 Peter Bryan consented to provide us with his confidential records and information. He also agreed to be interviewed. We are grateful to him for his cooperation.

2.24 We first assembled documentation and identified witnesses who we asked to provide written statements. We invited some of these people to interview in private where they gave evidence on oath or affirmation. They were able to be accompanied by a legal or other adviser, and in most cases chose to attend with a solicitor retained by the West London Mental Health Trust. Their evidence was recorded and each witness was provided with a transcript which they were invited to amend, modify or add to as they saw fit on reconsideration.

2.25 In addition to such formal interviews the panel or members of the panel met more informally various members of Peter Bryan’s and Richard Loudwell’s families.

2.26 Having considered the oral evidence we decided it was necessary to examine the medical records of a number of patients other than Peter Bryan and Richard Loudwell. This took a long time. First we had to tell those patients that we wanted to examine their records. There were difficulties in tracing some of them. Second, legal assistance had to be obtained so that patients could understand their rights, to facilitate any representations they wished to make about the request for disclosure and to enable them to make an informed decision whether to consent to it. In most cases the patients refused consent and we had to decide whether to exercise our statutory powers to require the disclosure to us. In every case we had to balance the rights of the individual to privacy with the public interest in disclosure of this information to help the inquiry. We decided to order disclosure of any records we thought would help the inquiry. Where reference is made to these patients and their records in the report, material likely to lead to the identification of the patients has been excluded. They are referred to anonymously throughout so we are satisfied that their rights to confidentiality and privacy have been proportionately safeguarded and that the use of their private information has been proportionate to the public interest.

2.27 We met all witnesses on the understanding that what they told us would be used and included in the report to the extent considered necessary but would otherwise be kept confidential. Much evidence is quoted, in our view necessarily, in this report, but it is not our intention to disclose to the commissioning authority or elsewhere the transcripts
or other records of evidence we have. We intend that they should be destroyed after a suitable period.

2.28 Where we considered that fairness required it, persons whose conduct or performance might be commented upon adversely in this report were contacted and given an opportunity to respond to such matters in writing before the panel reached a concluded view on them. The Trust were also given the opportunity to comment on various issues raised and their responses were provided by the chief executive. In some cases such contact has occurred on more than one occasion. We have taken into account the responses obtained in this way in this report.

2.29 We had statutory powers to summon witnesses but all those we invited to attend did so voluntarily. Every witness was cooperative and answered our questions fully. We have no reason to believe that any witness has done other than sought to be honest, candid and helpful in evidence. We would like to thank all of them, and to note that it is a tribute in particular to the staff of Broadmoor Hospital that they contributed to the inquiry in this way in spite of the stress that must have been involved. While we will have critical comments to make, some of them directed at individuals, we do not consider that any individual approached this inquiry other than in a spirit of openness. This is to the credit of the hospital as an organisation today. This contrasts positively with the impression we have gained from our inquiry into its recent history of an institution which has had a culture of being inward-looking and isolated from the rest of the mental health service. We hope it is a sign that this culture can change for the better.

2.30 We have considered a great deal of evidence:

- We received about 22,000 pages of documentary materials.
- We interviewed 58 witnesses over 32 days and took into account the written statements of 25 other witnesses.
- We visited Broadmoor to inspect various facilities on two occasions.

2.31 The inquiry has been protracted - more so than either we or the hospital and its staff would have wished. We have been conscious from the outset that an inquiry of this nature places considerable strains on the individuals and organisations subjected to scrutiny, but the time taken has been unavoidable. First, we have had to consider a large amount of documentation and evidence. Second, the scope of the inquiry broadened with
emerging realisation in the course of the inquiry of a need to consider managerial issues as well as the specifics of the events leading up to the death of Richard Loudwell. Third, obtaining disclosure of patient records took a long time. Finally, no member of the panel or any of its advisers was engaged to work on this inquiry full time.

2.32 The inquiry has been difficult, but considerable help was provided by the hospital staff, and in particular Service Director 5, service director of high secure services men - London, who provided administrative liaison between us and the hospital.

The objectives of the inquiry

2.33 We sought to fulfil the terms of reference in the detail of the report; we have kept in mind what appear to be the overarching objectives of an inquiry of this sort.

Establishing the facts and learning the lessons

2.34 The late mother of Richard Loudwell told us that she wanted to know why her son had died and why he had telephoned her the night before the assault to say he was in fear for his life. Another member of the family said that they were shocked by what had happened; after all, they had thought that in Broadmoor, Richard Loudwell would be safe and everyone else would be safe from him. It was terrible, there were crimes on both sides, and he had killed and then was killed himself. From the day he was arrested the family had wanted more information but felt that ‘they were kept in the dark’.

2.35 We met Peter Bryan in the course of the inquiry. He was asked what he wanted to come out of it. He replied:

“I’m hoping that it doesn’t happen to anybody else again, so anything you can learn from it, that’s what I am seeking now, because I wouldn’t like somebody else to be in my position.”

2.36 A principal purpose of this report is to seek to provide answers to all concerned about what happened and why and to point up the problems that require addressing to minimise the chance of a recurrence. It has to be recognised, of course, that whatever precautions are taken the risk of attacks by dangerous patients on others in the hospital cannot be eliminated. However, we are clear that more can and should be done to
improve Luton Ward’s standard of care, security and attention to the needs of individual patients. Along with this, improvements are required in the management not only of the ward but also of the hospital in general.

Improving practice

2.37 A report like this is a waste both of money and of the considerable resources deployed in the inquiry unless it is widely disseminated, discussed and acted upon. Our conclusions and recommendations are not the only ones that could properly be reached. Indeed, a small panel consisting of a barrister and a nursing manager, however ably assisted by a forensic psychiatrist, and counsel to the inquiry are unlikely to have a monopoly of wisdom in that regard. The report must be regarded as the start of a process in which improvements can be generated, developing on the findings, not as the end of one.

2.38 The history of Broadmoor and our experience in this inquiry do not give cause for optimism that this is likely to occur unless there is more commitment to learning the lessons from serious incidents than has been in evident so far. It is instructive to consider some examples of where it seems to us this has not happened.

2.39 In 1997 an internal report into an attack by one patient on another, albeit on a different ward, made criticisms about observation methods, team working, and the interchange of information within the hospital. The authors stated that their report:

“...highlights the lack of consistent and applied standardised frameworks for the management of patient care. The nature of the hospital is such that unless these omissions are remedied a high risk environment will remain. The existence of autonomous wards contributes to the fragmentation in the development of policies and procedures. We draw the attention of the new Chief Executive to this.”

2.40 The report concluded that there had been a number of failures, including:

- “Failure to recognise [the victim’s] vulnerability as a target for assault within the hospital.”
• Failure to locate [the victim] in a room which was readily visible and observable by nursing staff.
• Failure to have [the perpetrator] under continuous observation [following an incident].
• Underestimation of the threat posed by [the perpetrator]…”

2.41 Investigating what did or should have happened with regard to this report in 1997 is not a central part of our inquiry but we have been concerned to note that there was a considerable internal debate at that time about whether and how the report should be disseminated and that there were considerable delays before any information about the conclusions were given to staff. Actions plans were prepared but the report itself seems to have been filed and forgotten.

2.42 In 1999 Professor Appleby, then director of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, issued a report into suicides at Broadmoor. This expressed concerns about observation methods, risk assessment and particular problems on Luton Ward. We have seen little evidence of these issues having been addressed by 2004.

2.43 We have seen reports of varying status into a number of other adverse incidents over the ensuing years and have identified themes they share with the incident we have investigated. ¹

2.44 We are particularly concerned that these reports were not disclosed to us until we asked for them. We do not believe this was a deliberate omission, but it indicates to us that there is no culture of retaining a corporate memory of previous incidents and the lessons to be learned from them and building good practice on the basis of that type of experience.

2.45 Concerns expressed by the Mental Health Act Commission in the period leading up to this incident were not treated with the appropriate respect and reaction.²

2.46 Finally, a striking incident occurred on the day we were scheduled to interview Peter Bryan in a suite of hearing rooms at the hospital. When we entered the room set

¹ A fuller account of these reports and their significance is given in Chapter 16.
² See chapter 16 on hospital management from 16.53 to 16.71
aside for the interview we found only two people there - Peter Bryan and the woman who helped the inquiry with recording proceedings. The two nurses escorting Peter Bryan were in an anteroom sitting in a place where it would have been difficult if not impossible to observe their patient, let alone intervene swiftly if necessary. We were shocked that it was felt appropriate to leave Peter Bryan on his own in a room with a defenceless woman given his history of unpredicted homicidal violence and his current status as a patient in the intensive care unit. In fairness, Peter Bryan appeared to us to be in an affable and cooperative mood, but it was precisely that appearance which had lulled staff on Luton Ward into believing he did not require close observation at the time he assaulted Richard Loudwell.

2.47 We are forced to the conclusion that Broadmoor is not an institution which has readily admitted to or responded adequately to constructive criticism in the past, to the detriment of the safety and welfare of its patients. We consider it is of the utmost importance that this culture is both changed and seen to have been changed so that there can be confidence that internal security and care are of the highest standard as is appropriate to a centre of excellence in forensic in-patient psychiatry.

Helping fulfil the duty of the State with regard to vulnerable patients

2.48 After the death of Richard Loudwell a local newspaper, the Medway News, published a letter stating the hope that he:

“...rots in hell...It’s about time that innocent, decent human beings like Joan Smyth (sic) were kept safe from these depraved monsters.”

2.49 It is understandable that people feel revulsion about the tragedy that led to Joan Smythe’s death, but it cannot be emphasised too strongly that patients detained in Broadmoor, whatever they have done, have as much right to a proper and humane standard of care as any other patient of the National Health Service. Indeed, compulsorily detained mentally ill patients who have committed horrific acts, often under the influence of their mental disorder, are particularly vulnerable and exposed to the risk of mistreatment out of sight of the public eye and mind. They are entitled to the highest standard of care a humane and civilised society can provide. Patients such as Peter Bryan and Richard Loudwell have committed acts which rightly provoke horror, but such patients need and are entitled to proper treatment and care for the mental conditions which have
caused or contributed to the violence and other unacceptable behaviour. Proper treatment and care are not provided if one such patient is not adequately protected from another. Society rightly makes rules which separate such patients involuntarily from the public, and detain them in a secure environment; this is not only to keep the public safe but also to keep the patient safe. Any system which fails to maintain an appropriate safe environment for patients is failing in a fundamental duty.

2.50 It is clearly established that the State has a duty under Article 2 of the European Convention on Human Rights to take steps to protect the life of hospital patients generally. Thus in one recent case the European Court on Human Rights (ECHR) said:

“The aforementioned positive obligations therefore require States to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives. They also require an effective independent judicial system to be set up so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable.”

2.51 All detained patients have the same human right to respect for their lives, to protection from inhuman and degrading treatment and to respect for their private lives, including their physical integrity under Articles 2, 3 and 8 of the European Convention on Human Rights as any other member of the public. Where a person is detained by the State, the State owes a duty both not only to abstain from active infringement of such rights but also to take positive steps to protect such individuals' rights. The only right removed by lawful and justifiable detention in a mental hospital is that of liberty: a detainee retains all other human rights so that any restriction or exception to them must be justified on the facts of the individual case. In a case concerning prisoners, but, in our view, equally applicable in principle to detained mental patients, the Grand Chamber of the ECHR said:

“The Court, as the Chamber, reiterates that there is no place under the Convention system, where tolerance and broadmindedness are the acknowledged hallmarks of democratic society, for automatic forfeiture of rights by prisoners based purely on what might offend public opinion.”

2.52 The duty of the State clearly extends to taking appropriate steps to protect the lives of vulnerable patients in its care. Thus the ECHR said in a recent case:
“The State duty to take appropriate steps to safeguard the lives of those within its jurisdiction also extends in appropriate circumstances to a positive obligation to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual, or from self-harm....In such cases, the Court’s task is to determine whether the authorities knew or ought to have known of the existence of a real and immediate risk and, if so, whether they did all that could have been required of them to prevent the life of the individual concerned from being, avoidably, put at risk.”

2.53 The State has a duty in the public health sector to make regulations compelling hospitals to ensure that appropriate measures are taken to protect patients’ lives. Where there has been a death in circumstances in which the rights of the deceased under Article 2 may have been engaged, it is the positive duty of the State to provide an effective legal and regulatory framework to enable the facts to be established and any relevant accountability for them to be established. Thus in the same case the Court said:

“79. The first sentence of Article 2, which ranks as one of the most fundamental provisions in the Convention and also enshrines one of the basic values of the democratic societies making up the Council of Europe, enjoins the State not only to refrain from the ‘intentional’ taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction...”

“80. Those principles apply in the public-health sphere too. States are required to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients’ lives and to set up an effective independent judicial system so that the cause of death of patients in the care of the medical profession, whether in the public or the private sector, can be determined and those responsible made accountable...”

“81. Unlike Calvelli and Ciglio, which concerned medical doctors’ errors, in this case the negligent act that endangered Mrs Stoyanova’s life was apparently committed by a medical orderly and/or technical auxiliary staff. However, there is no reason why the requirement to regulate the activities of public health institutions and afford remedies in cases of negligence should not encompass such staff, in so far as their acts may also put the life of patients at risk, the more so...
where patients’ capacity to look after themselves is limited, as in the present case."

“82. Where a Contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, it cannot be accepted that matters such as error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are sufficient of themselves to call a Contracting State to account from the standpoint of its positive obligations under Article 2 of the Convention to protect life.”

2.54 In spite of the qualification in the last paragraph quoted, the case makes clear the State has a positive duty to ensure that there is a legal and judicial system in place to “secure an effective possibility to establish the facts surrounding” the death of a patient. This inquiry is likely to be at least part of the process whereby the State will seek to fulfil its duty under Article 2 in this. We therefore consider it important to do our best to elicit all the facts, however inconvenient that may be for the State, or the hospital or its staff and allow public scrutiny and consideration of what we have found.

Publication

2.55 This inquiry was set up with a view to its report being published, and it has been written with a view to publication in full. However, the decision and responsibility in relation to publication are those of the commissioning authority, not ours. In order to assist the authority in coming to a decision about publication the panel consider it would be helpful to make known its views on the subject.

2.56 We write mindful that a number of potentially conflicting rights and obligations are engaged in the issue of publication.

2.57 Publication of our report as it stands will inevitably bring into the public domain private and confidential information about both Peter Bryan and Richard Loudwell. Generally a health authority owes a duty to patients and service-users to keep their personal information confidential, both at common law and under the Data Protection Act 1998. Further as a public body the commissioning authority has a duty to respect patients’ private lives in accordance with Article 8 of the European Convention on Human Rights as
incorporated into domestic law by the Human Rights Act 1998. The right of freedom of speech under Article 10 must also be considered.

2.58 The applicable principles have recently been considered by the Administrative Court in Stone v South East Coast Strategic Health Authority and others. In that case the proposal to publish a homicide report on the care and treatment of Michael Stone was challenged. Davis J said:

“As has been emphasised in the European Court of Human Rights, the protection of personal data, and the need for appropriate safeguards, is of fundamental importance to a person’s enjoyment of the right to respect for private and family life provided by Article 8: and that is particularly so in the case of medical data…”

“Moreover it seems to me of importance that in the present case Mr Stone is not seeking simply to assert his private rights and private interest (although he is doing that): he is also himself asserting a matter of public interest. That consists not only of the upholding of the general principle of a right to privacy but also the upholding of a wider matter of public interest: viz. that a person can freely and frankly discuss sensitive matters with his or her doctor, probation officer and social worker etc. and, further, can cooperate with an inquiry of the present kind without being deterred by the risk of subsequent disclosure…”

“Any restriction of the right to freedom of expression must be subjected to very close scrutiny. But so too must any restriction of the right to respect for private life. Neither article 8 nor article 10 has any pre-eminence over the other in the conduct of this exercise.”

“…Article 8 is not the only Convention right that has to be considered. As Campbell v MGN Ltd makes clear, Article 10 also has to be considered and given due weight. In the present case, it is now…accepted…that - even though the three Defendants, as public bodies, cannot themselves directly invoke the provisions of Article 10 - such Article comes into play: if only because of the general corresponding right of the public to be free to receive information where it is sought to be published…”
“...an ultimate balance has to be struck not only by weighing the considerations for and against a restriction on the right to privacy by reference to Article 8 itself but also by weighing the considerations for and against a restriction on publication by reference to Article 10.”

2.59 In Stone the court recognised that the patient had a right to confidentiality and privacy; not only was this a right in which he had a private interest but there is a public interest in patients being able to confide freely in medical advisers and mental health workers without fear that their disclosures will be published. In order for publication to be justified those factors have to be outweighed by public interest factors such as the protection of public health. That interest can include the protection of public confidence in the management of the health service, and allowing the public to know sufficient of the facts to enable them to judge whether the conclusions reached by an inquiry such as this are justified. The court held that the public had a “true public interest” in knowing what treatment and care were provided and to be able to reach an informed assessment of the failures identified. As the judge put it:

“The...community has a reasonable and justified expectation that an inquiry undertaken after such a high profile case as the present will be publicised in full, so that the public is not left in the dark (or in the shade) about how it happened or left to speculate about the lessons that have been or should be learned and about the recommendations made, with a view to implementation, to reduce the risk of such occurrences in the future.”

2.60 Such objectives are not met merely by circulating the report among health professionals. Where public agencies are criticised, the public have a right to know about it and an expectation of being able to consider the details. Finally, the court suggested that much of the substance of the information is already in the public domain by reason of the criminal court proceedings.

2.61 We think the public interest considerations in this case outweigh the rights of privacy and confidentiality to the extent of justifying publication of this report as it stands. We have taken care to omit from the report matters we consider are immaterial to our conclusions, and have recited oral evidence and documentary records only where we consider it necessary to enable the reader to understand what has happened and why we
have make our findings and recommendations. Our reasons for considering this is where the balance lies are as follows:

- The human rights case law referred to above makes clear that it is part of the State’s duty in a case such as this to undertake an independent and thorough investigation into the incident leading to the death of a detained mental patient in order that interested persons can be informed about what happened and for steps to be taken to prevent a similar occurrence in future.

- One purpose of this inquiry is to inform the public of the standard of care and treatment provided in its name to vulnerable persons detained for reasons of public safety.

- It is a necessary part of the inquiry process that the public - not only mental health professionals not concerned with the case - Government, Parliament, and the media but also the wider public are told what the inquiry has found. For them to understand the findings and recommendations and to be able to form their own judgment on whether there is an adequate official response to this incident, they need to have access not only to the findings and recommendations but also to the facts, evidence and material on which those findings and recommendations are based. We do not expect that everyone will agree with us. There are likely to be other points of view to be expressed and taken into account. Any debate on the proper care to be provided in a secure mental hospital needs to be informed by the material we have included in this report.

- It is in the public interest that confidence is maintained in the provision and management of the care and treatment given to seriously mentally disordered patient who pose a danger to or are at risk from others. The maintenance of that confidence requires an assurance that when something serious goes wrong, a thorough and informed inquiry has taken place and that the lessons to be learned are being taken on board.

- The public also expects that those with responsibility for the care of vulnerable patients are, where necessary, held to account for their actions. This inquiry is emphatically not a disciplinary process and is not about casting blame, but it is part of its functions to identify where things could have been done better by
individual professionals, as well as to note areas of good practice. This requires an account to be given and understood by a wider audience than the hospital staff and management themselves of what was done and by whom.

- The problems we identify in this report are unlikely to exist only at Broadmoor, and the lessons to be learned may have a wider application elsewhere in the mental health services.

- A significant amount of confidential information about Peter Bryan and Richard Loudwell is already in the public domain because of the trial processes and the resulting publicity.

2.62 These factors persuade us that publication of the report is not only desirable but essential if the inquiry is to fulfil its intended purpose, and the resulting invasion of the rights referred to above is thereby justified.

2.63 Finally we consider that publication of the report is not prevented by the Data Protection Act 1998 for reasons analogous to those considered in the *Stone* case. Section 4 of the Act provides that processing of sensitive personal information, including medical information, is permitted if one of the conditions in each of Schedules 2 and 3 of the Act are satisfied. Schedule 2 paragraph 5(2) refers to the processing of information “necessary for the purpose of any...functions of a public nature exercised in the public interest by any person”. Publication of this report would be for such a purpose. Paragraph 7(b) of Schedule 3 refers to the processing “being necessary...for the exercise of any functions conferred on any person by or under an enactment”. It was held in *Stone* that publication of a homicide inquiry report such as this was an exercise of a function under section 2 of the National Health Service Act 1977. In any event under paragraph 8 of the same Schedule publication is permitted if necessary for medical purposes that include “the purposes of preventative medicine, medical diagnosis, medical research, the provision of care and treatment and the management of healthcare services”. The judgment in *Stone* supports the proposition that publication of this type of report falls within that condition.
Recommendations

R1  This report should be considered not only by the board of West London Mental Health Trust, but also by NHS London, by the Mental Health Act Commission and its successor body, the Care Quality Commission and by the Department of Health.

R2  The board of the Trust should produce an action plan addressing the recommendations in this report. The plan should contain details of action already taken and an updated version should be reviewed on a regular basis by the bodies mentioned above.

R3  Each of the bodies referred to above should review, in a manner appropriate to their functions, the report and the action plan and consider whether the action taken by the Trust is sufficient and what, if any other, action ought to be taken to address the issues raised in this report.

R4  This report should be published in full at the earliest opportunity.
3. The attack on Richard Loudwell

3.1 Richard Loudwell and Peter Bryan were patients in Luton Ward, the male admission ward of Broadmoor Hospital. A plan of the ward as it was at the time of the incident is to be found at appendix C.

3.2 The assault on Richard Loudwell took place in the Luton Ward dining room at Broadmoor Hospital on 25 April 2004 just after 6pm. In circumstances which may never be satisfactorily explained, Peter Bryan and Richard Loudwell were on their own, unobserved, in the dining room when there were a number of patients in the dayroom, but, we find, no staff in line of sight of the dining room. No member of staff appears to have known that either patient was in the dining room.

3.3 Peter Bryan strangled Richard Loudwell with the cord of his trousers, banging his head against the floor, table, or wall, or all three, over a sustained period. He intended to kill Richard Loudwell as quickly as possible, but gave up because he became tired.

3.4 He left the room to go to wash his hands in the toilets and to rest, intending to return. Staff on a break in the ICA (intensive care area) room heard noises through the wall and went to investigate. Peter Bryan was seen in the dayroom with blood on his hands and, it was later discovered, on his trainers. He was taken to the clinical room where he claimed he had been banging the wall.

3.5 A member of staff then went into the dining room and found Richard Loudwell lying on the floor with obviously serious injuries. He was alive, but it was soon clear that his injuries were life-threatening. He was taken to Frimley Park Hospital by ambulance where he remained unconscious until he died on 5 June 2004.

3.6 Peter Bryan admitted he had attacked Richard Loudwell soon after the discovery of the latter and his injuries. He claimed he had been planning to attack Richard Loudwell for some days because he was vulnerable and was not entitled to live. He denied that any other patient or group of patients had encouraged him to attack Richard Loudwell. This was contrary to the suspicions of some staff who thought in retrospect that there had been some unusual behaviour among some patients at about the time of the attack. There is no evidence on which we can be satisfied that there was premeditated involvement of other patients. It is at least possible that patients encouraged Peter Bryan. The possibility

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of such involvement cannot be ruled out because of the history of bullying of Richard Loudwell by a number of patients in the period before the assault.

3.7 Later in the evening Peter Bryan’s trainers were found in the smoking room. There is no satisfactory explanation as to how they came to be there, but Peter Bryan may have hidden them there himself, in which case he must have been left unsupervised after the alarm was raised. Another possibility is that another patient put them there, which would suggest a degree of collusion.

Patients on ward

3.8 On Sunday 25 April 2004 there were 19 patients on Luton Ward. We do not propose to list their names.

3.9 The whereabouts of Peter Bryan and Richard Loudwell during the day or up to the time of the incident are unknown. The only records of checks undertaken are those performed on the patients’ rooms. A copy of the “corridor checks” form can be found at appendix D. The limited purpose of the form is to record whether patients are in their rooms on observation at 15-minute intervals. It is not possible to deduce the whereabouts of patients if they are not in their rooms. The incident with which this inquiry is concerned took place at about 6pm. We know that both Peter Bryan and Richard Loudwell were in the dining room at the time. This form records that neither Richard Loudwell nor Peter Bryan were in their rooms.

Staff on duty in Luton Ward

3.10 The staff on duty are listed in appendix E. There were ten staff on duty during the morning shift, supplemented by the clinical nurse manager until 11.30am. There were nine staff on duty during the afternoon shift when the incident occurred. They were supplemented by two further staff who came on duty at 7.15pm. The night shift had eight staff on duty throughout, supplemented for various parts of the shift by six others.

3.11 We interviewed all the staff on duty that day. None noticed anything untoward before the incident. It seemed to be a routine, quiet day.
3.12 Between 4.15pm and 5.45pm no access to other rooms was allowed so that tea could be served to patients in the dining room before medication was dispensed.

3.13 Between about 4.30pm and about 6.30pm staff on duty were allowed to take a break in rotation, three at a time. Initially HCA1, a healthcare assistant, told us he had been in the first group to take a break at about 4.30pm. He could not remember when this ended, but breaks normally lasted 45 minutes, and it must have been before the incident, which he timed at about 6.05pm. He took his break with Team Leader 1, a team leader, and HCA2, another healthcare assistant. HCA1 said in his statement to police that he had finished the break just before the incident. HCA1 thought on reflection it was more likely that he had been in the second group to have a break. However, this does not accord with the evidence of the group of staff who definitely were on their break at the time of the incident and who discovered it. He was not part of this group.

3.14 Team Leader 1 said that the breaks were supposed to last between 30 and 40 minutes. She could not remember when she had hers. If she had been on the 4.30pm break it would have lasted 45 minutes to an hour. She had come on duty at 7am and was due to continue until 9.30pm. In the event she stayed on duty until about midnight.

3.15 HCA2 was also working on the long shift from 7am to 9.20pm. He told us the first break would have been taken at 4.30pm and would have been over by 5.15pm when the second staff group would have gone off. He could not remember which break he went on.

Comment

It is clear from their evidence that when the incident was discovered, the three members of staff on a break were staff nurse Nurse 1 and healthcare assistants HCA3 and HCA4. The incident was too late to have been during the first break and too early to have been during the third. We think it is highly likely therefore that HCA1 did not take the second break. From the evidence noted above we conclude some or all of the first group may have taken a break longer than 45 minutes. HCA4 told us the break was intended to last an hour. The evidence also suggests that the durations of breaks were regarded as flexible.
Analysis of the incident and events on the day

3.16 We now turn to the incident and the order of events surrounding it. The evidence is unclear, but we will set out in detail what we have been told before outlining our conclusions. We first consider the information we have received from staff, grouped according to their whereabouts at the time. A plan of Luton Ward can be found at appendix C.

3.17 HCA5 was the radio nurse “on the gallery”, monitoring the bedroom corridor at the time of the incident with HCA6 and HCA7, healthcare assistants, who confirmed this.

3.18 HCA4, Nurse 1 and HCA3 were on a break in the ICA room. HCA3 remembered that he came out of the ICA room to investigate the noise and saw Team Leader 1 in the office. He accepted there might have been three members of staff in the office:

“It happened now and again, mostly if staff had to go and get things out of the office for patients and that sort of thing.”

3.19 HCA4 did not know whether there were any staff in the dayroom when he came out of the ICA room to investigate the noise. He was more confident that there were staff in the office. Indeed, he remembered three staff there, one of whom was Team Leader 1. The impression that there were probably no staff in the dayroom was reinforced by the following answer he gave in oral evidence:

Q. I am wondering whether you thought, I'd better go and have a look because there might not be any staff there.
A. Probably yes, that’s why I went to check it out. If you are six people there, three are on a break, so if there are three on the corridor, there will be three in the office, or three should be in the dayroom. No - I can’t remember: three, three, three.

3.20 Later he confirmed that when he came out of the ICA room there were no staff in the dayroom.
3.21 HCA1 said he, Team Leader 1 and HCA2 were in the office. He was asked what they were doing. He said he was there “to look at the duty sheet”, which he expanded to “probably looking whether I could put in for overtime”. With regard to the other two, his evidence was as follows:

A. I think I remember HCA2 sitting at the back of the office, but I could not tell you what he was doing.

Q. If someone is sitting at the back of the office, presumably they are looking into the office, rather than on to the dayroom?

A. The office has a panoramic view, apart from one wall, where the fire board is. Other than that, you can see pretty much the whole -

Q. But looking one way would be on to the corridor, and one way would be looking onto the dayroom, and the window in between, looking in the opposite direction to the fire wall, would be looking at the entrance to the ward, is that right?

A. That is right, yes and, at the time, the smoking room.

Q. When you talk about the back of the office, which is a room that we have seen, do you mean the side of it nearest to the dayroom, or the side nearest the corridor, or the side nearest what was then the smoking room?

A. It would be the side nearest the corridor.

Q. He could have been sitting or standing, but you think he was sitting?

A. I believe he was sitting down, yes.

Q. Generally, when people are in the office, are they doing something that requires them to be in the office, rather than just carrying out general observations?

A. Generally, yes. Sometimes, if there are no patients around in the day area, they may go and sit in there and just browse through the duty sheets, just to see whether they can put themselves in for overtime, or just basically check up on their shifts.

Q. But if your role at a particular moment was observing generally - not a particular patient, but generally observing - if it was your role to observe the dayroom, would you carry that out by being physically in the dayroom? Or might you sit in the office and not do anything else, but just observe from the office?

A. No, you would sit out in the day area.
3.22 HCA1 did not remember seeing any staff in the dayroom when he approached Peter Bryan as he emerged from the toilets.

3.23 Team Leader 1 said that at the time of the incident she, HCA1 and HCA2 were in the office.

3.24 HCA2 told the inquiry he had been in the office at the time of the incident. He could not remember who else was there. He accepted it was possible there were no staff in the dayroom at the time.

Conclusion

C1 We conclude that at the time of the incident three members of staff were observing the corridors and three were on an extended break. That left three to supervise the dayroom, the smoking room, the dining room and the toilets. At the time of the incident, all these three were in the office attending to administrative duties and no member of staff was in the dayroom. We do not know how long this had been the case but it was clearly long enough for the assault on Richard Loudwell to take place. The assault involved strangulation with a ligature and a sustained beating, so we consider it must have lasted some minutes. As no-one was aware that Peter Bryan or Richard Loudwell had entered the dining room, and at least one member of staff would have been aware of this had they been in the dayroom at the time, the period in question is longer than the actual assault itself.

The accounts of staff taking a break

3.25 Nurse 1 was taking his break with HCA3 and HCA4 at the relevant time. Initially they were in the staff room but had moved to the ICA room, which is next to the ward dining room. Nurse 1 recollected HCA4 going into the staff resource office, which is a partitioned area within the ICA room, to make a telephone call. Before completing his call he came out and said he thought he could hear a banging noise or a thud. HCA3 looked out of the window towards the dining room - apparently patients had been known to feed birds by opening the dining room window - but could see nothing. According to Nurse 1 HCA4 insisted they listen carefully. He heard two bangs then the noise stopped. Nurse 1 told HCA4 he should go to see what
was happening. HCA4 left the room but, according to Nurse 1, came back within seconds saying “Nurse 1, this is one for you.” HCA4 said that Peter Bryan had blood on him. Nurse 1 left the room and found Peter Bryan with Team Leader 1 and HCA1 in the clinical room (which is on the other side of the dining room from the ICA room). Nurse 1 noticed blood on Peter Bryan’s trainers; he said he had been hitting the wall in frustration. The alarm was activated and Nurse 1 went to the dining room. He recollects being one of the first to enter. He saw Richard Loudwell lying in a pool of blood in the corner. There were no other patients in the room. Nurse 1 called for help and gave first aid to Richard Loudwell. He could not explain how Peter Bryan’s trainers came to be in the smoking room.

3.26 HCA3 said they heard a banging noise, twice, while HCA4 was making a phone call. HCA3 had looked out of the window but could not see anyone in the dining room. He followed HCA4 out of the ICA room into the dayroom. In his police statement he said he saw Peter Bryan coming out of the dining room with blood on both his hands. HCA4 asked him what had happened, and Peter Bryan said he had been punching the wall. But the recollection of HCA3 in his oral evidence was different. He said he saw Peter Bryan coming from the direction of the dining room and asked why he had blood on him. Peter Bryan did not answer but tried to walk round him. It was possible Peter Bryan had come from the toilets and that HCA3 had taken 20 seconds or so to follow HCA4 out of the ICA. Peter Bryan was taken to the clinical room. As they got there the alarm sounded. HCA3 immediately went to the smoking room because that is where most incidents occur. He then went towards the patients’ rooms but turned back when he saw staff coming the other way. He saw people going to the dining room and went there himself. He saw Richard Loudwell on the floor and two patients standing near the hatch where medication was dispensed. He escorted them back to the dayroom.

3.27 HCA4 said he went on a break at about 5.30pm with HCA3 and Nurse 1. It was meant to last until about 6.30pm. They spent about 20 minutes having a meal in the staff room before moving to the ICA room. While he was making a telephone call he heard a banging noise. He thought it sounded like someone punching the wall and asked the other two if they had heard it. He could not tell where the noise was coming from because of noise in the dayroom. After HCA3 looked out of the window and was unable to see anything, HCA4 left the ICA room. In a written statement he described what he saw:
“There were about 5 patients in the dayroom when I exited the ICA room. There was quite a lot of noise in there because music was playing. Two patients that I remember being in the dayroom were [patient A] and [patient B], as detailed in my statement to the police from August 2004. They were being loud, singing and shouting together with another patient whose name I do not recall. At the same time as I came out of the ICA room, I saw Peter Bryan coming out of the dining room on his own with blood on his fist.”

“I note from my police statement that I asked Peter Bryan where he was going and whether or not he had been banging the wall. He ignored me and walked straight to the patients’ toilets. I then continued across the dayroom to the ward office where I immediately reported what I had seen to Team Leader 1 who was the Team Leader and nurse in charge of the shift. I do not recall seeing any other blood on Peter Bryan at that time. Team Leader 1 came out of the ward office at the same time as me. I went straight to the dining room while she stopped to speak with Peter Bryan who had come out of the toilets, having been in there for about a minute or possibly less. I went to the dining room to see whether or not there was any blood on the walls because I believed that Peter Bryan had been banging the walls with his fists.”

3.28 HCA4 saw Richard Loudwell lying on the floor. He was shocked and activated the alarm. Six or seven staff quickly attended to help and HCA4 left the room to direct others.

Staff on duty in corridor

3.29 The three members of staff on duty in the corridor did not and could not have witnessed anything relevant to the incident. They were only alerted to it by the alarm going off.

Staff on duty in communal areas

3.30 HCA1 said he was in the office with Team Leader 1 and HCA2 at the time of the incident. He was unable to explain how he had been recorded by the duty manager Service Director 1 in her report as being in the dayroom at 6pm, apart from suggesting that he might have been “passing through”. His statement, appended to
Service Director 1’s report, was consistent with his having been in the office at the time. HCA1 said HCA4 came over to say Peter Bryan was in the toilet with blood on his hands saying he had been punching the wall. They approached Peter Bryan and took him to the clinic room. They asked him why he had been hitting the wall. He said he had been doing it to relieve tension. He appeared calm and said he was fine. However he dropped his trousers and said there was something wrong with his legs. The alarm then went off. They told Peter Bryan to go to his room and keep out of the way. When HCA1 entered the dining room there were four or five members of staff already there. He saw Richard Loudwell on the floor with a pool of blood in front of his head. He said there was little he could do there so he went out to the dayroom. He was present during the interview of Peter Bryan conducted by doctors later that day.

3.31 HCA1 was asked whether he would have been concerned if he had known that Peter Bryan and Richard Loudwell were alone together in the dining room:

“Not particularly. We would have gone in and observed and made sure nothing untoward was going on. Peter Bryan - there was nothing that he had done, and no way that he had acted or anything, that would have led us to believe that he would do anything like that.”

3.32 Team Leader 1 was on duty as team leader. After tea she was in the office doing administrative work. HCA1 and HCA2 were also there. HCA1 had returned from the toilet. HCA2 had just come in and was entering his name on an overtime form. Team Leader 1 accepted that for that period of time there was no member of staff in the dayroom. She did not think HCA1 was in the office for more than four or five minutes. She did not notice anything untoward except a group of patients singing “Lazy Sunday Afternoon” in a sarcastic fashion. She believed this was directed at the staff in the office, including her. At about 6pm she was approached by HCA4 who reported that Peter Bryan was in the toilet. She thought HCA4 said that Peter Bryan was hitting the wall. She left the office and saw Peter Bryan coming out of the toilet wiping his hands on his shirt. HCA1 went to the toilets to check the area. Team Leader 1 asked to look at Peter Bryan’s hands and noticed a small abrasion. She asked him to come to the clinic room so she could investigate further. When questioned in the clinic room Peter Bryan said he had hit the wall as a coping mechanism. He said he had sore skin on his legs and dropped his trousers and underpants. Nurse 1 came into the clinic room and Team Leader 1
asked him to get some cream. At that point the alarm went off. She joined other staff in
the dining room and saw Richard Loudwell on the floor. Throughout this Peter Bryan
seemed calm and Team Leader 1 did not immediately associate what had happened
with him.

3.33 HCA2 said he was in the office when he saw HCA4 approaching and Peter Bryan
heading towards the toilet. He followed HCA4 into the dining room where he saw Richard
Loudwell on the floor. He had a clear recollection of seeing patient C sitting at a table in
the dining room and of asking him to leave. In his police statement he said he remembered
patient C being in the dayroom after the alarm sounded, so conceded he could not be
clear about the order of events. But he presumed he had gone into the dining room from
the dayroom. HCA2 helped escort Peter Bryan to his room and was present when he
admitted assaulting Richard Loudwell.

Whereabouts of other patients at time of incident

3.34 Nurse 1 could not remember how many patients were in the dayroom at the
time of the incident. He had some memory of patients singing after the assault was
discovered.

3.35 HCA3 recalled seeing two patients in the dayroom, other than Peter Bryan who
was coming out of the dining room with blood on his hands. The two patients were sitting
on the side of the dayroom opposite the dining room, at the end closer to the toilets. He
did not think they could have seen into the dining room. He could not remember who they
were. He told us he saw two patients in the dining room when he entered it after the
alarm was raised, but could not remember who they were. His evidence did not suggest
these patients had been in the dining room at the time of the assault.

3.36 HCA4 saw five patients in the dayroom. To begin with some of them were in the
corner near the staff room. In his police statement, confirmed in his evidence to us, he
noted that three of these patients were sitting on a sofa with another patient in a position
with a clear view into the dining room. He told us that when he came out of the ICA room
to investigate the noise one of them, patient A, was standing near the dining room
entrance. He said patient A could have clearly seen what was going on in the dining room
from where he was standing. He was laughing. This was something HCA4 had not mentioned in his statement to the police.

3.37 HCA1 thought there were two or three patients in the smoking room, and one or two in the dayroom. After the alarm went off and Richard Loudwell was discovered he found eight or nine patients in the dayroom and the smoking room. He could not remember there being any patients in the dining room when he went in there. He told the police that patient C, patient D and patient E were in the smoking room and that patient B, patient F and patient G were in the dayroom. He checked for signs that other patients had been involved in the incident but found none. After the incident, at the end of his shift, patient C asked him if Team Leader 1 was going to be in trouble. HCA1 told him she probably would and patient C appeared concerned.

3.38 Team Leader 1 thought that patient B, patient F and patient G were in the dayroom and that patient D might have been in the smoking room. She remembered three or four patients sitting along one wall of the dayroom and another group at the end opposite the office. She thought patient C was there at one point.

3.39 HCA2 recalled seeing patient C in the dining room, but on reflection thought he went in after the alarm went off. When HCA2 entered the dining room there had been no other patients there.

Atmosphere

3.40 Nurse 1 did not notice any particular atmosphere that day. HCA3 noticed a “jokey” atmosphere among patients after the alarm went off, but he was unable to say that they had been aware of what had been going on as it happened. He accepted there was a possibility that other patients had put Peter Bryan up to the attack. He suggested the names of some patients based on their previous bullying of Richard Loudwell, but offered no evidence that this had happened.

3.41 HCA4 told both the police and ourselves that two patients he identified as patient A and patient B, were in the dayroom and appeared to be fooling around, singing and shouting:
“...outside there was music, the patients were singing. It was weird because I never heard them singing or make that kind of noise before.”

3.42 HCA4 also told the inquiry that earlier on the day of the incident he had been told by a patient that Richard Loudwell had asked the patient to smash his face in as he did not want to live. HCA4 said he did not have time to record this in the medical records before the incident. He did not do so later. In his police statement there was no mention of this incident.

3.43 HCA1 stated that before the incident two or three patients, one of whom he thought was patient B, had been singing quite loudly which was unusual. He had not been aware of any atmosphere on the ward although he had been aware of atmospheres developing on other occasions. HCA1 said the singing was like a crowd of football supporters, but denied it sounded as if they were cheering something on. After the alarm went off he noticed that patient B in particular seemed to be smiling.

3.44 Team Leader 1 remembers patients singing in a sarcastic manner which she thought was directed at the staff. She remembered the singing had stopped by the time she went out to meet Peter Bryan in the dayroom. She recalled nothing in the atmosphere to suggest a serious incident had occurred. The teasing of staff by patients occurred from time to time but singing was unusual. In retrospect she thought the purpose had been:

“To distract from any noise that may come from [the dining room], which I think one of the patients did say that that was what he was doing.”

3.45 The patient to whom she referred was the one who had been singing, patient B, but the suggestion that he said this was reported to Team Leader 1 by other staff. HCA2 could not remember any singing. HCA7 considered from the outset that there was a strange atmosphere on the ward.

3.46 While medication was dispensed after tea, Richard Loudwell, patient B, patient C, patient D, and patient H had been playing cards. They were making a lot of noise, laughing and joking. HCA7 had mentioned her feelings to colleagues on the “gallery”. This was the first time she had seen Richard Loudwell playing cards with the others.
Conclusions

C2 We are satisfied on this evidence that there were at least two occurrences before and during the incident which were unusual for Luton Ward.

C3 Firstly, a number of patients were seen playing a game with Richard Loudwell. As will be apparent later in this report, Richard Loudwell was universally unpopular with fellow patients and had been bullied - often by the people playing cards with him that day. It is surprising that this apparent rapprochement occurred, and of concern that it should do so just before a lethal attack.

C4 Secondly, the same group of patients indulged in loud singing. At the time this was thought to be a form of sarcasm directed at the staff, but in retrospect it was thought that the patients were seeking to distract attention from what they knew was happening, or about to happen, in the dining room. We consider the possibility of collusion below, but we are satisfied there was an unusual atmosphere in the ward that afternoon. We are also satisfied that few, if any, staff thought the atmosphere was significant before the discovery of the assault.

C5 These features were not noted in the records. As the Trust has suggested to us, these were subtle signs, the significance of which would have been difficult to identify at the time. We also accept that it would be difficult to train staff to identify this sort of thing as significant at the time, but we would have expected experienced staff to note such occurrences even if only for later analysis and to consider whether something unusual and of significance was happening. Insufficient curiosity about unusual events was displayed.

Mr Bryan’s footwear

Nurse 1 has described on a number of occasions that he saw blood on Peter Bryan’s trainers when he first saw him in the clinic room while he and colleagues were investigating the banging noise. In his police statement he said he noticed blood on the toecap of one of Peter Bryan’s shoes. He could not recall the colour or type but said they were soft trainers. In his inquiry statement he reiterated that he had seen blood. He had asked Peter Bryan how it got there. He confirmed this account in his oral evidence.
3.48 HCA3 could not remember what Peter Bryan had on his feet. HCA4’s recollection was that he was wearing Broadmoor slippers. HCA1 stated that Peter Bryan was wearing slippers.

3.49 Team Leader 1 told police that some time after the incident, patient C told her there was a pair of trainers under a chair in the smoking room. She said that patient C told her this as if he did not want anyone to know he had said anything. At the time of the incident she thought Peter Bryan had been wearing slippers. She could not remember if he was wearing anything on his feet when they later took his clothes from him as evidence. She was confident he was not wearing blood stained trainers when she was with him in the clinic room. She said she would have expected someone to notice if Peter Bryan had come out of the dining room and taken his trainers off in the smoking room before going to the toilet. She informed Nurse 2 about the location of the shoes as he came on duty just before 9pm to lead the night shift. Nurse 2 accepted he had been told about the shoes, and in his police statement said Team Leader 1 had done this. However in his inquiry statement he said he had been told by a patient. He told us that he had been told about the shoes both by Team Leader 1 and, later, by a patient.

3.50 Nurse 2 did not look for the shoes immediately. He considered that if staff had gone immediately into the smoking room to search it the patients would have thought that this was odd. Instead he planned to check the room when it was cleared as a matter of routine later in the evening. At that point he did search the smoking room with HCA3 and found the trainers hidden under a chair, which had to be lifted to reveal them. The trainers were placed in a sealed bag and given to the police.

3.51 When the shoes were analysed forensically, it was found that they were stained with Richard Loudwell’s blood.

Conclusion

C6 The evidence does not permit us to come to a conclusion as to how Peter Bryan’s shoes came to be in the smoking room. As the victim’s blood was on them we can infer they must have been placed there after the assault. The staff evidence suggests that Peter Bryan went straight to the toilet after the assault and was then accompanied to the clinical room. His principal opportunity to remove and hide the shoes was when the alarm

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was raised and he was asked to go to his room. No member of staff noticed that Peter Bryan was not wearing shoes. We consider the most likely explanation is that Peter Bryan put the shoes in the smoking room on his way back to his room. This went unnoticed by staff who were probably preoccupied with the alarm, but not by at least one patient who later told staff where the shoes were. It is possible that the shoes were hidden for Peter Bryan by another patient, but that would be speculation.

Emergency treatment of Richard Loudwell

3.52 Nurse 1 was one of the first to enter the dining room after the incident. He was trained in first aid and immediately started administering it. He was assisted by HCA7. We were given detailed accounts of what staff did for Richard Loudwell. Resuscitation was performed as necessary and effectively in that it was possible to transfer Richard Loudwell by ambulance to Frimley Park Hospital.

Comment

We do not consider it necessary to include all the details of the steps taken to administer first aid and resuscitation to Richard Loudwell after he was found in the dining room. Never having experienced an incident of this severity before, the staff involved were distressed and shocked by their experiences. We were impressed by their professionalism in these difficult circumstances, and are satisfied that everything that could reasonably have been done for Richard Loudwell at that time was done.

Peter Bryan’s account

3.53 When he was first asked why he had blood on his hands the nursing observation notes record Peter Bryan indicating he had hit his hands on the wall. When the injured Richard Loudwell was found in the dining room and the alarm was raised Peter Bryan was asked if he knew about it. It is recorded that he admitted causing the injuries. After being formally secluded he was asked how he had caused the injuries. At first he said he had hit him. When it was pointed out that the injuries were extensive, he said he had hit Richard Loudwell’s head on the floor. Peter Bryan was asked if he had done anything else. At this point he produced a ligature and said that he had tried to strangle Richard Loudwell with it. The observation notes record:
“When asked why, he stated he had thought about it for a while, said he wanted to eat him, but didn’t have time...Denies any other patient involvement...Did state that [patient I] is next in the chain. Also stated to the doctor that if there were two people in the room only one of them would leave.”

3.54 Peter Bryan was seen by Consultant Psychiatrist 1, the duty resident medical officer and SHO1, the duty senior house officer at 7pm on the day of the assault. Peter Bryan’s description of the assault was noted and is reproduced here in full:

“I get these urges you see.”

“It’s like a sort of chemical reaction going through my body. Do you know what I mean?”

“I’ve had these urges towards him [Richard Loudwell] ever since I saw him. He’s the bottom of the food chain, old, haggard...he looked like he’s had his innings.”

He said nobody incited him to do it, but staff feel otherwise.

“I’ve had these urges towards him for a long time. I was just waiting for my chance to get at him.”

“I wanted to kill him and then eat him”.

“I didn’t have much time. If I did, I’d have tried to cook him and eat him.”

“I found him alone, used my pyjama string to strangle him. And when he was unconscious I just took his head and banged it against the floor until I saw blood. Then I knew he was dead.”

3.55 A note written by RMO2, Peter Bryan’s RMO at a seclusion review at 8.20am on 26 April recorded:

“He said he approached Richard Loudwell in the dining room, took the cord from his trousers and used it to strangle him, but he was still breathing, so he started
banging his head on the floor. ‘I was aiming at his temple’. He said he stopped because he needed ‘a breather’ and by then staff had been alerted. He said he had ‘urges’ through his body to attack…[illegible]…He had had urges about fellow patient I but no-one else, no staff. He denied being put up to this by other patients although he said there were a lot of comments going round but he did not take much notice of these.”

3.56 This interview was also noted by Team Leader 2 in the nursing observation records. Peter Bryan had told RMO2 that he had identified Richard Loudwell as vulnerable and also another patient, patient I, whom he would target. He explained that he had removed the cord from his jogging trousers and tried to kill Richard Loudwell, but:

“…the cord did not do the job properly so he attempted to smash his intended victim’s temple against the ward [sic] he had hit his victim’s head against the wall but became tired he then went to the toilet for a rest and to wash his hands. He was then planning to return to his victim.”

3.57 Later that day the nursing observations record that Peter Bryan said he hoped his victim would die:

“…as if he hasn’t he will have to ‘finish him off’. He went on to say that he got such a buzz from the assault that he will have to carry on doing them.”

3.58 On 27 April it was recorded that Peter Bryan had talked to staff at length, stating:

“…he took an opportunity, he saw patient RL enter the dining room, he himself entered the room, pretended to use the water fountain and then went behind him and strangled him with the ligature, when they fell to the floor he began hitting his head on the floor as he wanted it to be over quickly as he didn’t want RL to suffer, but he couldn’t bang his head and keep the ligature in place. Eventually he got out of breath and had to stop. He stated he had picked on RL because he was old and vulnerable and had been thinking about assaulting him for 4 or 5 days. He had also thought about assaulting [patient I] as he sits all day doing nothing. He said it was almost like being God, when referring to choosing victims, but that ‘I’m not God, am I?’ He believes that there are other people in prison who deserve
a bed in Broadmoor more than his victim and planned victims. He admits that assaulting others gives him a ‘buzz’…”

3.59 He is recorded as having admitted to being sexually aroused since the assault.

3.60 In an interview, on 29 April, Peter Bryan is recorded as speaking of Richard Loudwell’s “vulnerability”:

“…as he felt he was old and ‘looked like he was in pain’. Peter also spoke of his ‘urges’ and ‘the buzz’ he experiences when he has just killed a person. He felt the victim’s energy is immediately inherited in his own body and that he does get a buzz eating people’s flesh, which is a reaction to the hunger he feels soon after killing.”

3.61 SH01, recording the same interview, noted that Peter Bryan admitted he had been planning the assault for two days and had been waiting for a chance to get at Richard Loudwell when he was in the toilet:

“Initially I wanted to suffocate him against a pillar, but that wasn’t working so I saw I had a cord in my pants and I used that to strangle him…I must have banged his head fifteen times. I went for his temple. I wonder how he survived. I must have been doing something wrong. He’s had his innings. I must’ve not done it properly.” He said he judged vulnerability by the age, how down the person looked and ‘You just know. They don’t fit in with the environment’.”

3.62 Later, when Peter Bryan was moved to Isis ward, he told staff he had been feeling “cracks” in his legs at the time of the assault:

“He indicated he was feeling cracks in his legs just as he did before the incident on Luton. He said that he had felt the cracks on his legs before the Luton incident and that it had something to do with his mental state. He said after feeling the cracks on Luton he felt that he could not talk to staff about it. Therefore he went away and committed the incident.”

3.63 On 19 May he told staff on Isis ward that he had banged Richard Loudwell’s head on the table 15 times and could not believe he was still alive.
3.64 When interviewed by the inquiry on 21 March 2006 Peter Bryan gave more detail about the incident. He confirmed he had identified Richard Loudwell and one other patient as victims some days before the incident. In the case of Richard Loudwell he said he chose him because Richard Loudwell had told him:

“...he didn’t want to be there for the rest of his life...he said he was too old to be in the position that he was in. So I took it from there that if I attacked him he wouldn’t put up much of a struggle.”

3.65 Peter Bryan then told the inquiry that he knew the other patients teased Richard Loudwell but he did not join in. He followed Richard Loudwell around waiting for an opportunity. This arose when Richard Loudwell went into the dining room and no staff were around. He attacked Richard Loudwell rather than the other patient because he perceived Richard Loudwell to be more vulnerable. Peter Bryan also said that he thought his voodoo beliefs required him to attack Richard Loudwell. Richard Loudwell was in the dining room reading when the opportunity arose. Peter Bryan said he had not realised he could use the draw string of his trousers until he was in the dining room. At the time of the assault he felt his ankles clicking and got a “buzz”. This made him feel he could overcome his victim if he had to.

3.66 In the course of the assault he felt tired. He had blood on his hands and left the room to wash them. He intended to return to the dining room to finish what he had started, but was intercepted by staff. Peter Bryan told us he had taken off his blood stained shoes in the smoking room after the alarm was raised when he was asked to go to his room from the clinic room. He denied receiving any encouragement or help from anyone else in preparing for or carrying out the assault, but while he was taking off his shoes he was asked by patients what he had done and what it was like. He thought they would have known it was Richard Loudwell because he was the one everyone was “troubling”.

3.67 He told us he did not feel any remorse for what he had done, but did regret that Richard Loudwell had suffered. He wished one result of the inquiry to be that a similar assault would not be suffered by anyone else.
Reaction of other patients after the incident

3.68 For reasons of privacy we do not intend to identify the patients whose behaviour or reactions after the assault were described to us. We were told that some patients seemed stimulated and excited by the events, and some appeared pleased that Richard Loudwell had been assaulted. However there was also evidence of distress and anxiety on the part of some patients once it became clear how serious the assault had been. The impression staff received was that some form of attack on Richard Loudwell was approved of by at least some patients, but none were happy that he had been seriously attacked.

Overall conclusions on incident

On the basis of the evidence summarised above, and the totality of the information we have received we have come to the following conclusions about the incident:

C7 Peter Bryan intended to kill Richard Loudwell for some time before the incident and was waiting for a suitable opportunity.

C8 No member of staff was aware of this or even suspicious of any hostile intent towards Richard Loudwell on the part of Peter Bryan, although it was known that Richard Loudwell was unpopular and had been bullied by others.

C9 The assault was sustained and took place over a matter of several minutes.

C10 No member of staff was aware that Peter Bryan or Richard Loudwell were in the dining room either before or during the assault.

C11 No member of staff was aware of anything untoward happening until a noise was heard in the ICA room.

C12 At the time of the assault no member of staff was in the dayroom or in a position to see into the dining room. This was the case for an appreciable time before the assault.

C13 Other patients in the dayroom were, or may have been, in a position to see into the dining room and be aware of what was happening there.
C14 The behaviour of some patients before, during and after the incident suggests they might have been aware that an attack was taking place or was about to take place, but it is unlikely that any patient anticipated the severity of what occurred.

C15 While some members of staff noticed a different atmosphere no change was made to monitoring arrangements.
4. Richard Loudwell - forensic history

4.1 Richard Loudwell killed Joan Smythe on 2 December 2002. She was 82 years of age. He was arrested that day and remained in police custody until 6 December 2002. He was then transferred to HMP Elmley where he remained for six days before being transferred to HMP Belmarsh on 12 December 2002. This inquiry is concerned with Richard Loudwell’s care and treatment from his arrival at Belmarsh onwards. Events leading up to the killing of Joan Smythe were considered in a separate inquiry, chaired by Anthony Harbour, which reported in March 2006.

4.2 In order to better understand the care and treatment of Richard Loudwell at Belmarsh and then Broadmoor it is useful to have a summary of events before the killing of Joan Smythe. This summary is based on the findings of Anthony Harbour’s report.

4.3 Richard Loudwell was born on 18 August 1944. He was 58 when he killed Joan Smythe. In August 1995 he was first referred by his GP to mental health services with a history of depression. He was informally admitted to hospital for treatment for a ‘brief depressive episode’ for six days in March 1997. A second informal admission took place for a month in July and August 1999 when Richard Loudwell was described as experiencing psychotic symptoms for the first time.

4.4 He was arrested in August 1999 following an alleged indecent assault on an adult female member of his family. She also alleged he had sexual contact with her when she was a child but that no charges had been brought against him at that time. During 1999 police had concerns for the safety of his mother, as Richard Loudwell was reported to have been abusive and threatening towards her on a number of occasions.

4.5 In December 1999 Richard Loudwell pleaded guilty to indecent assault (both for the recent offence and that which had occurred when the victim was a young child). He was sentenced to two years probation.

4.6 While on probation Richard Loudwell was regularly reviewed by mental health services. He remained under their care when his probation order expired.

4.7 During 2002 Richard Loudwell’s behaviour became increasingly strange. On 27 February 2002 his psychiatrist, Consultant Psychiatrist 2, noted that Richard
Loudwell’s sister who accompanied him to outpatients was concerned that he had been acting strangely for about six weeks, had been aggressive and wandering around naked. He was admitted informally to hospital on 6 March, staying there for a week. During this admission he was reported as acting inappropriately to female patients and to have persisted with this behaviour despite being requested to stop. He was threatened with assault by other patients.

4.8 In May 2002 Richard Loudwell was again admitted informally to hospital, this time for three days, following concerns raised by his family that he was neglecting himself, had stopped taking his medication and was hoarding it.

4.9 In early October 2002 police received a report that Richard Loudwell was sitting in a petrol station with a pornographic magazine with his trousers open and his penis exposed. A locum associate specialist at Medway Hospital reported that Richard Loudwell had pre-senile dementia.

4.10 In late November 2002 police received a further report. Richard Loudwell had gone into a pharmacy, naked from the waist up, and discussed intimate sexual details with the pharmacy assistant. He asked to take her photograph.

4.11 On 30 November 2002 Richard Loudwell was arrested for the assault and rape of a man in Canterbury. He was taken to Canterbury Police Station, where he was seen by the custody nurse. Richard Loudwell described himself as “manic depressive and bi-sexual”, indicated that he had been in hospital for depression and stated that he had “no control over his sexual urges”. He admitted certain aspects of indecent assault but denied rape. He was bailed.

4.12 On 2 December 2002 it appears that Richard Loudwell met Joan Smythe at Tesco in Rainham, Kent and offered to help with her shopping. Later that night he called an ambulance. The ambulance crew arrived at Mrs Smythe’s home to find Richard Loudwell naked. Joan Smythe was taken to Medway Hospital by ambulance and Richard Loudwell went there separately by taxi. He was later arrested and charged with her murder.

4.13 He was transferred from police custody to HMP Elmley on 6 December 2002. On 12 December 2002 he was transferred to HMP Belmarsh. On 15 January 2004 he was transferred to Broadmoor Hospital.
4.14 It is not necessary to set out full details of Joan Smythe’s injuries. The post mortem reports indicated she had suffered multiple injuries but died from a major compressive injury to the neck, consistent with strangulation. There was evidence of multiple bruising and multiple cigarette burns to Joan Smythe’s body and genitalia. There was further evidence of serious sexual assault.

4.15 On 22 April 2004 at Maidstone Crown Court, Richard Loudwell pleaded guilty to manslaughter on the grounds of diminished responsibility. The Court ordered that he be subject to an interim hospital order under section 38 of the Mental Health Act 1983. He was returned to Broadmoor.

4.16 Simon Crawford, chief executive, in the Trust’s response to a draft of this report, observed that Richard Loudwell’s offence was unusual even by Broadmoor standards in its nature and choice of victim. The case attracted widespread publicity and we accept the Trust’s observation that it was inevitable following press reports at the time of Richard Loudwell’s guilty plea that the full facts of his offence would become known by fellow patients. We also note the acceptance by the Trust that in the light of the hostility of some other patients to Richard Loudwell and given this widespread publicity a higher level of oversight of Richard Loudwell should have followed from this date.

4.17 Three days later, on Sunday 25 April 2004, Richard Loudwell was assaulted by Peter Bryan. He was taken to Frimley Park Hospital where he remained in a serious condition until his death on 5 June 2004.
5. Richard Loudwell - HMP Belmarsh

Terms of reference

With respect to HMP Belmarsh this inquiry’s relevant term of reference is:

“…to review the plans in place to care for Richard Loudwell and the management of his mental state and behaviour following his detention in HMP Belmarsh in December 2002. This includes looking in particular at any assessments made by the prison and health authorities of the risk of him being harmed by others.”

Documentation

5.1 We have seen Richard Loudwell’s medical notes for the period between his remand to HMP Elmley on 6 December 2002 and his transfer to Broadmoor on 15 January 2004. These are in his inmate medical record (IMR). In addition we have seen his inmate personal record (IPR). We have also seen security intelligence reports and a variety of other documents from Richard Loudwell’s prison file to which we will refer. We have seen only one cell sharing risk assessment for Richard Loudwell which was completed on 14 September 2003, nine months after his arrival at Belmarsh. We have seen only three nursing care plans but believe there were probably others which have been lost or destroyed.

Nursing care plans

5.2 We have seen one plan dated 10 August 2003 which addresses “express bizarre behaviour” and appears to have been discontinued in October 2003. We have also seen two plans dated 1 December 2003. The first addresses “history of mental health problems” and “poor hygiene”. The second addresses “diabetes”. We have seen no other care plans.

The model of care at HMP Belmarsh

5.3 Belmarsh serves both as a local prison and a category A prison designed for prisoners (and at times detainees under anti-terrorism measures) requiring the highest levels of security. It has, therefore, to deal with a very difficult mix of prisoners, many of
whom will need mental health care and treatment. The mental health service in Belmarsh is managed and provided by the Oxleas Mental Health NHS Trust as part of a forensic service covering HMP Belmarsh, HMP Brixton, and various medium secure and other units. RMO1, the consultant psychiatrist at Belmarsh, is employed by the Oxleas Mental Health NHS Trust. He spent the bulk of his time meeting the needs of service users in Belmarsh. The Trust recently won a Beacon Award for its prison service and, we were told, its lead in designing prison mental health services. The service has referred to it some 2,000 patients a year. Many can be seen in the main prison but some require more specialist, hospital equivalent, inpatient care in the health care centre. RMO1 has two staff-grade junior psychiatrists and four community psychiatric nurses working in the service.

HMP Elmley 6 to 12 December 2002

5.4 Richard Loudwell was arrested on 2 December 2002 and was in police custody until 6 December 2002. On that day he was remanded in custody by Medway Magistrates and went to HMP Elmley, Sheerness. We are not asked to consider Richard Loudwell’s detention at Elmley. We will however provide a brief account of his time there because it provides the background to his arrival at Belmarsh.

5.5 When he arrived at Elmley, Richard Loudwell was admitted to the healthcare wing because he was deemed to be at risk of self-harm. It was noted in his IMR that he was “aggressive in manner” and that he became “gradually more settled but unpredictable and evasive”. F2052SH was instituted. This is the prison regime for prisoners deemed to be at risk of self-harm. Richard Loudwell was transferred from Elmley to Belmarsh after six days, on 12 December 2002.

Behaviour at Elmley

5.6 Richard Loudwell’s behaviour at Elmley was reported as bizarre. There were moments of calm when he was described as being capable of conversing well and at length, but more often his behaviour was noted as loud and disruptive. He wanted to undress, as he had done in police custody, and had to be persuaded to get dressed to be interviewed. He flooded his cell and covered the observation panel with faeces. On 10 December 2002, the weekend after his admission, his behaviour deteriorated. An injection of intramuscular Haloperidol and Lorazepam as a sedative was considered.
5.7 On 11 December 2002 it was noted that he continued to be abusive to staff and visitors and that he remained locked up “due to threats from other inmates”.

Mental health care provided

5.8 A mental health assessment was requested on 7 December 2002, the day after Richard Loudwell arrived at Elmley. The pro-forma request asked for an assessment ‘as soon as possible (within six working days)’. The reason given in support of the request was Richard Loudwell’s “bizarre behaviour” in custody. On 11 December 2002 Consultant Psychiatrist 3 noted in Richard Loudwell’s IMR that she had been unable to see him. Consultant Psychiatrist 3 is a consultant forensic psychiatrist at the Trevor Gibbens Unit, Maidstone. She later saw Richard Loudwell in Belmarsh on 9 January 2003.

5.9 Just as later at Broadmoor, some staff at Elmley did not believe that Richard Loudwell was mentally ill. An entry by the night shift on 10/11 December 2002 reads:

“Remains confrontational and demanding: however I don’t believe this man to have a mental illness: only presents as anti-social with poor anger management.”

HMP Belmarsh, 12 December 2002 to 15 January 2004

5.10 On 12 December 2002 Richard Loudwell arrived at HMP Belmarsh, Woolwich, from HMP Elmley. We will consider Richard Loudwell’s custody in Belmarsh under the following headings:

- Richard Loudwell’s behaviour and interaction with staff
- Interaction with other prisoners
- Risk assessment, security and care planning
- Mental health and medical assessment.

Richard Loudwell’s behaviour and interaction with staff

5.11 Richard Loudwell’s behaviour changed during the 13 months he was at Belmarsh. There appear to have been three different phases. From his arrival in December 2002 until about March 2003 he presented as disruptive. Between about April 2003 and August 2003
he became quieter but was withdrawn and interacted little with others. From about September 2003 onwards his spirits appear to have lifted and he was thought to be behaving appropriately.

December 2002 to March 2003

5.12 Richard Loudwell was admitted directly to the health care centre, placed in a single cell and put on F2052SH and a 15 minute watch. On arrival at Belmarsh his behaviour was highly disruptive, abusive and confrontational. It was noted that he could respond in an “over-the-top” way to being challenged or directed. He was on a 3-man unlock from 12 December 2002 until 3 January 2003.

5.13 A possible fit was recorded in the evening of 12 December 2002 and it was thought that Richard Loudwell might have been incontinent of urine.

5.14 Shortly after arriving at Belmarsh, Richard Loudwell told medical staff he had been persecuted by Elmley prison staff and had suffered repeated head trauma. On arrival at Belmarsh he was noted to have a black eye. In a referral letter of 20 December 2002 addressed to the medical team at Queen Elizabeth Hospital, Woolwich, Specialist Registrar 1 from Belmarsh, noted:

“He claims to have suffered repeated head trauma during his time at HMP Elmley and whilst in custody at Chatham. We cannot prove or disprove these claims, although he is certain that no injury resulted in a loss of consciousness. He had an episode of what was labelled a ‘fit’ on December 12th.”

5.15 On 5 January 2003 he was involved in an altercation with other prisoners. This will be considered in more detail below.

5.16 When Consultant Psychiatrist 3 first met Richard Loudwell on 9 January 2003 at Belmarsh, she noted that his behaviour had settled somewhat although he continued to exhibit considerable sexual disinhibition.

5.17 On 3 February 2003 it was recorded in his IMR that he had been very angry, aggressive and had said to a female member of staff “stick a red poker up your arse”.

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5.18 A security report records that on 6 February 2003 Richard Loudwell was moved to another cell. It was reported:

“Loudwell was not very happy with the move and began to verbally abuse staff. Later in the morning I went to answer his cell bell and dropped the inspection hatch. When I did so, Loudwell threw a bowl of water at me. He then went on to flood his cell.”

5.19 Richard Loudwell was not put back on a 3-man unlock but advice was given to staff that he should not be unlocked unless two members of staff were present.

5.20 Also on 6 February 2003 Richard Loudwell was noted to have called a healthcare worker a “chapatti munching ****”. The same day the Samaritans asked that Richard Loudwell stop calling their phone because he was using it as a “sex line” and causing the operators distress.

5.21 On 7 February 2003 he assaulted a prison officer and was placed in a ‘safe cell’ for a ‘time-out’. This appears to have led to a complaint by Richard Loudwell that he was assaulted on that occasion. His complaint was first recorded on 13 February 2003 in his IMR. He complained of having been assaulted by “various officers”. On examination there were “no obvious physical signs of any assault” and a plan was recorded to photograph any areas where Richard Loudwell claimed to have been assaulted. We have not seen any photographs. An entry on 14 February 2003 records an allegation by Richard Loudwell that he was “beaten up” by officers on 7 February 2003. He complained of bruising to his back and right thigh but on examination it is recorded that there were no visible injuries. Richard Loudwell apparently complained to his solicitors that he had been severely beaten by up to ten prison officers. A letter to the Governor from his solicitors dated 26 February 2003 records that the solicitor’s representative had seen no evidence in support of the allegation:

“As you are probably aware, I visited Belmarsh Prison yesterday to take photographs of Mr Loudwell following a complaint to us that he had been severely beaten up by approximately 10 officers, and I would say that I was treated with a very high standard of courtesy by staff.”
“On examining Mr Loudwell there were no visible injuries to be seen on his body apart from a few minor marks on one leg. However, Mr Loudwell went into a coughing spasm, and doubled up in pain, clutching his chest on the right hand side and I would be grateful if he could be examined by the Prison Doctor regarding this matter.”

5.22 On 13 February 2003 Richard Loudwell was noted to have collapsed on his way to court. An ambulance was called and no obvious cause was found. A security report was submitted on the basis that he might have been feigning illness.

5.23 An entry in the IMR for 27 February 2003 timed at 4am records that Richard Loudwell had been pressing his cell call-bell repeatedly asking for various items. This had escalated to him continually banging his cell hatch. The entry in his notes states:

“...when I went to his cell and dropped his hatch he grabbed my arm, pulling it in towards him. I broke his grip quite easily and closed the cell hatch, staff should be aware of this tactic.”

5.24 The typical pattern of Richard Loudwell’s behaviour in February 2003 is summarised by the following entry in his supervision and support record for a single afternoon (18 February 2003):

“No change to report regarding this old chap who continues to alternate between foul abusive language and polite requests throughout.”

5.25 On 21 February 2003 Richard Loudwell was restrained by staff after throwing his dinner at hot plate staff. Control and restraint was used after which he complained of injury to his right arm, wrist and ribs. This incident led to Richard Loudwell being charged under prison rules. It is not clear what the outcome was although it appears a psychiatric assessment was requested.

5.26 For much of March 2003 Richard Loudwell was generally more settled. At a care plan review on 24 March it was noted: “generally more settled with less aggressive outbursts”. However an entry on 31 March 2003 notes: “General deterioration in mental state over the past few days, shouting, banging most of the day, verbally abusive towards staff.”
April 2003 to August 2003

5.27 There are very few entries in Richard Loudwell’s IPR (as distinct from his IMR) from April 2003 onwards which is probably indicative of improved behaviour. There is no indication in these notes of any management issues in April 2003. In his IMR for 24 April 2003 it was noted at a care plan review:

“States his mood is somewhat more elevated than from previous review. Staff have observed that his behaviour has moderated from initial reception to [Belmarsh] and aggressive outbursts are less frequent…”

5.28 The only incident of any note in his IPR in May 2003 was on 14 and 15 May 2003 when Richard Loudwell was said to be misusing his cell bell. At his care plan review on 11 May 2003 it was noted that Richard Loudwell was “much more settled, not abusive or demanding”. He was also noted to be taking care with personal hygiene.

5.29 On 1 June 2003 it was recorded in the IPR that Richard Loudwell was “more settled of late however is very lethargic”. In the IMR at a care plan review on 2 June 2003 it was recorded that deterioration in Richard Loudwell’s mental state had continued. He was showing signs of poor self-care, lying in bed for most of the day and declining to get up for some meals. There is some suggestion this might be related to his Metformin medication. Richard Loudwell complained he was tired during the day because he could not sleep at night due to noise.

5.30 On 28 July 2003 it was noted that Richard Loudwell was continuing to conform to the health-care regime although he was still spending long periods in bed. An entry in the IMR for 13 August 2003 records:

“...remains very quiet and withdrawn although he is polite to staff. He spends most of his time sleeping.”

5.31 On 25 August 2003 Richard Loudwell came off F2052SH, the prison regime of enhanced observation for those believed to be at risk of self harm.
September 2003 to January 2004

5.32 In September 2003 Richard Loudwell’s mood appears to have brightened. An entry for 7 September 2003 reads:

“Loudwell’s mood has lifted considerably in recent days. He is more alert and this afternoon attended exercise for the first time in a long time.”

5.33 An entry in Richard Loudwell’s record for 12 September 2003 testifies how he had become more settled in the second half of 2003:

“Becoming a regular down the CASS unit, Loudwell is now a cheerful individual who has not been a management problem however he has the potential to be inappropriate especially with fellow staff.”

5.34 An entry for 11 October 2003 refers to a “very polite and well behaved prisoner who participates in association and exercise...Baths and showers regularly.”

5.35 If Richard Loudwell’s overall behaviour improved, some of his particular characteristics persisted. It was noted on 21 September 2003 that although his mood continued to be upbeat he was becoming ‘inappropriately friendly’ with female staff and had reverted to his habit of “sitting around his cell naked”. A female member of staff noted on 24 November 2003 in his IPR:

“Remains inappropriate to female staff. I have spoken to him on a few occasions about talking through the hatch with no clothes on and I have also had to tell him not to touch me when I am speaking to him.”

5.36 A similar entry was made on 1 January 2004 when a nurse recorded in his IMR:

“...better behaved with staff but needs to be reminded about invading individuals’ personal space, is always apologetic.”

5.37 A document dated 26 November 2003 is headed “Nursing assessment of Mental Stage [sic] on Transfer from HM Prison Belmarsh”. This document appears to have been completed when Belmarsh was told Richard Loudwell had been offered a bed at
Broadmoor. The document is interesting because it suggests Richard Loudwell’s bizarre behaviour when he was first in custody had largely been resolved.

5.38 Under the heading “Aggression or Self Harm” it is recorded: “No forms of aggression either verbal or physical since admitted in the Health Care [Centre]. Has no ideation of self harm since in the Health Care [Centre].”

5.39 Under the heading “Abnormal beliefs perceptions behaviour and orientation” it is recorded: “He has no fixed abnormal beliefs, or false perception. General behaviour at present is appropriate at all times…”

5.40 Under the heading “Interactions with staff” it is recorded: “Interacts well with both staff and other inmates.”

5.41 On a different sheet, which is undated, but appears to have been completed by the same person and which it is assumed therefore is part of the same document there is reference to Richard Loudwell’s earlier behaviour having been inappropriate. Under the heading “Summary of management at HMP Belmarsh” it is recorded “His general behaviour was inappropriate. Dressed inappropriate.”

5.42 On 1 December 2003 Richard Loudwell was assessed by Nurse Consultant 1, nurse consultant from Broadmoor, with a view to his admission to Luton Ward which was planned for the following six to eight weeks. Her assessment is considered in the section of our report which covers Richard Loudwell at Broadmoor.

5.43 At Richard Loudwell’s care plan review the following day, 2 December 2003, it was noted:

“Coping very well, pleasant and appropriate with staff, making good attempts at keeping clean and tidy, attends CASS and exercise.”

5.44 This appears to have remained the position until Richard Loudwell left Belmarsh for Broadmoor on 15 January 2004.
Interestingly in view of the apparently poor relations between Richard Loudwell and staff early on in his time at Belmarsh the lasting recollection of the Head of Healthcare at Belmarsh was of a character for whom staff felt affection:

A. He was what could be described as a character within the unit. He was there for such a long time that everyone knew Dickie Loudwell and knew of the way he behaved and the tale[s] he used to tell and such like. He was one of the characters you have who everyone has an affection for, I suppose.

Q. The last-but-one entry in his IMR, 5 January 2004, says “Sometimes quite difficult to close a conversation with him”

A. Absolutely. That is a very good summary.

Q. That is how you remember him?

A. Yes. Even though you have a steel door between you and him, it was sometimes almost impossible to disengage.

Q. Was it therefore your perception that he wanted to engage?

A. Absolutely. The man was desperate for human contact.

Q. Would staff regularly give him that human contact?

A. You do what you can. They have duties to perform etc. and other people to look after and it is not always possible to give as much time as you would like. The environment you are trying to deliver that care in is not conducive to a therapeutic approach towards care.

Interaction with other prisoners

The health care centre has 18 single cells and two six-bedded wards. Other prisoners in the health care centre had beds in shared wards. Richard Loudwell was initially placed in a single cell because he was on F2052SH and a 3-man unlock but he remained in a single cell throughout his time at Belmarsh. His opportunity for interaction with other prisoners was therefore limited. On 5 January 2003 he was allowed into a ward during association to watch television. This apparently led to an incident or incidents with the other prisoners.

An intelligence report for 5 January 2003 suggests that other prisoners may have become aware of Richard Loudwell’s index offence and that a prisoner had threatened him. The report states:
“5.1.03 - Just before dinner [prisoner A] and Loudwell knocked on the bubble window [of the ward], when the door was opened Loudwell rushed out and [prisoner A] said ‘Get him out of here’. It would seem that prisoners had become aware of Loudwell’s offence. It was also reported that [prisoner B] was also a threat to Loudwell.”

5.48 This report was generated following the submission of a security intelligence report (SIR) by a prison officer to the security office. Richard Loudwell had been allowed on the ward with prisoners A and B to watch television in association. The initial report stated:

“Loudwell has been bullied before and this led to him attempting suicide last week. [Prisoners A and B] have previous for threats/ bullying”.

5.49 We do not understand the reference to a suicide attempt by Richard Loudwell. There is no other evidence to suggest a suicide attempt at any time at Belmarsh. He was on F2052SH and it may be that the officer completing the security form on 5 January 2003 had misunderstood the reason for this. Nor can we find any other written reference to earlier incidents of bullying. The Head of Healthcare at Belmarsh told us other prisoners called Richard Loudwell a ‘nonce’ but it is not clear when such name calling started. There is some documentary evidence of poor relations between Richard Loudwell and other prisoners after this date which will be considered further below.

5.50 Later on 5 January 2003 it was noted that Richard Loudwell had “become very aggressive to staff and threatened that when he was unlocked he was going to sort out [prisoner B] also threatened to sort staff out”.

5.51 We have also seen details of a complaint by prisoner C, made on 6 January 2003, about Richard Loudwell’s inappropriate behaviour towards him on 5 January. Prisoner C’s account was as follows:

“On Sunday 5th January I was touched by another prisoner with scruffy hair and a beard...The person asked me for writing paper and I gave him two sheets. He then sat on my bed and asked if I wanted a roll up cigarette, I said I didn’t and he rubbed his hand over my frontal area, I was quite shocked by the incident and went over by bed number [x] and spoke to [prisoner D] and [prisoner E]. [Prisoner E] told him to pull up his fly (zip). I was mixed up and shocked, nervous and
agitated. I want the police informed so that this prisoner does not get away with this on anyone else.”

5.52 The first intelligence report suggested Richard Loudwell may have been ‘chased’ out of the ward once prisoners found out about his index offence. However the prisoners may have been responding to Richard Loudwell’s alleged behaviour towards prisoner C. Alternatively it may have been a combination of both.

5.53 Although we are not in a position to reach a firm conclusion about the incident reported by prisoner C we note the report of 10 January 2003 from a security officer who interviewed both Richard Loudwell and prisoner C about the incident. He notes:

“Firstly I spoke to Loudwell, who denies touching anybody inappropriately, I do not believe him...I then spoke to [prisoner C] who explained how the event took place, and still appeared in shock when relaying the facts to me. I believe his side of the story...As there are no witnesses to the incident, I have advised both inmates that we can take no action…”

5.54 Consultant Psychiatrist 3 noted on 9 January 2003 that Richard Loudwell had recently been in an altercation with another inmate who had called him a ‘nonce’. This may well have been a reference to the incident(s) on 5 January 2003:

“Mr Loudwell was then observed to shout through his cell to the inmate and described in explicit detail the sexual behaviour he would like to enact on the inmate.”

5.55 On 17 February 2003 Richard Loudwell told RMO1 on review that he was scared of the reaction of prisoners and staff to him. He claimed he was kicked and spat at and that things were thrown at him on his way to exercise.

5.56 The threat to Richard Loudwell from other prisoners continued. An intelligence report for 23 March 2003 recorded:

“It was reported that [prisoners B, F and G] are planning to assault Loudwell on the stairwell on his return from exercise.”
5.57 There is a security report of a serious incident on 28 April 2003 which demonstrates that Richard Loudwell’s relations with other inmates remained strained. A member of staff reported that six inmates were unhappy about Richard Loudwell attending the same class:

“The students in my class were upset that Loudwell may be with them during [association]. He is at present in a single cell. He is being termed by the students as a ‘nonce’. It was decided that if he came to the ward he would be killed.”

5.58 In section 6 of the report under the heading “Summary of supporting/related intelligence” was written “There has (sic) been several reports of this type from the HCC”.

5.59 There were however no further security/intelligence reports regarding threats to Richard Loudwell before he left Belmarsh in January 2004.

5.60 The security report form contains a box for the intelligence officer to suggest any action in response. The suggestions made in this case were to restrict Richard Loudwell’s association by keeping him in his cell for longer and to deal with the other prisoners by means of the incentives and earned privileges (IEP) scheme.

5.61 The inquiry was told by the Head of Healthcare at Belmarsh, manager of the health care centre, that throughout 2003 the opportunities for association in the health care centre were limited because of the space available. Association was limited to areas outside each wing within the health care centre. This was no more than the space at the end of a corridor or landing. From the beginning of 2004, when Richard Loudwell was leaving for Broadmoor, one of the wards was closed to permit an association space.

5.62 The Head of Healthcare was asked about the degree of interaction between Richard Loudwell and other prisoners:

Q. Can you recall whether [Richard Loudwell] had any interaction with any other prisoners or patients?
A. It was extremely limited. One of the concerns I have about keeping people with mental illness problems for any length of time in the inpatient unit is that the
time out of cell is more limited within the inpatient unit than it is on normal location. He would spend the majority of his day locked in a single cell on his own.

5.63 The Head of Healthcare went on to say that a prisoner in 2003 would probably have had association a couple of times a week for up to an hour on each occasion. There would be between five and ten prisoners in association at any one time depending on the needs of the group. The Head of Healthcare thought it unlikely that Richard Loudwell had association with other prisoners:

Q: Is it possible that [Richard Loudwell] therefore did not have association with other prisoners?
A: Yes.
Q: If he didn’t have association with other prisoners, is it possible that he didn’t have any association at all?
A: He would have had association with the staff, and I know he was well known particularly to the discipline staff upstairs. When he had interaction with others it would almost certainly have been with staff more often than anybody else...

5.64 Richard Loudwell’s IMR does however suggest some opportunity for interaction with other prisoners. On 24 October 2003 it was noted:

“Much more settled and happier in his mood. Enjoys taking part in as much association/activity as possible and even attended the gymnasium today.”

5.65 Association could still give rise to difficulties however. For instance on 31 October 2003 it was noted:

“Remains in good spirits. However he has taken to talking about his offence with other inmates. This has led to problems before and I have advised him to keep his mouth shut.”

5.66 On 11 November 2003 the same prison officer noted “Good spirits continue. No repetition of earlier problems with other inmates.” The advice to “keep his mouth shut” may therefore have been followed by Richard Loudwell which would be of some significance in view of later events at Broadmoor.
Use of CASS unit

5.67 The CASS unit at Belmarsh is a facility offering access to various therapeutic activities for prisoners. It is named after a former prison officer.

5.68 There are frequent entries in the latter months of Richard Loudwell’s time at Belmarsh suggesting that he used the CASS facilities. Although he probably did spend most of every day alone in his cell this means there were some opportunities for him to leave the cell.

5.69 On the basis of documents we have seen it appears that in April and May 2003 he attended the CASS unit on at least five occasions and that in September 2003 he attended for a further five sessions. A note of his attendance at the last session of which we have a record, a yoga class on 22 September 2003, includes the following comment from the teacher: “Concentrated well although unable to stop the jokes and comments. Took part well”. This would seem to be a reference to jokes and comments directed at Richard Loudwell by other prisoners.

5.70 It appears that Richard Loudwell did continue attending the CASS unit although we do not have a record of further attendances. An entry in the IMR for 23 October 2003 states “attending CASS unit”.

Nursing assessment on transfer

5.71 We referred above to the document dated 26 November 2003, headed “Nursing assessment of Mental Stage (sic) on Transfer from HM Prison Belmarsh”. Under the heading “Nursing problems identified” it was recorded: “3. Would not participate in the ward activities. 4. His interactions with others was poor.”

5.72 Under the heading “Social interactions with other patients” it is recorded, apparently contradicting the above entry: “Remains good”.

5.73 Under the heading “Interactions with staff” it is recorded: “Interacts well with both staff and other inmates.”
5.74 We are not sure exactly what to make of this document. However in the context of Richard Loudwell’s changing behaviour at Belmarsh we conclude that while his relationship with other prisoners was initially poor, it improved in the latter part of 2003. By this time Richard Loudwell’s interaction with other prisoners was no longer a problem provided it was limited and closely supervised. We are of the view that the risk to Richard Loudwell of physical harm, if left unsupervised with other prisoners in association, was no less in December 2003 than it had been on 5 January 2003.

Risk assessment, security and care planning

5.75 On the pro-forma “Prisoner Security Information” sheet completed on 12 December 2002 Richard Loudwell was noted to be of a violent nature and a possible suicide risk but was not regarded as a vulnerable prisoner.

5.76 We have not seen a risk assessment tool or any document to demonstrate how Richard Loudwell was seen as a possible suicide risk but not a vulnerable prisoner.

F2052SH

5.77 On arrival at Belmarsh, Richard Loudwell was placed on F2052SH, the prison regime for prisoners at risk of self-harm. He remained on this regime for eight and a half months until 25 August 2003. There is evidence in the IMR of F2052SH reviews being undertaken at regular intervals but we have no documentation to demonstrate on what basis a decision to continue/discontinue F2052SH was made.

3-man unlock

5.78 When he arrived at Belmarsh Richard Loudwell was placed on 3-man unlock. As early as 19 December 2002, a week later, some staff questioned whether that was necessary. An entry in his IPR reads:

“Since his arrival on Healthcare this patient has not presented any physical control problem though his manner can be belligerent and somewhat insolent. However in my opinion he does not warrant his 3 man unlock status. With proper discipline he is manageable and if set boundaries I believe he can be taught to comply with the regime.”
5.79 Richard Loudwell came off 3-man unlock on 3 January 2003 when staff felt that it was no longer necessary. An entry in his IPR for 3 January 2003 reads:

“Is very upset at being located on West Wing but has to remain in a single cell due to his 3 man unlock status. Thoughts amongst the staff on duty at this time are that he no longer requires 3 man unlock status and would benefit from being located in a ward away from the noise of the west wing. Gov. Ford contacted and has agreed on the basis of the staff’s recommendation that Loudwell can be taken off his 3 man unlock status.”

Single cell

5.80 Within 48 hours of the suggestion in the IPR on 3 January 2003, that Richard Loudwell should move to a shared ward, there was an altercation between him and prisoners on the ward. It is not clear from Richard Loudwell’s IMR or IPR what further consideration was ever given to moving Richard Loudwell to a ward. It may well be that following this incident on 5 January 2003 staff believed it would not be safe or appropriate for Richard Loudwell to move to the ward.

5.81 The only cell-sharing risk assessment that we have seen for Richard Loudwell at Belmarsh is dated 14 September 2003. This assessment describes Richard Loudwell as:

“Elderly man who, at times, has had trouble coping in prison. Not suitable for shared accommodation due to his sexual habits.”

5.82 The Head of Healthcare at Belmarsh told us if Richard Loudwell was admitted directly to the health care centre (as appears to have been the case) it is possible that no cell-sharing risk assessment would have been carried out when he arrived at Belmarsh. It is possible therefore that the cell-sharing risk assessment of 14 September 2003 was the first and only such risk assessment carried out for Richard Loudwell. We cannot explain its timing unless it was carried out in September 2003 because from the closure of F2052SH at the end of August 2003 Richard Loudwell was at least in principle eligible for transfer to a ward.

5.83 It is interesting to contrast the approach of staff at Belmarsh to the approach at Broadmoor regarding the interaction of prisoners and patients. At Belmarsh the risk to
Richard Loudwell from other prisoners was reduced by restricting Richard Loudwell’s opportunity for interaction and keeping him in a single cell for most of each day. At Broadmoor Richard Loudwell frequently asked to go to his room but was instead required to be in association with other patients during the day. Because he was allowed to associate with other patients, which we do not criticise, the risk to Richard Loudwell was increased, as was the need for vigilance.

Security

5.84 In the section above detailing interaction between Richard Loudwell and other prisoners there is reference to security intelligence reports. There was clearly therefore a system in place for gathering intelligence and taking action in response. We have no evidence that Richard Loudwell sustained injury at the hands of other prisoners and to this extent at least his safety appears to have been successfully preserved at Belmarsh. However, as the Head of Healthcare pointed out in his evidence above, the opportunities for interaction between Richard Loudwell and other prisoners were limited so the risk to Richard Loudwell’s safety was reduced.

Care planning

5.85 The only care plan available to us which addresses Richard Loudwell’s behaviour in prison is dated 10 August 2003. It appears to have been discontinued by the time of review on 24 October 2003. Under the heading “Patient’s Problem” it says “Express bizarre behaviour.” The “Aim of Care/Goal” is recorded as being “For Loudwell to behave appropriately”. Four nursing actions are listed:

“a) Inform Loudwell what is appropriate in certain situations.

b) Inform Loudwell disinhibited behaviour is not acceptable in prison environment.

c) Allow Loudwell access to Listeners.

d) Encourage Loudwell to attend CASS unit.”

5.86 It is interesting that the primary strategy appears, as later in Broadmoor, to have been to tell Richard Loudwell to alter his behaviour. Implicit in this strategy is an assumption that he was responsible for acting in the way he was.
It would be surprising if this was the first care plan to tackle Richard Loudwell’s interactions with other prisoners and his behaviour, but in the absence of any record of previous care plans we are not able to comment further.

**Bullying**

We were told by the Head of Healthcare that some prisoners verbally abused Richard Loudwell by calling him a “nonce”. He would not routinely expect that sort of comment to generate an SiR although it would be for an individual prison officer or nurse to judge. There was an anti-bullying policy but no evidence that it was deployed in Richard Loudwell’s case. The Head of Healthcare was asked if limiting the opportunity for bullying may have been thought the most appropriate strategy in Richard Loudwell’s case:

**Q:** Was that done in Loudwell’s case [putting the anti-bullying policy in place] or was the fact that he spent most of his time in a single cell sufficient?

**A:** The structural security of having someone in a single cell within healthcare and having nursing staff and psychiatrists available, regular review, was probably considered to be ‘satisfactory’. That is a strange word to use. I didn’t think it was at all ‘satisfactory’ in terms of whether or not he was being cared for adequately as someone with a serious mental illness, but in terms of what was available within a high secure environment, that was considered to be ‘satisfactory’.

**Observation**

The inquiry asked the Head of Healthcare if a prisoner of Richard Loudwell’s background could ever be let out of sight of a staff member whilst in association. He said it was a weakness of the Belmarsh model that, with the exception of those in a six-bedded ward, prisoners never had the opportunity to be in association out of sight of staff:

“**It is one of the weaknesses of the model we have here that, unlike Broadmoor or a medium secure unit where prisoners are allowed to freely associate, although under various amounts of direction and supervision by clinical staff, here there is no general association.**”
5.90 He was asked if he could envisage a patient of Richard Loudwell’s background being put on such a ward:

“No. Certainly initially because of his disinhibited sexual behaviour and the nature of his index offence, he would not have been considered for shared accommodation.”

5.91 It does appear that contrary to this view on 3 January 2003 at least some staff did think Richard Loudwell should move to a ward and that he was allowed unsupervised association on a ward on 5 January 2003. This in turn appears to have led to the altercation with other prisoners referred to above.

**Psychiatric care of Richard Loudwell at Belmarsh**

5.92 Throughout Richard Loudwell’s time at Belmarsh he was seen regularly by RMO1 or one of the other psychiatrists. His case was reviewed regularly at management rounds. Richard Loudwell underwent a number of formal assessments whilst in Belmarsh and these are described in a subsequent chapter headed “Richard Loudwell - diagnostic assessment”.

5.93 In terms of psychiatric management, the plan was to secure admission to either a medium or high secure unit for a full multi-disciplinary assessment. The progress towards achieving this aim was at times slow, not least because of the complexity of his case and uncertainty as to whether he was most appropriately cared for in conditions of medium or high security. This process of securing admission to Broadmoor is described in a subsequent chapter headed “Richard Loudwell - admission to Broadmoor”.

**Conclusions in respect of mental health/medical care**

5.94 In summary we make the following findings about Richard Loudwell’s care and treatment at HMP Belmarsh:

C16 Richard Loudwell was admitted directly to the Health Care Centre on 12 December 2002 and remained there until his transfer to Broadmoor Hospital on 15 January 2003.
Throughout his time at Belmarsh he was detained in a single cell, his behaviour and history making him unsuitable to share a cell or ward with other prisoners because of risks to his safety.

From the time of his arrival in December 2002 until about March 2003 Richard Loudwell presented as disruptive and was a challenge to management.

Between about April 2003 and August 2003 he was quieter and more withdrawn, interacting little with others.

Between about September 2003 and January 2004 his mood was brighter and he was believed by staff to be behaving appropriately.

Richard Loudwell had limited opportunity to interact with other prisoners. When he did, particularly in the period January 2003 to March 2003 he was perceived to be at risk of harm from other prisoners who he claimed spat and kicked at him. Intelligence reports suggested that on at least two occasions there were threats to inflict serious harm on Richard Loudwell who was considered to be a ‘nonce’.

It appears that other prisoners were aware of his index offence.

The threat of harm to Richard Loudwell from other prisoners was managed by staff by keeping Richard Loudwell away from other prisoners.

Although Richard Loudwell spent most of each day in his cell he did on occasion take the opportunity to visit the prison’s CASS unit.

We make a recommendation in respect of the information that is provided by the prison to those from outside agencies such as Broadmoor when carrying out assessments of prisoners. This recommendation can be found at the conclusion of the chapter headed “Richard Loudwell - care and treatment at Broadmoor”.

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6. Richard Loudwell - admission to Broadmoor

6.1 At the time of Richard Loudwell’s admission to Broadmoor he was 59. The question arises as to whether it was appropriate for him to be admitted to Broadmoor in the first place.

Broadmoor admissions policy

6.2 The criteria for admission to Broadmoor are set out in the Broadmoor Hospital admissions panel operational policy.

6.3 The admissions guidelines refer to section 4 of the National Health Service Act 1977 which requires the Secretary of State to provide special hospitals for the detention of mentally disordered individuals “who in his opinion require treatment under conditions of high security on account of their dangerous, violent or criminal propensities.”

The guidelines continue:

“1.3 When an application is made for a bed at Broadmoor Hospital there are three main issues which need to be considered: the presence or absence of a recognisable mental disorder, liability to detention under the Mental Health Act 1983 and risk to others.”

6.4 The most controversial of the three issues in Richard Loudwell’s case was ‘risk to others’. The guidelines continue:

“Risk to Others
The regimes of care and observation at Broadmoor Hospital can only be justified when the highest level of security is required and no lesser degree of security will provide a reasonable safeguard to the public. It is an unacceptable infringement of a patient’s rights to detain them in a higher level of security than they require. Standard 5 of the National Service Framework for Mental Health states that an appropriate hospital bed is one that is in the least restrictive environment consistent with the need to protect the service user and the public and is as close to home as possible. The high security available within Broadmoor is necessary to detain patients who, if at large, would present a significant risk to the public and
who could not be safely contained within the security available at a medium secure unit.”

6.5 The guidelines give nine examples of types of behaviour which constitute a significant risk requiring conditions of high security. At one point the guidelines are worded to suggest that before admission to Broadmoor can be contemplated at least one of these ‘behaviours’ must be present. However on the following page, and within the same section, it says the list of behaviours is not exhaustive.

6.6 The list includes “Evidence of serious planned or unprovoked assaults on others including other patients or staff in secure establishments as well as members of the public” and “Evidence of serious sadistic behaviour or serious sexual assaults on others including other patients or staff or members of the public may be a reason for detention in conditions of high security.” This last example is qualified by the following: “However in order to require high security it would be necessary to demonstrate that any sexual assaultative behaviour could not be contained in a unit of lesser security with single sex accommodation.”

6.7 The guidelines make clear that any lack of local provision of services for patients is not accepted as a reason for admission to Broadmoor Hospital.

The admissions panel procedure

6.8 The referral procedure requires the applicant to seek an opinion from the medium secure unit consultant in a patient’s catchment area before submitting a referral to Broadmoor Hospital. This report should demonstrate that there has been discussion of the referral within the forensic psychiatric service in a patient’s catchment area.

6.9 Broadmoor then allocates a consultant to provide a report for the hospital which is placed, with all other available reports, before the admissions panel. The admissions panel structure includes two directorate panels, one to consider male referrals and one to consider female referrals. Membership of both directorate panels is as follows:

- clinical director
- nurse consultant or deputy director of nursing
- head of psychology department
• head of social work department
• head of occupational therapy for men’s services/women’s services.

6.10 If a clinical director has undertaken the assessment then he or she cannot sit on the panel. A quorum of three panel members, including medical representation, is required. All panel members are trained. The training includes attending at least two panels as an observer.

6.11 Panel procedure is for one member, identified in advance, to present the case to the other panel members. The panel can accept or reject cases as well as requesting further information or a further assessment. It decides on cases by a majority vote if a consensus is not possible.

The decision-making process in Richard Loudwell’s case

6.12 On 9 January 2003 Richard Loudwell was interviewed at Belmarsh by Consultant Psychiatrist 3, consultant forensic psychiatrist from the Kent Psychiatry Service, on the instructions of Richard Loudwell’s solicitors. Her report is dated 23 January 2003. Significantly, at that time Consultant Psychiatrist 3 felt that detention in conditions of medium security would be problematic:

“I have considered whether it would be appropriate to admit Mr Loudwell to conditions of medium security for a period of assessment and treatment but I feel given the nature of the index offence and the fluctuating state of his disturbance which at times required him to be secluded and only allowed out of his cell whilst three officers were present might make his management in medium security problematic. Whilst I accept that his behaviour is a little more settled at HMP Belmarsh the pattern of fluctuating disturbance is such that this is no guarantee that it will continue to be so. I think it will be most appropriate if a special hospital were consulted with regard to their opinion of an admission for assessment and treatment at this time. It is my view that Mr Loudwell does indeed fulfil the criteria as presenting a grave and immediate risk to the general public at large.”

6.13 Richard Loudwell was seen by Consultant Psychiatrist 4 from Broadmoor at Belmarsh on 21 March 2003. He was instructed by Richard Loudwell’s
solicitors to provide a second opinion. His initial view was that Mr Loudwell did not require admission to Broadmoor. He tried to secure a referral for Richard Loudwell to the Trevor Gibbens Unit, the regional secure unit (RSU) for patients from Kent, but was unsuccessful. On 30 April 2003 he wrote to Broadmoor to formally refer Richard Loudwell for assessment. His letter states:

“My opinion differs slightly from Consultant Psychiatrist 3 in that I felt he does not merit treatment in maximum security. However many weeks have now gone and I don’t think I have been able to persuade the Trevor Gibbens Unit (his catchment area RSU) to take him and I suspect that is largely due to the nature of the index offence. Having exhausted all other options I would now like to formally refer him for a Broadmoor Assessment.”

6.14 Consultant Psychiatrist 4 felt it would be better if a different Broadmoor consultant or registrar were to carry out the assessment because of a potential conflict of interest between his role as defence expert and Broadmoor consultant.

6.15 Richard Loudwell was seen by Specialist Registrar 2, a specialist registrar, for Broadmoor on 28 May 2003. He was unclear as to the diagnosis and thought that there might be an organic element, for example dementia secondary to vitamin B12 deficiency. He noted in Richard Loudwell’s IMR:

“Addition(ally) his behaviour, particularly during the first few months in prison suggest maladaptive response to life situation, exacerbated by his previous lifestyle. He may also be malingering to some extent.”

6.16 Specialist Registrar 2 said he thought hospital transfer for fuller assessment would be “a cautious and sensible approach given the diagnostic difficulties”. He said he would discuss the setting with colleagues at Broadmoor but “my initial thoughts are that this would be more suitable in conditions of medium rather than maximum security”.

6.17 Richard Loudwell’s case was first considered by the Broadmoor admissions panel on 31 July 2003 when admission was refused on the grounds that he would be more suitable for a medium secure placement. A letter from the Associate Medical
Director, who had chaired the panel, to Consultant Psychiatrist 3 who had supported Richard Loudwell’s referral stated:

“...On the basis of the information which we had, it did not seem appropriate to offer a place for Mr Loudwell for admission for assessment in conditions of high security, given how he has settled at HMP Belmarsh. We agreed that it was appropriate for him to be admitted to hospital under Section 35 for assessment, but were of the view that this could probably be undertaken quite safely in conditions of medium security.”

6.18 After Richard Loudwell was rejected by Broadmoor Consultant Psychiatrist 3 wrote to Redford Lodge medium secure service to ask if they would offer Richard Loudwell a period of investigation and assessment.

6.19 On 8 September 2003 Redford Lodge declined to offer Richard Loudwell a place because his history of sexual offending excluded him under their admissions criteria.

6.20 On 16 September 2003 Stockton Hall Hospital, York, declined to offer Richard Loudwell a place because they did not think that they could meet his needs.

6.21 On 29 September 2003 Kneesworth House, a medium secure unit in Hertfordshire, declined to assess Richard Loudwell for admission. Their consultant forensic psychiatrist, Consultant Psychiatrist 5, wrote to Consultant Psychiatrist 3 as follows:

“I have discussed the prospect of Mr Loudwell’s admission to Kneesworth with our Medical Director and psychologist colleagues. We have no doubt whatsoever that Mr Loudwell’s clinical needs should be provided in conditions of special security at Broadmoor. How such a person is not deemed to be a ‘grave and immediate danger’ we do not know in light of the history of his disordered sexual behaviour over a number of years, the most serious nature of the alleged offence and the account of behavioural disturbances since his time in HMP Belmarsh.”

6.22 On 10 October 2003 a consultant psychiatrist in the Kent Psychiatry Service, Consultant Psychiatrist 6, prepared a court report on Richard Loudwell, instructed by Richard Loudwell’s solicitors. He made the following recommendation:
“In my opinion Mr Loudwell represents a continuing unpredictable and grave risk to women and should not be assessed in a mixed gender clinical environment. I am also aware that several private sector secure units have refused to accept him. In view of the gravity of the offence, and because of his unpredictability the issue of immediacy of risk is unknowable, Mr Loudwell should not be assessed in a medium secure environment. I recommend that my colleagues at Broadmoor Special Hospital are asked to reconsider their opinion.”

6.23 On 23 October 2003 Richard Loudwell’s trial at Maidstone Crown Court, which was due to start on 3 November 2003, was adjourned in order that the further investigations recommended by Consultant Psychiatrist 6 could take place, in particular further consideration of his admission by Broadmoor. On the same date Consultant Psychiatrist 6 wrote to Broadmoor requesting they reconsider their earlier refusal to admit Richard Loudwell.

6.24 Richard Loudwell’s case was considered again by a reconvened admissions panel on 20 November 2003. This time a place at Broadmoor was offered. In his letter of 21 November 2003 to Consultant Psychiatrist 6, the Associate Medical Director wrote:

“On the basis of the further reports that we have received, the consensus view was that it was appropriate to offer a place for Mr Loudwell for a 12-week assessment admission under section 35 of the Mental Health Act in order to clarify the complex issues raised in the various original and supplementary reports presented... Whilst Mr Loudwell’s behaviour on remand latterly, his age and his relative lack of serious previous offences all make the offer of a bed in conditions of high security unusual, we felt that the complexity of the case, and the consequently uncertain level of risk meant that in the first instance he should be assessed here. As discussed, however, it may well be that the conclusion of the assessment is that further treatment in conditions of high security may not be necessary.”

6.25 A few days later, on 25 November 2003, Chadwick Lodge, a private secure unit in Milton Keynes, wrote to Consultant Psychiatrist 3 to say that, subject to funding approval, they would admit Richard Loudwell for a period of assessment and that they had a bed available.

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6.26 We are not aware of what further steps, if any, were taken in response to this offer. It seems likely that since a bed at Broadmoor was the preferred option of both Consultant Psychiatrist 3 and Consultant Psychiatrist 6, no attempt was made to obtain funding for an assessment at Chadwick Lodge. We don’t know if the respective options were discussed with Richard Loudwell by his representatives.

6.27 It is clear from Richard Loudwell’s file at the Mental Health Unit of the Home Office, now held in the Ministry of Justice, that the Home Office would not have been happy for Richard Loudwell to go to a medium secure unit given the nature of his crime.

6.28 An entry on Richard Loudwell’s Home Office file for 27 November 2003 states:

“The telephone call received from Chadwick Lodge to say that a bed was available at Chadwick Lodge MSU w/c Monday 1 December. She also asked that the warrant be forwarded ASAP once the reports were received as L is Cat A & they need to get a movement order from Cat A section.

The appropriateness of placing a remand Cat A prisoner in a MSU, especially bearing in mind the nature of L’s offence (a sexual murder against a vulnerable victim) concerned me & after discussion with Home Office Grade 7, I approached Cat A section to establish why L is a Cat A.

Spoke to Cat A section & confirmed that the decision on Cat A status was made because L is considered a highly dangerous individual who committed a horrific murder. The escalation in the severity of his crime & his manipulative behaviour (they believe he is trying to manipulate the system by feigning mental illness) also influenced the decision.

I then made a number of telephone calls with both Broadmoor Hospital & Trevor Gibbens Unit & established that L was considered too dangerous for medium security & has now been offered a place at Broadmoor under S35. The place will become available in the new year.”

6.29 An entry in Richard Loudwell’s medical notes (IMR) at Belmarsh for 18 December 2003 from Social worker 1 states:
“Was accepted by Chadwick Lodge but Home Office has intervened and insisted that he goes to High Security.”

6.30 The concern felt by the Home Office may have contributed to the decision that Richard Loudwell should go to Broadmoor. We do not need to speculate on what steps would have been taken by the Home Office had Broadmoor once again declined to offer a bed for Richard Loudwell.

Was it appropriate to admit Richard Loudwell to Broadmoor?

6.31 The first requirement for admission to Broadmoor was the presence of a recognised mental disorder. In her report of 23 January 2003, Consultant Psychiatrist 3 concluded that at that time Mr Loudwell was unfit to instruct solicitors or to plead. She diagnosed recurrent depressive illness but thought an organic disorder was likely. In a psychiatric report of 23 May 2003, the Author considered that Richard Loudwell was fit to plead and that he had an abnormality of mind the nature of which he could not be precise about. Consultant Psychiatrist 6 in his report of 10 October 2003 concluded that Mr Loudwell was suffering from a degree of brain damage and at the time of his offence had been suffering from an abnormality of mind within the meaning of section 2 of the Homicide Act 1957 (such that a verdict of manslaughter on the grounds of diminished responsibility would be available).

6.32 We note the reference in Richard Loudwell’s Home Office file to concern that he might have been feigning mental illness. None of the psychiatrists who examined Richard Loudwell at Belmarsh suggested that he might be feigning mental illness, whether in an attempt to manipulate the system or otherwise. In our view there can be no dispute that Richard Loudwell was reasonably believed to be suffering from mental disorder both times his case was considered by the admissions panel in 2003. The nature of the disorder was more difficult to establish but a diagnosis was not required prior to admission.

6.33 The second requirement for admission was that Richard Loudwell was liable to be detained under the Mental Health Act. Richard Loudwell was on remand for the murder of Joan Smythe. There was never any doubt that this criteria would be met. On 13 January 2004 the Crown Court ordered Richard Loudwell be remanded to Broadmoor under section 35 of the Mental Health Act 1983 for a period of assessment.
6.34 It is the third requirement that gives rise to potential controversy. Was the risk presented by Richard Loudwell so great that he could only be detained in conditions of maximum security?

6.35 RMO3, who was Richard Loudwell’s RMO at Broadmoor, was very clear in his evidence to the inquiry that it had been appropriate for Richard Loudwell to be admitted to Broadmoor rather than a medium secure facility:

Q: You said... that you have no doubt that it was appropriate for Richard Loudwell to be in Broadmoor?
A: No doubt, I am just sorry that the decision reached by the Associate Medical Director was not reached first time when the panel considered it, as I thought it was the right decision. I think he would still be in Broadmoor today. My view is that he was well within the risk profile and required conditions of maximum hospital security...

A. I think it is to do with the degree of risk which, at the time of admission, was unquantifiable. Although I had done this risk assessment, I had not yet reached a determination on whether long-term incarceration in hospital was appropriate, which is why I was going for a 38 and not a 37, as I did not know whether his dementia would be reversible. Secondly, if his dementia was likely to get worse, and I thought that it might as opposed to reversing, which we were trying to achieve, the risk profile may change. I thought he was a compulsive man who had offended in a very disturbing way albeit against a vulnerable old woman. I thought that the potential risk to the general public, if he did manage to get out, and if he was in a medium secure unit he might have been given leave to wander around, was unacceptable.

6.36 The admission case conference for Richard Loudwell was chaired by RMO3 and held on 30 March 2004 after Richard Loudwell had been at Broadmoor for nearly three months. It also concluded that a high security hospital was more appropriate because of the risk he posed to others.

6.37 When RMO3 gave evidence to the inquiry he said he had not previously been aware that a place at Chadwick Lodge had been offered. The offer did not alter his view. He was...
strongly of the opinion that it was right for Mr Loudwell to have been admitted to Broadmoor.

6.38 RMO3 said he thought the risk presented by Mr Loudwell was unquantifiable at the time of his admission because of the complexity of his presentation. Therefore it was his view that Richard Loudwell could only be appropriately placed in conditions of high security. RMO3 also said he was not in a position to criticise Chadwick Lodge but thought the admissions panel would still have offered a place to Richard Loudwell at Broadmoor even if they had known about the Chadwick Lodge offer. He said he was aware of a concern at Broadmoor that some private sector facilities would agree to take patients who should be detained in high security conditions.

6.39 The Associate Medical Director, who chaired both admissions panels expressed similar concerns. He could not say what the admissions panel would have decided in November 2003 if they had known about the Chadwick Lodge offer. He said it would not have been a straightforward decision in the way it might have been if there had been a place offered at an NHS medium secure facility. He said it is likely Richard Loudwell would have gone to an NHS medium secure facility if a place had been offered.

Conclusions

C25 In our view it is unwise to speculate about what might have happened had the offer from Chadwick Lodge been made earlier. It is possible that Richard Loudwell may have gone there but we are not in a position to say whether he would then have remained there or been transferred to Broadmoor.

C26 The key question is whether it was appropriate to admit Richard Loudwell to Broadmoor at all. In our view the decision taken in November 2003 to offer Richard Loudwell a bed was a reasonable one, notwithstanding the initial view of the admissions panel that he would be more suitably placed in a medium secure unit.

C27 In our view Richard Loudwell did satisfy the criteria for admission. He was suffering from a recognisable mental disorder, albeit the diagnosis was unclear; he was liable to be detained under the Mental Health Act 1983 and, by November 2003, it was reasonable to believe he could not be detained in conditions of lower security.
Richard Loudwell’s presentation was not straightforward. In our view it was reasonable for the admissions panel in July 2003 to decline admission for the reasons that they gave. Following unsuccessful attempts to find Richard Loudwell a medium secure placement and having received further evidence, particularly a report from Consultant Psychiatrist 6, it was reasonable for the admissions panel in November 2003 to come to a different conclusion and to offer a bed.

The fact that Richard Loudwell had a difficult time at Broadmoor is not a reflection on the appropriateness of his placement but on how he was cared for once he was there.
7. Richard Loudwell - care and treatment at Broadmoor

7.1 Richard Loudwell arrived at Broadmoor on Thursday 15 January 2004 from HMP Belmarsh. He was admitted, in common with virtually all new patients at this time, to Luton Ward for a period of assessment.

7.2 There is no doubt that Richard Loudwell’s time on Luton Ward was an unhappy one. He was subjected to frequent bullying and was at risk of serious physical assault from some of his fellow patients. In the end he was fatally assaulted by Peter Bryan. He did not receive the protection to which he was entitled as a mentally ill individual compulsorily detained in hospital.

7.3 Richard Loudwell was a patient in Luton Ward for over three months. A full chronological account of that time would not help fulfil the terms of reference of this inquiry. Therefore in this chapter the following aspects of his stay on Luton Ward are considered:

- Pre-admission nursing assessment, page 98
- Richard Loudwell’s first week, page 103
- Risk assessment and CPA, page 122
- Bullying, page 125
  - 22 January to admission case conference 30 March 2004
  - The final month
  - Evidence from a patient
- Richard Loudwell’s own behaviour - the unpopular patient, page 157
- Strategies for tackling bullying, page 159
- The quality of observation and engagement, page 162
- Care planning, page 166
- The role of the primary nurse in caring for Richard Loudwell, page 168
- The link between bullying and the assault on 25 April 2004, page 171
- Did Richard Loudwell invite the assault by Peter Bryan, page 175
- Richard Loudwell’s general health, page 176
Pre-admission nursing assessment

7.4 Nurse Consultant 1, a nurse consultant at Broadmoor, carried out a pre-admission nursing assessment of Richard Loudwell at HMP Belmarsh on 1 December 2003.

7.5 She saw Richard Loudwell in the healthcare centre at Belmarsh. She told the inquiry that she relied on the following sources of information for her report:

- medical reports and referral letters issued to the Broadmoor Admissions Panel
- Inmate Medical Record (IMR) at Belmarsh
- nursing notes and Care Plans in IMR
- conversation with CPA co-ordinator Social worker 1
- conversation with a Health Care Officer in the Health Care Centre at Belmarsh
- interview with Richard Loudwell in the presence of three officers.

7.6 In a letter to the inquiry Nurse Consultant 1 stated that aside from those individuals listed above she:

“...did not discuss RL with any other staff members for reasons of confidentiality.”

7.7 If Nurse Consultant 1 restricted herself in this way this was unfortunate. The purpose of the visit to Belmarsh was to obtain information rather than to pass it on. In those circumstances it would have been better to speak to as many sources of information as possible and we cannot see how doing so would have breached Richard Loudwell’s confidentiality. On the contrary speaking to more sources is likely only to have improved the quality of her report.

7.8 An important source of information which Nurse Consultant 1 apparently did not see is the Inmate Personal Record (IPR) in which observations by non-clinical staff would be made. It is not clear to us whether Nurse Consultant 1 would have been able to see the IPR had she wanted to or not although we can see no good reason why she should not have been permitted to look at this document. The IPR would have been an important source of information to Nurse Consultant 1, for example with respect to interactions between Richard Loudwell and other prisoners.
7.9 Nurse Consultant 1’s report sets out a brief social and family history, a summary of physical health and a brief psychiatric history. In relation to Richard Loudwell’s current state the report noted that:

- He had been described as sexually disinhibited, abusive, assaultative, angry and hostile.
- He had sudden bouts of verbal aggression and sudden appropriateness in how he related to people, particularly sexually.
- He was said to be of much concern to prison officers and very disruptive.

7.10 Nurse Consultant 1 considered on the basis of her own observations that Richard Loudwell was very psychotic, but that some of his symptoms were due to physical ill-health. She observed that he was:

“...very bizarre...at times extremely vague, then all of a sudden he would be very spontaneous. He was quite unpredictable.”

7.11 She told the inquiry that she had anticipated that once he was admitted to Broadmoor his behaviour would change completely. While Richard Loudwell had not been rude or abusive to her she was “unnerved” by his manner: he “would go very blank” and stare.

7.12 Nurse Consultant 1’s observation that Richard Loudwell was “very psychotic” is at odds both with how he is described in his IMR by Belmarsh Health Care Staff and how he presented at Broadmoor. Apart from the entry by Nurse Consultant 1 in the IMR for 1 December 2003 in which she simply records that she had seen Richard Loudwell for the purposes of carrying out a pre-admission nursing assessment there is no other entry by Health Care Centre staff for that date. Had Richard Loudwell presented as ‘very psychotic’ that day, or indeed on any date, we would have anticipated that this would have been recorded in the IMR. The entry in the IMR immediately preceding that made by Nurse Consultant 1 on 1 December 2003 is dated 27 November 2003 and states that Richard Loudwell had attended the CASS unit with no problems reported. The next entry was for 2 December 2003 under the heading Care Plan Review where it was recorded:
“Coping very well, pleasant and appropriate with staff, making good attempts at keeping clean and tidy, attends CASS and exercise...”

7.13 The final section of Nurse Consultant 1’s report is headed “Nursing recommendations”. On her template the following prompt/reminder is included underneath this heading:

“Include seclusion on admission, obs levels, gender issues, suicide/ self-harm, no. of staff required, any other precautions.”

7.14 Nurse Consultant 1 made the following recommendations for nursing Richard Loudwell at Broadmoor:

“1. Allocation of Primary Nurse - suggest should be male, particularly during the initial assessment period.
2. A drug free period would provide a baseline assessment of his mental state.
3. He has specifically requested to be allowed access to the vicar and attendance at church services.
4. General observation levels as appropriate to Luton Ward admission procedures as there are no suicidal ideations or wish to self-harm elicited on the current assessment today.”

7.15 In our view these four recommendations were of little practical value to the nursing team that received Richard Loudwell at Broadmoor on 15 January 2004. This report could more usefully have identified a number of issues.

7.16 Firstly that despite Richard Loudwell’s disturbed behaviour when he first arrived at HMP Belmarsh he had been considered to be reasonably settled and well-behaved since at least September 2003. This taken with his very disturbed behaviour when he first arrived at HMP Elmley and HMP Belmarsh indicated that a careful approach to his management on first arrival was likely to ease his transition to Broadmoor. When this was put to Nurse Consultant 1 she stated that all newly admitted patients to Broadmoor could be expected to find the process of admission traumatic and an upheaval and to require careful management by staff. In our view the particular features of Richard Loudwell’s case - his age, personal habits, the nature of his index offence and his disturbed behaviour
on arrival at Elmley and Belmarsh - all point to a particular need for careful handling of this patient at the time of his admission.

7.17 In a letter to the inquiry Nurse Consultant 1 stated that at the time of her assessment she had found nothing to indicate that there was a significant improvement in Richard Loudwell’s behaviour given staff reports which consistently highlighted concerns around his unpredictability.

7.18 We find this at odds with the IMR. On the page in the IMR immediately before Nurse Consultant 1 wrote her entry stating that she had visited is recorded a Care Plan Review for 24 October 2003 which starts:

“Much more settled and happier in his mood.”

7.19 That entry is in keeping with previous entries going back to at least August 2003.

7.20 Secondly, the report could usefully have identified the risk of harm from other patients. When Nurse Consultant 1 was asked whether, had she considered Richard Loudwell to be at risk of harm from other patients, she would have put that in her pre-admission assessment report, she replied:

“I would have put that in my report if I had assessed that risk, but I would not have assessed that risk in the prison setting because it would be quite difficult to assess, unless in his IMR he had been bullied by other prisoners, and I did not see any evidence of bullying by other prisoners...”

7.21 In fact there had been serious concerns at HMP Belmarsh about the risk to Richard Loudwell from other prisoners. In the IPR it was recorded on 5 January 2003 that a prisoner had threatened Richard Loudwell having heard of his index offence (presumably from Richard Loudwell); on 17 February 2003 Richard Loudwell had told RMO1 that he was kicked and spat at and that things were thrown at him on his way to exercise; an intelligence report for 23 March 2003 had recorded that three prisoners were planning to assault Richard Loudwell on the stairwell on his return from exercise; a further security report notes that students in a class had told their teacher that if Richard Loudwell, whom they termed a “nonce” was moved from a single cell onto their ward, they would kill him.
7.22 Given the nature of Richard Loudwell’s index offence, his age, the description of his personal habits, and the fact that he was not sharing a cell there was in our view more than enough material to prompt Nurse Consultant 1 to ask the question whether Richard Loudwell was at risk of harm from other patients. Had that question been asked it is in our view probable that, with or without further enquiries of staff at Belmarsh or consulting his IPR, Nurse Consultant 1 would have come to the conclusion that Richard Loudwell was at greater than normal risk of harm from his peers.

7.23 Thirdly, it would have been useful for Nurse Consultant 1 to consider the risk of Richard Loudwell’s index offence becoming known to his peers. When asked whether she had considered the risk to Richard Loudwell if his index offence had become known Nurse Consultant 1 replied that it was reasonable for her to assume that his index offence would not become known. This was because an index offence would not be disclosed to other patients by any member of staff. If his index offence had become known she would have expected this to be dealt with by ward-based staff.

7.24 We acknowledge that Richard Loudwell’s history of revealing his index offence is documented in his IPR rather than his IMR and that, for whatever reason, Nurse Consultant 1 did not have access to the IPR. We also acknowledge that, as Nurse Consultant 1 points out, Richard Loudwell had very little contact with other prisoners at Belmarsh because he was kept in the Health Care Centre. Nevertheless in our view even the barest outline of the facts of Richard Loudwell’s case ought to have led Nurse Consultant 1 to at least ask the question whether there was a particular risk to Richard Loudwell of his index offence becoming known at Broadmoor. She knew that there he would have to spend much of each week in association with other patients on the admission ward. Had this question been asked it seems to us likely that she would have concluded that a particular risk did exist in Richard Loudwell’s case, both of the index offence becoming known and of Richard Loudwell being left vulnerable to the attention of his peers as a consequence. The particular risk in Richard Loudwell’s case arose not only from the history of disclosure by him, recorded in the IPR, but from his generally disinhibited behaviour. Furthermore Nurse Consultant 1 ought to have paid particular attention to the risk of Richard Loudwell’s index offence becoming known given the very serious consequences of such a disclosure.
7.25 *Fourthly* Nurse Consultant 1’s assessment could usefully have identified that specific nursing interventions were likely to be required to address the fact, identified within the body of her report, that Richard Loudwell was known to exhibit bizarre behaviour, including gross sexual disinhibition and personality changes, which were possibly due to an organic cause.

**Richard Loudwell’s first week**

7.26 When Richard Loudwell arrived at Broadmoor he was admitted directly to the ward. He arrived on Luton Ward at 2.55pm on 15 January 2004.

7.27 Richard Loudwell was compliant with staff on admission. His primary nurse, Primary Nurse 3, noted at 4.45pm on 15 January 2004 as follows:

> “Arrived on the ward in good spirits. Orientated to ward and procedures. Appeared pre-occupied with past events during interview. Seen by duty M/O [medical officer] SHO2.”

7.28 SHO2 saw Richard Loudwell at 4pm. He noted that Richard Loudwell was cooperative and able to give a full history, his mood was normal and he was fully orientated.

**Comment**

*Neither in SHO2’s or Primary Nurse 3’s note is there any hint of trouble being caused by Richard Loudwell. This is in contrast to his arrival at HMP Elmley and HMP Belmarsh.*

7.29 In a care plan dated 15 January 2004 Primary Nurse 3, identified that Richard Loudwell was a “new admission and may need reassurance due to his new environment.” The nursing interventions recommended by the plan were:

- “Orientate Richard to ward layout and procedures.
- Offer Richard time to express any anxieties he may have and offer support.”
Comment

This generalised care plan suggests nursing staff, particularly Primary Nurse 3, were not aware of and did not address issues specific to Richard Loudwell, including risks, when he first arrived on the ward. It also suggests Richard Loudwell’s behaviour on admission was not thought to be noteworthy.

7.30 The first problems with other patients emerged within hours of Richard Loudwell’s arrival. The Luton Ward day report for 15 January 2004 states as follows:

“Loudwell - Admitted from HMP Belmarsh. Section 35 MHA. Fully co-operative and appropriate during admission procedure. Interviewed by medical records and seen by duty medical officer. Level 3 [observations] until seen by doctor. Level 2 after...Settled in well although appears to be getting some abuse from other patients i.e. shouting abuse and spitting due to alleged index offence.”

7.31 The day report identified the perpetrators of the abuse and the fact that Richard Loudwell’s index offence was known to them already:

“[Patient J], [patient F], [patient K], [patient L]: elevated in mood this afternoon. Loud and excitable. Involved in horseplay. Involved in physical, i.e. spitting, and verbal abuse of a new patient due to what they consider his index offence to be.”

7.32 An entry in patient F’s nursing observation notes for 15 January 2005 at 8.30pm states:

“Seen to be laughing and joking whilst obscenities were being shouted at another patient.”

7.33 An entry in Richard Loudwell’s nursing observation notes timed at 6.45am on 16 January 2004 reads:

“Richard was encouraged to retire to bed early at 2100 hours. He had been the victim of verbal abuse from a number of patients over his alleged index offence.”
7.34 This entry, made by staff nurse Nurse 2, was made at the end of the night shift referring to events the previous evening. Nurse 2 did not note that patients had also been spitting at Richard Loudwell.

Comment

This should have been noted by someone, not just in the ward’s day report but in Richard Loudwell’s own nursing observation notes.

7.35 Richard Loudwell had arrived on Luton Ward at 2.55pm on 15 January 2004. Within six hours his index offence had become known to other patients who were shouting abuse at him and spitting at him. In evidence to the inquiry Nurse 2 said Richard Loudwell had told fellow patients about his index offence from the first day:

“He actually told patients, went into the dayroom, I think, on the first day, and talked about his offence...In fact, there was a number of patients on the ward that where Richard was concerned - he was a horrible little man to them, if you like, for what he’d done. In their view, he would deserve whatever he got...It’s a very difficult thing, Broadmoor, because a lot of our patients come from prison, or the majority come from remand or they come from a prison, so you have a prison culture. And you come from there into a hospital and, as I see it, with somebody like Richard saying what he’s done, there was always an element of risk to him from other patients.”

7.36 Staff repeatedly told the inquiry that no member of staff would ever reveal a patient’s index offence. It was unthinkable that they would do so because such a disclosure could put a patient at significant risk of harm. This was particularly so when the index offence involved the killing and possible sexual assault of an elderly woman as in Richard Loudwell’s case. The inquiry was told that patients are advised not to disclose their index offence and that Richard Loudwell would have been given this advice. Primary Nurse 3 told us that on admission he had specifically warned Richard Loudwell not to disclose his index offence.
Comment

This was a serious matter. As soon as Richard Loudwell’s index offence became known his risk of harm from other patients increased significantly. That he was immediately the subject of verbal abuse and spitting following the disclosure only emphasises this increased risk.

7.37 Team Leader 1, who was on duty on the afternoon of Richard Loudwell’s arrival at Broadmoor, told us she could not remember if any staff had witnessed Richard Loudwell revealing his index offence. She did remember a patient telling staff that Richard Loudwell was discussing his index offence:

“I remember a patient saying, or it being reported that a patient had come up and said ‘You’d better do something. He’s in there saying what he’s done.’ Then certain comments started.”

Comment

The consensus of all staff was that the disclosure of his index offence came from Richard Loudwell himself. Although it is possible that a member of staff leaked the nature of Mr Loudwell’s offence to patients, we think that this is unlikely.

There is ample evidence that Richard Loudwell was only too willing to disclose this information. His index offence appears to have become known at Belmarsh within a few weeks of his arrival. Richard Loudwell was capable of acting in a disinhibited fashion and might well not have understood the need for discretion. Therefore we conclude that Richard Loudwell’s index offence was disclosed by him on the day of his admission.

7.38 It is not clear from the records what level of observation Richard Loudwell was on when the abuse started. The day report suggests that he was initially on level 3 (continuous) observations until seen by SHO2 - the doctor who undertook the admission examination at 4pm. He then went to level 2 observations. These are intermittent observations and normally a frequency is specified. For example, level 2/5 would mean a patient is observed every five minutes. When a patient is on level 3 (continuous) observations a member of the nursing team is allocated to observe that patient over a
particular period, usually one hour. That team member is then supposed to make an entry in the patient’s observation record.

7.39 Richard Loudwell’s observation record starts at 4.30pm on 15 January 2004 and states that he was on level 3 observations. There is no record on the observation form of observations before 4.30pm. Observations are made every 45 minutes or an hour from 4.30pm until 9pm. There is no record from 9pm until 7am the following morning.

7.40 Between 4.30pm and 9pm on 15 January 2004 Richard Loudwell’s observation record contains five separate entries by nurses who observed him in five different periods. There is no record of any abuse of Richard Loudwell recorded in his observation form for 15 January 2004. The closest to any such mention is in HCA4’s entry for the period between 8pm and 9pm hours when he has written:

“Had cup of tea at 8pm and returned to TV room. Settled and quiet. Level 3 observations maintained. No further problem.”

7.41 The reference to “no further problem” might indicate there had already been a problem. This would be consistent with the nursing observation notes of patient F, patient J and patient K for 15 January 2004 each of which contains reference to the patients verbally abusing Richard Loudwell and, possibly, spitting at him. Nurse 2, on the night shift, referred to verbal abuse having taken place earlier on 15 January 2004 in Richard Loudwell’s nursing observation notes.

Comment

The observation record for the first 24 hours of the admission raises a number of questions about the system of observation on Luton Ward. Firstly, the absence of a record between 2.55pm and 4.30pm may be explained by his being in the company of nursing or medical staff at all times. Secondly, if Richard Loudwell was on level 3 observations from 4.30pm as appears to be the case from the observation record why does the day report say that he was on level 2 observations? It may be that there was some confusion amongst nursing staff as to what level of observations Richard Loudwell was on. This would be consistent with the patchy compliance with the requirement for continuous observation over the following days. Thirdly, if Richard Loudwell was on continuous observations from the time he finished the admissions
process, why did no member of the nursing team witness Richard Loudwell disclosing his index offence to his peers?

It is hard to understand why there is no account in Richard Loudwell’s continuous observation record of the verbal abuse and spitting that he was subjected to. If Richard Loudwell was being observed continuously, as he should have been, then staff should have witnessed this abuse and recorded it. Either the recording of observations or the observation itself was deficient. In the observation notes for patient D, patient F and patient J there is a query about whether each of them had been spitting at Richard Loudwell. So the observations of Richard Loudwell were not sufficient for staff to know whether or not Richard Loudwell had actually been spat at, and if so by whom. This leads to the conclusion that neither the observation of Richard Loudwell nor the recording of those observations was of an acceptable standard that day. The standard of observation and record keeping was not to improve.

7.42 The first day’s abuse ended when Richard Loudwell retired early to bed. It appears to have started again the following morning. A nursing observation timed at 9.50am, less than three hours after patients rise in the morning, states:

“Again Richard has been targeted for some abuse (verbal) this morning, but continues to interact with peer groups in more vulnerable areas.”

7.43 The continuous observation record for 16 January 2004 mirrors that of the previous day in that there is no record of the verbal abuse. Between 7am and 8am Richard Loudwell is noted to be up and sitting in the day area. There is no mention of other patients. The entry for 8am to 9am refers to Richard Loudwell having been “quiet, appropriate”. The entry for the period between 9am and 10am by Nurse 4 reads:

“Quiet and settled. Sitting in day room. Interacting well with staff. Expressing some concerns regarding other patients.”

Comment

If, as the 9.50am record in the nursing observation notes clearly states, Richard Loudwell was being targeted for verbal abuse and was putting himself in “vulnerable
areas” this should have been, but was not, recorded on his continuous observation record.

7.44 Team Leader 1 completed the continuous observation form for the periods between 10am and 11am and between 11am and 12pm. She notes that Richard Loudwell was “reassured regarding verbal abuse by other patients”. There is no record of what action, if any, was taken in respect of the patients who were abusing him.

7.45 The entry on the continuous observation record for 3pm to 4pm notes:

“Spent some time in association, expressed concern re: fellow patients’ attitude towards him. Reassured and settled.”

7.46 The only entry in respect of the afternoon of 16 January 2004 was made in the nursing observation notes at 7.35pm:

“Level 3 [observation] maintained whilst up in association, interacting with staff, no problem noted from other patients this afternoon.”

7.47 This entry in the nursing observation notes is inconsistent with that on the continuous observation record.

7.48 Further abuse of Richard Loudwell was noted to have taken place that evening. An entry in the nursing observations notes at 6.35am on 17 January 2004 refers to the events of the previous evening. It states:

“Patient observed at level 3 whilst in association, up in the dayroom area until 2300 hours. Patient complained of being spat at and called names by some of his peers, advised not to spend too much time in the smoking room where he claims this was going on. Patient chose to ignore this advice and went and sat down in the smoking room.”

7.49 For the period between 9pm and 11pm staff nurse Nurse 5 has recorded in the continuous observation record:
“Up in association, complaining of abuse by peers. Advised to try and avoid others, but chose to sit in with peers.”

Comment

These entries refer to Richard Loudwell “complaining” of abuse. Neither entry says whether or not the abuse took place or what form of abuse it was: verbal abuse or spitting. If Richard Loudwell was being observed continuously then the member of staff responsible should have been able to record what happened, not what Richard Loudwell reported subsequently. It is also of concern that the only recorded staff reaction to Mr Loudwell’s complaints was advice to avoid his peers. Even at this early stage it ought to have been apparent that this was unlikely to be effective in keeping Mr Loudwell safe.

7.50 The day report for 16 January 2004 states:

“Loudwell - Appropriate in his interactions with staff and peers, still subject to verbal abuse.

[Patient L], [patient J], [patient K], [patient F]: Appear to be the main people involved in abusing patient. Counselling.”

7.51 Patient J’s nursing observation notes for 1pm hours on 16 January 2004 records:

“Again abusing patient [Richard Loudwell], but less today.”

7.52 In patient K’s nursing observation notes for 12.20pm on 16 January 2004 it is recorded:

“Less vocal regarding newly admitted patient [Richard Loudwell] due to staff presence.”

7.53 The night report for 16 January 2004 states:

“Loudwell - Patient observed at level 3 in association, up in the day room area until 2300 hours. Complaining of being called names and spat at by peers, advised
by staff not to spend too much time in the smoking room, but patient chose to ignore this advice and remained in the smoking room.”

7.54 On Saturday 17 January 2004 Nurse 4 spent some time with Richard Loudwell and, according to his entry in Richard Loudwell’s nursing observation notes, explained the assessment process. They also discussed the abuse that he was receiving. Nurse 4 recorded:

“He was also, again advised to try and spend some time in either the day room or the dining room, away from the people who are being abusive towards him. He again ignored this advice and so was counselled further regarding this, the risks he may be posing to himself and the fact that staff were advising him regarding his safety. He agreed with this and stated that he would not put himself in such a situation again, although then went straight back to the smoking room with fellow patients.”

7.55 It was a feature of Richard Loudwell’s time on Luton Ward that he frequently ignored advice from staff to stay in the dayroom rather than the less easily observed smoking room (also referred to as the TV room).

7.56 In his statement to the inquiry RMO3, Richard Loudwell’s RMO said this:

“I was aware that from an early stage in his admission, Mr Loudwell was counselled by nursing staff in respect of bullying. He was advised how to deal with this and how to reduce the risk to himself by keeping out of the smoking room and keeping himself within the eyesight of staff. Despite this advice, which was repeated throughout his admission, he chose to go and sit in the smoking room where those patients who were most likely to pick on him tended to gather.”

7.57 We heard from many members of the nursing team that they found this frustrating. A number of staff believed Richard Loudwell ignored their advice out of sheer obstinacy and that if he was putting himself at increased risk then he was doing so voluntarily.

7.58 This was also RMO3’s view. In a letter to the inquiry he made it clear that he thought Richard Loudwell deliberately ignored safety advice:
“Mr Loudwell had the capacity to understand both the requests being made of him and the consequences of not following the instructions that we gave to him. He deliberately placed himself in situations where he was more likely to be bullied.”

7.59 Returning to the notes, an entry for 8pm on 17 January 2004 in the nursing observation notes reads as follows:

“Whilst in the smoking room this afternoon it appears that fellow [patient J] poured a bottle of water over him calling him a ‘nonce’ and telling him to get out. Both patients counselled about the incident and Richard has once again been advised to spend as little time as he can in the smoking room and to stay in the dayroom where he can be more carefully observed...Level 3 observations [continuous] maintained whilst in association.”

7.60 This incident was not recorded on the continuous observation form. In fact the spaces for recording observations between 3pm and 4pm, and 4pm and 5pm on the observation form have not been filled in at all.

7.61 No incident report form was completed in respect of this incident.

Comment

We find that this incident was not observed by staff. It clearly should have been. It is of great concern that patient J was able to pour water over Richard Loudwell without being observed. Richard Loudwell had already been warned by Nurse 4 that he was in danger from other patients. It had been noted by him that Richard Loudwell was acting without apparent regard to the danger. The only strategy in place to protect Richard Loudwell was continuous observation yet this could not have been happening. If it had been then the incident would have been seen by staff and recorded on the continuous observation form.

7.62 The incident is described in patient J’s nursing observation notes as follows:

“It appears that whilst [patient J] was in the smoking room he became verbally abusive towards fellow patient Richard Loudwell due to what he considers to be his index offence and threw a bottle of water over him calling him a ‘nonce’.
[Patient J] was removed and counselled by staff in the ICA. [Patient J] stated that ‘He was a nonce, but as he was old he would not hit him, but make his life hell’. [Patient J] was told about the consequences of his actions but said that he did not care as he would be out of Broadmoor in a few weeks...Please can all staff be watchful of [patient J] when he is around fellow patient Richard Loudwell.”

7.63 The day report for 17 January 2004 summarises the incident in this way:

“[Patient J]: It appears that whilst [patient J] was in the smoking room he became verbally abusive towards fellow patient Richard Loudwell due to what he considers to be his index offence and threw a bottle of water over him calling him a ‘nonce’. Both patients removed from smoking room and [patient J] was counselled about his actions at length.”

7.64 Patient J was described as follows by Ward Manager 1 from Luton Ward:

“He was a young personality disordered man who had suffered significant sexual and physical abuse whilst he was in care as a young boy. He had an open hatred for people he perceived to be sex offenders and never let an opportunity to show his feelings go by. He found it extremely traumatising to have to live in an environment with individuals whom he in-directly blamed for the troubles he experienced in his life.”

Comment

There is a specific warning in patient J’s nursing observation notes that staff should be watchful of patient J whilst around Richard Loudwell but this does not appear in the day report. Further, there was no alteration to either Richard Loudwell’s or patient J’s care plans to deal with the risk posed by patient J even though a member of the team had specifically warned staff to be watchful of him around Richard Loudwell. This is an example of a general lack of coherence in note-making, information-sharing and care planning on Luton Ward in relation to this patient. In addition, the warning to watch patient J around Richard Loudwell was not followed with any thoroughness, if at all.

3 Ward Manager 1 has been variously described as ward manager and clinical nurse manager, or CNM. For the purposes of this report, we have used the term ward manager throughout.
It is clear from the nursing notes that within 72 hours of Richard Loudwell arriving on Luton Ward he was the subject of verbal and physical abuse from his peers and was not himself doing anything to reduce that risk. A competent nursing team could have been expected to initiate a strategy to address the obvious risk to Richard Loudwell. There was no strategy. The only step taken was to maintain Richard Loudwell on continuous observations. This was an inadequate response, particularly as such observation was not succeeding in detecting, let alone preventing, abuse.

As an example of the inadequacy of the regime there is no record of continuous observation having taken place on 17 January 2004 after 7pm despite the events that afternoon.

7.65 On Sunday 18 January 2004 the continuous observation forms have been completed throughout the day time. Nothing untoward is noted although Richard Loudwell is often reported to be in the smoking room.

7.66 The day report for 18 January 2004 contains the following entry:

“[Patient J]: still vocalising verbal threats against patient Richard Loudwell threatening to hit him if he sits next to him in smoking area.”

7.67 A note to similar effect appears in patient J’s nursing observation notes but there is no corresponding entry in Richard Loudwell’s notes (neither in the nursing observation notes nor in the continuous observation record), even as a warning to other members of staff.

Comment

Although it is possible that patient J’s threats were made when Richard Loudwell was not present this is unlikely. If threats were made in the presence of Richard Loudwell then these ought to have been noted on the continuous observation forms and in Richard Loudwell’s nursing observation notes so staff on later shifts would be aware that the threat from patient J was continuing. It is surprising that this was not done.

7.68 Between Monday 19 January and 10am on Thursday 22 January 2004 there is no express description of specific further incidents of abuse in the continuous observation
forms, the nursing observation notes or the day/night reports. However there are some entries in the records which are ambiguous.

7.69 An entry in the nursing observation notes at 7.10pm on Monday 19 January 2004 states:

“...little interaction with nursing staff and fellow patients remains a target after disclosing index offence hence level III observations.”

7.70 An entry by Primary Nurse 3 in a “Periodic Evaluation” and dated 19 January 2004 states:

“Richard appears to be under verbal assault from his peers due to his telling them what his alleged index offence is. He has been advised by staff to spend as little time as he can in the smoking room, but it appears that he chooses to ignore this advice.”

Comment

While the possibility that abuse continued during this period cannot be ruled out, there is insufficient evidence to enable us to determine that it did.

7.71 From about 10am on Thursday 22 January 2004 Richard Loudwell’s observation form was discontinued. This may imply that he was taken off level 3 observations. The nursing observation notes for the day do not refer to an observation level. He had been at Broadmoor for a week. RMO3 told us he would not necessarily have expected this decision to be taken in conjunction with a doctor given that it was a reduction from a level of observation set on admission.

7.72 A new care plan was started on 22 January 2004 to replace the continuous observation regime. It is divided into three headings and reads:

“Problem/ need: There is a potential risk to Richard from his fellow peers as to what they believe to be his index offence.

Objectives: To minimise the risk to Richard from his fellow peers.
For Richard to live in a safe and un-abusive (sic) environment.
For Richard to be able to express his feelings openly.

Nursing interventions / patients actions:
To keep Richard in full view of staff at all times.
To minimise the amount of time he spends in the smoking room.
To offer Richard time to express his feelings.

7.73 This nursing care plan should be seen in the context of the ward’s observation policy. It was policy that on a normal level of observation a patient should be seen by a member of staff at least once every 15 minutes. Therefore it was accepted that patients could be out of sight for up to 15 minutes at a time, even if in practice they were seen more frequently.

7.74 The consensus amongst the nursing staff who gave evidence to us was that this care plan reflected an opinion that Richard Loudwell should be encouraged to remain in parts of the ward where staff would have a better view of him i.e. the dayroom rather than the smoking room or the dining room. Staff did not understand the care plan to mean they should follow Richard Loudwell to keep him in sight. For example in his witness statement Team Leader 2 from Luton Ward, told the inquiry:

“In my view, the wording of the care plan is odd in that it requires Richard Loudwell to be kept in the sight of staff at all times. This is in effect the same as being on Level 3 observations. In my view, the care plan has probably been carelessly worded. What I understood was to happen was that staff were to keep an eye out for Richard Loudwell and that he was encouraged to keep himself within the sight of staff.”

7.75 Primary Nurse 3 wrote the care plan. We asked him what he intended it to say:

Q. ...I am trying to understand what it is that you were trying to say.
A. Just staff to monitor Richard and make sure he was not being verbally abused...this care plan was not designated (sic) as for one person to keep an eye on him, it was just a general overview that everybody kept an eye on him during the shift...
Q. What you have written is ‘To keep Richard in full view of staff at all times’.
A. Yes, what I meant by that was to say not for him to be going into corners so we knew where he was.

7.76 We heard evidence from some staff that they knew Richard Loudwell was to be ‘kept an eye on’ but he was not nursed on the basis of this care plan. For example Nurse 4, a staff nurse and subsequently a team leader, gave this evidence:

Q. The proposal in the bottom paragraph [of the care plan dated 22.1.04] was: ‘To keep Richard in full view of staff at all times’. In your statement, you said you did not take that literally. It just meant that extra vigilance was required in respect of Richard, is that right?
A. Yes. Reading that, I would have thought it would have meant level 3 observations, as it was called at the time, but I understand he was not on level 3 observations, so that was interpreted to mean keeping an extra close eye on him and to be vigilant.

Q. Do you remember ever reading this care plan or ever following this care plan?
A. Not that I can recall.

Q. And that would not surprise you, would it, because you did not nurse patients on the ward by reference to their care plans?
A: Generally no. There are too many patients with too many care plans to be able to remember all of them and to nurse each patient in accordance with their particular care plans.

7.77 Nurse 6, a staff nurse, was asked about the care plan for Richard Loudwell dated 22 January 2004. She considered that staff tended to rely on what they were told in handovers rather than what they might read in care plans:

Q: If it is handed over to you that you have to keep a close eye on someone would there always be a care plan that would say that as well?
A: There should be.

Q: To what extent would you rely on the handover and to what extent would you rely on the specific written care plan?
A: Handover is more. People do not read the care plan as much as they should. They are there to be read, not just to be written and read and evaluated by the primary nurse.
Q: In reality.
A: The reality is handovers.
Q: In reality between January and April 2004 to what extent do you think nurses in general, or you if you can remember, would read care plans for individual patients?
A: Unless there was a specific incident that was flagged up that was handed over to everyone and told ‘Read this care plan because it’s important’, the majority of time we would be relying on handovers and communication and reading what has been written in the nursing notes and in the CTM.

7.78 In any event the abuse of Richard Loudwell continued. An entry in the nursing observation notes for 9.25pm on 22 January 2004 reads:

“Richard approached myself covered in cigarette ash and water, claiming that [patient J] threw water over him and threw ash over him. Counselling by staff and cleaned up, encouraged to go to his room.”

7.79 From the nursing observation notes of patient J and patient F it is clear that staff had no idea of the incident until afterwards. Patient J’s notes state:


Patient F’s notes read as follows:

“A fellow patient came out of smoking room [Loudwell] and with water all over his shirt claiming that [patient F] did that to him, threw ashtray, buts and water. [Patient F] accepted having done that.”

7.80 An incident report was completed for this incident, which was timed to have happened at 8.50pm. The report suggested there was a 20 per cent chance of recurrence. It confirmed that no members of staff had witnessed the incident, and that patient F had “owned up”.

7.81 The night report states that patient F was responsible for the incident:
“[Patient F]: Seclusion ended at 2130...Patient settled and calm, fully accepted responsibility for throwing water and contents of ash tray over patient Richard Loudwell. Patient remained out of the day room until 2200 hours at staff request to allow situation to settle.”

7.82 In his witness statement HCA8, a healthcare assistant, describes dealing with the aftermath of this incident:

“During the evening shift staff Nurse 6 approached me and told me that Richard Loudwell had come to the office, and that he was wet and covered with ash. Nurse 6 stated that Mr Loudwell had said that [patient J] had thrown ash and water at him. I then went into the day room with Nurse 6 and HCA9. I asked [patient J] to come out of the dayroom for a chat because I wanted to get hold of all the facts of what had happened.”

“At this point, [patient F] admitted to throwing water over Richard Loudwell.”

“On asking [patient F] what had happened and why, he told me that he believed Richard Loudwell was a ‘nonce’, i.e. a sex offender.”

“[Patient F] admitted that he and patient J had been flicking cigarette butts in Mr Loudwell’s direction whilst they were sitting in the smoking room. No words were spoken between the patients and it was not observed by staff because, although there is Perspex in the smoking room wall, making the room observable from the ward office, staff would not have noticed the flicking of cigarette butts. [Patient F] said that initially all they had done to Richard Loudwell. Richard, rather than moving away from the area or reporting the incident to staff as he had been advised to do, chose to pick up an ashtray and empty the contents over both [patient F] and [patient J]. [Patient F] responded by emptying the contents of his cup over Richard Loudwell, at which point Mr Loudwell came to the nursing office to complain about the incident, as I described above.”

7.83 A note in patient F’s nursing observations notes following a one-to-one discussion between a member of the nursing team and patient F records:
“[Patient F] insisted that it was a reactive response to Richard Loudwell’s initial verbal abuse. He claimed Richard Loudwell ‘Has a tendency to shout out obscenities’. For no apparent reason, probably in…response to hallucinations of which staff are unaware.”

Comment

We cannot say what happened between Richard Loudwell, patient F and patient J. Had the smoking room been closely observed by staff as it should have been, then staff would have observed the incident and been able to intervene at an early stage. If it is correct that there were no staff in the dayroom or smoking room, only in the ward office then not only may this have encouraged patient F and patient J in the first place but it suggests a failure to adequately observe the ward. We shall see later that when Richard Loudwell was assaulted by Peter Bryan on 25 April 2004 there were once again no staff in the dayroom, only the ward office.

7.84 We note that patient F was secluded for a short time following this incident. Without examining the merits of the reason for his seclusion we note that on this occasion action was taken to address the abuse of Richard Loudwell. We acknowledge that seclusion cannot be used as a sanction but it may legitimately be used to control dangerous or challenging behaviour on the part of a patient, where no less restrictive means of protecting him and others is appropriate, for as short a time as possible.

7.85 In the clinical team meeting following this incident, on 26 January 2004, it was noted that other patients (in addition to patient F) were suspected of involvement:

“[Patient F]: Secluded on 22.1.04 after throwing a glass of water and the contents of an ashtray over patient Richard Loudwell. It is suspected that other patients were involved in the incident. During counselling by staff he claimed patient Richard Loudwell had been verbally abusive to him.”

7.86 Although Richard Loudwell had come off level 3 observations earlier that day a further entry about this incident was made on the continuous observation forms by HCA10, a healthcare assistant, for the period between 8pm and 10pm:
“In day area, involved in a conflict with fellow patients in smoking room. Referred to own side room at 2120.”

7.87 It appears Richard Loudwell then returned to association and may have been kept on level 3 observations for the rest of the evening. Certainly the continuous observation forms have been completed as if he were on continuous observation.

7.88 The entry for 10pm to 11pm notes:

“Counselling by staff in the dayroom concerning animosity from other patients. Advised to be wary as to his personal safety.”

Comment

Once again the recorded notes suggest Richard Loudwell was reminded of the need to take care. However there is no reference to a care plan, to staff observation levels or what are described in the pro forma care plans as ‘nursing actions’.

7.89 Richard Loudwell was noted to have remained in the smoking room between 11pm and midnight.

Comment

On the first day of a care plan which stated Richard Loudwell was to be kept in view of staff at all times he was attacked by one or more fellow patients who poured water and ash over him. The incident was not seen by staff. It is clear that staff were not paying appropriate attention to Richard Loudwell. If he was in the smoking room with patients, including patient F and patient J who had already been identified as abusing him, then staff should have been in a position to see this.

On 25 April 2004 Peter Bryan was able to attack Richard Loudwell in the dining room for several minutes without being noticed by staff. The incident on 22 January 2004 in the smoking room demonstrates that the state of affairs on Luton Ward in early 2004 meant there were many opportunities for patients to attack one another undetected by staff if they chose to do so.
There is no evidence in Richard Loudwell’s notes that any thought was given to the implications of the attack on 22 January 2004. At the very least putting Richard Loudwell back on continuous observations should have been considered. A more fundamental requirement was addressing the animosity between Richard Loudwell and other patients, rather than relying on Mr Loudwell to follow the advice he was given.

Risk assessment and CPA

7.90 By January 2004 patients at Broadmoor were supposed to be cared for under the Care Programme Approach (CPA) programme. There is some doubt about exactly when it was adopted and implemented in the hospital. Integral to the CPA approach is record-keeping. We have seen a large number of pro-forma CPA documents. The format of some of them has evolved over time.

7.91 There was concern at the time that the required CPA procedures were not being followed. Luton Ward clinical meetings were held monthly and often a single issue was listed for discussion. At the meeting on 17 November 2003 the topic was CPA. The minutes begin:

“The Trust CPA Policy and procedures for the Forensic Division were introduced on 1.6.03. It is evident that the procedures have not been fully implemented on Luton ward.”

7.92 The minutes suggest that care coordinators, a patient’s primary nurse under Trust policy, did not routinely attend pre-CPA and CPA meetings:

“Care co-ordinators (Primary Nurses) are not routinely present at pre-CPA and CPA meetings. There is no system for organising a deputy. This is partly due to the fixed shift system and partly a reluctance to attend multi-disciplinary team meetings on the part of some care coordinators. Although care coordinators are attempting to complete the documentation this is not being done in conjunction with the Consultant or the rest of the clinical team. There is no evidence that the documentation is being distributed in line with the procedures. These difficulties were thought to reflect training, the issue of ownership in relation to CPA, as well
as wider difficulties in the relationship between the nursing staff and the rest of the clinical team.”

7.93 The minutes of this meeting identify the main task of risk assessment to be determining if a patient needs high security:

“Risk management

The risk assessment and management documentation in relation to CPA was discussed. Nursing staff have particular anxieties about completing this part of the CPA. A draft risk assessment should be completed by the care coordinator in conjunction with a medical member of the team prior to the meeting. This is not currently happening. The possible use of actuarial and clinical tools was discussed but it was agreed that this should be part of a separate discussion. It was agreed that our main task is to determine whether or not someone needs high security, which is essentially a matter of clinical judgement.”

Comment

It was right to identify risk assessment as an important part of the CPA process. However it is important to note that risk assessment should include considering whether a patient is at risk from other patients.

7.94 We found a blank pro-forma risk assessment among Richard Loudwell’s CPA documents. The only completed risk assessment was written by RMO3, Richard Loudwell’s RMO. It is included in the admission case conference report and as a stand-alone document within Richard Loudwell’s case notes. It was not prepared using CPA documentation. This risk assessment was the one discussed at the CPA meeting on 30 March 2004. There was no other completed CPA assessment.

7.95 RMO3 said he put a great deal of work into the risk assessment:

“It was the most detailed risk assessment I have ever done on any patient in my career. So I was thinking about risk all the time but that was not being translated into this CPA documentation...I showed it to Mr Loudwell, as I went through the
The risk assessment is considered in more detail later in this chapter. It identified the risk of further physical assault from other patients as “likely”.

It was put to Ward Manager 1 that he and the nursing team ought to have taken greater note of this risk assessment when caring for Richard Loudwell on the ward. Ward Manager 1 replied that he had never seen this risk assessment.

We are unable to determine whether or not the risk assessment was in the ward based case notes for Richard Loudwell whilst he was on the ward. Ward Manager 1 was not at the admission case conference at which RMO3 told us the document was discussed.

RMO3 was asked about the failure to complete the CPA risk assessment within two weeks of Richard Loudwell’s arrival or at any time before or after the CPA meeting. He said he only discovered after the assault on Richard Loudwell that the CPA documentation, in particular the risk assessment, had not been completed. He was asked whether the failure to complete large parts of the CPA documentation had impacted on his assessment of Richard Loudwell:

A. I did not see it. I had been told that a document had been completed and it was only way after the event when I discovered that large parts of it, the risk assessment part, were blank. It was astonishing to me as I had not seen it.

Q. Who told you that it had been completed?

A. At the CTM’s [Clinical Team Meetings] it had been discussed. One thing that I quite often ask is whether the documentation is okay, finished or complete and, if no, I say let us finish it, let us do it together but, if the answers is yes, fine.

Q. Can you recall that specifically in respect of Richard Loudwell?

A. Not the date, no, but my overall impression, certainly at the time of the CPA, was that it had all been completed and done, which is what I had been told. Certainly staff nurse [Primary Nurse 3] had led me to believe that.

Q. From conversations you had had with him?

A. And, indeed, the ward manager - yes indeed...With hindsight I should have looked to see but I was reassured that it was fine. It was only after it had all
happened that I saw it and was absolutely horrified that it had not been completed in large respect.

Comment

No assessment was completed as required by CPA policy as understood by staff at the time. If the CPA risk assessment was not completed before the admission case conference on 30 March 2004 it should have been completed afterwards. Had there been a draft risk assessment prior to the case conference it should have been revised in the light of the meeting.

This failure to complete some of the most basic CPA documentation is of considerable concern. As demonstrated below, the issue of bullying and associated risk of assault from others was consistently underestimated. The failure to complete the CPA risk assessment was both symptomatic and to some extent, causative of this failure. It was not completed because risk was not taken sufficiently seriously on Luton Ward. Had the risk assessment been completed then more thought would, or should, have been given to the need to keep Richard Loudwell safe on the ward and to ways of doing this. RMO3 may well have done the most detailed risk assessment of his career for Richard Loudwell but this was of little use on Luton Ward if the risk assessment was not given to those providing day-to-day care for him there. It was this risk assessment which concluded that further physical assaults from other patients were likely.

Bullying

22 January 2004 to Admission Case Conference 30 March 2004

7.100 The minutes of the clinical team meeting on 26 January 2004 in respect of Richard Loudwell read as follows:

“Still subject to verbal and physical abuse from some patients on the ward. Involved in an incident in which a glass of water and the contents of an ashtray were thrown over him. He has been advised not to sit in the smoking room other than to have his cigarette. He has consistently ignored this advice.”
7.101 This note suggests that as at Monday 26 January 2004 the abuse was continuing, but RMO3’s note of the clinical team meeting of 2 February 2004 does not contain any reference to bullying.

7.102 On 3 February 2004 Richard Loudwell was seen for the first time by RMO3, his RMO, who noted:

“He has been very frightened of being abused in prison and by the police, and while here.”

7.103 An entry in the nursing observation notes on 4 February 2004 is the first mention of any bullying of Richard Loudwell since the incident involving patient J on 22 January 2004. However the next but one entry timed at 6.30pm on 4 February implies that the bullying continued:

“Seen by Social Worker 2, reported that he is still being seriously bullied, but it is done less obviously than previously, difficult to monitor as it is generally not done openly. Staff to be aware.”

7.104 On 8 February 2004 at 12.05pm it was noted that Richard Loudwell complained to staff that he was being verbally abused by patient F. The note records that this was not witnessed by nursing staff.

7.105 At 7.56pm on 8 February 2004 Primary Nurse 3, Richard Loudwell’s primary nurse, made the following entry:

“[Richard Loudwell]...appears to isolate himself from his fellow peers due to his (sic) alleged verbal abuse he gets from them. No verbal abuse noted by staff this pm.”

7.106 Primary Nurse 3 was sceptical about the extent of abuse Richard Loudwell was subjected to. He accepted that Richard Loudwell was frequently the subject of verbal abuse but did not accept it also happened when staff did not witness it:

Q. Was your view that there was more name-calling going on than you witnessed yourself?

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A. I wasn’t there 24 hours a day, so I can only say for the shifts that I was on.

Q. When you were on shift, sometimes you would witness things being said.
A. You would hear things being said.

Q. Fairly frequently or very occasionally?
A. Occasionally.

Q. Most weeks?
A. Most weeks.

Q. Most days?
A. There were days when it didn’t happen, and days when it did.

Q. If Richard Loudwell was sitting in the corner of the smoking room, the door would be closed, wouldn’t it?
A. No, the door would be open.

Q. Always open. The TV might be on.
A. Yes.

Q. If there wasn’t a staff member standing inside the smoking room, it would be difficult to know whether he was being called names at a particular time.
A. It would be very difficult.

Q. But if you were on duty, say, in the ward office or in the dayroom so that you were out of earshot, would it be your view that at times Richard Loudwell was being verbally abused.
A. He might have been, I don’t know.

7.107 The minutes of the clinical team meeting on Monday 9 February 2004 record:

“Loudwell: Mr Loudwell remains at risk of bullying from his peers. He became slightly argumentative on one occasion but calmed down quickly when he was threatened. He is being verbally abused by another patient.”

7.108 On 13 February 2004 Nurse 7 noted “minimal interactions with others... no risk behaviour”.

7.109 On 19 February 2004 it was noted in patient K’s nursing observation notes (at 1.10pm) that he was abusing Richard Loudwell:
“Report from Luton OT that [patient K]’s behaviour at this morning’s session had given them cause for concern. He openly bullied fellow patient Richard Loudwell calling him offensive names.”

7.110 At 7.30pm on the same day it was noted in patient K’s nursing observation notes that he appeared to have thrown an empty bottle at Richard Loudwell:

“An empty water bottle was thrown at patient Richard Loudwell in the dayroom, the bottle appeared to come from K’s vicinity, on observing K appeared to find the event very amusing.”

7.111 Neither incident on 19 February 2004 was written into Richard Loudwell’s nursing observation notes. There does not appear to have been any follow up to these incidents. No incident report form was completed.

7.112 On 21 February 2004 at 1pm Nurse 7 made the following entry in Richard Loudwell’s nursing observation notes:

“Richard does appear to be getting a hard time from certain fellow patients [patient K] to name the possible ring leader.”

7.113 At 8.20pm that day Primary Nurse 3 made the following entry:

“It appears that Richard is the brunt of verbal/physical abuse. Stated that a patient (not witnessed by staff) threw a plastic bottle at him, advised by staff to stay close to staff so that the above can be monitored. I have spoken to the most likely patients and warned them of their actions.”

7.114 On 22 February 2004 at 1.30pm Primary Nurse 3 recorded that no further abuse or bullying had been noted.

7.115 On 23 February 2004 there was a clinical team meeting. At this meeting there was a discussion about the bullying of Richard Loudwell. The minutes record the following in respect of Richard Loudwell:

“Still being bullied by some patients on the ward.”

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7.116 Three patients are identified in the minutes as being “part of the group of patients who are currently bullying patient Richard Loudwell”: [patient K], [patient F], [patient A].

7.117 HCA1 gave the following evidence about the bullying of Richard Loudwell:

Q. To what extent were you aware of the specific bullying of Richard Loudwell?
A. Everyone was very aware of it.
Q. Because it was happening all of the time?
A. It was sporadic. Sometimes they would leave him alone. I suppose it depended on the patients’ mood at the time and whether they could be bothered, if you like, to say anything to him or do anything. Sometimes he would not be bullied, and others we would have to intervene and say, ‘bang it on the head’.

7.118 On 29 February 2004 Primary Nurse 3 completed the periodic evaluation section of Richard Loudwell’s nursing care plan. He wrote:

“Richard appears to be finding it hard on the ward at this time due to abuse from fellow peers.”

7.119 No minutes are available of the discussion relating to RMO3’s patients at the clinical team meeting on 1 March 2004 because these were never typed or have been lost. RMO3 has provided a transcript of his note of the discussion relating to Richard Loudwell at that meeting which states:

“...Bullying appears to have settled.”

7.120 On 1 March 2004 Nurse 8 noted in Richard Loudwell’s nursing observation notes “no obvious signs of bullying by others”.

7.121 On 5 March 2004 Richard Loudwell was seen by SHO1 who noted that Richard Loudwell was complaining of abuse. He is quoted as saying:

“I’m sick of the sods who threaten you, who stamp on you when they walk past...”
7.122 SHO1 also noted there had been a history of other patients picking on Mr Loudwell.

7.123 On 6 March 2004 there was an incident in the dayroom when patient N stepped on Richard Loudwell’s foot. This was interpreted by Primary Nurse 3 as an accident and written up as such in the nursing notes:

“Whilst he was sat in the main thoroughfare of the day room [patient N]... accidentally stepped on his toe. Richard became extremely verbally abusive calling him a ‘c**t’. This incident was witnessed by staff and appeared to be a complete accident. Situation calmed by staff intervention.”

7.124 No entry was made in patient N’s nursing observation notes regarding this incident.

7.125 RMO3’s notes of the clinical team meeting on 8 March 2004 do not include any comment about bullying.

7.126 On 9 March 2004 a new patient, patient C, arrived on the ward. He was vocal in his dislike of Richard Loudwell. Ward Manager 1 described patient C as follows:

“Following admission to Broadmoor [patient C]’s attitude towards people he believed to be sex offenders was extremely hostile, although this presentation could not normally be considered as unusual in prison transfers, in fact most behaved as if it was expected of them, [patient C]’s was characterised with a degree of consistency that raised questions about his own experiences with the thought that it would account for the particular venom he had for people he perceived to have abused others.”

7.127 Richard Loudwell was regarded by some of his peers, including patient C, as a “nonce”. HCA7 told the inquiry:

“[Patient C] had said on many occasions that he did not like ‘nonces’. He nearly always referred to Mr Loudwell as ‘bacon’, including calling him this to his face. The term ‘bacon’ (bonce) is rhyming slang for ‘nonce’: a prison term for a sex offender.”
7.128 Nurse 6 described how certain patients would make sizzling noises in the dayroom and talk about bacon. She said she had not understood the reference at first but other staff had explained it to her. It was not something she had heard at Broadmoor in respect of other patients. She was asked:

Q. When you describe having witnessed a group of patients making sizzling noises, for example, would that be in the presence of Richard Loudwell?
A. Yes, but not always.

Q. What would be the situation if he wasn’t present?
A. It was a joke between them. They would be in the dining room having their dinner and you could hear them giggling and being very childish, or if he walked into the smoking room, and you would have to come in and say something and they would stop immediately.

Q. Did you form an impression as to whether Richard Loudwell was aware he was the butt of these comments?
A. Yes. He kept making comments—I think he spoke to his mum—that he was being bullied.

7.129 Nurse 8, a team leader since December 2004, was patient C’s primary nurse. He recalls hearing a group of patients shouting “bacon” and being shocked:

“One of the first incidents that happened to me...was when I walked on duty and I heard a group of patients shouting the word ‘bacon’, and I had absolutely no idea what that meant. I asked somebody what that was about, and when it was explained to me what that meant, I thought, ‘It’s getting worse, they’re not hiding the bullying from staff’. They weren’t doing it covertly but they were being quite open about it.”

7.130 Nurse 8 was not clear when this incident occurred. He recalled hearing about other incidents such as biscuit throwing by patient C. He told us when he discussed this behaviour with patient C the response from patient C was that it was justified to treat a “nonce” in this way:

“He’s a fucking nonce, a beast and he deserved it.”
7.131 Nurse 8 said he did not believe patient C had ever changed his behaviour towards Richard Loudwell.

7.132 There are references by other patients to Richard Loudwell as a “child molester” or “paedophile”. HCA7 told the inquiry:

“On one occasion I found [patient C] throwing biscuits at Mr Loudwell and I challenged him about his behaviour. In private I reprimanded him and advised him not to behave like that in the future. In the course of the conversation I asked him what he thought he was doing throwing biscuits at Mr Loudwell. I recall that he jokingly responded that we do not supply the patients with bricks.”

7.133 HCA2 told us that on one occasion he saw patient C tipping Richard Loudwell out of his chair:

Q. You describe in your statement an occasion when [patient C] tipped Richard Loudwell out of his chair. Can you just describe what happened?
A. Basically again, in the middle of the room, and he just came behind him and just bullied him. I think that time Richard got up and walked off in a huff and just sat down in the corner.
Q. When that happened, were there any other staff present?
A. If they were, they would have been in the office. But then, it had been continuous.

7.134 Neither of these incidents are recorded either in patient C’s or in Richard Loudwell’s nursing observation notes.

7.135 On 13 March 2004 Nurse 4 made the following entry in the nursing observation records at 12.35pm:

“Richard stated this morning that yesterday evening fellow patients had been throwing wet paper towels at him. He did not name any of the other patients doing this...”

7.136 On 15 March 2004 Richard Loudwell was reviewed by SHO1 who noted:
“...He still complains of physical abuse at the hands of other patients. ‘Bashes around the head, physical abuse’. On being queried (sic) about who it was:”

“Some of them have moved on, but still replacements.”

“Does still happen.”

7.137 No details of the discussion at the clinical team meeting on 15 March 2004 are available. On 22 March 2004 the minutes of the clinical team meeting noted that Richard Loudwell “remains vulnerable to the attentions of other patients”.

7.138 On 24 March 2004 Primary Nurse 3 wrote in the periodic evaluation section of Richard Loudwell’s care plan:

“Remains under threat of verbal abuse from his fellow peers due to his alleged index offence but as yet he hasn’t identified anyone for this.”

7.139 On 30 March 2004 Richard Loudwell’s admission case conference took place. A case conference for all newly admitted patients at Broadmoor is held about three months after they arrive. The case conference is normally held in two parts (a pre-CPA meeting and a CPA meeting) with the patient attending the second part of the meeting only. Richard Loudwell’s case conference was attended by his own responsible medical officer RMO3, [name deleted] a consultant neuropsychiatrist at the Maudsley Hospital, Consultant Psychiatrist 6 (consultant forensic psychiatrist at the Trevor Gibbons Unit), Social Worker 2, Occupational Therapist 1, Clinical Psychologist (clinical psychologist), SHO1 (SHO) and Barrister 1 (Richard Loudwell’s barrister). Team Leader 3 attended to represent the nursing team.

7.140 Before the case conference Richard Loudwell was seen by SHO1, who noted he was:

“Still complaining about being bullied.”
7.141 Following the case conference a 43-page report was prepared by RMO3 to summarise the conclusions of the meeting. The report said this about abuse received by Richard Loudwell since arriving at Broadmoor:

“Care in the setting of a maximum security hospital has revealed serious difficulties in the containing of other patients inclinations to subject Mr Loudwell to abuse. Some patients have difficulties in accepting the presence of alleged sex offenders as patient peers. Despite the best efforts of staff in this therapeutic environment, some abuse did regretfully occur, and Mr Loudwell remains vulnerable. By virtue of his behaviour towards others in some circumstances Mr Loudwell may have placed himself at greater risk from this. His vulnerability in this regard is likely to be increased if he was to be imprisoned. He would be at risk from bullying and exploitation.”

7.142 Later in the report there appears a risk analysis. This was prepared by RMO3, in advance of the case conference. It also appears in Richard Loudwell’s notes as a freestanding document. According to RMO3, it was discussed with Richard Loudwell and shown to his primary nurse, Primary Nurse 3, prior to the case conference. Under the heading “Risk of self-neglect, vulnerability to being bullied, assaulted or exploited” is a table addressing various risks. In that table the following is said about the risk of physical abuse:

<table>
<thead>
<tr>
<th>Types of harm</th>
<th>Severity</th>
<th>Probability</th>
<th>Circumstances in which he may be harmed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical</td>
<td>Got into an altercation with other patients/ inmates. Has been assaulted by other patients.</td>
<td>Likely</td>
<td>Worse when indignant, frustrated, provocative, intoxicated, depressed or disinhibited.</td>
</tr>
</tbody>
</table>

Comment

It was clearly recognised at the case conference that Richard Loudwell was being bullied, that he had been physically assaulted and that it was likely to happen again. Circumstances were identified where this would be more likely. For example, when Richard Loudwell was indignant, frustrated, depressed or disinhibited.
The significance of this risk assessment should not be underestimated. It identified as ‘likely’ the risk that Richard Loudwell would be physically assaulted by another patient. This risk assessment took place at a case conference less than a month before Richard Loudwell was fatally assaulted by Peter Bryan on Luton Ward. RMO3 told us he had prepared this risk assessment before the case conference and had shown it to Richard Loudwell and to the primary nurse, Primary Nurse 3.

7.143 Following the case conference Team Leader 3, the nurse who attended, made a lengthy entry in Richard Loudwell’s nursing observation notes setting out the conclusions of the case conference. She included the probable diagnosis of dementia, the fact that further investigations were required and the fact that Richard Loudwell would remain on the ward throughout his trial. She made no mention of bullying or the case conference’s conclusion that Richard Loudwell remained at risk of physical assault from other patients.

Comment

It may be that the issue of bullying and future risk was identified more clearly in the case conference report than at the case conference itself. We therefore do not criticise Team Leader 3 for not relaying the conclusions of the case conference on this issue to her colleagues in the nursing notes. However the fact that there was no mention of bullying or the risk of physical assault in her case conference note indicates the low priority attached to this issue by the nursing team.

7.144 The report of the “Critical Incident Review into Incident on Luton Ward on 25 April 2004 Involving Patients Richard Loudwell and Peter Bryan” states at page 3:

“Within the patient group on the ward there is a culture of intimidation and bullying, which needs to be actively addressed by the clinical team.”

Comment

The critical incident review (CIR) was held on 26 May 2004. Its conclusion that there was a culture of intimidation and bullying on the ward which needed to be addressed should have been evident to members of the team in the preceding months when Richard Loudwell was on the ward.
We are satisfied that, while the bullying varied in its intensity and overtones, it never stopped being a problem. On days when there was no overt abuse of Richard Loudwell the underlying tension between him and some of the other patients remained.

In our view there was insufficient concern on the part of the clinical team as a whole about the bullying and intimidation to which Richard Loudwell was subjected during his time on Luton Ward.

A number of factors may have contributed to this lack of concern. Firstly, some members of the team felt Richard Loudwell’s index offence, appearance, demeanour and manner of interacting with others on the ward meant a certain level of abuse was inevitable. If so, for these members of staff it may have become less important to observe or note.

Secondly, there was an understandable but regrettable sense of frustration amongst some staff that Richard Loudwell would not comply with the safety advice given to him. If Richard Loudwell had appeared to take more care of himself then some staff may have been inclined to do more to watch out for him. Primary Nurse 3, Richard Loudwell’s primary nurse, put it this way:

Q. Did you see any evidence of him avoiding the people who were abusing him?
A. No. That is one thing I can say with hand on heart. He was asked when having a cigarette to go into the smoking room, stand at the front, have his cigarette, come out and sit down. Richard would not do that, he would go right, right to the back, into the corner, he would have a cigarette and stay there, and make himself a target. He just would not listen to staff trying to help him as if he wanted to put himself into that situation.

Q. Did you find that frustrating?
A. Very frustrating.

Q. Was that a pattern that continued throughout his time on Luton Ward?
A. Yes.

Q. As his primary nurse, did you form any view as to why he acted in that way?
A. I thought he was doing it out of sheer devilment. He would not listen to myself and other team members. He put himself into that situation.
Thirdly, among many staff there was disturbing complacency about the risk of a patient coming to serious harm. We were struck by how confident staff were of their ability to manage even the most dangerous patients. Staff were happy for most patients to be in association out of sight of staff (e.g. in the smoking room or the dining room) for up to 15 minutes or, in reality, for longer. Staff did not sufficiently appreciate the risk presented by patients many of whom remained unknown quantities. This was one reason why they were on an assessment ward. Similarly staff did not consider adequately the real risk that persistent verbal abuse or modest physical abuse (such as water being thrown over Richard Loudwell) could escalate to more serious physical violence. Some staff accepted a baseline of bullying which was in their view not serious enough to justify further action.

If staff had appreciated these matters the observation level for Richard Loudwell would have been higher; he would not have been allowed out of sight to the extent that he was; and more proactive steps would have been taken to deter or prevent other patients from pursuing their campaign of bullying and victimisation against him.

The final month

7.145 It has been suggested by some staff that the bullying of Richard Loudwell reduced towards the end of his time on Luton Ward, possibly because of a change in the patient composition of the ward.

7.146 The critical incident report states at page 2:

“During his time on Luton ward he had informed other patients of the nature of his index offence and had been the victim of intimidation from other patients. He had declined to accept advice about keeping himself safe on the ward and had at times been placed on increased nursing observations because of concerns about his safety. However immediately prior to the incident on 25 April 2004 there had been fewer concerns about his vulnerability as a result of changes in the patient population on the ward.”

7.147 Team Leader 1 was asked whether she would have been concerned had Richard Loudwell and Peter Bryan been alone in the dining room playing cards. She said
she would not. She said by the time Peter Bryan arrived on the ward (he came out of seclusion on 19 April 2004) concerns about Richard Loudwell had diminished and he was playing cards with peers he had previously complained about:

Q,...in accordance with the plans that you know already existed for those two patients, if a member of your staff had seen Richard Loudwell and/or Peter Bryan go into the dining room, or be in the dining room and be out-of-sight, what would you expect them to do?
A. That wouldn’t have caused any concern because Peter Bryan wasn’t involved in bullying or anything of this patient, and leading up to that incident, Richard had started interacting with some of his peer group and was often in the dining room either talking to them or playing cards, so the concern had lessened at that point. So if those two were seen in there it wouldn’t have been ‘Right, we’ve got to sit and watch them’, whereas if somebody else was in there it may have been that case. But it wasn’t, there was nothing to cause concern. If those two were in a room, it wouldn’t have been, ‘We’ve got to go in’. It would be ‘That’s fine’.
Q. Even if they were actually out of sight?
A. It’s just the structure of the ward at that time. You just allow for that area to be out of sight for up to 15 minutes if that was the case. But in general staff would be present around there. I remember spending a few hours at a time standing in the doorway so that it could be observed...
Q. Was it up to him to stay in sight of a member of staff?
A. There was a certain amount of responsibility for him. Obviously he was one of the patients that we kept an eye on where he was and things like that, but by that time he wasn’t complaining about any bullying on the ward, whereas he was quite prolific in complaining about things.

7.148 Ward Manager 1 told the inquiry he believed the bullying of Richard Loudwell had dramatically reduced before the assault on 25 April 2004:

Q. Was it your impression that the bullying was as much of a problem at the time he was assaulted, towards the end of April 2004, as it had been earlier on?
A. No. He’d started to participate in board games and things like that with some of his peer group, which led me to believe he was being accepted into the hierarchy in the community the patients had amongst themselves. My general thoughts were that the number of incidents and the general attitude towards him
had softened. You could never say the problem had gone away, but it had diminished dramatically.

7.149 Nurse 4 was another experienced member of the nursing team. He too recalled that the level of bullying had reduced towards the end of Richard Loudwell’s time on Luton Ward:

A. The alleged bullying hadn’t stopped, and Richard’s behaviour on the ward had changed. He was interacting more with his peers. I can recall that one day I was in the nursing office, I looked out across the dayroom and he approached some of his fellow patients and they were playing cards together.

Q. Can you remember when that was?
A. I cannot remember exactly.

Q. Can you remember how close it was to the time of his assault?
A. Fairly close.

Q. Could it have been on the shift, the three days you were working immediately prior to this?
A. Possibly, possibly, but I cannot say for definite. Behaviour like that suggested that the bullying had receded.

Q. You referred to the ‘alleged bullying’ which suggests some scepticism on your part as to whether in fact it was taking place?
A. We still don’t know if he was definitely being bullied or not. As you said earlier, it could have been that the patients were actually bullying him, we don’t know or I don’t know.

7.150 Whilst some staff were reassured by Richard Loudwell playing cards with other patients, others were not. HCA7 told the inquiry:

“I do remember that in the week before the incident it was mentioned in a handover meeting that [patient B], [patient C] and [patient H] had been playing cards with Mr Loudwell. This was noteworthy because Mr Loudwell had isolated himself within the ward, usually sitting in a chair by himself.”

“Whilst it was good that Mr Loudwell was socialising, we were concerned about these patients spending time with Mr Loudwell. [Patient C] had said on many occasions that he did not like ‘nonces’.”
7.151 Patient C’s primary nurse Nurse 8 said that in his view patient C’s behaviour towards Richard Loudwell never changed:

Q. Did you form a view as to whether [patient C] ever moderated his behaviour towards Richard Loudwell?
A. I’m not aware that he changed towards Richard Loudwell, but the events then happened.

7.152 On 1 April 2004 at 7.15pm Team Leader 1 made the following entry in Richard Loudwell’s nursing notes:

“Quiet and appropriate, although limited interaction observed with staff or peers, but at one point sitting with the peers he often complains about.”

7.153 On 2 April 2004 at 8.25pm the following entry was made in Richard Loudwell’s nursing notes:

“Appears to be attempting to socialise with fellow patients although tended to sit alone.”

7.154 On 5 April 2004 the minutes of the clinical team meeting recorded in respect of Richard Loudwell:

“...His behaviour on the ward has remained the same, i.e. he has occasionally been abusive and argumentative to staff on a number of occasions. He also isolates himself. He is occasionally being bullied by other patients and staff are attempting to minimise this as much as possible.”

7.155 An entry in the nursing observation notes of patient C at 12.35pm on 5 April 2004, and therefore probably in respect of an incident which occurred during or after the clinical team meeting, reads:

“...appeared in a small amount of horseplay throwing fruit at patient Richard Loudwell.”

7.156 There is no corresponding entry in Richard Loudwell’s nursing observation notes.
7.157 On 8 April 2004 at 12.30pm Team Leader 1 wrote:

“Continues to receive mainly verbal abuse from other patients.”

7.158 The wording of this entry suggests that at times there may also have been some physical abuse – perhaps the fruit throwing on 5 April 2004.

7.159 On 12 April 2004 Primary Nurse 3 made the following entry in Richard Loudwell’s periodic evaluation within the nursing care plan:

“Richard now is interacting with fellow patients playing cards with them. The risk to Richard now appears to have diminished from his fellow peers. Care plan now discontinued as of this date.”

7.160 Accordingly the care plan dated 22 January 2004 which required Richard Loudwell to be kept in sight of staff at all times was discontinued. It was replaced with a new care plan, dated 12 April 2004. This care plan reads as follows:

“Problem/ need: There is a potential risk of verbal abuse from his fellow peers as to what they perceive as his alleged index offence.

Objectives: For Richard to live in an un abusive (sic) environment.
For Richard to express his feelings openly.

Nursing interventions/ patients actions:
To keep Richard on general observation and to encourage Richard to tell staff of any verbal abuse he may get from fellow peers. Nursing levels to respond to any untoward incidents.”

7.161 The rationale for the change in care plan was that there was no longer a significant risk of physical abuse to Richard Loudwell.

Comment

We have already stated that the impact of nursing care plans on a patient’s nursing care on Luton Ward was often limited. In our view the change in nursing care plan on

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12 April 2004 did not change the way Richard Loudwell was observed by staff. The 12 April 2004 nursing care plan put the onus on Richard Loudwell to report verbal abuse. It therefore reflected what had been happening since his second week on the ward, when he came off level 3 observations.

We find the verbal and physical abuse of Richard Loudwell between 12 April 2004 and Peter Bryan’s assault on him less than a fortnight later on 25 April 2004 was as bad as ever. There was a collective failure on the part of the ward staff to appreciate or accept the unacceptable nature of the abuse to which Richard Loudwell was subjected.

7.162 On 14 April 2004 at 12.15pm an entry in the nursing notes records that Richard Loudwell had requested a telephone call to the Mental Health Act Commission (MHAC) to complain about tobacco stolen from his locker and about “alleged abuse”. He also requested to see the duty social worker.

7.163 The duty social worker was Social Worker 3. Her entry in Richard Loudwell’s notes reads:

“Interview with Richard following his request to see the Duty Social Worker. Richard made the following complaints:
1. Says he is being verbally and physically abused by fellow patients.
[complaints 2 and 3 related to missing tobacco]...

In interview he stated that he had made a complaint to the Mental Health Act Commissioners this morning. I agreed to relay his complaints to the nurse in charge...

The above discussed with Team Leader 2. Team Leader 2 is aware of the complaints. No further action taken by myself as matter is being dealt with at ward level.”

7.164 Richard Loudwell did telephone the MHAC that morning. The MHAC’s note of his telephone call at 11.30am on 14 April 2004 reads:

“Bullied by other patients.

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Possessions disappeared from room and locker to which only staff have master keys.
Would also like to see a commissioner.”

7.165 The day report for 14 April 2004 refers to Richard Loudwell’s complaint about his missing tobacco but makes no mention of bullying or abuse:

“Loudwell: complaining of missing tobacco, contacted MHAC to complain, complained also to duty social worker, Social Worker 3. Advised to use hospital complaints procedure.”

7.166 The entries in respect of 14 April 2004 were put to Ward Manager 1 when he gave evidence to the inquiry. His response was:

“…I didn’t say it stopped [the abuse]. My recollection was it had reduced, but he was subject to different degrees of verbal and physical abuse.”

7.167 On 20 April 2004 Richard Loudwell attended Maidstone Crown Court where his solicitor told members of the Broadmoor escort that Richard Loudwell was complaining of bullying by patient C. This was recorded by Nurse 1 in the nursing observation notes later that day. The complaint also appears in Richard Loudwell’s leave of absence authorisation under the heading “Outcome/ Evaluation Report”, again completed by Nurse 1:

“His solicitor came and reported that Richard complained of another patient [patient C] having bullied and sat on his armchair and hitting him.”

Comment

It is significant that this report contains a specific record of physical abuse - Richard Loudwell being hit by a patient sitting on his armchair - but this level of detail was not transferred to the nursing observation notes which record that he “complains of being bullied by fellow patient [patient C]”. This implies that complaints of this nature were accepted as part of the bullying that Richard Loudwell was known to suffer. If staff thought physical violence represented significant escalation in the
bullying of Richard Loudwell then Nurse 1 might have been expected to make a specific note to that effect in the nursing observation notes.

7.168 The day report for 20 April 2004 notes that Richard Loudwell was at court until 13.30pm but makes no mention of the bullying complaint.

7.169 HCA2, who only started work on Luton Ward in April 2004, recalled patient C bullying Richard Loudwell “round a chair”:

Q. Do you remember being asked to look out for him [Richard Loudwell] for any other reason?
A. Not at that particular point. Maybe as time went on we had to watch him. He was getting teased by, I think it was [patient C], like bullying him round a chair and calling him ‘bacon’ and that.
Q. Do you remember [patient C] ever doing that?
A. Yes, I do at one particular point. We just told him to stop it. Then he called “Well, d'you like bacon?” and I said, ‘Only with my eggs’ but I didn’t know what bacon meant.”

7.170 HCA2 elaborated on the nature of the abuse of Richard Loudwell:

Q. At that time, the first time, you didn’t know what the reference was to, so why did you tell [patient C] to stop it on that occasion?
A. Because Richard was being bullied by him and he was told to leave him alone. So I just basically said to him to leave him alone, again.
Q. What was it about the incident that you regarded as bullying?
A. Walking around in circles, you know. The chairs you mentioned earlier on, they weren’t against the wall and this particular chair was out in the open, which enabled [patient C] to just walk around in circles, calling him names.
Q. And in what sort of manner was [patient C] doing this?
A. Just being a big oaf, really and picking on the small guy.
Q. Did you form an impression of how Richard Loudwell was reacting to that?
A. He didn’t react at all, to be honest with you. Like I say, I was quite new to the ward but as the days go on, I get a bit more confident and get to know the patients so I had the confidence to tell [patient C] to leave him alone.
Q. So it was something that happened on more than one occasion?
A. Yes, but other members of staff told [patient C] to stop it and told Richard that if it happens again to just walk away. I think on one occasion, Richard did get up and walk off and go and sit in another chair. The time before that, that’s when he started going into the dining room and read his book. Because basically, what he wanted to do was just to be left alone.

Comment

The only direct reference in patient C’s nursing observation notes to his abuse of Richard Loudwell is the entry on 5 April 2004. There are no entries of staff witnessing abuse by patient C in Richard Loudwell’s nursing observation notes. This is despite evidence from staff such as HCA2 that this abuse was taking place. This was at best poor communication and at worst an acceptance amongst staff of what was happening on the ward. It allowed the misconception that Richard Loudwell was simply making up or exaggerating his allegations to grow.

7.171 On 21 April 2004 Primary Nurse 3, his primary nurse, had a one to one meeting with Richard Loudwell. He recorded it in the notes as follows:

“Had a 1:1 with Richard this evening. He became very upset and crying saying that he didn’t have anything to look forward to as he says that he is going to spend the rest of his life in either hospital or prison…”

“Made a complaint against [patient C] saying that he had been kicking and punching him. I asked him to show me any bruises that he had. At this Richard became irate saying just forget it. Remains isolative in behaviour.”

7.172 Primary Nurse 3 wrote up the ward’s day report on 21 April 2004:

“Loudwell: Refusing all physical medication - tearful during the evening about his forthcoming trial and future.”

7.173 The day and night reports only contain information about individual patients if something significant has happened or they leave the ward for part of the day. Primary Nurse 3 saw fit to make an entry in the day report about Richard Loudwell but did not
consider it necessary or appropriate to include his allegation of physical abuse by patient C.

7.174 This appears to be because Primary Nurse 3 did not believe Richard Loudwell’s allegation:

“On a one-to-one with me he said to me that he had just been kicked and punched by a patient, and I asked him to show me the marks, which he declined to do, which I then said to him, ‘Look if you show me I can deal with it’, because he said he had been repeatedly kicked in the legs which would have left marks. He declined to do so, which then again made me feel that it was another false allegation.”

7.175 Patient C was described by Ward Manager 1 as a “big lad, very muscular”. His nursing care plan on 9 March 2004 noted, at plan 1:

“[Patient C] has a longstanding history of assaults on others.”

7.176 Plan 2 of patient C’s care plan, undated but apparently written on the day he arrived on Luton Ward, notes:

“[Patient C] has expressed violent fantasies directed against paedophiles and has attempted to strangle a fellow inmate causing loss of consciousness believing he was a paedophile.”

Comment

The treatment of Richard Loudwell’s complaints of bullying by patient C is surprising given patient C’s history. Patient C’s nursing observation notes contain no reference to his interactions with Richard Loudwell after Richard Loudwell’s complaints of bullying by patient C from 14 April 2004. Had these complaints been taken seriously and dealt with properly we would have expected to see references in patient C’s nursing observation notes to his interactions, if any, with Richard Loudwell.
7.177 Commissioner 1 of the Mental Health Act Commission visited Richard Loudwell on Luton Ward on 22 April 2004, three days before Richard Loudwell was attacked by Peter Bryan. He noted that Richard Loudwell:

“Feels is bullied by other patients + staff endorse the fact that it is happening.”

7.178 Commissioner 1 wrote to Richard Loudwell on 24 April 2004 following their meeting. His letter concluded:

“You initially came to me because of the bullying you experienced on the Ward. As you will remember we discussed this with the staff and they made a number of suggestions regarding how you can help yourself in minimising the bullying. They will do what they can to stop you being victimised when they see it happening. However you should do what you can to stay in areas of the ward which are well observed by staff. In the longer term, if you do return to Broadmoor [after sentencing] the staff aim to find you a ward which will minimise this kind of behaviour.”

7.179 In a letter to Simon Crawford, chief executive of the West London Mental Health NHS Trust, dated 21 July 2004, the chief executive of the MHAC, noted that Commissioner 1 had discussed Richard Loudwell’s bullying with the team leader on the ward:

“In relation to the questions that you raise Commissioner 1, Commissioner, met with Mr Loudwell on 22nd April 2004 where the issue of bullying was raised by the patient. Commissioner 1 asked the Team Leader of the afternoon shift on Luton Ward to join the interview so that the matter could be jointly discussed at this time.”

Comment

We find this is an accurate description. Commissioner 1 did discuss Richard Loudwell’s bullying with the team leader on the afternoon of 22 April 2004. It is of regret and significance that neither the team leader, nor any other member of the nursing team, recorded the meeting in Richard Loudwell’s nursing notes for 22 April. In our view this demonstrates the ongoing failure of the nursing team to treat the
issue of Richard Loudwell being bullied with sufficient seriousness. The meeting between Commissioner 1 Richard Loudwell and the ward team leader ought to have triggered a review of how Richard Loudwell’s bullying was being addressed. However neither the subject-matter of the meeting nor its outcome appear to have been relayed to nursing staff.

7.180 An obvious place to make reference to the discussion between Richard Loudwell, Commissioner 1 and the team leader was in the ward day report. Nurse 4 made only the following entry in the day report for 22 April 2004:

“Loudwell: Seen by Mental Health Act Commissioner.”

7.181 On the same day the following entry appears in Richard Loudwell’s care plan within the section headed “Periodic Evaluation”:

“Richard appears to be socialising with his peers striking up conversations and playing cards with certain peers. To remain on general observations.”

7.182 That entry was made by Richard Loudwell’s primary nurse, Primary Nurse 3. There is no corresponding entry in the nursing observation notes.

7.183 In his statement to the police, made on 1 July 2004, during their investigation into Richard Loudwell’s death, Primary Nurse 3 said:

“After Richard was attacked in the dining area, I was not on duty until the following morning. I had left work at 2.30pm on the Sunday. After I had found out what was going on, I thought it was strange that before I went home on Sunday he had been playing cards in the day area with other patients, about six of them altogether. I am sure that Peter Bryan and patient B were amongst this group. It looked like a happy little card game, they were laughing and joking while they were playing.”

7.184 In evidence to the inquiry Primary Nurse 3 accepted that according to the ward day/night reports and daily plan he had not been working on 25 April 2004. His last day on the ward before the assault had been 23 April 2004 on a day shift. Primary
Nurse 3 insisted that although he had been wrong about the date his description of what he had seen was correct.

7.185 The inquiry had cause to consider the reliability of Primary Nurse 3’s recollection on matters of significance. He told police:

“During his time at Broadmoor Richard was not what I would call a complainer. He never complained to me as his primary nurse about bullying or mistreatment within the hospital.”

7.186 In his evidence to the inquiry Primary Nurse 3 accepted this was incorrect.

7.187 Primary Nurse 3 also told police he had only seen Richard Loudwell being verbally abused once, when he was called a “nonce” by patient N who had been put up to it by patient J. Primary Nurse 3’s statement said he had spoken to patient J and that “I never saw anything like this again”. In his evidence to the inquiry he accepted that this was probably incorrect. He also told police “I never received any similar reports concerning Richard from any of the other primary nurses.” Again he accepted when questioned for the inquiry that this was incorrect.

Comment

We are concerned about the inaccuracy of the account given by Primary Nurse 3 to the police on 1 July 2004. We do not suggest he was deliberately misleading. We conclude that Primary Nurse 3 never took Richard Loudwell’s complaints of bullying and mistreatment seriously. This coloured all his dealings with Richard Loudwell and his subsequent recollection of events. Primary Nurse 3 tended to treat with great scepticism Richard Loudwell’s complaints of being bullied, yet was quick to note positive interaction between Richard Loudwell and his peers. It was the interactions rather than the complaints which tended to be recorded by Primary Nurse 3 and highlighted in the periodic evaluation within the care plan. Similarly in his account to the police he did not give appropriate weight to the extent of the bullying to which Richard Loudwell had been subjected.
On some occasions Primary Nurse 3 appears to have acted as if Richard Loudwell’s complaints of bullying and abuse were not true. In our view when managing a vulnerable patient, any complaints of bullying or abuse should be assumed to be true until the contrary is shown to be the case. That should be the minimum standard of nursing care expected of any member of ward staff. As Richard Loudwell’s primary nurse Primary Nurse 3 ought to have known Richard Loudwell at least as well, if not better, than other staff. He had a responsibility to take a lead in ensuring his safety and well-being. This required him to be an advocate for Richard Loudwell, encourage others to take the complaints seriously and do whatever possible to ensure the incidents ceased. By failing to act in this way Primary Nurse 3 contributed to an assumption among staff that the only action needed was to advise Richard Loudwell to avoid other patients.

7.188 The ward manager Ward Manager 1 told the inquiry he believed Richard Loudwell was bullied. He said he never witnessed it:

Q. Did you ever witness him being bullied?
A. Not directly. It had been reported to me and I’ve been in the direct vicinity when it has been said patients were throwing cigarette butts at him and stuff like that, and I would have walked into an environment where that behaviour had been carried out almost immediately before. I never saw anything thrown at him or was within earshot of when he had been abused. However, I have a firm understanding that these behaviours were going on.

7.189 Later in his evidence Ward Manager 1 appeared to contradict his earlier answer. He was referred to the notes which suggested that on 14 April 2004 Richard Loudwell was complaining to the duty social worker about being bullied. Ward Manager 1 was asked whether in the light of this entry he still thought the bullying had diminished:

Q. In the light of those incidents from 14 April onwards, do you think the description in the critical incident review of the level of bullying having decreased as a result of a change in patient population in the period prior to the assault is accurate or not?
A. By the very fact that the patient population may have changed, and I believe with [patient J] leaving. If that was the case, the most vocal part of the bullying,
the most obvious and loudly displayed agitation and inappropriate interactions with Richard would have come from that individual.

Q. Why do you say that?
A. Because he was the most vocal and loud patient in showing his distaste for Richard.

Q. Did you ever observe that?
A. It’s difficult to fail to. He would loudly shout these things at him.

Q. I had understood you hadn’t witnessed abuse of Richard Loudwell?
A. Then I’m clearly mistaken. [Patient J] would vocalise loudly - again it’s a case of not being sure, bearing in mind where we are in the timeframe of things. [Patient J] would frequently speak about sex offenders in a derogatory and very loud manner, to which Richard Loudwell would probably have been in earshot.

Q. Just to clarify, are you saying you witnessed verbal abuse of Richard Loudwell by [patient J]?
A. No, I’m saying I’ve heard [patient J] making reference to sex offenders in an inappropriate manner, which Richard Loudwell may quite well have taken offence to in the nature of the charges he was accused of.

Q. And [patient J] has done this in the presence of Richard Loudwell.
A. Yes. Presence being you visit the ward environment, all the patients are up, somebody is shouting loudly and everyone can hear.

Comment

Ward Manager 1’s apparent confusion over whether he had witnessed verbal abuse of Richard Loudwell indicates to us that he, along with many of his staff, did not take the complaints and incidents of abuse seriously. When reviewing past incidents staff were able to recognise behaviour as bullying. Hence the description in the critical incident review of a ward culture of intimidation and bullying. But at the time much of the barracking of Richard Loudwell was not recognised as bullying or abuse by many staff. It was this failure to recognise and to tackle bullying as it was happening which contributed in large measure to its continuing.

7.190 In another example Nurse 1, a staff nurse on Luton Ward, could think of only one episode of bullying of Richard Loudwell - the assault on 22 January 2004. Yet it was Nurse 1 who filled in the report of bullying by patient C made by Richard Loudwell’s solicitor at court on 20 April 2004:
Q. Is your general perception that the level of bullying remained the same over the three months or so that Richard was on Luton Ward before this attack, or that it increased or decreased?

A. Because of how he presented, sometimes in the handover I would hear people say that he was being bullied, but as to myself seeing that, I think I saw it only once, so I am not in a position to say whether it went up, because I only observed it once but there were reports of that nature.

Comment

If the bullying had been properly acknowledged and if there had been a strategy for observing abuse and dealing with it, then in our view it is unlikely Nurse 1 would only have noted one incident of ‘bullying’ in three and a half months.

A further example is the fact that Ward Manager 1, along with a number of others, associated the departure of patient J with a decrease in the bullying of Richard Loudwell. This was because patient J’s bullying was the most overt and unsubtle. However, Richard Loudwell remained on Luton Ward for a further ten weeks after patient J’s departure, on 16 February 2004, and during this period the bullying continued albeit in a less obvious manner. The understanding of Ward Manager 1 and many of his staff was at best superficial indicating the poor quality of observation and engagement on Luton Ward at the time.

For Richard Loudwell the fact that neither the ward manager nor his primary nurse understood or believed his difficulties on the ward left him vulnerable to a particularly troublesome group of patients whose desire to make his life a misery might have been expected.

The CIR was correct that were changes in the patient population. Patient J, identified early on as bullying Richard Loudwell, left on 16 February 2004. Patient K, one of three bullies identified at the CTM on 22 February 2004, left on 5 March 2004. However patient C had arrived on 9 March and others including patient A and patient F (both identified as bullying Richard Loudwell at the CTM on 22 February 2004) remained.
In our view there may have been some change in Richard Loudwell’s behaviour on the ward but not in the overall level of bullying. He was observed to be interacting more with other patients but that does not mean the bullying was less. Richard Loudwell had watched TV in the smoking room with the perpetrators when patient J and others poured water and ash over him but he was still being bullied.

In our view the bullying of Richard Loudwell and the risk of further abuse did not significantly reduce before the assault on 25 April 2004. Less than a fortnight before Primary Nurse 3 downgraded Richard Loudwell’s care plan, the admission case conference concluded further physical assaults were likely. The evidence of him interacting well with other patients was limited in the context of weeks of bullying. It is right that the abuse received by Richard Loudwell was principally verbal but there was an underlying threat of physical abuse. Richard Loudwell had repeatedly complained of physical abuse from other patients and there are a number of instances where physical abuse (such as water being thrown over him) was noted by staff. The underlying animosity towards Richard Loudwell because of his index offence and (to them) objectionable behaviour meant it was illogical for staff to think patients who were verbally abusing Richard Loudwell would not, given the opportunity, also physically abuse him.

As already noted some staff believed the bullying of Richard Loudwell was reducing and the risk of physical assault was receding. This was encouraged by a number of factors:

- Richard Loudwell was seen playing cards with other patients, including those whom he had previously accused of bullying him.

- Staff were not observing Richard Loudwell’s interactions with his peers closely enough to know if the bullying was continuing.

- Richard Loudwell’s own complaints of continuing bullying were not taken seriously.

- In particular, neither Richard Loudwell’s primary nurse nor the ward manager treated the complaints of bullying as seriously as they ought to. Both thought Richard Loudwell exaggerated his complaints and both had misplaced confidence in the ability of staff to see what was going on.
Richard Loudwell’s complaints of bullying were not properly recorded or shared with other members of staff.

7.191 A good example of staff failing to pass on Richard Loudwell’s complaints of continuing bullying came from team leader Team Leader 3 (she had attended Richard Loudwell’s admission case conference):

Q. Would it be fair to say that your perception was that the bullying of Richard Loudwell was verbal rather than physical?
A. Predominantly verbal, I would say.
Q. And that whether it was verbal or physical, it improved prior to the assault on 25 April?
A. Yes.
Q. That was your perception, if you like, when you arrived here this morning?
A. [Agrees]
Q. But at that time, were you aware of these entries that I have drawn your attention to in the notes?
A. I was not aware of the entry with the Commissioner. I was not aware of the entry with Primary Nurse 3. As it is progressing, I do recall Ward Manager 1 speaking to [patient C] and him saying, ‘He’s an old man, I wouldn’t do that…you’re not to treat people this way’. I recall that happening.

Comment

If staff had been aware of Richard Loudwell’s complaints of physical abuse to the duty social worker on 14 April 2004, to the MHAC on 14 and 22 April, and to Primary Nurse 3 on 21 April 2004 it is open to serious doubt whether they could have believed that the abuse and/or the risk of physical assault really did diminish in April 2004 prior to Peter Bryan’s assault.

Evidence from a patient

7.192 On 29 April 2004 patient O, a patient on Luton Ward, wrote to the Mental Health Act Commission to complain about the bullying Mr Richard Loudwell was subjected to, mainly by fellow patients, from admission to the day he was assaulted, 25 April 2004. Patient O wrote:
“Mr Richard Loudwell is a 54 year old small-bodied Caucasian patient who, since his admission to Luton Ward in January this year, was subjected to systematic bullying by fellow inmates. He was spat at, pelted with fruits and plastic water bottles. Such derogatory terms as ‘nonce’ and ‘beast’ were used by his tormentors in reference to him. On no less than 3 occasions, he approached ward staff with his clothing drenched in water, poured on him by the bullies. No decisive action was taken by staff to stop this bullying. I diarised most of the incidences of bullying and I will only avail my diary to external investigators. On one particular occasion (17.2.04) Staff Nurse Primary Nurse 3 perfunctorily looked at the inmates who were bullying him and, with a smile, shook his head, supposedly in ‘disapproval’. Staff, in general, handled his bullying with such cavalier attitude.”

“On 14th April 2004 Mr Loudwell complained to the Ward Manager, Ward Manager 1 (sic), about his tobacco that kept mysteriously disappearing. Ward Manager 1 told him to: I quote ‘Fuck off!’ unquote. Please note other inmates heard and saw Ward Manager 1 swearing to Mr Loudwell. I immediately advised Mr Loudwell to contact the Mental Health Act Commissioners (please check MHAC) records. This kind of response to his concern by the Ward manager epitomises the disdainful treatment meted out to him by both staff and fellow patients…”

“…On behalf of Mr Loudwell, his family, and the general public, I demand answers to the following questions:
i) why did Luton Ward nursing staff allow the systematic bullying of Mr Loudwell to continue without taking decisive action? Broadmoor pledges, in its admissions package, to protect patients from bullying.
ii) Since it was so glaringly obvious that Mr Loudwell was most vulnerable to bullying, why was he not constantly observed to ensure his safety?
iii) Why was his assailant, whose potential danger to us inmates was well trumpeted by staff, days before his admission, not constantly observed?”

7.193 Patient O wrote in almost identical terms to the Nursing and Midwifery Council in a letter dated 10 May 2004. This letter begins:
“I am writing to make a formal complaint about the gross ill-treatment that Mr Richard Loudwell was subjected to by both fellow patients and nursing staff from admission to the day of his severe assault, 25th April 2004.”

7.194 The NMC investigated patient O’s complaint by commissioning a report from Nurse Consultant 2, a nurse consultant from Women’s Services, West London Mental Health NHS Trust (WLMHT). Her report concluded that Richard Loudwell had been bullied in the context of “a culture of intimidation”. She could not establish the nature of the bullying and intimidation but was satisfied that the issue of bullying on Luton Ward was being addressed. She did not make any findings in respect of the specific allegations made against Primary Nurse 3 or Ward Manager 1 because patient O had refused to speak to her about his allegations. She noted that patient O did not regard her as independent because she was employed by the WLMHT.

7.195 Patient O’s allegations, as set out in his letters to the MHAC and NMC, were put to Ward Manager 1 and Primary Nurse 3 by this inquiry. Both denied the allegations. Ward Manager 1 recalled an incident on 14 April when Richard Loudwell swore at him when he was refused permission to go to his room. Ward Manager 1 denied swearing back, but accepted he had spoken “quite loudly”. This was, he thought, a reflection of his “heightened emotion” and anger.

7.196 The inquiry has not heard directly from patient O although he provided a witness statement. He also provided his diary for 2004. This is sometimes hard to decipher but contains various references to Richard Loudwell being bullied by other patients and to staff taking no, or no effective, action.

7.197 There has been no opportunity for Ward Manager 1 or Primary Nurse 3 to put questions to patient O about his allegations. In addition, Ward Manager 1 suggested matters which, if correct, would lessen the weight which might otherwise be accorded to patient O’s account.

7.198 We therefore make no specific finding in respect of Primary Nurse 3’s conduct on 17 February 2004 or Ward Manager 1’s conduct on 14 April 2004, save that Ward Manager 1, on his own admission, did raise his voice to Richard Loudwell. We do accept that the description given by patient O in his letters to the MHAC and NMC is
an accurate account of Richard Loudwell’s life on Luton Ward. He describes continuing abuse of Richard Loudwell by some of his peers and a failure by staff to get to grips with it. To that extent his account is consistent with the totality of evidence we received.

Richard Loudwell’s own behaviour - the unpopular patient

7.199 We have referred to Richard Loudwell’s apparent unwillingness to follow safety advice from staff. This appears to have been seen by some staff as obstinacy on Mr Loudwell’s part. There is little doubt that Richard Loudwell’s own behaviour towards staff and other patients made him more vulnerable to bullying. His behaviour and language were likely to make it difficult to restrain natural reactions of anger, and even disgust, particularly if mental or organic illness was not seen as the cause. Patients were more likely to bully someone they saw as provoking them or was otherwise ‘deserving’ of that attention. At least some members of the clinical team found it hard to look out for a patient who they found rude, unpleasant and unwilling to help himself. We gained the impression during our interviews with staff that some found it difficult not to be influenced by wholly understandable feelings of revulsion at Richard Loudwell’s index offence, which he would talk about repeatedly.

7.200 RMO3 in his statement to the inquiry said this:

“Mr Loudwell was dressing scantily which was a problem he continued to present. He was also malodorous, unkempt and unhygienic. He would walk round with a pyjama top on but which would be open to the waist with his abdomen on display. He could also be intrusive, inserting himself into situations where it was clear that his presence was not necessarily welcomed by the other patients. He had been incontinent of urine immediately on arrival on the ward on the day of admission. We did not know whether this was an act of defiance or whether there was a biological problem. His attitude was that no one really seemed to care what happened to him and it did not matter what happened to him because he was already doomed. It was very difficult to manage Mr Loudwell because through his actions he increased the risk to himself on many occasions.”

7.201 The inquiry asked Ward Manager 1 if Richard Loudwell was an “unpopular patient”. His response was striking:
“More so than anybody I’ve met before in my career.”

7.202 He went on to say this had a direct bearing on staff’s ability to look after Richard Loudwell:

Q. What particular challenges and tasks followed from that [Richard Loudwell being the ‘unpopular patient’] when you were leading the nursing team looking after him?
A. My personal view: tolerance, appropriateness of boundary keeping; all of those things were challenges. You have an individual who sits in a room full of his peers and graphically describes the charges made against him in a manner with complete abandonment to any shock or horror that might cause for people around him, and then expresses this disgust that he’s been bullied, harassed or challenged about the comments he’s just made to his group of peers, as if it’s the fault and duty of everybody else around him to prevent that from happening. He was complex and challenging in that respect.

7.203 There was little interaction between Richard Loudwell and other patients on the ward. There was overt hostility from many patients towards him. The following description of group occupational therapy sessions was given by Occupational Therapist 2:

Q. [in your notes for] 10 February, page 374, you have written this: ‘Richard attended and spent some of the session reading the paper, he spontaneously became engaged in a group crossword. When Richard took over the writing, [patient K] and [patient H] disengaged and played another game.’
Q. You have written that down on the notes. Did you do that on the basis that it was potentially significant?
A. Yes. The minute he stood up to get involved, those two were like ‘right, I do not want to do this anymore’. It seemed to me they lost interest because Richard became involved. That was why I documented that.
Q. You saw a link between him joining and you thought they were responding to him?
A. Yes.
Q. Why do you think that was?
A. I do not think they liked Richard. He was quite provocative at times and I think - again this is me just recalling a bit - he used to talk a lot about what he had done and things like that.

A. I just had the overall sense that he was not a patient that was liked by others, and I would say there is a specific patient here who, on a couple of occasions disengaged when Richard engaged, but on the whole he was not a patient who was very popular on the ward at the time.

7.204 There are frequent entries in the nursing observation notes that Richard Loudwell had to be reminded about personal hygiene. We heard from staff that patients complained about him eating with his shirt unbuttoned to the waist or that he smelled. Others complained that Richard Loudwell ate too slowly which meant all the patients had to wait before leaving the dining room after meals.

7.205 The overall picture we have of Richard Loudwell on Luton Ward is of an older man out of place amongst his mainly younger peers. One member of staff said Richard Loudwell had “no redeeming features”. This impression of Richard Loudwell was widely shared by staff and peers. It increased the risk to Richard Loudwell of bullying and physical assault.

Strategies for tackling bullying

7.206 Ward Manager 1 told the inquiry:

“I remember the issue of Richard Loudwell being bullied was raised at several clinical team meetings by nursing staff. The rest of the multidisciplinary team seemed to be of the view that this was a problem which nursing staff should be managing. Certainly, I do not recollect nursing staff being given any guidance on how to handle the situation by the multi-disciplinary team.”

7.207 He said he felt the multi-disciplinary team had been unfair in leaving the nursing staff to deal with the issue of bullying. Poor relationships within the multi-disciplinary team are dealt with elsewhere but Ward Manager 1’s view was clearly that this had a direct impact on the nursing staff’s ability to deal with the issue.
7.208 In a letter to the inquiry RMO3 said there was a strategy for tackling the bullying of Richard Loudwell:

“As part of the strategy to deal with this problem, the team did feel that it was reasonable and prudent to request and to assist Mr Richard Loudwell, who was indeed a mentally unwell man, to moderate his own behaviour in order not to inflame an already difficult situation in relation to bullying…”

“The main way in which the bullying was to be managed was staff observation of Mr Richard Loudwell and other patients and interventions were aimed at modification of the bullying behaviour of other patients. At the time we believed that this was working.”

“With hindsight we have to acknowledge that the bullying continued despite our attempts to stop it, and therefore in this respect our management interventions were not as effective as we believed at the time. We later therefore took steps to develop a strategy which did not exist at the time.”

RMO3 went on to say:

“The team did review the action plan regularly, and there were attempts to bring the bullying to a close. The team were concerned about the bullying and did not accept it. It is not true that we only gave advice to the patient...The issue of bullying was continually reviewed from the time he was first admitted to the time of his death. Numerous actions were taken by us in addition to the advice given to Mr Richard Loudwell:

- we raised the observation levels when it was thought appropriate
- enhanced monitoring was considered on many occasions
- other patients were spoken to when appropriate
- incidents were monitored and reported to the team at the weekly CTM
- some of the patients at greatest risk of bullying him were indeed moved...”
Comment

Notwithstanding RMO3’s description of a formal bullying strategy we can find no evidence of such a strategy in the contemporaneous notes. The notes of the weekly clinical team meetings note bullying but do not record any strategy for dealing with it. RMO3 may be describing the sort of interventions that took place - telling Richard Loudwell to avoid trouble and speaking to the perpetrators - but that is not the same as a strategy or coordinated plan to address the issue.

With respect to the other matters raised by RMO3:

- There is no evidence in the records or from what we have heard in oral evidence that observation levels were ever increased on Richard Loudwell after 22 January 2004.

- There is no evidence of any discussion of enhanced monitoring or of enhanced monitoring taking place.

- There is evidence of other patients being spoken to but our impression is that many incidents went unnoticed by staff. When staff were aware of incidents they did not always intervene. We found no evidence of any instruction being given to staff that they should always intervene.

- There is no evidence of any systematic monitoring of the bullying of Richard Loudwell. The CTM minutes merely report ‘bullying’.

- There is no evidence that patients were moved because they were bullying Richard Loudwell. In early February 2004 it was noted in the CTM minutes that patient J was likely to leave the ward imminently and it was hoped this would impact on the bullying of Richard Loudwell. This is different from suggesting that pro-active steps were taken to reduce bullying by moving patients.

We do not doubt that staff wanted to prevent Richard Loudwell being bullied. We accept that the nursing team in general, and Ward Manager 1 in particular, did not receive sufficient help or guidance on how to deal with bullying. At the same time we note that the nursing team must have been unaware of the extent of the bullying.
Key figures such as Ward Manager 1 believed it was significantly reducing from mid-February onwards. In this context it is unclear if the nursing team sought guidance for a problem they significantly underestimated.

The lack of guidance and appreciation of the extent of the bullying indicates that the multi-disciplinary team (MDT) was not functioning effectively. A well-functioning MDT would have been sufficiently engaged with Richard Loudwell to be aware of the difficulties he was encountering on the ward. It would have been concerned not solely with his ‘assessment’ but with his living conditions on Luton Ward. It would not have relied solely on reports from nursing staff in respect of bullying. At the same time nursing staff would have been more likely to pay attention to bullying as an issue if it had been given greater importance by the clinical team and a strategy for addressing it.

7.209 Team Leader 2 from Luton Ward, told the inquiry he once asked RMO3 in the ward office whether Richard Loudwell should be transferred to the infirmary, opposite Luton Ward, for his own safety. Team Leader 2 could not remember why this suggestion had been rejected. It is not clear when this suggestion was made. It does not seem to have been discussed at a clinical team meeting.

The quality of observation and engagement

7.210 As previously noted, the strategy for protecting Richard Loudwell was a combination of speaking to the perpetrators (although not always), advising Richard Loudwell to keep in sight of staff and away from the smoking room, and observing him. We note that on occasions, such as 22 January 2004 when patient F was briefly placed in seclusion, steps were taken to address the behaviour of other patients. Richard Loudwell apparently ignored advice as to his own movements and actions. Speaking to the perpetrators appears not to have been very effective in reducing bullying. No consideration was given to the separation of Richard Loudwell from the perpetrators or vice versa as a protective measure. This left observation as the single most important tool in the protection of Richard Loudwell on Luton Ward.

7.211 Before 22 January 2004 Richard Loudwell had been on a regime of continuous observation when in association. This was clearly ineffective at times. Nurse 4, a team leader since about October 2004 and an acting team leader when Richard Loudwell was on
the ward, was asked about the gaps in observation on 17 January 2004 when Richard Loudwell was drenched in water by patient J. He was asked why there was nothing in the text box for observations between 3pm and 4pm and between 4pm and 5pm that day:

Q. Do you know why that is?
A. No.
Q. Should that have happened?
A. No.

Q. Does it surprise you that it did happen, by which I mean that it managed to happen without being observed?
A. No, it doesn’t...Sometimes there are gaps in systems, sometimes there are gaps in people’s competencies. Generally, when I am in charge of a ward, if I have a patient who is on a level observations, I will draw up a rota to cover the whole shift so that everybody knows when they are assigned to do observations. Sometimes in practice, you cannot get away from what you are doing or you get busy and tied up with something else. If you look at the rota and it is half an hour through your observation period when you should be observing the patient. In that case the staff who were observing him before you should still be there, they cannot then leave...Sometimes there are flaws, sometimes people may see their hour is up and wander off.

7.212 In a letter to the inquiry RMO3 said:

“...there was adequate observation of Mr Richard Loudwell in the light of the bullying. If Richard Loudwell had been subject to constant observations at the time of the incident it would not have happened. However there was no need for constant observations because the bullying appeared to have died down.”

7.213 Ward Manager 1 said he was content to allow Richard Loudwell to be out of sight in the dining room with at least some other patients:

Q. If you had been aware that Peter Bryan had gone into the dining room with Richard Loudwell and that there was no one else in there, and they were out of sight in the dining room, what would you have done?
A. On that day, if I’d been aware that Richard Loudwell was in the dining room and Peter Bryan had walked in, I would have been quite comfortable with that. It wouldn’t have caused me any anxiety.

Q. Even though you couldn’t see them.

A. At best I might have followed them in, seen who else was there and walked out again. I would have quite happily left them in that environment on their own.

Comment

Richard Loudwell apparently repeatedly ignored advice about his own movements and actions. Speaking to the perpetrators appears not to have been effective in reducing bullying. This left observation as the single most important tool for protecting Richard Loudwell on Luton Ward.

In our view it is likely that the incidence of bullying was greater than the incidents recorded in the notes of Richard Loudwell or other patients. We note that on many occasions staff were not alert to bullying when it was taking place in their presence. A certain amount of abuse or horseplay seems to have been accepted, at least by some members of staff.

It is of great concern to us that for much of Richard Loudwell’s time on Luton Ward he was out of sight of staff. We accept this was often because he ignored advice to stay close to staff. However, we do not accept that Richard Loudwell’s non-compliance with instructions from staff absolved them from responsibility to keep a close eye on him. Indeed it made proactive observation more important.

The care plan in place between 22 January 2004 and 12 April 2004 required Richard Loudwell to be literally in sight of staff at all times. Staff who were aware of this care plan, and it appears many were not, did not interpret it this way. Instead they were aware of a general instruction to keep an eye out for Richard Loudwell. The evidence we have received suggests even this did not happen consistently or effectively.

The care plan was downgraded in accordance with a perceived reduction in risk on the part of Primary Nurse 3, the ward manager and other senior members of the nursing team. In our view the care plan should never have been downgraded as it was
on 12 April 2004 because the risk of harm to Richard Loudwell never reduced. Even if it had been reasonable to downgrade it that day, it should have been reinstated on 14 April 2004 when Richard Loudwell complained of continuing abuse to the duty social worker.

Richard Loudwell should have been kept within sight of staff at all times. Instead Richard Loudwell was allowed to be out-of-sight of staff throughout this period.

Ward Manager 1 told us that he would have been content for Richard Loudwell and Peter Bryan to have been alone in the dining room, out of sight of staff. His answer implies there would be some combinations of patients that he would not have been happy to leave out of sight. He was not asked if he would have been similarly content for Richard Loudwell and patient C to be alone in the dining room. In our view it was wrong to allow two or more patients on an assessment ward to be out of sight of staff during association. That would particularly be the case when one was as vulnerable as Richard Loudwell or when one, as in Peter Bryan’s case, was a relatively unknown quantity. Peter Bryan had only been out of seclusion for six days after his arrival on Luton Ward. The observation policy for patients has to be contrasted with common practice for the protection of staff. Staff would not have been content to allow one staff member to be alone and out of sight with a patient in the dining room. It is difficult to understand why a different standard should have applied to the protection of patients. The Trust has argued that staff may be at more risk because they carry keys and may be more vulnerable to being taken hostage. Staff may be at risk for the reasons mentioned and for many others and they are entitled to protection but that does not mean that patients are not just as entitled to protection from the risk of attack and abuse when it is known that they are vulnerable. In some situations, patients will be at greater or more immediate risk than staff, as was the case here.

There is another troubling aspect to Ward Manager 1’s answer. If it was reasonable to allow some combinations of patients to be unobserved for up to 15 minutes at a time, how would individual members of the nursing team make a judgement about the risk posed by a particular combination? There is no suggestion in any of the notes or care plans that we have seen of thought being given to which patients Richard Loudwell could be left alone and out of sight with. Ward Manager 1 might have been sufficiently experienced to make a judgement about two
particular patients but what of less experienced members of staff? What information would be used to make a judgement?

On the basis of the evidence set out above we disagree with the assertions in RMO3’s letter both as to the adequacy of the observation and the belief that the bullying was reducing.

Care planning

7.214 In Richard Loudwell’s case care planning should have been at the heart of a strategy to protect him from other patients. There were two care plans during his time on Luton Ward which addressed the risk of abuse (physical or verbal) from other patients. The first was dated 22 January 2004 and addressed the risk to Richard Loudwell from his peers due to his alleged index offence. We note that it took seven days to complete a care plan to deal with abuse that had started within a few hours of Richard Loudwell’s arrival on the ward. For his first week on Luton Ward there was no care plan in place to address bullying or the risk of assault to Richard Loudwell.

7.215 This first care plan continued until 12 April 2004 when it was revised in accordance with Primary Nurse 3’s perception that the risk to Richard Loudwell had diminished.

Comment

These two care plans are intended to address the risk of ‘abuse’ but it is interesting that they do not refer specifically to ‘bullying’. In our view there should have been a care plan in place throughout Richard Loudwell’s time on Luton Ward, which expressly addressed the risk of physical and verbal bullying. This care plan should have emphasised the need to take bullying seriously, should have provided for monitoring of the frequency and degree of bullying as well as providing specific measures to tackle the bullying.

We accept that a perennial problem for staff dealing with Richard Loudwell was his non-compliance with instructions. But this problem was not addressed in his care plans. There was no point recommending nursing actions, such as telling Richard Loudwell to keep out of the smoking room, if he was likely to ignore that instruction.
A plan to forestall incidents of bullying which consists only of giving an instruction to the victim gives the impression of staff merely going through the motions. It is possible that those bullying Richard Loudwell formed such an impression. A care plan was required to address the reality that Richard Loudwell would go into the smoking room and put himself unnecessarily at risk of verbal or physical abuse. The least preventive action required was for Richard Loudwell to be closely observed so that if he ignored advice and went into the smoking room he would be followed by a member of staff who could observe and stop any incident. A visible form of protection would have given patients the message that any bullying of Richard Loudwell would be taken seriously.

We find that on Luton Ward in early 2004, at least in respect of Mr Loudwell, care plans were sometimes no more than forms to be filled in by primary nurses and then filed.

We have noted that the care plans of patient C included a previous incident in prison where he strangled to the point of unconsciousness a fellow inmate whom he regarded as a paedophile. Despite patient C's history no precautions appear to have been taken to restrict patient C's movement on Luton Ward, or his interaction with Richard Loudwell or any other ‘vulnerable’ patient. His care plan recommended only that he had 1:1 sessions with “primary nurse for continual assessment of risk to others, and to discuss thought and feelings with regard to violent fantasies”.

In our view this is another example of mis-use of a care plan. The nursing actions in patient C’s care plan should have included measures such as observing his interaction with named vulnerable individuals, particularly Richard Loudwell. Richard Loudwell was clearly at risk from patient C in the light of patient C’s history. It was Peter Bryan rather than patient C who attacked Richard Loudwell in the dining room on 25 April 2004 and we have been told repeatedly by staff that this could not have been predicted. However, the failure to address the obvious risk presented to Richard Loudwell by patient C is in our view illustrative of an endemic failure on Luton Ward to understand the risk posed by patients to each other. The failure was underlined by the fact that nothing was done when Richard Loudwell reported that patient C was targeting him for physical abuse. Patient C’s care plans should have been re-visited at that stage, if not before, and a plan formulated to observe his interactions with
Richard Loudwell. It would also have been appropriate to revisit Richard Loudwell’s care plans to ensure a strategy was in place to deal with the risk from patient C.

7.216 Used effectively care planning can be an important tool in nursing patients on any ward. On Luton Ward where all new admissions to Broadmoor would spend three or more months being assessed, care planning was particularly important. There were a wide range of patients with vastly differing needs and problems. Furthermore, new patients were arriving all the time presenting staff with new challenges. Care planning provides a straightforward way of identifying the needs of a particular patient and advising how these should be dealt with.

7.217 The failure of care planning in respect of Richard Loudwell and patient C and the failure to observe patients properly, even when they were supposed to be on continuous observation, are illustrative of a wider problem on Luton Ward. There was a lack of understanding amongst many nursing staff of the risks presented by patients, both to each other and to staff, and a failure to appreciate the importance of basic steps such as observation and care planning to address that risk. This would be of concern on any ward in a high security hospital but particularly on the assessment ward.

The role of the primary nurse in caring for Richard Loudwell

7.218 Primary Nurse 3, an E grade staff nurse with nearly 20 years’ experience at Broadmoor, was Richard Loudwell’s primary nurse. He was given the role about a week before Richard Loudwell arrived but was not involved in his pre-admission assessment. Although he had access to the pre-admission psychiatric reports seen by the admissions panels our impression is that he paid little attention to them. He told us these reports give “someone else’s view”:

“My own personal view is that you have to build your own view when you actually meet somebody.”

7.219 He found working with Richard Loudwell difficult:

“I would have liked to think it was a good relationship, but I know that he did not like me one little bit.”
Most of the time Richard Loudwell declined one-to-one sessions with Primary Nurse 3. This must have impacted on Primary Nurse 3’s ability to work with Richard Loudwell. We asked if Richard Loudwell could have had a different primary nurse. Primary Nurse 3 said it would have been possible if either he or Richard Loudwell requested it, but neither had made such a request. He stayed with Richard Loudwell believing he was doing as well with him as anyone else would be able to:

“...I felt that I was doing the best that I could do with Richard, and I do not think that anybody else at the time would have got more out of Richard.”

Comment

In our view one of the main functions of Richard Loudwell’s primary nurse was to be a ready point of contact for him and to foster a trusting and positive relationship. The primary nurse was the obvious person for Richard Loudwell to approach with any problems, in particular the bullying that he was being subjected to.

Primary Nurse 3 did not succeed in developing that sort of relationship with Richard Loudwell. They did not get on. They hardly spoke. We have already noted our impression that the reason for Primary Nurse 3’s inaccurate account of Richard Loudwell to police on 1 July 2004 was ignorance - he did not know nearly as much about Richard Loudwell as one would have expected a primary nurse to know about any patient, let alone one as needy as Richard Loudwell.

We recognise that Richard Loudwell was a difficult patient and would have been a challenge for any primary nurse. We do however criticise Primary Nurse 3 for not reacting to the fact that there was no effective primary nurse/patient relationship between himself and Richard Loudwell by asking that another nurse take over the role, or by taking other steps to mitigate the resulting challenges in managing this patient.

We are also concerned that the multi-disciplinary team in general and the ward manager in particular did not recognise the poor relationship between Primary Nurse 3 and Richard Loudwell or its significance for the patient’s management. It was not Primary Nurse 3’s responsibility alone to recognise that remedial steps were required. Ward Manager 1 should have supported Primary Nurse
3 in his relationship with Richard Loudwell. But when, early on, it become clear there was no prospect of a successful relationship, Primary Nurse 3 should have been replaced or other steps taken to facilitate the care of Richard Loudwell. This was particularly important when Richard Loudwell was being bullied to such an extent.

The second principal function of Richard Loudwell’s primary nurse was care planning. It was the common practice on Luton Ward in 2004 for care plans to be prepared by the primary nurse and all of Richard Loudwell’s care plans were prepared by his primary nurse Primary Nurse 3.

We discuss above how properly used care plans are a valuable tool in caring for patients on a ward such as Luton Ward. In our view Primary Nurse 3’s care plans for Richard Loudwell in respect of the risk of abuse from other patients were ineffective. This meant a valuable opportunity to help Richard Loudwell was lost. The failure to have effective care plans to address the relationship between Richard Loudwell and other patients on Luton Ward materially contributed to the failure to protect him from bullying and, ultimately from the assault by Peter Bryan on 25 April 2004.

Had there been an appropriate care plan to address the risk of serious physical assault, and had Richard Loudwell been nursed according to that care plan it is unlikely Richard Loudwell would have been allowed to be unobserved in the dining room with Peter Bryan or any other patient on 25 April 2004. The opportunity for a prolonged assault would have been significantly reduced.

In our view it would not be practical for every patient’s care plan to be known by every member of the Luton Ward nursing team. However, the plans that there should have been for Richard Loudwell’s safety should have been identified as sufficiently important to be known by all members of the nursing team. In our opinion there should be a system of red-flagging those care plans which it is important for all members of the nursing team to be familiar with.

Primary Nurse 3’s care plans for Richard Loudwell fell below this standard. On 22 January 2004 he recognised the need for a care plan to address the risk of abuse but failed to produce a workable, coherent plan. He agreed he could have written it a “lot better”. Whereas he had written that Richard Loudwell should be kept “in full
view of staff at all times” what he meant was that he wanted “Basically just staff to keep an eye on him”.

If that is what is meant by words which suggest something approaching level 3 observations, then not only did Primary Nurse 3 not express himself clearly, but he failed to grasp the basic requirements for trying to keep Richard Loudwell safe.

On 12 April 2004 Primary Nurse 3 was wrong to regard the risk of physical assault as having diminished. Richard Loudwell’s care plans at that time, or at any time, should not have been changed to reflect a reduction in risk to him.

Our criticism in respect of care plans is not limited to Primary Nurse 3. He worked in a nursing team led by Ward Manager 1. Care planning to deal with the twin threats of bullying and physical assault should not have been left to Primary Nurse 3. Richard Loudwell’s problems were such that the ward manager and team leaders should have considered care plans to address his needs from his first days on Luton Ward. They should have been aware of care plans in place for Richard Loudwell and any inadequacy in these care plans should have been obvious to them and addressed as a matter of urgency. These care plans and their implementation should have been reviewed regularly by not only Primary Nurse 3 but by his senior colleagues in the nursing team and by Ward Manager 1 as ward manager. There is no evidence that this occurred. In this regard Primary Nurse 3 did not receive the support to which he and his patients were entitled.

The link between bullying and the assault on 25 April 2004

7.221 Most of the nursing team seen by the inquiry said that they saw no link between the bullying of Richard Loudwell and the assault on 25 April 2004 by Peter Bryan. Staff saw the bullying as a response to Richard Loudwell’s index offence and his presentation on the ward. Ward Manager 1 said:

“...I don’t believe [Richard Loudwell] was a victim of that assault because of the nature of the charges against him.”
Similarly, we were told by both RMO2 and RMO3 that they saw no link between the bullying of Richard Loudwell and the assault on him by Peter Bryan. In a letter to the inquiry RMO3 said:

“...in my view the bullying had nothing to do with the patient’s death. Whether the bullying had not been dealt with at all, or had been dealt with to the satisfaction of all concerned, it would have made no difference in the circumstances of the incident.”

“The patient was killed as a result of the mental disorder of Mr Peter Bryan, not because of any failure to act on any bullying behaviour at the time. Mr Peter Bryan had not been one of the patients engaged in bullying Mr Richard Loudwell, nor is there any evidence to suggest that he was prompted into carrying out the assault by other patients...Had we stamped out all of the bullying the incident would still have occurred because it was unconnected to it.”

The bullying of Richard Loudwell started on the day of his arrival on Luton Ward, Peter Bryan only arrived on 15 April 2004 and was in seclusion until 19 April 2004. Therefore the bullying was well-established long before Peter Bryan’s arrival on the ward. There is no suggestion from any member of staff that Peter Bryan was engaged in bullying, or that he had any contact with Richard Loudwell whatsoever.

We have considered the possibility that Peter Bryan was put up by another patient to attack Richard Loudwell. In his evidence to the inquiry, Peter Bryan denied being put up to the attack on Richard Loudwell. Nurse 8, primary nurse for patient C, thought that it was possible that patient C had encouraged Peter Bryan to attack Richard Loudwell. He thought patient C’s reaction to the assault was significant:

A. The only thing I would say about [patient C] was his reaction after the events happened; he looked genuinely shocked...I have my own theories about that.
Q. What are your theories about that?
A. That he underestimated what Mr Bryan would do, and he was shocked when it was such a severe attack. I don’t think he expected that.”
7.225 Nurse 8 stressed he had no evidence to suggest that Peter Bryan was encouraged by patient C to attack Richard Loudwell but he did think that it was possible that patient C, or possibly patient B or patient L, had encouraged some sort of assault:

Q. On the basis that this is theorising, do you think [patient C] might have known an incident was going to take place before it took place?
A. Theorising, yes.
Q. Why do you say that?
A. I know that is the type of person he was, and a relationship struck up with Mr Bryan when he came to the ward. They interacted well with him and he became a - celebrity is not the word, but somebody who stands out.
Q. He was popular.
A. Yes. He was within that particular group of patients we had at the time, and there was a lot of joking and interacting going on between [patient C] and Mr Bryan which probably said (sic), ‘Go and give him a smack’ - my words - and I think that’s what happened. He may not have been the only person who said that; there are two other patients who could potentially have said the same thing [patient B and patient L], if it was said at all.

Comment

We cannot safely conclude that Peter Bryan was put up to assaulting Richard Loudwell by another patient or patients. It is certainly possible that he was, but it is also as likely that he acted independently, as he asserted to the inquiry.

We do find however that the persistent bullying of Richard Loudwell by other patients materially contributed to the risk of a serious assault on Richard Loudwell of the type carried out by Peter Bryan. We reject RMO3’s assertion that there was no link between the bullying and the assault for a number of reasons:

- Peter Bryan described Richard Loudwell as “weak” and “at the bottom of the food chain”. His perception of Richard Loudwell may well have been influenced by the attitude of other patients on the ward. Those who were engaged in bullying Richard Loudwell, particularly patient C, were well-established within a ward hierarchy as ‘top dogs’. Any view of Richard Loudwell as “weak” or
“vulnerable” would be highlighted by public abuse from dominant personalities such as patient C.

- The vulnerability of Richard Loudwell can only have been emphasised by staff being unwilling or unable to prevent the persistent abuse meted out to him. This is unlikely to have gone unnoticed by Peter Bryan.

- The attack on Richard Loudwell by Peter Bryan was prolonged. We cannot say if it was witnessed by any of the patients in the dayroom but there is a reasonable chance that some of these patients either knew or suspected something untoward was happening in the dining room. If a less unpopular patient had been attacked, in our view it is more likely that one of the patients in the dayroom would have done something to intervene directly or by summoning staff. The effect of the prolonged victimisation of Richard Loudwell on Luton Ward was that those patients in the dayroom were less likely to intervene to prevent or end an assault on Richard Loudwell than on other patients. This may have been because these patients did not care sufficiently about Richard Loudwell to do anything or because, in some cases, they did not feel able to take a stand in front of their peers to protect Richard Loudwell.

- The bullying made it more likely that Peter Bryan would have an opportunity of attacking Richard Loudwell. As previously mentioned, HCA2 noted that Richard Loudwell’s typical response to taunting by patient C in the dayroom was to get up and go to the dining room to read his book. Given the abuse he received from patient C in particular, there was always a real risk that Richard Loudwell would hide himself away in the dining room. There he was safer from abuse but, in retrospect, more vulnerable to serious assault than in the dayroom where he was closer to staff in the ward office.

The risk of serious assault on Richard Loudwell was materially increased by the bullying he was subjected to. It is clear this risk was enhanced by the poor, often non-existent response by staff to this bullying and the associated risk of assault. We do not consider that any patient should have been out-of-sight of staff during association on Luton Ward. Even if it was thought reasonable to permit unobserved association for some patients, it was unreasonable to allow a patient subject to
persistent abuse to be out-of-sight of staff while in association. In particular we highlight the following:

- **Within hours of his arrival on Luton Ward Richard Loudwell had been targeted for verbal and physical abuse.**

- **By 22 January 2004 a care plan which required Richard Loudwell to be kept in sight of staff at all times was implemented. Although it appears the plan was not intended to be read literally and was not followed, its sentiment was correct and the rationale behind it never disappeared.**

- **On 30 March 2004 the initial CPA meeting to discuss Richard Loudwell concluded he was vulnerable to physical assault from other patients and that further physical assaults were likely.**

- **The risk of verbal and physical abuse to Richard Loudwell never, despite the recollections of some staff, reduced. The evidence suggests the abuse, particularly from patient C, increased in the fortnight before the assault by Peter Bryan.**

The level of bullying to which Richard Loudwell was subjected made it imperative that he was never out-of-sight of staff when he was with other patients. Had this imperative been translated into a properly implemented care regime then Richard Loudwell would never have been out of sight of staff in association and Peter Bryan would not have had the opportunity to fatally assault Richard Loudwell on 25 April 2004.

Did Richard Loudwell deliberately invite the assault by Peter Bryan?

**7.226** We have considered if Richard Loudwell may have deliberately invited attack by Peter Bryan or put himself at risk of such an attack. He had been the subject of bullying and victimisation. Four days before the attack he pleaded guilty to manslaughter and was facing a lifetime in Broadmoor or prison. Therefore, the possibility to be considered is whether he had lost the will to carry on. He may have invited Peter Bryan to attack him, possibly after Peter Bryan had told him what he was planning to do, or done nothing to resist once the attack was imminent or started. In our view there is no substance to such a
possibility, principally because there was no significant change in Richard Loudwell’s behaviour prior to the assault.

7.227 The reality is that Richard Loudwell consistently placed himself at risk by insisting on sitting with his tormentors in the TV room. The view of RMO3, Ward Manager 1 and other members of the nursing team is that Richard Loudwell did this deliberately. However, there is no evidence that Richard Loudwell’s will to live or the degree of his risk-taking behaviour altered significantly whilst he was on Luton Ward. The Trust has suggested that it is possible Richard Loudwell was seeking the protection of the bullies, but this has not been suggested by any individual witness and is inconsistent with his objectionable behaviour. In any event, the ward team did not seek any understanding of why Richard Loudwell was acting in this way.

Richard Loudwell’s general health

7.228 Richard Loudwell was medically assessed on his arrival on Luton Ward on 15 January 2004 by duty SHO2 who found him cooperative and able to give a full account of his previous psychiatric and medical history. His mood was noted to be normal and there was no evidence of depression or feelings of self harm.

7.229 On 27 January 2004 SHO3 attended Richard Loudwell following his request to see the doctor. Richard Loudwell was complaining of feeling drowsy and blamed this on a change in his medication since admission to Broadmoor. He was reassured that his medication had not changed.

7.230 On 3 February 2004 Richard Loudwell met RMO3, his RMO, for the first time. RMO3 made the following note:

“Seen. Discussion regarding admission, purpose of assessment, and nature of case conference. He has been very frightened of being abused in prison and by the police and while here. He appears to be somewhat low in mood. He cannot understand why his offence occurred. Requires full MDT assessment.”

7.231 On 10 February 2004 Richard Loudwell complained of feeling unwell. He was seen by the duty doctor who noted that his blood sugar was high at 18 mmol/l and had been 19.7 mmol/l the previous day. He was prescribed Glicazide to bring his sugar levels down.
7.232 He was reviewed by the duty doctor, Associate Specialist, the following day 11 February 2004. His blood sugar remained high (18.6mmol/l) His Glicazide was increased and he was to be reviewed by a GP, the following day.

7.233 On 12 February 2004 the GP saw Richard Loudwell and continued him on Glicazide. He ordered that his blood sugar levels should be checked twice daily. It is not clear from Richard Loudwell’s notes whether his blood sugar levels were in fact checked twice a day. We have seen a pro-forma “blood glucose recorded” but this starts on 12 March 2004. It is not clear if there was an earlier document which has been lost. There are entries in the nursing notes on the following dates: 12 February 2004 - glucose recorded morning and afternoon; not recorded on 13, 14, 15 or 16 February 2004. On 17 February blood glucose is recorded in the morning but not the afternoon. On 18 February blood glucose is recorded in the morning but not the afternoon.

7.234 On 19 February 2004 Richard Loudwell attended the diabetic clinic and it was recorded in the nursing observation notes that his blood glucose was to be checked twice daily. There is no record of it having been recorded on 20 February 2004 or subsequently until the evening of 24 February 2004.

7.235 In Primary Nurse 3’s nursing report for the admission case conference he recorded that Richard Loudwell’s:

“...blood sugar (tested with BM stix) was regularly high. He was advised to stick to a diabetic diet but was unable to.”

7.236 The GP reviewed Richard Loudwell on 20 February 2004 when it was noted that Richard Loudwell was “always tired”.

7.237 On 26 February 2004 on review by the GP it was noted that Richard Loudwell’s blood sugar remained high but was improving slightly. There is a note of a discussion with a medical registrar at an external hospital who suggested increasing the dose of Glicazide further, to 160mg twice per day. It appears that he remained on this dose of Glicazide throughout his time at Broadmoor (the CPA report of 30 March 2004 wrongly notes the dose as being 80mg once a day).
The next entry in Richard Loudwell’s ward clinical notes (as opposed to the GP notes) after 12 February 2004 is for 20 February 2004 when SHO1, SHO on Luton Ward, noted that Richard Loudwell had been seen in the diabetic clinic and made a note for nursing staff to continue with twice daily blood sugar checks. On 2 March 2004 SHO1 requested bloods for dementia screening. Again he could not say that he had seen Richard Loudwell on this occasion.

SHO1 saw Richard Loudwell on 5 March 2004 and carried out a mental state examination. This was the first proper mental state examination of Richard Loudwell since his arrival on Luton Ward seven weeks earlier.

Comment

In our opinion it is not acceptable practice for any patient on an admissions ward in a high security hospital to go for seven weeks without a detailed examination of their mental state.

We note that SHO1 was the second SHO to work on Luton Ward, the first having been appointed for six months from 1 August 2003. It was the SHO’s responsibility to provide day-to-day medical cover for Luton Ward, including carrying out mental state examinations every week on every patient. As at 25 April 2004 there were 19 patients on Luton Ward. RMO2 thought that this was a reasonable workload for an SHO and commented that in terms of SHOs at Broadmoor generally they found the workload relatively light compared with other posts on their rotation.

SHO1 was appointed in February 2004. He told us RMO2 asked him to carry out a mental state examination on each patient on Luton Ward every week and gave him “gentle reminders” of this requirement as he went along. He told us it took him two and a half to three months to realise he was not capable of carrying out mental state examinations at that frequency. Until that time he thought his inability was because he was learning a new job.

When SHO1 saw Richard Loudwell on 5 March 2004 he complained of being bullied as we have noted above. He also complained of feeling tired and sleepy all day. He had complained of similar symptoms to the GP on 20 February 2004.
The following incident is recorded in the nursing observation notes by Nurse 8 on Wednesday 18 February 2004 at 12.25pm:

“Complaining of feeling tired and unwell this am and asked to return to his room. Observations completed and are as follows...It was felt that all he wanted to do was go back to sleep, so access was denied. He then proceeded to call the CNM a ‘C**t’ (sic) and because of this he has lost room access for today. Observed in day area.”

Ward Manager 1 was asked about this incident. He described the denial of room access as a “sanction” imposed because of what Richard Loudwell had called him. He also said he thought that he had been sworn at in this way on another occasion. Ward Manager 1 said being sworn at in this way would have made him angry “today or tomorrow”.

Ward Manager 1 said he considered room access was “provided following both parties agreeing that certain standards will be met”. He said that if Richard Loudwell had presented to him as consistently confused he might have reacted in a different manner.

Comment

Richard Loudwell had been under the supervision of the GP with symptoms of lethargy and tiredness and there was sufficient concern that an instruction had been given for his blood sugar to be checked twice daily. In this context we question the approach taken by Ward Manager 1 to deny Richard Loudwell room access to sleep. Richard Loudwell should have been dealt with more sympathetically. He was older than most of the other patients on the ward, he was feeling unwell and being bullied in the public areas of the ward. In those circumstances it would have been justified to modify the normal room access rules which were designed to permit proper assessment of patients who might otherwise spend all their time in their rooms. Ward Manager 1 did not ask for medical advice about Richard Loudwell’s symptoms of fatigue. In addition, denying room access as a sanction indicates to us an uncompromising, unsympathetic and punitive attitude on Ward Manager 1’s part that we consider to have been unjustified in the circumstances.
7.246 On 12 March 2004 Richard Loudwell was seen by Specialist Registrar 3, specialist registrar, complaining of chest pain. We heard from Specialist Registrar 3 that she happened to be on the ward when she was asked to see Richard Loudwell. She noted that he felt dizzy. His blood pressure was high at 190/100 and he had mild oedema (swelling) in both ankles. She concluded “Most likely dizziness due to high blood pressure” and gave instructions for Richard Loudwell’s blood pressure to be monitored daily for two weeks.

7.247 SHO1 recorded in Richard Loudwell’s notes on 15 March 2004 that blood results (requested on 2 March 2004) had not been received yet. There is no indication that he followed up Specialist Registrar 3’s instruction on 12 March 2004 that Richard Loudwell’s blood pressure was to be monitored for two weeks.

7.248 On 25 March 2004 RMO3 saw Richard Loudwell for the second time. RMO3 made a detailed note of this consultation but he did not formally assess Richard Loudwell’s mental state. It was noted that Richard Loudwell was to attend Central Middlesex Hospital later that day for a SPECT scan to assess frontal lobe/ temporal lobe function.

7.249 On 30 March 2004 SHO1 reviewed Richard Loudwell prior to the CPA meeting later that day. A mental state examination was performed. This was summarised as follows by RMO3 in the admission case conference report of 30 March 2004:

“Mental State Examination 30.3.04
Throughout the admission Mr Loudwell’s mental state remained largely unaltered. He was unkempt, somewhat drawn, with a somewhat blunted affect. His eye contact was poor, and he stared out of the window. He was often abrupt and unfriendly almost to the point of hostility. He complained of being ignored, and of abuse from others. At times he complained of poor sleep and poor appetite, although staff have not noticed this. He complained of being tired most of the time. He stated that his future was all stitched up and that it did not matter what he did or said. There has been no evidence of psychosis or self harm. A Becks depression inventory revealed a score of 26.”

7.250 Following the case conference on 30 March 2004 Richard Loudwell was seen by Consultant Psychiatrist 6, a consultant forensic psychiatrist at the Trevor
Gibbons Unit (medium secure) at RMO3’s request. He made an entry in the notes confirming that in his opinion Richard Loudwell had a mental disorder of a nature and degree that required his further detention in hospital for treatment, for his health and safety and the protection of others.

7.251 On 8 April 2004 SHO1 noted that RMO3 would refer Richard Loudwell for a Schillings Test. This had been discussed at the admission case conference. A further note on 16 April 2004 records a discussion with the haematologist at Wexham Park Hospital who had advised that a Schillings Test was no longer available.

7.252 On 16 April 2004 Richard Loudwell was seen by RMO3 who noted that Richard Loudwell “feels very low”.

7.253 There is no evidence of any further medical contact with Richard Loudwell prior to the assault on 25 April 2004.

Comment

Richard Loudwell’s contact with his RMO RMO3, and the ward SHO1 can best be described as intermittent or patchy. As we will consider further below there was a thorough assessment of Richard Loudwell’s condition by RMO3 and the multidisciplinary team. We do not feel that more frequent contact between Richard Loudwell and either RMO3 or SHO1 would have made any difference to the quality of the overall assessment of Richard Loudwell’s condition at the admission case conference on 30 March 2004.

However we are critical of the arrangements in place for day-to-day medical cover of Luton Ward and in particular the medical cover made available to Richard Loudwell. This criticism is not reserved for the infrequent contact made by SHO1. As Richard Loudwell’s RMO, RMO3 should have ensured that SHO1 was seeing his (RMO3’s) patients with appropriate frequency. We note that SHO1 was specifically under the supervision of RMO2. Therefore the responsibility for SHO1’s failure to see Luton Ward patients more frequently is in our view shared between RMO2 and RMO3. The necessary steps may have involved greater supervision of SHO1 or arrangements for other doctors, even the RMOs, to see the patients on the ward more frequently.
The intermittent nature of contact between doctors and Richard Loudwell had a direct effect on both the quality of Richard Loudwell’s life on Luton Ward and on his vulnerability to bullying and physical assault. Had there been at least weekly contact between medical staff and Richard Loudwell then the doctors, specifically RMO3, would more likely have been aware of the abuse Richard Loudwell was suffering and the inadequate steps being taken to address it. We find that the medical staff were not as aware of what was going on in the ward as they should have been. The principal reason for this was that the medical team, whether RMOs or the SHO who could report to the RMOs, were not spending sufficient time with patients on the ward.

A further consequence was the nursing team felt they were unsupported in dealing with issues like bullying. In our view the relative absence of medical staff from the ward led to the nursing team failing to face up to the reality of the bullying that was going on and the associated risk of physical assault to Richard Loudwell. It also meant that when the nursing team asked for advice about bullying they received less help from the rest of the multidisciplinary team than they would have done if the doctors been aware of what was going on.

Conclusions

In summary we make the following findings about Richard Loudwell’s treatment and assessment on Luton Ward between his admission on 15 January 2004 and the assault on 25 April 2004:

C30 As we comment elsewhere in the chapter “Richard Loudwell - admission to Broadmoor”, the multi-disciplinary assessment of Richard Loudwell’s condition, incomplete as it was by the time of the assault on 25 April, was thorough and carried out to a high standard. However the implications of the assessment for the management of Richard Loudwell’s care on the ward were not identified and acted upon.

C31 The pre-admission nursing assessment of Nurse Consultant 1 was a missed opportunity. It failed to report significant improvements in Richard Loudwell’s behaviour at Belmarsh whilst describing him as very psychotic at the time of the assessment. This is
at odds with contemporaneous clinical notes and with descriptions of Richard Loudwell’s presentation throughout his time at Belmarsh and subsequently at Broadmoor.

**C32** The four nursing recommendations contained in Nurse Consultant 1’s report were of little practical value when combined with the inaccurate description of Richard Loudwell in the body of the report. We conclude that as a result the pre-admission nursing assessment was of little practical assistance to the admitting nursing team on Luton Ward.

**C33** Specifically the pre-admission nursing assessment could usefully have identified:

- The need for sensitive handling of Richard Loudwell to avoid the difficulties encountered as a result of his poor behaviour on arrival at Elmley and Belmarsh
- The risk of harm to him from other patients
- The risk of Richard Loudwell revealing his index offence
- The risk to Richard Loudwell that resulted from his tendency to exhibit bizarre and grossly disinhibited behaviour including of a sexual nature.

**C34** We acknowledge that at the time of the pre-admission assessment work was being done in the Trust to improve the model for these assessments and that Nurse Consultant 1 has played an important role in this process.

**C35** Staff were ill-prepared to deal with Richard Loudwell’s disclosure of his index offence to other patients on the day of his arrival on Luton Ward.

**C36** Richard Loudwell should have been kept under constant observation from arrival on Luton Ward but was not. There were frequent periods when observations were not adequately maintained. This allowed bullying, both verbal and physical (spitting and the throwing of water/ash) to take place.

**C37** The Trust has observed that Richard Loudwell’s offence was unusual even by Broadmoor standards in its nature and choice of victim; that the offence was described in the media very publicly on Thursday 22 April 2004 when he pleaded guilty to manslaughter at Maidstone Crown Court; and that the reaction of some other patients to Richard Loudwell’s behaviour on the ward and to his offence was one of real hostility. The Trust has also stated that in the light of the hostility of some other patients to Richard Loudwell
and given the widespread publicity given to his offence from 22 April 2004 a higher level of oversight of Richard Loudwell should have followed from this date. We agree.

C38 Despite RMO3’s adamant assertion that the bullying of Richard Loudwell had nothing to do with the assault by Peter Bryan on 25 April 2004 the Trust has accepted that the failure to ensure a higher level of oversight of Richard Loudwell following publication of details of his guilty plea on 22 April 2004 may have been relevant to the events of Sunday 25 April 2004. We agree.

C39 There was a delay of seven days, until 22 January 2004, in devising a written care plan to address the risk of abuse from other patients.

C40 The care plan of 22 January 2004 was poorly written and largely ignored by staff. It required Richard Loudwell to be kept in view of staff at all times although its author only intended to require Richard Loudwell to be encouraged to stay in visible areas of the ward. Staff were aware of a general need to keep an eye on Richard Loudwell but compliance with this requirement was patchy and often non-existent. The care plan did not give sufficient importance to the need to protect Richard Loudwell from harassment and bullying.

C41 The risk of bullying and/or serious assault should have been reflected in a care plan but was not.

C42 The ward manager and team leaders should have contributed to devising, reviewing and supervising the care plan and its implementation.

C43 Throughout Richard Loudwell’s time on Luton Ward he was subjected to varying degrees of physical and verbal abuse from his peers. This varied in intensity and overtness but the threat of abuse never receded.

C44 Some perpetrators of abuse left the ward, but others arrived.

C45 Richard Loudwell regularly ignored advice given to him by staff for his own safety. RMO3’s view, which was shared by some staff, was that this was deliberate.
Whether or not this assessment was correct, Richard Loudwell’s disregard of the advice given to him for his own safety increased the risk of harm to him and should have been addressed in a care plan and risk assessment.

Staff knew Richard Loudwell would not comply with advice given for his own safety, in particular the advice to avoid putting himself in danger. Therefore there was a greater need to keep him under constant observation.

There was no serious attempt to investigate the option of moving Richard Loudwell to a different ward to complete his assessment. Given the extent of the difficulties encountered by him on Luton Ward, such a move to another ward should have been considered. The fact that there was no recent precedent for such a move should not have prevented this.

There was no reduction in the bullying of Richard Loudwell in April 2004. We could find no adequate grounds in the contemporaneous records for the belief that the abuse to which Richard Loudwell was subjected reduced in the period before 25 April 2004. This belief was shared by his RMO, the ward manager and some of the team leaders and senior members of the nursing team. In our view they were mistaken.

Richard Loudwell did interact more with his peers in April 2004 but the abuse to which he was subjected did not decline.

At the time of the assault on 25 April 2004 Richard Loudwell was subjected to physical assaults by at least one patient, patient C. He was at significant risk of serious physical assault from this patient. This risk alone justified Richard Loudwell being placed on continuous observations for his own safety. Instead his complaints of physical abuse by this patient were ignored by staff, including his primary nurse, who believed them to be another “false allegation”.

CPA risk assessments which should have been completed within a fortnight of Richard Loudwell’s arrival on Luton Ward were never completed, even after the admission case conference on 30 March 2004.

The detailed risk assessment carried out by RMO3 in advance of the admission case conference was not heeded by the nursing team and did not influence the day-to-day
management of Richard Loudwell on Luton Ward. It was not seen by the ward manager and it may not have been in Richard Loudwell’s ward notes. This document correctly identified the likely risk of physical assault of Richard Loudwell by his peers.

C54 Bullying, even when there was clear evidence about it was not treated sufficiently seriously by any member of the clinical team on Luton Ward, nor was it given the priority it merited in Richard Loudwell’s case.

C55 There is a link between the failure to address the bullying to which Richard Loudwell was subjected and the assault on 25 April 2004. If bullying had been taken sufficiently seriously it is unlikely Peter Bryan would have had the opportunity to mount a sustained attack on Richard Loudwell in the dining room without being observed by staff.

C56 Richard Loudwell’s relationship with his primary nurse was poor. The person who should have known him better than anyone did not take his complaints of bullying sufficiently seriously and failed to take proper account of the significant risk of serious physical assault of Richard Loudwell in April 2004.

C57 The tone for staff’s dealings with Richard Loudwell was set by Ward Manager 1, who failed to ensure that Richard Loudwell was provided with the respect, care and treatment he was entitled to on Luton Ward.

Recommendations

R5 The Trust should review its procedures for carrying out pre-admission nursing assessments to ensure that the lessons of Richard Loudwell’s case are properly learnt and incorporated into future practice including by the development of assessment tools, training, peer review and audit of assessments to ensure that the highest standards are maintained.

R6 Agreement should be sought with referring bodies such as the prison service as to what sources of information will be routinely made available to staff from Broadmoor carrying out pre-admission assessments; in particular those carrying out such assessments ought to have the same access to a patient’s IPR and IMR as their colleagues, whether nurses or prison officers, in the prison service. Those carrying out assessments should not
feel restricted from discussing a patient with members of prison staff for the purposes of carrying out a more thorough assessment.

R7  All incidents believed by staff, or perceived by the victim, of serious or persistent harassment and victimisation should be the subject of an incident report and review by senior management.

R8  Any allegation of verbal or physical abuse of a patient should be treated as having substance unless there is persuasive evidence to the contrary, and the RMO agrees that the allegation may safely be rejected.

R9  When an incident of abuse by one patient on another occurs, the perpetrator must be managed on the basis of the threat posed to other patients on the ward.

R10 Any incident of abuse between patients must be reviewed by the team and a joint management plan in relation to both the victim and the perpetrator agreed and implemented.

R11 When a patient is the victim of more than one incident of verbal or physical bullying the second and any subsequent incidents must be reported to security and logged as a serious incident regardless of whether any injury is sustained.

R12 Patients must be given information in an accessible form about the anti-bullying policy and their rights to complain about harassment, victimisation and bullying and to have their complaint recorded.

R13 The anti-bullying policy of the Trust should be reviewed to take into account the findings of this inquiry.

R14 A system of ‘flagging’ should exist in order to identify any critically important care plans that all staff on a ward need to be aware of.

R15 Where a care plan is of critical importance the ward manager and team leaders ought to have an input in its creation and direct involvement in any review of it.
R16 A system of supervision of practice in nursing should be in place to include care plan formulation and implementation.
8. Richard Loudwell - diagnostic assessment

At Belmarsh

8.1 A number of psychiatrists and other professionals assessed Richard Loudwell at HMP Belmarsh between December 2003 and January 2004. These assessments were for a variety of purposes including identifying and meeting his immediate needs, deciding whether he should be admitted to Broadmoor or a medium secure unit and on the instructions of his defence team.

8.2 Richard Loudwell was assessed when he arrived at Belmarsh by Specialist Registrar 1 and Social worker 1. A mental state examination was performed and the impression recorded was of mild depression. On 16 December 2002 Specialist Registrar 1 recorded possible diagnoses, in addition to depression, of mixed affective state and/or a frontal lobe syndrome/temporal lesion.

8.3 On 17 December 2002, after only four days in Belmarsh, a brain CT scan was ordered. On 19 December 2002 RMO1, consultant forensic psychiatrist at Belmarsh, requested an MRI scan. On 20 December 2002 Specialist Registrar 1 referred Richard Loudwell to the medical team on call at the Queen Elizabeth Hospital, Woolwich.

8.4 Richard Loudwell returned to Belmarsh after one night at the Queen Elizabeth Hospital. He had been admitted under a consultant in general medicine. A discharge letter dated 21 December 2002 suggested that while a CT scan was appropriate there was no need for Richard Loudwell to remain in hospital pending this investigation. It appears that there was some confusion as to whether Richard Loudwell was to undergo CT or MRI scanning but that in the end he had an MRI rather than a CT scan.

8.5 The first assessment by RMO1 was on 6 January 2003. On his examination of Richard Loudwell’s mental state he could find no major symptoms. He concluded:

“Initial impression suggests that there may be neurological issues perhaps causing an organic personality change.”
8.6 On 9 January 2003 on the instruction of his solicitors, Richard Loudwell was interviewed at Belmarsh by Consultant Psychiatrist 3. Her report is dated 23 January 2003. At that time she felt that detention in conditions of medium security would be problematic.

8.7 On 13 January 2003 RMO1 formally requested Richard Loudwell’s admission to Broadmoor for assessment under section 35 of the Mental Health Act 1983.

8.8 Richard Loudwell had an MRI scan on 15 January 2003 which was reported on 20 January 2003 as showing “no significant intra cranial abnormality”.

8.9 Richard Loudwell was seen by Consultant Psychiatrist 4 from Broadmoor on 25 March 2003 at Belmarsh. He referred Richard Loudwell for assessment for admission to Broadmoor.

8.10 Consultant Psychiatrist 3 wrote to RMO1 in May 2003 noting that Consultant Psychiatrist 4 had referred Richard Loudwell for assessment for admission to Broadmoor. She asked RMO1 to arrange a blood test for Huntington’s Chorea and commented on the difficulty of diagnosis together with the apparent prominence of symptoms of an organic illness:

“…It does seem to me having referred Mr Loudwell again in April 2003 (sic) that the neurological signs are really quite prominent in addition to his sexual disinhibition. It is hard to fit his particular symptoms to any specific form of mental illness, however they do seem to have a strong organic flavour.”

8.11 Richard Loudwell was seen by a Consultant Neuropsychologist at the request of his solicitors on 14 May 2003. The Consultant Neuropsychologist noted:

“Prior to meeting Richard Loudwell I was told by staff at the Health Care Centre that his behaviour appeared to be more settled in the weeks prior to my visit. He was considered to be less sexually inappropriate.”
8.12 The Consultant Neuropsychologist conducted an extensive analysis of the available medical information and concluded that Richard Loudwell had an affective disorder at the time of his offence and that there was:

“...good evidence that there was an additional dementia with evidence of some frontal preponderance. Such dementias are characterised by change in personality and behaviour which may include an exaggeration or disinhibition in previously evident behaviours.”

8.13 On 29 December 2003 Richard Loudwell was seen at Belmarsh by a Consultant Neuropsychiatrist at the request of Boys & Maughan Solicitors. He described Richard Loudwell as “affable and cooperative” and concluded that he could be suffering from a fronto-temporal dementia.

8.14 On 15 January 2004 Richard Loudwell was transferred to Broadmoor Hospital.

The multi-disciplinary assessment

8.15 The initial purpose of admission to Broadmoor for most patients is assessment. Luton Ward is specifically an ‘assessment ward’. A patient’s assessment almost always starts on Luton Ward and will often be completed there. The assessment of most patients takes about three months culminating in an admission case conference (also known as a first CPA meeting).

8.16 Richard Loudwell had a thorough and, we find, impressive multi-disciplinary assessment on Luton Ward. His RMO, RMO3, described him as the most challenging patient diagnostically he had ever encountered. It is not our role to review the assessment itself but we have seen nothing which leads us to doubt that description or the conclusions, albeit interim, of that initial assessment.

8.17 At the time of his death the assessment of Richard Loudwell was incomplete. The CPA meeting on 30 March 2004 decided no firm conclusions could be drawn at that time and a further period of assessment was required. The final paragraphs of that admission case conference report summarised its conclusion under the heading “Future Care”:
“If Mr Loudwell is convicted of murder and a mandatory life sentence follows, consideration will have to be given regarding delivery of Mr Loudwell’s future care. He has a condition which has not yet been fully investigated, and treatment may have a significant impact upon him. He would need to be managed within the health care centre of any receiving prison establishment. He suffers from both mental and physical problems. He was able to cope within the prison environment during the remand period, but should his mental condition deteriorate, it may be difficult to contain him safely and deliver the standard of care he requires. Under these circumstances it would be clearly appropriate for the prison authorities to consider referral to hospital for treatment and this could be effected by transfer under Section 47 of the Mental Health Act 1983. In my view, in the light of the risks that this man poses, he would warrant management in conditions of maximum hospital security, and an opinion should be sought as necessary regarding his suitability for this whenever deemed appropriate by the prison.”

“If Mr Loudwell is convicted of manslaughter on the grounds of diminished responsibility I would recommend that he be made the subject of an interim hospital order under Section 38 of the Mental Health Act 1983 in the first instance. I have reason to believe Mr Loudwell suffers from a mental illness (dementia) which is a mental disorder, and that this may be of a nature or degree which would make it appropriate for a recommendation to be made for a hospital order to be made. However this is not certain at this stage. Further investigations are required to determine whether the progression of his disorder can be halted or perhaps reversed. It may be that after such treatment he would not require long term treatment in a hospital setting. A further period of assessment in hospital under an interim hospital order might allow a determination to be made regarding the progression of his disorder, and a final recommendation to be made about his suitability for a hospital order. This is not certain at this stage of his illness.”

“I am of the view, in the light of the risk he poses to others, that treatment in conditions of maximum hospital security would be required. I intend to make a recommendation to the admissions panel at Broadmoor Hospital that a bed be offered to Mr Loudwell should the court see fit to impose an interim hospital order in the event that discretion in sentencing can be exercised. No such order can be made until a bed offer is made by the hospital.”
8.18 The following reports were prepared for the case conference:

- nursing report from Primary Nurse 3
- report from [name deleted] a Speech and Language Therapist, a professor
- social history report from Social Worker 2
- neuropsychology report [name deleted]
- psychology report from Clinical Psychologist
- occupational therapy report from Occupational Therapist 2.

8.19 The following sources of information are listed in the admission case conference report:

- interviews with Mr Loudwell
- clinical multidisciplinary team meetings
- medical record
- psychiatric report [name deleted] (undated, but about 13 January 2000) relating to previous proceedings
- post mortem report [name deleted] dated 3 December 2002
- post mortem report [name deleted] dated 7 January 2003
- psychiatric report by Consultant Psychiatrist 3 dated 23 January 2003
- letter by Consultant Psychiatrist 4 to solicitor dated 24 March 2003
- dental report [name deleted] dated 31 March 2003
- fingerprint record [name deleted] dated 10 April 2003
- referral letter to Broadmoor Hospital dated 30 April 2003
- psychiatric report [name deleted] dated 23 May 2003
- psychological report [name deleted] dated 16 June 2003
- admission psychiatric report by Specialist Registrar 2 dated 21 July 2003
- medical report by [name deleted] the Consultant Neuropsychologist dated 15 October 2003
- psychiatric report by Consultant Psychiatrist 6 dated 10 October 2003
• medical report by [name deleted] the Consultant Neuropsychiatrist from Maudsley Hospital dated 29 December 2003
• criminal record
• prosecution case summary
• prosecution committal statements
• transcript of police interviews
• notes from solicitor
• disclosure with solicitors dated 3 December 2002
• psychiatric record
• GP record
• unused material
• papers regarding indecent assault
• custody record
• photographs
• inmate medical record
• social work interviews with the family.

8.20 The following attended the case conference:

• RMO3
• The Consultant Neuropsychiatrist [name deleted] from Maudsley Hospital
• Consultant Psychiatrist 6, consultant forensic psychiatrist (Trevor Gibbons Unit - a medium secure unit)
• Team Leader 3 (a last minute stand-in for Primary Nurse 3 who was unable to attend)
• Social Worker 2, senior social worker
• Occupational Therapist 1
• Clinical Psychologist, clinical psychologist
• SHO1
• Barrister 1 and Barrister 2.
8.21 This was an impressive array of witnesses and sources to discuss Richard Loudwell’s case. As previously stated it is not our role to make a diagnosis but the complexity of Richard Loudwell’s diagnosis was a factor in making him difficult to care for. This complex underlying condition should have been taken into account by those looking after him on Luton Ward. The complexity is evident from a review of opinions from different doctors who assessed him. These views were set out by RMO3 in his admission case conference report from which the following extracts are quotes:


“…She concluded that Mr Loudwell did not have the capacity to instruct his solicitors, understand the nature of the charge against him or follow proceedings: she pronounced him unfit to plead. She diagnosed recurrent depressive illness but thought an organic disorder was likely. She recommended admission to special hospital for assessment.”


“…Mr Loudwell understood the nature of the charge and of proceedings and was fit to plead, but acknowledged that his mental state may fluctuate daily.”

Consultant Psychiatrist 3 (addendum report dated 22 May 2003)

“…Mr Loudwell had become more familiar with the details of the case against him when compared to her previous interview with him…he was now fit to plead. She noted previous concerns there had been about his sexualised behaviour and lack of self control. She raised the possibility of a genetic disorder such as Huntingdon’s Chorea which needed to be excluded.”

Psychiatric report [name deleted] (report 23 May 2003)

“…Mr Loudwell was fit to plead.” He highlighted Mr Loudwell’s sexual problems, including sexual offending, sexually disinhibited behaviour and sexual dysfunction. He also described Mr Loudwell’s psychiatric difficulties including recurrent episodes of depression and made a possible link between his mental state and
sexual offending. The Author drew attention to blackouts, perhaps caused by diabetes, and to “memory difficulties with cortical atrophy on scans...”

“The Author concluded that Mr Loudwell was probably suffering from an abnormality of mind, the nature of which he could not be precise about. He thought that a combination of depressive symptoms and organic personality change (that may have accentuated his ‘previously sexually inappropriate characteristics’) may have made a contribution. The Author suggested that he may be suffering from organic brain damage, but this was not clear...


“The author conducted a neuropsychological evaluation, and concluded that his full scale IQ was 90, but she revealed a verbal-performance discrepancy of 34 (Verbal IQ 106, Performance IQ 72) which was significant and abnormal. She revealed a deterioration in functioning with a pre-morbid IQ estimation of 121. The tests revealed impaired visual memory and temporal lobe function, with problems in frontal lobe functioning, especially impulsivity, some impairments of executive functioning and semantic memory. She concluded that there was a very high probability of brain damage...”

The Consultant Neuropsychologist [name deleted] (report dated October 2003)

“The Consultant Neuropsychologist noted the psychiatric position of a long history of recurrent depressive disorder, which was responsive to medication. The clinical picture changed in 2002 with increasingly disinhibited behaviour, often sexually, and he noted difficulties with memory function. There was no evidence of a head injury or resulting brain damage. He thought that the most striking evidence for organic damage came from [another psychologist’s] neuro-psychological evaluation, which despite the presence of depression, revealed frontal and temporal impairments of brain function. This was supported by MRI scan findings of diffuse atrophy. The Consultant Neuropsychologist concluded that in the light of all the evidence, Mr Loudwell was in the early stages of a dementing illness...He suggested that his
dementia caused a change of personality and an exaggeration or disinhibition of previously evident behaviour.”

Consultant Psychiatrist 6 (report dated 10th October 2003)

“...diagnosed paraphilia with cross dressing, exhibitionism, fetishism, perhaps paedophilia, poor sexual relationship formation, and which might point to an abnormal premorbid personality with schizoid personality traits. Other abnormalities include low serum vitamin B12, high blood sugar, high cholesterol, intermittent high blood pressure, nystagmus, left ptosis, erectile dysfunction, intermittent but recurrent depression, a possible episode of hypomania, inappropriate sexual behaviour in public settings from the late 1990s and other intermittent complaints. Consultant Psychiatrist 6 concluded that Mr Loudwell has suffered brain damage consequent upon B12 deficiency.”

The Consultant Neuropsychiatrist [name deleted] (report dated 29th December 2003)

“...He suggested that increasing sexual and socially inappropriate behaviour revealed there was a declining level of self restraint since at least 1998, accompanied by lethargy, inactivity and memory problems. He concluded that fronto-temporal dementia was most likely, given the cognitive deterioration, apathy, poor self-care, disinhibition, verbal stereotypy, social withdrawal, loss of insight, and a relatively well preserved day to day memory.”

8.22 The conclusion of the case conference is set out in the report under the heading “Opinion”. This begins with the statement:

“Mr Loudwell’s case is highly complex and unusual...the diagnoses still require further investigation and treatment.”

8.23 A number of possible diagnoses are then listed, none of which are exclusive of the others. We quote from the case conference report:
“Asperger’s Syndrome

Mr Loudwell may suffer from Asperger’s Syndrome. This is a disorder of psychological development whereby there are qualitative abnormalities of reciprocal social interaction, similar to that seen in autism, together with impairments in social communication and imagination, and a restricted stereotyped repertoire of interests and activities…but it is inappropriate to make a definitive diagnosis at this stage.

Paraphilia (disorders of sexual preference)

...further psychosexual investigation is required. Nevertheless, there are strong suggestions in the history for a variety of sexual interests, some of which could be considered perverse. They include bi-sexuality, older women, paedophilia (especially interested in 10 year old girls), fetishism (nylon and leather), cross dressing, possibly sadism (demonstrated in the alleged index offence) and exhibitionism.

Depression

Mr Loudwell has a significant history of recurrent depressive disorder...Between depressive episodes he appeared to make a good recovery.

Dementia

It appears that Mr Loudwell’s presentation began to change during 1997/1998. He did not appear to fully recover to a normal level of functioning between episodes of depression...

It appears that the evidence for dementia, as revealed by his history, is strong. However, the extent of his difficulties at this stage is difficult to determine...One might have expected more obvious pathology to be evident on the scans at this stage in the dementing process. This suggests that Mr Loudwell’s condition is slowly progressive and in the early stages, despite the presence of such overwhelming evidence for clinical deterioration, and evidence provided by the neuropsychological tests that have been performed. The absence of more
demonstrable advanced pathology does not in my view negate the validity of the diagnosis of dementia...

The cause of dementia has been difficult to determine, and investigations are not complete. A recent blood test has shown dramatically reduced vitamin B12 in the bloodstream. This in the face of oral vitamin B12 supplements and a healthy diet provided by the hospital is strongly suggestive of an absorption problem. Further investigation for this is required...

In conclusion, although vitamin B12 deficiency appears at this stage to be the most likely cause of the dementia this has not yet been confirmed.

Physical health

Mr Loudwell’s physical health is poor. He has high blood pressure and non-insulin dependent diabetes, and despite significant medical input into these problems while at Broadmoor Hospital, both remain out of control. This is partly due to his poor adherence to dietary advice. He requires further treatment for these conditions.”

Conclusions

C58 We repeat our view that in terms of access to appropriate expertise the process of assessment of Richard Loudwell was impressive, both at Belmarsh and subsequently at Broadmoor.

C59 At Broadmoor, the actual multi-disciplinary assessment of Richard Loudwell’s condition, incomplete as it was by the time of the assault on 25 April, was thorough and carried out to a high standard. We comment in the chapter “Richard Loudwell - care and treatment at Broadmoor” that unfortunately the implications of the assessment for the management of Richard Loudwell’s care on the ward were not identified and acted upon.
9. Peter Bryan - events before admission to Broadmoor

Events before admission

9.1 A separate inquiry will report on the history leading up to Peter Bryan’s arrest for the killing of Brian Cherry. Therefore it is not proposed to address this in detail, but to report on what came to the knowledge of those caring for Peter Bryan after his arrest up to the time of the assault on Richard Loudwell in Broadmoor. This includes two homicides: Nisha Sheth in 1993 and Brian Cherry in 2004.

The killing of Nisha Sheth

9.2 Peter Bryan’s account of the homicide of Nisha Sheth is contained in Consultant Psychiatrist 7’s report of 3 March 2004 which was available at the time of PB’s admission to Broadmoor. Peter Bryan told Consultant Psychiatrist 7 that in 1993 he had been working in a shop and had lent the owner some money. He had asked the man on a number of occasions to return his money which the man would not do. Peter Bryan said that on about the fourth occasion the man’s daughter, who was then aged 21, had told him he should leave and had pushed him. Peter Bryan described to Consultant Psychiatrist 7 how this “meant my head went, I was not all there”. He took a claw hammer to his victim, hitting her on the head about six times. He had then left and jumped off a wall at the top of a block of flats which he told Consultant Psychiatrist 7 was about 90 feet high. He had broken both ankles and been admitted to hospital. Following this homicide Peter Bryan had pleaded guilty to manslaughter on the grounds of diminished responsibility and been detained at Rampton High Secure Hospital. He remained in Rampton for eight years.

The killing of Brian Cherry

9.3 Brian Cherry was killed on 17 February 2004 and Peter Bryan was arrested by police at the scene of the crime on the same day. Police were called to Brian Cherry’s flat by a friend who reported that she had gone to visit Mr Cherry but had encountered Peter Bryan who emerged from the living room bare chested and holding a knife. Behind him on the floor she saw what she believed was Brian Cherry lying on the floor naked with one arm

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4 This summary account is taken from the description given by prosecuting counsel at Mr Bryan’s sentencing hearing.
clearly separated from his body. Peter Bryan told her she should go. When the police arrived they found Peter Bryan there with bloodstains on his hands, jeans and trainers. He was asked if there was anyone else there and he said there was not. When asked what he was doing he said he had broken in through the door and that there had been “a bit of a struggle”. Officers went into the kitchen where they saw a bloodstained knife and a frying pan on the stove containing what turned out to be tissue from Brian Cherry’s brain. In the living room they found Mr Cherry’s body from which both arms and one leg had been severed. There were various bloodstained knives and a claw hammer on the floor; Peter Bryan had bought the hammer earlier that afternoon. When asked, Peter Bryan said he had killed Brian Cherry and that it was he who had cut his limbs off. Peter Bryan surrendered peacefully to the police. He was arrested and charged with murder.

9.4 Later, in a police cell Peter Bryan told police:

“I ate his brains with butter. It was really nice.”

and

“I would have done someone else if you hadn’t come along. I wanted their souls.”

Comment

This was the second killing committed by Peter Bryan. Both homicides involved victims known to him and the use of a hammer. The later offence involved substantial violence and cannibalism. The healthcare professionals responsible for caring for Peter Bryan had not predicted that he was likely to be dangerous in the community in this or any other way. Therefore, when this horrific offence was discovered there was no indication or information to explain why Peter Bryan had behaved in the way he did nor reason to manage him as other than a highly dangerous person.

Initial psychiatric assessment

9.5 While in police custody, in the early hours of 18 February Peter Bryan was assessed by Consultant Psychiatrist 8. Peter Bryan claimed he had gone to Brian Cherry’s flat to commit burglary because he was tired of telling people about his previous
conviction for manslaughter. He said Brian Cherry opened the door and called him a “coon” and that this made him go berserk. He denied having a mental disorder and claimed to have just a temper. Consultant Psychiatrist 8 did not think Peter Bryan’s then mental state required urgent transfer to hospital and thought he was fit to be interviewed in the presence of an appropriate adult.

Comment

This account of Peter Bryan’s actions was untrue in several respects and varied from subsequent accounts. The information Consultant Psychiatrist 8 gleaned from Peter Bryan might later have suggested to professionals that Peter Bryan was not being straightforward about this killing or his reasons for committing it.

HMP Pentonville

9.6 On 19 February 2004 Peter Bryan was remanded to HMP Pentonville where he stayed for a short time until his transfer to HMP Belmarsh. A note of a cell sharing risk assessment of 19 February, recorded that Peter Bryan had said he would attack a cellmate if he felt he could not trust him. Given the nature of the offence and what he had said, his risk of harming others was assessed as high and a psychiatric review was performed at Pentonville on 20 February 2004 by Camden and Islington Mental Health Team. This included a brief history, but the team had no information on Peter Bryan at this stage. On assessment of his mental state it was found that Peter Bryan was cooperative, had good eye-contact, normal speech and articulation, no hallucinations or delusions and no suicidal ideation. He claimed he used various illicit drugs. It was not thought that he was psychotic, suicidal or paranoid at the time. It was planned to continue Olanzapine and to refer him to east London area forensic services.

9.7 On 21 February 2004 it was recorded in his IPR that Peter Bryan remained on an “SO + 3 man unlock in kits”. This indicated a regime under which the escort required on any occasion when he was out of his cell a senior officer, plus three others in riot gear with shields. The reason recorded for this was that “he still presents as unpredictable”. A medical note of the same day recorded a complaint by Peter Bryan that his body was “very clicky” and was “getting buzzes”. He said this had happened before the killing of Nisha Sheth in 1993. He was recorded as saying he enjoyed being in prison and that staff tried to be as helpful as possible.
HMP Belmarsh

9.8 On 23 February 2004 Peter Bryan was transferred to HMP Belmarsh. According to prosecuting counsel Peter Bryan was involved in a number of incidents while at Belmarsh:

- On 13 March 2004 a noose was found in his cell and he was transferred to the intensive care unit.
- On 20 March 2004 he assaulted a member of staff on returning from the shower.
- On 22 March 2004 RMO1, the consultant forensic psychiatrist based at the prison, reported that he was dancing around his cell “like a boxer in training”. He told RMO1 he wanted to hit or kill a member of staff and eat someone’s nose.
- On 23 March 2004 he started a fire in his cell on two occasions.

9.9 Peter Bryan spent most of his time in HMP Belmarsh in the health care centre. On Peter Bryan’s reception on 23 February 2004 a cell sharing risk assessment was carried out: again he was assessed as a high risk of assaulting a cellmate and adjudged to need a single cell.

9.10 On 23 February 2004 Peter Bryan was recorded as complaining of “clicking”. He said he had suffered from increased tension in the last few weeks. He was said to be ambivalent about his diagnosis and the need for medication. However, he was also recorded to be quietly spoken, pleasant, controlled and calm.

9.11 On 24 February 2004 Peter Bryan was examined by RMO1. He found him to be calm but slightly irritable and guarded: he had mild persecutory beliefs about staff.

9.12 On 28 February 2004 Peter Bryan was noted to be presenting no management problem.

9.13 On 3 March 2004 Peter Bryan was examined on behalf of his defence by Consultant Psychiatrist 7, consultant forensic psychiatrist. His report is dated 4 March 2004 and addressed to Peter Bryan’s solicitor, although a copy was made available to HMP Belmarsh and to Broadmoor before his transfer there. The report contained a full
history derived from the inmate medical records from Belmarsh, but not Pentonville. The report explored Peter Bryan’s background and past psychiatric history, but said that this was an area which “clearly requires considerably more exploration”. He is recorded as having denied any deterioration in his mental state while he was in hospital before the index offence. He gave a description of the first index offence: he had been owed money by the shopkeeper and had returned to the shop several times for it. He alleged that the shopkeeper’s daughter, the victim, had “turned on me”, and had pushed him. He had taken a claw hammer to the shop, partly because he was paranoid and partly because he wanted to frighten the shopkeeper. He had hit the young woman on the head about six times. He walked out of the shop and went to a block of flats where he jumped off a wall and broke his ankles. He thought he had been “severely provoked” into doing what he had done.

9.14 Peter Bryan was also asked about the killing of Brian Cherry. He said that he had been carrying a hammer because he had twice been stopped by police and they had given him a “hard time”. He thought that when police next stopped him they would think he was a burglar and he would be less hassled than if he told them about the manslaughter. He claimed he also intended to commit a burglary with it. With that in mind he jumped over a fence and saw a man looking at him through a window. This man looked strange in some way. He claimed that he had coaxed the man to open his front door. The man then called Peter Bryan a “coon” and a struggle ensued. Peter Bryan said the man bit him and that he hit the man with his hammer and could not stop himself. He said the man kept saying “make me”, which he interpreted as a request for sexual intercourse. This infuriated him and he hit him again. Peter Bryan then spoke to Consultant Psychiatrist 7 about having seen blue and that “on the streets there are Bloods or Crips”. He believed he had hit the victim at least six times and maybe more than ten, mainly on the head. He said he saw “some meat” on the floor which he started to eat. He could not remember whether he had eaten part of the victim, but thought it was possible: “it could have been him but it could have been pet food”. Peter Bryan claimed that the victim continued to say “make me” which infuriated him; so he chopped off his arms and one leg with a Stanley knife which he might have brought with him or which he might have found in the house. He was uncertain whether he had chopped off the limbs with the intention of eating them. He denied any similarity between what he had done and the plot of the film Silence of Lambs, or that he was inquisitive about the taste of human flesh. He suggested that if there was no food available what he had done would not have been considered bad. He had admitted he had not been in that type of situation but claimed to
have been very hungry. He said it was not as bad as sleeping with family members. He had been infuriated when the victim kept on saying “make me”.

9.15 Consultant Psychiatrist 7 found it difficult to know what to make of the reported “clicking” and thought this needed more exploration. He found Peter Bryan had expressed persecutory ideas but not of delusional intensity. He thought Peter Bryan might be suffering from partly formed delusional ideas. Whether Peter Bryan suffered from hallucinations (as suggested by his hearing the words “make me” and being called a “blood”) he noted that Peter Bryan did not think he was psychiatrically unwell, but claimed to have been compliant with his medication. In his conclusion Consultant Psychiatrist 7 said:

- Peter Bryan was fit to plead and stand trial.
- He was suffering from a paranoid schizophrenic illness.
- There appeared to have been no concerns about his mental state during his voluntary admission to the Newham Centre for Mental Health.
- There appeared to be striking similarities between the previous offence of manslaughter and the present index offence in that both victims were hit on the head a number of times with a heavy instrument.
- There was “little doubt that Mr Bryan must be regarded as extremely dangerous”.
- He was concerned but not surprised that Peter Bryan had been discharged into the community for follow-up by a consultant psychiatrist as opposed to a forensic psychiatrist, but surprised he had been discharged on oral medication, when there had been concerns about compliance.
- The evidence was incomplete, but there was enough to justify a transfer to hospital under section 48/49 or recall under section 37/41 of the Mental Health Act.
- “Although he is contained in a Category A prison and in the Health Care Centre I would not accept that this is as safe as being contained on an acute ward in a maximum secure hospital...It is difficult to disagree that he would pose a grave and immediate danger to others.”
- There were features suggesting that Mr Bryan was under the influence of psychotic symptoms at the time of the index offence.
Comment

This was a thorough and thoughtful report, even though the information available to Consultant Psychiatrist 7 was limited because of the early stage at which he made this assessment. It draws attention to a number of features which seem to us to have significance in relation to the management needs of Peter Bryan from this point on:

- Peter Bryan had now killed two people.
- Neither killing had been predicted.
- It appeared likely that Peter Bryan was under the influence of psychotic symptoms at the time of both offences.
- There were striking similarities between the killings.
- Peter Bryan was denying that he was mentally unwell.
- If the account he gave to Consultant Psychiatrist 7 is compared with the evidence available to the police, there were significant differences: whether this was due to deliberate misleading by Peter Bryan or not, he was obviously not a totally reliable witness in relation to his own thought processes and motivation.
- On the other hand he did evidence a willingness to engage with others about the offence and his mental state.
- He was highly dangerous to others and required the protection of an acute ward of a high security hospital.

9.16 On 5 March 2004 a nurse recorded Peter Bryan as presenting no management problems:

“Presents no management problems. Complies [with] regime, takes adequate diet & fluids. Complies with meds. Tends to keep himself to himself, does not participate in exercise/association. While appropriate with staff can be a little snappy when talking to them.”

9.17 On 8 March 2004 matters deteriorated. A nursing record noted that he had been uncooperative, probably because officers could not give him a light straight away.
“Declined to clean cell and had been banging and knocking door. Settled down once given light for cigarette.”

9.18 Later the same day Peter Bryan punched an officer when his cell door was opened for lunch, injuring him. He was placed on a three-man controlled unlock. We heard from a discipline officer about this incident. He told us that in the course of the morning he heard the bell of Peter Bryan’s cell being rung as he walked past. He opened the hatch and found out that he wanted a light for his cigarette. After the officer had given Peter Bryan a light another officer who was on duty near the cell had called the officer a “care bear”. The first officer said that he did this sort of thing as it made life easier and that the second officer could have answered the bell. The latter responded with some derogatory remarks that Peter Bryan could have heard. At lunchtime Peter Bryan’s door was unlocked so he could come out to eat. As he came out he assaulted the officer who had not responded to the bell earlier. The other officer told us that Peter Bryan had been no trouble before this incident. He thought the assault had occurred because Peter Bryan took umbrage at the remarks he had heard.

Comment

Later records suggest that there was no reason for this assault and that it was “unprovoked”. The evidence we heard suggested that there was at least a reason why this incident occurred. We fully accept that there are likely to be justifiable reasons why a discipline officer, in this case designated to observe another prisoner, refuses to go to another cell to attend to another prisoner’s request for a light. If, as was suggested to us, such an officer makes derogatory comments in the hearing of that prisoner that is not only uncalled for, but in the volatile atmosphere of a high security prison and in the health centre in the presence of mentally unstable prisoners, this is a departure from acceptable practice. Further it seems that this led to an inaccurate note being made to the effect that there was no reason for the assault. We consider that this trivial incident led to the assault and thereafter to the restrictive conditions in which Mr Bryan was kept. This in turn contributed to the violent and uncooperative behaviour that occurred subsequently in Belmarsh. We have not heard and did not seek the other officer’s side of the story and we make no personal criticism of him, but we consider that what we have heard suggests that greater sensitivity must be shown to the needs of mentally ill prisoners difficult though this may be to ensure.
9.19 On 12 March 2004 officers searched Peter Bryan’s cell and found bed sheets tied together in a manner that could have been used as a garrotte or noose. They also found a spoon hidden in a pillow. In the following days he was noted to be agitated, confrontational, interspersed with periods where he presented no management problems. On 19 March 2004 Peter Bryan was recorded as saying he wanted to hit the officer he had hit before. The level of unlock was increased at a review meeting to 4, meaning that an escort of four men plus a senior officer and protective equipment would be required for an escort out of his cell. His behaviour was described as “challenging” and “unpredictable”.

9.20 On 20 March 2004 while being escorted back from the shower he dropped his towel and attempted to attack staff. He had covered himself with soap making restraint difficult. The discipline officer we interviewed gave us a full description of this incident. He thought Peter Bryan may have thought he was going to be attacked because of the configuration of the escort. He thought the increase in security made Mr Bryan’s behaviour deteriorate. With hindsight, he was unsure that this was the right way to deal with Peter Bryan.

9.21 On 22 March 2004 an officer noted that Peter Bryan was:

“A very strange inmate who tends to hit without any warning. He tells me he cannot help it and does not know how to stop it."

9.22 On 23 March 2004 Peter Bryan set fire to his cell. Once this was put out he started another fire. It was recorded that when he was removed from his cell by a control and restraint team to segregation on each occasion he fought them all the way. The officer we interviewed suggested that it reached the stage where Peter Bryan fought all the time, whether because he liked it or because he wanted exercise.

9.23 On 27 March 2004 Peter Bryan threw water over an officer. On the same day he was reviewed the medical record suggests that, while he was outwardly calm, he expressed frustration at the need to satisfy himself sexually with anyone and the desire to kill, while being frightened of these thoughts. He was thought to require consistent, interactive therapeutic intervention to keep him calm.

9.24 On 29 March 2004 RMO reviewed Peter Bryan and increased his dose of antipsychotic medication Olanzapine with a view to a further increase if necessary. RMO
could not recall there being any issues with regard to Peter Bryan complying with the medication regime. He explained that he could not give Acuphase (rapidly acting medication given by injection), as was subsequently done at Broadmoor because the Mental Health Act provisions did not apply at the time. However, he could not understand why Peter Bryan had previously been on a lower dose of Olanzapine (5mg a day) which was almost sub-clinical.

9.25 On 2 April 2004 Peter Bryan was seen by RMO2, from Broadmoor, who assessed him as clearly needing care in a high-security hospital. This assessment and the other input from Broadmoor before his admission there is addressed in the next chapter.

9.26 Peter Bryan remained in Belmarsh until 15 April 2004, the transfer order being made on 14 April 2004. He remained apparently disturbed during that time, but there do not appear to have been any further incidents.

Comments

Peter Bryan clearly presented the prison service with a difficult challenge because of his risk level and behaviour. We consider that within the limits of psychiatric care available in a category A prison, the discipline and medical staff in general acted appropriately. The one exception would be the inappropriate remarks made by the discipline officer as described above. We have not investigated this incident in depth, and therefore make no specific findings about it. However, we can easily believe that discipline officers might be inclined to make insensitive remarks without necessarily appreciating the effect this might have on mentally ill prisoners.

Recommendation

R17 Prison authorities should advise their staff of the constant need for sensitivity and training on the effect that insensitive or inappropriate remarks may have on mentally ill prisoners.
10. Peter Bryan - care and treatment at Broadmoor

Assessment before admission

10.1 Peter Bryan was referred to Broadmoor by RMO1 in a letter dated 23 March 2004. He requested an urgent assessment with a view to transfer under section 48 of the Mental Health Act 1983. The letter contained a number of existing reports and outlined a number of parts of Peter Bryan’s history which indicated a high level of risk including:

- the killing of a young woman in 1993
- the attempt on his own life by jumping off a building
- a history of violence, robberies and assaults in the community, membership of gangs, and carrying weapons
- claims of problems with medication
- the killing and dismembering of Brian Cherry and the claim of cannibalism
- recent challenging and violent behaviour in Belmarsh
- his informing RMO1 on 13 March that “he wanted to hit or kill a member of staff” and “a two week desire to eat someone's nose”
- starting two fires in his cell and continued attempts to assault staff.

10.2 RMO1 stated that:

“...it is his high level of arousal and aggressiveness which is a considerable cause for concern and makes him an on-going risk to others.”

10.3 From the time of his arrival at Broadmoor until he was transferred to Isis Ward after the assault on Richard Loudwell, Peter Bryan’s RMO was RMO2. From the time of Peter Bryan’s admission, RMO2 had access to the report of Consultant Psychiatrist 7, consultant forensic psychiatrist, dated 3 March 2004. This set out a detailed history, including medication tolerance problems that had resulted in staff at the John Howard Centre, Hackney changing his medication from Trifluoperazine to Olanzapine. The report suggested there had been concerns that Peter Bryan had not been continuing to take Olanzapine at the time of the index offence, but that he denied non-compliance. He had been prescribed the drug while on remand in Belmarsh. Consultant Psychiatrist 7 stated:
“There can be little doubt that Mr Bryan must be regarded as extremely dangerous.”

10.4 RMO2 agreed with this view in his evidence to the inquiry. He told us he had come to the same conclusion at the time of his own assessment immediately before Peter Bryan’s admission to Broadmoor.

10.5 He expressed surprise that previously Peter Bryan had been changed from one oral anti-psychotic to another and not placed on depot medication.

10.6 RMO2 went to see Peter Bryan at Belmarsh with SHO1 on 2 April 2004 as a result of which he wrote a short report dated 5 April. The history recorded by him included most, if not all, of the risk factors mentioned in RMO1’s report. RMO2 was only able to see Peter Bryan through the hatch of his cell. He told us it was not practical to assemble the necessary team to allow the cell to be opened. He doubted that the circumstances of the interview would have been much better if he had been able to do so. In any event it was obvious Peter Bryan was mentally unwell from his prison medical records and from the interview through the hatch. RMO2’s conclusion was that:

“It is clear that his risk to others could only safely be managed at Broadmoor Hospital”

10.7 Therefore he recommended admission to Broadmoor.

10.8 Such mental state examination as RMO2 was able to conduct was clearly limited by the circumstances. He thought Peter Bryan:

“...clearly was not right. He was dressed in boxer shorts, which was somewhat odd. He appeared perplexed and frightened...he suggested that he wanted his front teeth to be removed because they were eating him like worms. He said he recognised someone who was outside his cell who he said had been following him since the beginning of time. Then he disengaged with us and went to the back of his cell.”

10.9 His opinion was that Peter Bryan’s was a case of well established paranoid schizophrenia and that his mental health had deteriorated in Belmarsh.
“...despite his intermittent compliance with Olanzapine. He has become increasingly aggressive with evidence of thought disorder and delusional beliefs.”

10.10 RMO2’s report made no reference to the degree of risk Peter Bryan would present to others in Broadmoor or any suggestion of how that risk might be managed. There was no suggestion in the report that the deterioration in Peter Bryan’s behaviour was due to non-compliance with medication. RMO2 told us:

“I guess that, in terms of his risk to others, he is at the upper end of the spectrum. Even before the incident with Mr Loudwell, he has killed two people on two separate occasions.”

10.11 This was “relatively unusual” for patients at Broadmoor and put him “at the upper end of the spectrum in terms of risk to others but not exceptionally so”.

10.12 However, he also considered at the time that Peter Bryan’s case was straightforward so far as Broadmoor was concerned. His interpretation of the medical history was that when Peter Bryan was on medication he did not present a management problem and that he would respond to medication in “a fairly straightforward way”. This was based on his view that Peter Bryan was likely to have been complying with medication in Rampton where he was relatively stable and that his behaviour did not deteriorate in the community until he stopped taking the medication.

10.13 However, RMO2 accepted, albeit in respect of a slightly later time, that:

“With the benefit of hindsight, what we misjudged was how unwell he was and how dangerous he was despite the medication we were giving him when he was first admitted.”

10.14 On 7 April 2004 a pre-admission social work report was prepared by Social Worker 3, a forensic social worker. She had read RMO1’s letter and attachments and RMO2’s report in draft. Her report identified a number of risk issues:

- A documented history of assaultative behaviour to others, including a conviction for manslaughter, and unprovoked attacks on staff.
- The circumstances of the index offence.
- A history of self-harm in the form of an attempt to jump off a building, a noose having been found in his cell, and an attempt to set fire to his cell.
- A history of drug misuse.

10.15 Her conclusion was that:

“He presents a grave risk to others...He needs a thorough risk assessment to evaluate the risk he poses as the evidence indicates he is a high risk to himself and others.”

10.16 Social Worker 3 told us that it was normal for social work pre-admission reports to be prepared without having seen the patient. However, she was clear about the risk he presented. In comparison with other Broadmoor patients he was “Extremely high risk”.

10.17 On 8 April 2004 the Broadmoor admissions panel met and decided that Peter Bryan should be admitted for assessment. The panel had before it the reports the RMO at Belmarsh, Consultant Psychiatrist 7 and RMO2, together with the social work assessment and some older material. The grounds recorded for the decision to admit were:


10.18 The decision was communicated formally to Belmarsh on 16 April 2004, the day after Peter Bryan arrived at Broadmoor.

10.19 On 9 April 2004 Ward Manager 1 of Luton Ward and Primary Nurse 9 undertook a pre-admission nursing assessment of Peter Bryan at Belmarsh. There is no extant written record of their assessment. They interviewed him through the hatch in his cell door as otherwise the prison staff would have had to put on protective equipment and believed there would be a fight. Although prison staff had reported that Peter Bryan was extremely aggressive and incoherent Ward Manager 1 and Primary Nurse 9 found a different presentation: Peter Bryan was able to concentrate, and his speech was clear. He told them he had not been taking the medication prescribed, Olanzapine. Ward
Manager persuaded him to try it and suggested to staff that the dose be maximised. On occasions they used a needs assessment tool but probably did not do so on this occasion. Primary Nurse 9, who was to be Peter Bryan’s primary nurse, recollects the assessment taking only some ten minutes. Normally Primary Nurse 9 would have prepared a report of the visit, but he could not explain why there appeared to be no such report on this occasion. However, the absence of such a report did not surprise them given the time between the assessment and admission.

10.20 On 14 April 2004 an order was signed on behalf of the Secretary of State directing the transfer of Peter Bryan to Broadmoor Hospital under the provisions of section 48 of the Mental Health Act 1983. The grounds of the order were that Peter Bryan was suffering from mental illness within the meaning of the Act and that the mental disorder was of a nature and a degree which made it appropriate for him to be detained in hospital for medical treatment and that he was in urgent need of such treatment. The formal recommendations were signed by Peter Bryan’s RMO at Belmarsh and a staff grade psychiatrist at Belmarsh on 8 April.

10.21 Section 48 does not expressly authorise assessment, as opposed to treatment, but it is recognised that:

“The fact that assessment by itself cannot amount to treatment for section 3 does not mean that assessment cannot be a legitimate treatment under sections 3 and 20. Often assessment or monitoring of progress will be an important part of treatment. This will certainly be the case where as here there is an evolving programme of treatment.”

10.22 Nonetheless, it may be material to an assessment of what followed that transfer to Broadmoor was explicitly for the purpose of treatment, not just assessment. This was a patient with an established diagnosis who was known to be highly dangerous.

Comment

There was a clear case for Peter Bryan’s transfer from a prison to a high security mental hospital at the earliest opportunity. There was an established diagnosis of

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mental disorder, a history consistent with a high level of risk to the public and the patient, and a demonstrable and urgent need for a high-security setting for his care. Therefore, there can be no criticism of the decision to admit Peter Bryan to Broadmoor, and the urgency with which it was arranged is impressive.

However, the assessment of the patient before admission was not ideal. In particular, the RMO was unable to perform a full examination at Belmarsh because he was not allowed into the patient’s cell. This may have been justified but there appears to have been an unquestioning acceptance by the RMO of the prison officers’ view in this regard. In the admittedly difficult prevailing circumstances, the possibility of arranging for the RMO to see Peter Bryan in his cell should have at least been raised and discussed and the reasons for being unable to pursue this course documented.

Both the RMO and the nursing team appear to have given insufficient thought in advance of his arrival at Broadmoor to the management plan or to the documentation of the risk assessment. A regime of medication and observation might well have been appropriate but no documented risk assessment was linked to the management and care plans. As a result, the importance of a baseline mental state examination and of establishing Peter Bryan’s current thought processes was not given sufficient emphasis.

We note that the Trust accept that Ward Manager 1’s pre-admission nursing assessment of Peter Bryan should have been recorded, albeit that the timescales were unusual.

No documented discussion of the management of Peter Bryan or the goals of that management took place before his admission, even though this normally occurs in anticipation of the admission of a patient. Time was short and the normal time for such discussion fell on a public holiday, but arrangements should have been in place to enable one to take place.

Broadmoor and its staff are understandably confident of their ability to deal with even the most difficult cases but their approach to Peter Bryan’s risks and needs suggests undue confidence that even the highest risk category of patients can be managed with routine methods as opposed to a plan informed by careful and detailed

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consideration of the case before the patient arrives. In this context there was a failure to give sufficient weight to the unpredictability in this patient's behaviour and to the absence of any clear picture of what might be the warning indications of future dangerous behaviour.

The decision in advance of admission that Peter Bryan should initially be kept in seclusion while his behaviour was observed and risks assessed was justified. However, insufficient thought was given to what staff should look for on observation, how they should interpret what they observed, what mental state and other examinations should be conducted and by whom.

Admission examination

10.23 Peter Bryan arrived at Broadmoor on Thursday 15 April 2004. There is no record of his case having been discussed at a clinical team meeting before his arrival. This may have been because the previous Monday, the day for such meetings, was the Easter bank holiday. It may be that the general plan for his management was formulated by RMO2 the day he saw Peter Bryan for his pre-admission assessment. SHO1 thought that at least a tentative plan to place him in seclusion and administer Acuphase was mooted, if not at that time, then just before his arrival at Broadmoor. RMO2 told SHO1 on the day of admission or just before of Peter Bryan's impending arrival and what he needed to do, including the need to perform a mental state examination.

10.24 When Peter Bryan arrived at Broadmoor he was admitted by Nurse 1 who recalled that he was aggressive and uncooperative:

“When he first arrived, I was there and he was very aggressive in the sense that you could even see how tense he was in the way he was looking at us, and the mere fact that he mentioned he did not understand why he was brought to Broadmoor, he did not understand why he was there and he was very, very angry. You could see that he was very hostile and he didn’t want to take anything from us. When he was offered to take a shower, he declined the shower and said, ‘no, I don’t want it’. He was not very compliant with the admission procedures, and after the admission process, because he has to be seen by the [medics] who look for any injuries that he comes up with, after that his mental state would be assessed to see where best to nurse him. The decision was made to put him in
seclusion and stay there until he was reviewed later on, and that is what happened.”

10.25 Peter Bryan was seen formally on his arrival by RMO2. It was recorded that he was calm and asked appropriate questions. A brief physical inspection revealed nothing of note except a limp due to an ankle injury. RMO2 noted that he explained the need for medication to Peter Bryan who agreed to an injection of Clopixon Acuphase. It was recorded that he was to be placed in seclusion:

“...due to his disturbed behaviour in HMP Belmarsh and to be reviewed. Protective clothing and bedding. He will be seen by SHO1 for an admission physical and psychiatric examination and I will review him again tomorrow.”

10.26 RMO2 thought that Peter Bryan’s case at the time of his admission was:

“...pretty much as straightforward as you can get so far as an admission to Broadmoor was concerned.”

10.27 This was in spite of the acknowledged fact that it was unusual to have a patient who had committed two homicides, with a period of special hospital admission between the two, which led him to being at the upper end of the spectrum of risk.

10.28 The decision was taken to admit him to seclusion. The reason for this was, according to RMO2, in order to establish him on medication, as it was thought that on medication: “He did not present a management problem or a significant risk”.

10.29 SHO1 recorded the reason for seclusion, presumably in consultation with RMO2 as:

“New admission from HMP Belmarsh. Mental state unknown at the moment. Previous history of violence. Risk of harm to staff and other patients. Risk of self harm and suicide.”

10.30 RMO2 had decided to start Peter Bryan on Clopixon Acuphase as a loading dose of medication to cover the period before a depot (long acting injectable medication) could
be given and take effect. He said that he had decided on this course of action before the admission.

10.31 Ward Manager 1 told us that the reason for admitting Peter Bryan into seclusion was:

“...because of his index offence and his assaults...and because of his behaviour in prison.”

10.32 He accepted that such management on admission was unusual.

10.33 Team Leader 1 told us that frequently medication was lowered in order to assess a patient, but that in some cases, the level of disturbance was too high to risk taking such a course:

“We try and assess the majority of patients unmedicated, or if they come in on medication we may lower it to see their illness manifest. When someone is so disturbed that you probably won’t be able to do an assessment on their mental state because their symptoms may be such that it’s quite obvious and they’re so agitated that you wouldn’t be able to do an assessment because they would be in seclusion because of the way they’re presenting. Or they would be such a harm to others you wouldn’t be able to do an effective assessment on somebody, so you need to calm them and bring them down to a level so you can assess them and see what’s beneficial for that person.”

10.34 Therefore, while Broadmoor was accustomed to dealing with highly disturbed and dangerous patients, it can be inferred that Peter Bryan was considered to be at the most serious end of the spectrum.

10.35 Part of a mental state and physical examination was performed by SHO1, the SHO. It was recorded that Peter Bryan was handcuffed, but appeared to be quiet and not struggling. He was not aggressive but became irritated during the physical examination. He was prescribed Clopixol Acuphase 100mg every 48 hours, among other medication. Most of the physical assessment form was completed by SHO1, who noted that there was an abrasion on the patient’s head and right arm and that he was asthmatic and limping. However, virtually none of the mental state assessment form was completed. Most
sections were merely marked as “could not be assessed”. In the clinical records SHO1 recorded that the patient’s mental status had not been assessed. SHO1 thought that he had been unable to complete the examination because the patient had become distressed. A nursing observation note completed by Team Leader 3 recorded that Peter Bryan was “slightly agitated” when examined and was “agitated and guarded” later. SHO1 was a new SHO at the time and thought he might have been particularly cautious at the time about the risk presented by a patient such as Peter Bryan. He thought he had informed RMO2 that he had been unable to complete the mental state examination. RMO2 thought it would be reasonable to abort a mental state examination if there was an attempt at an assault but not merely because the patient was irritable: there would have been other staff on hand to help. RMO2 told us that had it not been possible to complete a mental state examination on admission then he would have expected the examination to be performed the following day. RMO2 did see Peter Bryan the day after his admission but did not record any comment in the notes to suggest that he was aware that a mental state examination had not yet been completed. He was unable to explain why he had not noted that, or why he had not asked the SHO to perform a complete mental state examination. It does not appear from the records that a complete mental state examination was carried out on Peter Bryan between his admission to Broadmoor and the assault on Richard Loudwell.

Admission care plan

10.36 SHO1 recorded a management plan on 15 April 2004 after his examination: the patient was to be sedated, maintained on level 3 observation and observed for dystonia, sudden collapse and wheezing.

10.37 A nursing care plan was formulated by Team Leader 1 on 15 April 2004 because the allocated primary nurse, Primary Nurse 9, was not on duty that day. It was divided into four areas of need or problems. The first area, continued without change until 19 April 2004, was that:

“Peter is to be nursed in seclusion due to unpredictable violent behaviour.”

The objectives were:
“To maintain a safe environment, minimise risk and minimise the time spent in seclusion.”

The planned interventions were:

“To observe Peter in seclusion as per policy and according to ward plans.”

“To allow Peter time (as appropriate) out of the seclusion room, depending on behaviour, staffing, environmental factors in liaison with the nurse in charge.”

“To spend time with him allowing him to ventilate his feelings and to get Peter up with a minimum of four staff.”

10.38 The second area related to the monitoring of side effects of medication. This plan continued throughout the patient’s time on Luton Ward.

10.39 The third problem identified was that:

“Peter has a history of violent/assaultative behaviour. This behaviour has recently been directed towards staff with little or no indication it will occur.”

The objectives of the plan were:

“To maintain a safe environment for patient/staff.”

“To minimise risk/opportunity of assaultative behaviour.”

The interventions planned were:

“For all staff to be aware of Peter’s history and precipitating factors for violence i.e. having to wait for a light, paranoia, crowds (dislike of).”

“To nurse Peter in a safe and therapeutic environment according to/dependent on mental state/behaviour and prescribed by medical/nursing team.”

“To nurse Peter with the appropriate staffing levels etc.”
10.40 This part of the plan was to be reviewed on 20 April 2004.

10.41 The fourth part of the plan related to the risk of suicide or self-harm and required interventions.

“To nurse Peter in a ligature free room on the ward.”

“To complete regular room searches according to policy.”

“To spend time with Peter exploring issues in a safe and therapeutic environment/manner.”

“To be nursed on level of observations as discussed with the clinical team.”

10.42 This part of the plan continued until 20 April 2004.

10.43 This plan reflected the concern that Peter Bryan was unpredictable and the view that his disorder could be best managed by medication.

Comment

The admission procedure failed to achieve a full and properly documented mental state examination. The SHO was relatively inexperienced. If the RMO was to task the SHO with carrying out the mental state examination of Peter Bryan on admission we would have expected the RMO to have been alert to whether this task was completed as instructed. It is a matter of concern that the RMO ought to have been aware from the records available to him next day that this examination had not been completed but did not then undertake a full mental state examination.

The result of this omission was that no mental state examination was performed either at admission or throughout Peter Bryan's period in seclusion. Therefore no baseline information was obtained from which to judge any changes in mental state. This was poor practice, especially in the case of such a high-risk patient.

The care plan rightly identified Peter Bryan's unpredictability but addressed only in broad terms what measures were required to monitor changes in his mood and
behaviour. In particular the plan failed to emphasise the need to engage Peter Bryan in order to find out more about his thought processes and thereby seek to elicit warning signs in relation to dangerous behaviour.

The prescription of Acuphase on Peter Bryan’s admission is notable because it suggests an initial view that his risk and clinical state were such as to require a high degree of control. It is surprising that the very concern which led to the prescription of Acuphase did not lead to greater caution when Peter Bryan was released from seclusion four days later.

Tilt risk status

10.44 In high security hospitals exceptionally high risk patients are designated ‘tilt high risk’. The general issue of the policy for risk assessment at Broadmoor is considered elsewhere in this report. The policy in force at the time required that:

“The risk assessment protocol will be used to assess the patient on admission...”

10.45 The policy required the clinical team to consider whether:

“Each patient presents an identified risk of harmful behaviour which is greater than can be managed by the ward’s regime which normally contains or manages the risk(s) presented by other patients.”

10.46 There is no evidence that such a risk assessment was carried out. The form set out in appendix 1 of the policy was certainly not used. The closest to a “Tilt” risk assessment was that performed before admission by the social worker, as described above.

Comment

Our comments on the security policy appear in the relevant chapter. We were told that the formal assessment of “Tilt” risk would have taken place at the first clinical team meeting at which Peter Bryan’s case was discussed. This had not taken place before the incident because of a Bank holiday and a clinical improvement group meeting.

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7 See chapter 13: Security and risk assessment
Given the overall view taken of Peter Bryan at the time and the limited perceived usefulness of the attribution of high-risk status, we have no doubt that he would not have been given such status even if the assessment had taken place as required by a literal application of the policy. Furthermore, as Peter Bryan was to be admitted to seclusion in the first instance, it is understandable that staff saw no pressing need to document such a risk assessment.

Given his history and presentation on admission, we consider that Peter Bryan should have been regarded as a classic case for Tilt high-risk status. The known factors, accurately set out in Social Worker 3’s report, together with the lack of knowledge of the trigger factors for his violent behaviour, all point to such a conclusion.

As we set out elsewhere, the application of Tilt is not without difficulty, but it has the merit of at least drawing attention to the danger of the individuals subject to it, and, just as importantly, why they are dangerous. The omission to apply Tilt status in this case can principally be attributed to the policy that requires a patient to be more dangerous than the norm for Broadmoor before being given high risk status. Such an approach encourages staff to think of all patients as the same and that the normal management approach will succeed in containing risk, rather than an individualised focus on each patient and the particular dangers each presents.

Seclusion

10.47 The aim of secluding Peter Bryan was said by Ward Manager 1 to be to allow integration with his peers with the assistance of medication and good rest, which he felt he had been without for months.

10.48 A nursing observation record was made every two hours while Peter Bryan was in seclusion until his discharge from seclusion on 19 April 2004.

10.49 On 15 April 2004 he was said to have had “minimal interaction with others”, was “unpredictable” and his mood was “changeable”. On medical reviews it was noted that he had said he used to react violently when people came to access him in prison but that he felt calmer now. Later in the day RMO2 recorded that the patient was “Calm. But remains a risk to others due to psychosis.”
10.50 Notes for 16 April 2004 have him still interacting only minimally but also being “appropriate” and “polite and cooperative” with staff during interactions. Team Leader 1 noted that he:

“Remains unpredictable therefore continue with seclusion, as continues to present as a risk to others.”

10.51 In evidence to the inquiry Team Leader 1 explained what was meant by the term “unpredictable” in this context:

“When you haven’t had a chance to assess someone you take it that they’re unpredictable because you don’t know what they’re going to be like from minute to minute...You can still have someone [out of seclusion] and be unpredictable. It’s just the terminology when you haven’t had a chance to assess someone properly and you don’t know everything about them.”

10.52 SHO1 reviewed the patient and noted:

“Said he was ‘really liking it here’; settled, a bit drowsy since yesterday’s medication. A bit concerned about his upcoming court case.”

and

“No psychotic/delusional [thoughts] No active DSH. No thoughts of harm to others. Not assessed in terms of mental state. Unpredictable. Still at risk based on previous history.”

10.53 RMO2 saw Peter Bryan later the same day and described him as “calm and generally appropriate”. His plan was to keep Peter Bryan in seclusion over the weekend.

“In view of his recent history, although it is likely that seclusion can be terminated early next week and that protection and level 3 observations can be reviewed then.”

10.54 This pattern continued on 17 April 2004. He was said to be “quiet and settled”. Medical reviews referred to Peter Bryan remaining “unpredictable” and “settled”.

Chapter ten: Peter Bryan - care and treatment at Broadmoor
10.55 On 18 April 2004 at 2.05am it was noted that he was awake and restless:

“When asked if he needed any help or anything at all he said he was confused and displayed irritability as if he was bored.”

10.56 For the rest of the day he was noted to be quiet and to have minimal interaction. There were “no overt management problems”.

10.57 At 8pm it was noted that he was:

“Interacting on a need to basis. Little reluctant to discuss any issues.”

10.58 He was thought still to require seclusion because of unpredictability.

10.59 On 19 April 2004 he was reviewed by SHO1 at about 9.45am. There is an entry by SHO1 in the clinical notes for this review. The entry was written in retrospect but it is unclear when. It reads:

“Seclusion r/v
Written in retrospect.

10.60 In the Seclusion Record Form for 19 April 2004 at 9.45am SHO1 had recorded as the reason for authorising continuation of seclusion:


10.61 At 10am Nurse 8 noted that “Despite appearing settled he remains unpredictable”.

10.62 At 11am RMO2 conducted a review. He noted that:
“He has remained settled over the weekend...Today he was affable but with slightly inappropriate effect. He denied any thoughts of suicide although he said he felt like banging his head on a shelf two days ago.”

10.63 RMO2 continued the Acuphase, to be followed by depot depixol and then noted the following instruction:

“To have normal clothing and bedding. General nursing observations. To remain in low risk room. To have access to his room if required this week.”

10.64 In the seclusion record at 11.50am RMO2 noted that the patient “remains settled”.

10.65 At 12pm Nurse 8 noted that Peter Bryan no longer required protective clothing. At 1.45pm it was recorded that seclusion was being terminated, as were level 3 observations. No express reasons were noted for this change of management, either by RMO2 or the nursing staff. The space for recording such reasons in the seclusion record is blank.

10.66 The primary nurse, Primary Nurse 9, noted on the care plan that the patient had been discussed in the clinical team meeting and that he:

“Appeared more settled since the commencement of acuphase on admission. Seclusion terminated.”

10.67 It is not entirely clear how and when the decision to end the seclusion was made. There was in fact no clinical team meeting on 19 April 2004, but a clinical improvement group. The minutes of the meeting contain no record of any discussion about Peter Bryan. Primary Nurse 9, who wrote the note referred to above, was at court with Richard Loudwell at the time and relied on information from colleagues.

10.68 RMO2 thought, at the time Peter Bryan was released from seclusion:

“...that Peter Bryan’s case would probably be relatively straightforward. I believed his behaviour in Belmarsh was attributable to his illness. He was dangerous as a result of his illness. Examination of his previous history suggested that when he..."
was compliant with medication he got better and did not present as dangerous or a management problem.”

10.69 He thought that Peter Bryan’s time in seclusion showed a change in behaviour in that although he had assaulted staff fairly regularly in Belmarsh his time in seclusion suggested he was no longer doing that. The staff had not been “particularly concerned” about the risk he presented to them, therefore both Ward Manager 1 and RMO2 had judged it to be safe to allow him on the ward. RMO2 said:

“Clearly, with the benefit of hindsight, we were wrong.”

10.70 He accepted that the implication of the decision to let Peter Bryan out of seclusion was that it would be safe to allow him to be unobserved for periods of time while in association with another patient, because he was not on level 3 observations. He accepted that Peter Bryan had not been subject to a mental state examination or observed interacting with other patients while in seclusion. By way of justification RMO2 said:

“In terms of his behaviour, when you are in seclusion, you go on the way that someone behaves towards the staff and certainly the concern when Mr Bryan was in HMP Belmarsh was his aggression towards staff rather than other prisoners. As far as his behaviour, I do not see any other way in which we could have assessed the ending of seclusion. With regard to mental state examination, I agree that the mental state examination prior to ending seclusion could have been more detailed than it was.”

10.71 There had been no reason other than time constraint why Peter Bryan could not have had a full mental state examination.

10.72 Ward Manager 1 thought that at the time of Peter Bryan’s discharge from seclusion he was much improved:

“His affect was more appropriate, there was no pressure of speech, he didn’t seem to be distracted by stimuli that weren’t apparent to us, he was able to converse readily, he didn’t report any unusual phenomena or symptomatology, he became more settled, he was able to interact with others; people around him didn’t find his behaviour abnormal or unusual. They are all judgements in trying
to establish whether or not the medication regime we’d introduced was effective.”

10.73 Nurse 4, allocated to Peter Bryan as the associate nurse, thought it was surprising that he had been discharged from seclusion on general observations, but said that was the way RMO2 did things. He told the inquiry that if he had been asked he would have suggested level 3 observations. In his view:

“It is common practice that, rather than getting people straight out of seclusion, you get them out gradually, give them time to see how they cope but even then, you never really know what will happen - you never know what is going to happen anyway. So it would be safer for the patient and for the ward environment for them to be on observations for a period of time. I may suggest that RMO2 put him on obs for review by nursing staff, so that we could have stopped the level rather than he having to come back to the ward to discontinue it.”

10.74 Nurse 1 had not been surprised at the decision to discharge Peter Bryan from seclusion without continuing level 3 observations because “…he was settled enough”.

10.75 He said this was what normally happened, based on the experience of dealing with patients who were more unsettled on arrival than Peter Bryan being successfully integrated into the ward.

10.76 When the inquiry interviewed Peter Bryan in June 2006, he had his own perspective on his period in seclusion. He had felt “all right” about the medication he was given, but:

“…I had come from [a] four man unlock and I said to myself, if there’s anybody vulnerable outside, where they kept mixing with the proper patients, that I would harm them. I would have it in my mind to harm them.”

10.77 He claimed he was thinking this when he arrived at Broadmoor and that:

“I think my life is worth more than one life…I didn’t want to be in Broadmoor for nothing as serious as what I’ve done, because I don’t want to be coming in there for GBH or something like that. People do ten, 15 years for that. And I think to
myself ‘Well I’m here. I’m never getting out. I’ve got nothing to lose’. So I targeted Mr Loudwell.”

The Acuphase had:

“…made me calm down a bit but I still had thoughts of harming someone if I got out of the situation that I was in…I have always had those thoughts. I was taking the medication because I have to take the medication: it does help. But I’ve got ideas in my head that I don’t always tell anybody.”

10.78 He accepted he had been seen by staff, including the ward manager several times and was asked if he was all right, which he was. This had not helped, and, in Peter Bryan’s opinion, he ought to have been in Isis Ward, the intensive care ward.

10.79 Peter Bryan was keen to emphasise in general that he had no complaints about the doctors who had seen him in Luton Ward, describing RMO2 as “first class”. He added:

“I guess it must have been my fault for holding back how I really felt.”

10.80 Reflecting generally on what he thought could have been done to prevent what happened Peter Bryan said:

“Really, RMO2 should have asked me maybe, if I feel like harming anybody. I am sure he must have asked it but - maybe I was too frightened to admit what I really felt. I don’t know really. It is a difficult question.”

Comment

During Peter Bryan’s period in seclusion the records suggest that he was reasonably settled, and that he was not regarded as a management problem. However there is no indication that more than superficial observation was conducted, or that any mental state examination or even meaningful engagement took place during this period. The evidence clearly suggested that there was no detailed, if any, exploration of whether he had thoughts of harming anyone. Indeed RMO2 had not thought that a seclusion room, in the presence of three nursing staff, was an
appropriate setting in which to discuss the index offence, although he accepted this should have been done at some point.

The decision to discharge Peter Bryan from seclusion appears to have been taken because it was perceived that he had “settled” on the medication regime prescribed, and that it was believed that his previous violent behaviour had been associated with non-compliance with the medication regime. Whatever reservations there may be about the quality of the assessment undertaken during the period in seclusion we accept that termination of seclusion was a reasonable course to take, but subject to what is said in the next paragraph.

There is no documented reason for the decision to permit Peter Bryan to go straight from seclusion onto general observations in association on the ward. This meant only that Peter Bryan’s whereabouts would or should have been noted every 15 minutes. This was a patient about whose current mental state virtually nothing was known. Having committed two previous homicides, each in different circumstances, and one of which at least involved highly unusual cannibalistic behaviour, he was obviously a patient presenting a very high level of risk to others. It was not possible to understand what might have motivated him to commit these offences nor to predict what might trigger similar behaviour in the future. It was possible that the offence was associated with non-compliance with medication regimes, but the history available did not suggest that these offences could have been predicted from his behaviour in the period leading up to them. For these reasons if no other Peter Bryan remained “unpredictable” as rightly described by the team leader and other staff at the time. The removal of level 3 observations may have been due to a misplaced confidence in the ability of staff to keep watch on dangerous patients routinely without the formality and resource demands of level 3 observations. We conclude, however, that such a rapid reduction in observation level could not be justified, and that with such a patient a high level of observation was required until staff could be satisfied it was safe to reduce it. The material for such a decision was not available at the time. Therefore we agree with the comment of Nurse 4 recorded above.

We are satisfied that Peter Bryan was doing his best to help us when we saw him, but it is difficult to know how much weight to place on his account of what was passing through his mind while he was in seclusion. There is always the possibility that what he said when we saw him in June 2006 was influenced by hindsight. However, we see
no reason to reject his account in this regard. It is distinctly possible, bearing in mind what he did within a week of release from seclusion, that he was already harbouring thoughts of harming someone. We doubt any doctor or nurse asked him any detailed questions designed to elicit whether he was thinking of harming someone. We consider that sensitive and thorough exploration of the patient’s thought process at the earliest possible stage is called for in cases like this. As Peter Bryan himself accepted, however, it is impossible to know whether he would have admitted to such thoughts at the time.

Change in care plan

10.81 As noted above, on release from seclusion Peter Bryan was placed on a regime of general observation. This change resulted in the cancellation of the care plan numbered 1 (see above) by Primary Nurse 9 on 19 April 2004. We could not obtain any replacement care plan for that date other than one numbered 5 which addresses blood pressure monitoring. There may have been an additional care plan, numbered 6, which has been lost or destroyed. This may be inferred from the existence of a care plan numbered 6A dated 20 April 2004 (see below) and another care plan numbered 6 dated 25 April 2004. Nurse 9 was unable to offer any other explanation for the discrepancy or to tell us what the missing plan might have said, other than that it would have addressed the same problem as care plan no 1. If such a plan had existed and been cancelled, correct procedure required it to be retained in the file but crossed through.

Care plan 6A, dated 20 April 2004 and written by Primary Nurse 9, set out a brief summary of the index offence and then went on:

“Objectives
To maintain a safe environment
To give Peter the opportunity to express himself in a safe environment should he feel assaultative (sic).

Nursing interventions/actions
Primary nurse to spend time with Peter to form a therapeutic relationship
All staff to be aware that alleged crime may have been psychiatrically driven
Be available to Pete to discuss any issues following the possibility that insight may increase following treatment
Continue multi-disciplinary assessment.”

10.82 Primary Nurse 9 told us he had initially been surprised to find that Peter Bryan had been down-graded from level 3 observation, but that:

“Having spoken to him, certainly on the 25th [sic⁸] and at times during the week, there was no manner in which he presented to me that made me feel he needed to be on a higher level of observation.”

Comment

Care plan 6A contained no reference to observation. Given the history and the awareness of the possibility of highly dangerous and unpredictable behaviour, we find this extraordinary. Even if it is accepted, as was suggested to us more than once, that patients on general observation were in line of sight most if not all the time they were out of their rooms, there was no provision for ensuring that Peter Bryan was kept even under this level of observation. It seems to us that the systems in place on the ward failed to take adequately into account that staff did not know enough about newly admitted patients to be confident that they had assessed the level of risk correctly. The understandable desire to allow the least restrictive regime compatible with safety was allowed to outweigh the risks involved in caring for highly dangerous patients who were properly regarded as unpredictable. In such circumstances we consider that a high level of observation was required for any patient about whom so little was known as in the case of Peter Bryan.

Nursing observation on ward

10.83 The only observation note made on 19 April 2004 after Peter Bryan’s discharge from seclusion was timed 1.45pm, 15 minutes after he had come out of seclusion. He was described as appearing settled. There were no further nursing observation notes that day. At some point during the afternoon he was interviewed by Social Worker 4 in the presence of Primary Nurse 9.

10.84 On 20 April 2004 three nursing notes were made. Peter Bryan had appeared to suffer some leg stiffness. He was noted to have played table tennis with staff, and to have

⁸ We think this should be taken to have been intended as a reference to the 21st.
been “civil and appropriate on approach”. Later he was said to have “settled into ward routine” and that he “feels he has orientated himself well”.

**10.85** On 21 April 2004 again three notes were made. These described the patient as “settled” and presenting “no management problems”.

**10.86** On 22 April 2004 only one nursing note was made, timed 6.15am, recording that he was “settled” and “interacting well with peers and staff”. This would have been referring to his presentation the previous evening.

**10.87** On 23 April 2004 four nursing notes were made. One concerned an abortive trip to the Central Criminal Court. The others noted again that Peter Bryan appeared “settled” and on one occasion that he was “singing and dancing and interacting well with others. Demonstrating a good sense of humour.” Another recorded that he had “attended airing court and participated in volley ball...appears settled”.

**10.88** On 24 April 2004 three nursing notes were made. He played volley ball in the airing court again and was thought to have been “interacting well with peers and nursing staff”. He complained of pain in his left foot and was thought to require podiatric help.

**10.89** One nursing note was made on 25 April 2004, the day of the incident. At 1pm Team Leader 1 noted:

> “Appropriate in his interactions with both staff and peers.”

**10.90** There was no earlier note by the night shift as there should normally have been.

**10.91** Primary Nurse 9 told us he had a “one-to-one” interview with Peter Bryan on 25 April 2004 after lunch.

> “I saw him in the clinical room, just him and me and did a number of observations - blood pressure, pulse, temperature, peak flows. I also asked him a number of questions about how he was feeling, how he felt about himself and others etc.”
10.92 He thought he had not recorded this because he was going off duty. He said he intended to write up the notes on his return, the following Monday. He had, however completed a nursing résumé in preparation for the clinical team meeting.

10.93 Among the questions he said he asked Peter Bryan was “whether he felt like hurting anyone else”:

“Mr Bryan’s responses to these questions were entirely normal and satisfactory. The only point of note was that I recall he did say he felt like banging his head against a wall. I asked him what he meant by this and I think he said that he felt like banging his head against a wall because he was back in hospital again but he didn’t want to discuss this further. I took this to mean that he thought he had let himself down by committing the offence and coming back into prison and then hospital.”

10.94 None of the detail of this account is reflected in Primary Nurse 9’s nursing résumé which identifies among the immediate risk factors the risk of harm to others and described the situation as follows:

“Up out of seclusion, mixing well with peers and staff. Placed on general observations. Recognises the reason why he was in prison, states that he feels more settled and less agitated here. Feels much happier in hospital, hopes he will settle into a routine. Speech content a little unusual/odd ‘need to bang my head against the wall’? Couldn’t elaborate. No obvious psychotic symptoms shown.”

10.95 Primary Nurse 9’s recorded recommendation was to continue the assessment.

10.96 We do not know if Primary Nurse 9’s recollection that he had a one-to-one with Peter Bryan on 25 April 2004 is accurate or not, nor, if such a meeting did take place, are we able to reach a conclusion about what was said during it.

10.97 The team leader, Team Leader 1, spent little time with Peter Bryan before the incident but to her he seemed:
“...pleasant and had a cooperative manner. He was able to joke with his peers and staff and there was nothing to indicate that he was unstable.”

10.98 She subsequently considered whether she or her team had missed any signs:

A. I don’t think Mr Bryan was voicing his delusional ideas at the time. You could have placed him anywhere within the hospital at that time. He was amiable, gave you no cause for concern, laughing, joking and nothing to indicate. I’ve racked and racked my brains since then to try and find an indicator that may have indicated that he may have done that, and I can’t see anything. At that particular point you probably could have put him on a mainstream ward, there was nothing at all.

Q. How did you know then that he did have delusional ideas?

A. I didn’t at the time because there was nothing. I’ve really thought hard about it because you’re trying to think ‘Have I missed something.’ I’ve thought long and hard about whether there was something that we missed but there was just nothing about his presentation voicing anything.

10.99 Nurse 8, subsequently appointed a team leader, but at the time an E grade nurse, was also unable to detect, even with hindsight, any indicators for concern:

“When regard to Peter Bryan, I have racked my brains many times about this, and there was no indication he would ever do something like that, and my personal belief is that he was put up to it...I have been working in Broadmoor long enough, and there is always something, some little thing, and there was nothing. He was popular with his peer group and he was posing us no management problem.”

“He was admitted straight into seclusion...and we get people gradually up out of seclusion as and when their behaviour dictates. We can’t assess anybody properly unless they are out of the room and interacting, and he responded very well. He is somebody with a long history of being an inpatient in psychiatric establishments, he knows the routine and he fitted very quickly into that routine. He gave us no indication of any paranoia or whatever.”

“The amount of time he was out of seclusion is not a great deal of time, and it’s not a particularly long period of time to make an assessment on somebody. You draw very much on previous experience with patients. As a nursing team we had
discussions about how dangerous he is and was, and my own opinion - and I stress this was my opinion - was that he had recently done this crime and the risk was low. I have nothing to qualify that remark, which is embarrassing, but that was the way I looked at it at the time. He gave me no indication, but it wasn’t a long enough time to formally and fully assess him.”

“Many of the patients who are deemed extremely dangerous and violent, and they are in the environment, when they come to Broadmoor they aren’t, if that makes sense. They are not in an environment where they are going to be a risk to the general public. Peter Bryan fitted very much into that and, being critical about ourselves, there was probably an element of complacency with him because he responded so well and he was not showing any signs. It’s not the first time with respect to patients who have come in after doing quite horrendous crimes - we’re not going to keep somebody in a locked room if they are not presenting as needing to be in there, whereas a lay person might say why haven’t you thrown away the key, to be blunt about it. We don’t; we get people up and we try to find out. He just gave us no indication, but he should have been observed, I’m not going to deny that.”

“He was no different from when he first came in until the last time I saw him. He was complying, he was polite, there were no obvious signs of mental illness, no florid symptoms of illness.”

10.100 Team Leader 2, a team leader on Luton Ward and author of two of the nursing observation records described above, recalled that after the Acu phase had been given, there was a complete change in Peter Bryan’s presentation from being guarded to appearing open, relaxed, confident, laughing, and interacting well, with no signs of paranoia or mania. When he mixed with other patients he appeared to interact well and showed a sense of humour. He was accepted by both the mentally ill and the personality disordered groups. Indeed Nurse 8 described Peter Bryan as being “very charismatic”.

10.101 Nurse 4, Peter Bryan’s associate nurse and author of one of the nursing entries thought that Mr Bryan had presented as being in a good mood, trying to make friends and trying to fit in with the others. Even if, as he would have preferred, level 3 observations had begun at the end of seclusion, he would not have expected this to have lasted more
than 24 hours. As to whether he would have been happy with Peter Bryan being unobserved, Nurse 4 thought he would not:

“Although many of our patients are an unknown quantity, Peter would have been more so than anyone else as he had only been on the ward for I think two weeks and he had only been out of seclusion for half of that time. So really we did not know him at all. So, no, I would not have been too happy. Although he was bright happy, cheerful, I still would not have been too comfortable because we did not know him.”

Nurse 4 told us that he thought such a time might have come after a number of weeks.

HCA1 remembers Peter Bryan as:

“...polite, friendly and happy on the ward when he first arrived. He caused no problems to my knowledge...He would be social and ask questions of staff and would interact normally.”

“Peter Bryan did not affiliate with any groups. He did not sit there, he did not get very verbal. He seemed quite cheerful but he never stuck out as being abusive or anything like that. He just seemed to potter round the ward, quite chirpy, chatting to staff and stuff.”

When asked whether staff judgements took into account the horrific nature of the index offence of a patient like Peter Bryan, HCA1 said:

“I suppose you have it at the back of your mind, and you think this one should be watched. However, when you have 19 other patients in the ward as well, you do not really think about the index offence. You read about it when they first come, and say, ‘Oh Christ, that is bad!’ However, once they are on the ward, generally, you treat them as everyone else. You try not to treat them differently from everyone else. You do not really think about the index offence when you are on the ward. You just treat them as the person who is in front of you.”
10.105 HCA7 described Peter Bryan as “a nice likeable chap”. He appeared to get on with the other patients, including Richard Loudwell.

10.106 HCA2 thought that Peter Bryan “seemed to fit in as though he’d been there for ages”.

10.107 HCA6 also saw no cause for concern, describing him as “likeable, talkative, chatty and easy to get on with”, both in the ward before the incident and subsequently on the intensive care ward:

“I can’t recall every time I spoke to him, but the overall view of him was he seemed quite amenable. You have probably heard he’s quite a likeable individual, polite. One of the patients you think this guy’s not going to be a management problem."

“He was extremely polite, very approachable. When I handed a message to him... he said, ‘Thank you ever so much, that’s really nice of you’, whereas some patients don’t engage staff as much. He seemed quite happy to talk to staff and interact with other patients on the ward as well. From him coming in from admission, from what I can remember about him initially, when he appeared quite suspicious and withdrawn, that had totally gone. My assumption now was that the medication was working well.”

10.108 Team Leader 3 was surprised that Peter Bryan had been let out of seclusion on to general observations so soon, but does not seem to have dissented from the general consensus:

Q. To what extent do you think staff may have been falsely reassured by the fact that Peter Bryan was so pleasant or easygoing once he came out of seclusion?
A. Because he was too pleasant! If Belmarsh had had so many problems with him - management problems - they don’t disappear within a couple of days. There must be some underlying reason for that behaviour, not just the regime within Belmarsh, within the prison service.
Q. That is your view now, but at the time, and on 21 April, for example, when you were on the ward and he is out of seclusion. You are surprised that he is on general observation but are you happy enough at that time to go along with it?
A. Because he had presented no problems. In retrospect you could say I believe they should have kept him on enhanced obs at the time, just for everybody else’s safety and as we didn’t know him very well, he was an unknown quantity in terms of, yes, you can read the reports but you don’t know what the actual person is like until you interact with them. But because the observations are quite high on Luton Ward, and there is the number of staff, I suppose maybe there is some sort of complacency was there, saying, ‘Well, we’ll keep an eye on him anyway to make sure something doesn’t happen’...to be able to get out of Rampton quite quickly and into the community, there is obviously another side of him that is able to convince people that he is well, or that he presents as well.”

Observations by occupational therapy department

10.109 The Manager of Occupational Therapy Services on Luton Ward completed an information summary in relation to Peter Bryan on 22 April 2004. This form is completed as a matter of routine by the occupational therapists at the first opportunity after admission from information in pre-admission reports and records. It set out a concise history of the background, index offence, diagnosis, and associated problems. The latter were noted to be:

“Irritable and unpredictable. Vague at times when giving history.”

10.110 The form provides for details of the risk assessment to be entered. The risks identified the Manager of Occupational Therapy were:

“Assault: long history of unprovoked assaults on staff
Self-harm: jumped off building in suicide attempt in 1993...Noose found in his prison cell.
Substance misuse: regular cannabis use...
Use of weapons: use of hammer in index and previous offences. Also used Stanley knife in index offence
Physical health risks: chronic mild asthma; uses inhaler.”

10.111 There is a space for indicating the “Tilt” risk status of the patient, but this could not be filled in at the time because there had been no discussion at a clinical team meeting at this stage.
10.112 The Manager of Occupational Therapy also made out a risk assessment on 23 April 2004 which effectively repeated the above-mentioned risk. A management strategy for occupational therapy was also set out which involved graded tool access and close observation of mental state whilst in the OT unit.

10.113 The Manager of Occupational Therapy explained that there had been no mention of the risk to patients, as opposed to staff, because of the history of what had happened in the previous two months. She was unaware of anything that made him a higher risk than any other patient. Patients are normally interviewed by occupational therapy in their first two weeks on the ward, if well enough, but this had not occurred in Peter Bryan’s case before the incident.

Observations by doctors

10.114 There are no entries in the clinical notes for the period between 19 April 2004 and 25 April 2004.

10.115 SHO1 told us he remembered seeing Peter Bryan on one occasion following his release from seclusion, but did not document it:

“...I have no idea why I did not record it at the time, but I assume that it must have been because I was busy and I meant to do it later and did not get round to it. On this occasion I remember Peter Bryan presented as being pleasant and cheerful and not manic. He did not give any indication that he was planning anything or that he had any kind of psychotic ideation. I think in this meeting we covered his past history in part. This interview took place in an interview room. I made an assessment of his mental state but as stated above unfortunately I did not record this.”

10.116 At the time of this assessment, SHO1 told us, Peter Bryan gave no indication that he was planning an assault. He told us he would have made rough notes for writing up later. He claimed to have discussed with RMO2 the fact that he had such notes, but had not written them up, but was told either that it was too late to insert something retrospective in the records or that this would not be appropriate. This conversation took place, he thought, about a week after the assault on Richard Loudwell. His mental state examination and interview had taken about 45 minutes. He could not now remember what
had happened to his rough notes. He also claimed to have mentioned this assessment to Consultant Psychiatrist 1 subsequently.

10.117 RMO2 had no recollection of ever having being told by a member of the clinical team that they had carried out a mental state examination of Peter Bryan between 19 and 25 April 2004.

10.118 Ward Manager 1 did have such a recollection though, and states:

“I do recollect Mr Bryan being interviewed by an SHO, with hindsight it would have clearly been helpful if I had checked the notes.”

10.119 SHO1 was asked if another member of staff had accompanied him while he conducted his mental state examination of Peter Bryan. He could not remember. He said he would have carried out this interview alone only if prompted to do so by the nursing staff. He thought this might have been the case since Peter Bryan was so cheerful and apparently settled.

10.120 Specialist Registrar 4 was RMO2’s registrar. He was in his second year of a three-year specialist training post in psychiatry. He had arrived at Broadmoor on 4 April 2004 and spent two weeks on a formal induction programme. 19 April 2004, the day Peter Bryan came out of seclusion, was Specialist Registrar 4’s first day on Luton Ward.

10.121 RMO2 asked Specialist Registrar 4 to take a particular interest in five of RMO2’s Luton Ward patients, including Peter Bryan. He was told to read up their case notes, to interview them and generally to get to know them so that he could discuss their progress with RMO2. On 19 April 2004 RMO2 gave Specialist Registrar 4 brief pen-portraits of each of the five patients but did not specify any task to be completed in respect of any of the patients by a particular date.

10.122 In his first week on Luton Ward Specialist Registrar 4 recalled having one-to-one sessions with two of the five patients who had been allocated to him by RMO2. He selected these patients on the basis that when he turned up on the ward and asked the nursing staff who was available to see it was those patients who were most...
readily available. He had asked about each of the five patients allocated to him but there had been no concerns expressed about any of them and he did not see any need to prioritise one over another.

10.123 Specialist Registrar 4 was asked whether it would have been sensible to start with Peter Bryan because he had just come out of seclusion. Specialist Registrar 4 explained that in this first week he had not been aware of anything unusual about Peter Bryan. He had assumed that all patients were routinely admitted to seclusion on arrival at Broadmoor and had therefore thought nothing of Peter Bryan having spent his first five days in seclusion.

10.124 It is impossible to know how much Specialist Registrar 4’s arrival on Luton Ward as RMO2’s registrar may have contributed to the absence of medical review of Peter Bryan between his release from seclusion on 19 April 2004 and his assault on Richard Loudwell the following Sunday. However, one can easily see how the circumstances in which Specialist Registrar 4 was allocated five patients to ‘work up’ but without any detailed instructions about what to do or by when, may have contributed to the overall failure of the clinical team to ensure adequate medical review of Peter Bryan during his first week out of seclusion.

10.125 Team Leader 1 was surprised there had been no medical note during that week, but doubted that a medical review would have led to any change in the care plan or management of the patient because he was thought to be doing well.

The objectives of observation and assessment

10.126 RMO2, as noted above, believed Peter Bryan’s illness would be kept under control by appropriate medication based on his understanding of the history. An objective of observation and assessment was to see if this was correct. RMO2 agreed that mental state examinations would have helped assess the effectiveness of the medication, but predominantly it was the patient’s behaviour which indicated this. He agreed that it followed that the more closely a patient was observed, the more opportunity there was to assess the effectiveness of medication. However, he doubted that continuous observation would have made much difference because:
“The patients on Luton Ward are observed most of the time anyway...he would have been seen a lot by the nursing staff on a day-to-day basis without being on continuous observation.”

10.127 He expected the nursing staff to have been engaged with him and to have performed a mental state examination.

“Also the nursing staff can tell whether someone is becoming difficult, irritable or responding abnormally to other people on the ward, be it staff or patients...My understanding was that they weren’t concerned about him over that week.”

10.128 He agreed it could not be assumed that medication had solved all difficulties and expected that nursing staff would appreciate that patients coming out of seclusion needed to be observed more closely than others but without necessarily being on increased observation levels. He did not agree that authorising the reduction of the observation level gave the staff a wrong signal.

10.129 As noted above RMO2 accepted that there should have been a discussion with Peter Bryan at some point about his index offence and his thought processes, if not in seclusion then during the following week. It should have been conducted either by himself, the SpR or the SHO.

10.130 With hindsight, RMO2 was clear what should have been done:

“With the benefit of hindsight, we focused too much - or we relied too much is the best way of putting it - on his behaviour. His presentation on arrival in Broadmoor and certainly over those first four or five days was very different to his presentation in Belmarsh when he had been perplexed, frightened and staring, and he certainly was not doing that over those four days at Broadmoor. In retrospect, we relied or I relied on those changes in his behaviour, the fact that he had not been at all disturbed over the four days that he had been in seclusion, I relied on the fact that he seemed to respond quite rapidly to the fairly low dose of medication in Rampton previously. Therefore, we relied on that assessment of his behaviour and the fact that we had given him medication as a means of assessing the ending of seclusion, whereas what we should have done was assess
his mental state as well which we omitted to do. We should have been doing all those things, not just two out of three.”

10.131 He agreed that part of the explanation for a lack of medical contact with the patient between 19 and 25 April 2004 might have been a view that the case was straightforward. Nonetheless, he felt he ought to have seen Peter Bryan during the week after his release from seclusion.

10.132 RMO2 was not convinced that constant observation was required. While patients were detained in Broadmoor because of the danger to other members of the public, he thought the situation was different within the hospital as patients do not have access to drugs, alcohol or to many things that can be used as weapons. While constant observation would theoretically be possible, it would be intrusive:

“What you are going towards when you starting policing the environment to that extent is running much more of a prison-like service, and you do not need nursing staff to guard the environment. You might as well not have nursing staff on the ward and have prison officers or the equivalent doing that sort of job.”

10.133 RMO2 thought that Peter Bryan’s ability to hide his symptoms was “relatively common” even at the level of danger involved in his case. He thought, in retrospect, that Peter Bryan had tried to hide his symptoms but also that no-one had asked him about them.

10.134 Ward Manager 1 stated that while it might have been helpful for Peter Bryan to have been placed on constant observations when he left seclusion:

“It is my firm view that in the light of his presentation these would have been reduced prior to the tragic events of 25 April 2004.”

10.135 Team Leader 1 suggested it was difficult to go on anything other than behavioural presentation:

“You continually assess their risk but you can only go on their presentation. Some people have horrendous histories up until they arrive on the ward and then there is a different environment and a different approach. Just calling someone by their
first name, introducing yourself and talking to someone with respect can have a completely different effect to when they were being transported in the van and they were creating a problem. It’s not unusual and you take it on a daily basis and feedback that people appear to be doing quite well.”

Comment

We have considered carefully whether we accept that a mental state examination was done by SHO1 as he described in his evidence. SHO1 receives some support from Ward Manager 1 who stated he recalled an interview by the SHO but gave no detail about when this took place, whether any other staff were present or whether the interview included a full mental state examination. It may be that Ward Manager 1 is recalling SHO1’s interview with Peter Bryan on the morning of 19 April 2004 which did not include a full mental state examination. There is no record of any assessment by SHO1 after Peter Bryan’s seclusion ended on 19 April 2004 until after the assault on Richard Loudwell. SHO1 is unable to produce the rough notes he said he made. There is no nursing record consistent with such an examination having taken place. Ward Manager 1 aside, no other member of staff has said that they recall being present at such an interview and it is unlikely that such an interview would have taken place without a nurse or other member of staff being present. RMO2 clearly had no recollection of being informed of such an assessment. SHO1 did not tell the police that he had undertaken an assessment before the assault. His oral evidence to us contained important detail which had not been offered in his written statement. Those factors persuade us to reject as unreliable SHO1’s evidence on this point. It is possible he is confusing the timing of a later event, but we cannot conceive of the possibility that some record would not have been made of a properly performed assessment in the week before the assault even if only retrospectively given the enormity of what then occurred. Even if we are wrong about this, no account could have been or was taken of any such assessment: no-one knew at the time of even a suggestion one had been carried out.

RMO2 was commendably frank with the inquiry about the shortcomings in the clinical assessment of Peter Bryan after his discharge from seclusion. We agree with him that there ought at least to have been a full mental state assessment by one of the medical staff. This was not done and it does not appear that any doctor was
instructed to do it. RMO2 suggested that whoever else saw the patient, he should have done so as well. We agree. Indeed we have been unable to discover from the extensive evidence we have received any noted reason why there was no medical contact with Peter Bryan after his release from seclusion and before the incident.

The removal of the requirement for level 3 observations was initiated by RMO2, but clearly agreed with by the nursing staff who, with their experience and authority, could have reinstated such a regime at any point. The belief that the normal level of general observations on this ward was adequate to ensure constant monitoring of a patient has been shown to be unwarranted by the sad facts of this case.

The impression of nearly all staff who recall how Peter Bryan presented following his release from seclusion was that he was affable, cooperative, easy to get on with, popular with his peers and generally integrating well into the routine of the ward. He was clearly liked both by staff and patients. No member of staff admits to seeing any form of behaviour or other warning sign to indicate that an event of the enormity of the assault on Richard Loudwell was likely to take place. Clearly this sort of impressionistic assessment, based on whether or not the patient was giving any “trouble” failed to discover signs of what Peter Bryan was thinking. It seems to us that the entire nursing and medical staff gave insufficient weight to the undeniable facts that they knew little about Peter Bryan and had no explanation for his commission of the index offence. He was known to be unpredictable, a word which appears repeatedly in the ward records, but due allowance was not made for the danger presented by an unpredictable patient with a history of multiple homicide. Even at this early stage in the assessment process, a proactive approach to the management and assessment of risk should have been taken, and not a mere reaction to overt signs of “trouble”. It should not have been assumed, as it clearly was, that because a patient was affable, cooperative and not presenting overt management problems, all was well and that the level of risk had diminished from that which required his initial placement in seclusion.

We do not think it is constructive or necessary to blame individuals in relation to the observation regime followed in this case. The explanation for both medical and nursing staff losing sight of the objectives of observation of a new patient in an assessment ward lies in broader failings affecting the entire team on the ward at the time and in the generic cultural and management issues identified elsewhere in this
report. In particular, there was a lack of focus on the particular dangers of individual patients. The approach was not sufficiently rigorous because of the prevailing view that Broadmoor staff successfully coped with the challenges presented by most of their patients, who were known to be among the most difficult in the country. This ‘can do’ attitude led to a belief that routine care was appropriate in all cases. Peter Bryan was clearly anything but a routine case.

There was a belief, as exemplified by Team Leader 1, that risk could usually be appropriately assessed by observation of behaviour. This is undoubtedly true of most mentally ill patients, but it is not necessarily true of those about whom insufficient is known and who are unpredictable. In the dangerous setting of the assessment ward of a high-security hospital, acting solely on the basis of what is usual and what is often achieved is likely to lull staff into a false sense of security. A more proactive approach is called for, whereby the clinical team collectively seeks to gain a good psychological understanding of the patients and of their states of mind as part of the assessment process; and in particular the nursing staff should aim to develop as far as possible a working knowledge on a daily basis of how each patient on the admission ward is feeling, thinking, and perceiving others.

It must be emphasised that we have no means of knowing whether proper mental state examination and a greater level of engagement by medical and nursing staff would have led to detection of Peter Bryan’s homicidal thought processes. However, as RMO2 accepted, it might have and thus, at best, an opportunity was lost.

Before leaving this topic, special mention should be made of the assessment undertaken by occupational therapy. On the basis of no more information than her nursing and medical colleagues, the manager of the occupational therapy on the ward succeeded in producing a commendably clear summary of Peter Bryan’s case and the risks he presented. Even this did not identify risk to other patients, but it did point to the risk of use of weapons. It is a matter for regret and concern that the nursing and medical professionals were unable to produce a comparable document for their use.
Conclusions

C60 Prior to his admission to Broadmoor Peter Bryan had committed two homicides, of Nisha Sheth in 1993 and Brian Cherry in February 2004. The fact that he had killed twice placed Peter Bryan at the upper end of the spectrum of risk at the time of his admission to Broadmoor.

C61 Consultant Psychiatrist 7, consultant forensic psychiatrist, in a report of 3 March 2004 had concluded that Peter Bryan must be regarded as extremely dangerous. RMO2 came to the same conclusion when he assessed Peter Bryan at Belmarsh shortly before he was admitted to Broadmoor.

C62 RMO2 interviewed Peter Bryan at Belmarsh through the cell door. There appears to have been an unquestioning acceptance of advice from the prison service that it was not possible to arrange for the RMO to see Peter Bryan in his cell.

C63 At the time of Peter Bryan’s admission his was wrongly considered by RMO2 to be relatively straightforward and it was wrongly assumed in the light of his previous history that provided his medication was maintained he would not be a significant management problem.

C64 Ward Manager 1 and Primary Nurse 9 visited Peter Bryan in Belmarsh a week before his admission to Broadmoor. Unusually for a pre-admission nursing assessment no written report was prepared.

C65 Both the RMO and the nursing team appear to have given insufficient thought in advance of Peter Bryan’s arrival at Broadmoor to a management plan or to the documentation of a risk assessment.

C66 Peter Bryan was a classic case for designation as Tilt high risk status, but was not given this status.

C67 A management plan for Peter Bryan ought to have included instructions for what staff should look for on observation, how they should interpret what they observed, what mental state and other examinations ought to be conducted, when and by whom.
Insufficient thought was given to the need to assess a baseline mental state as soon as possible after admission.

A full mental state examination was not performed from the time of Peter Bryan’s arrival at Broadmoor on 15 April 2004 until after the assault on Richard Loudwell on 25 April 2004.

It was appropriate to seclude Peter Bryan on admission. He was relatively calm in seclusion and it was appropriate for seclusion to end on 19 April 2004.

Whilst Peter Bryan was in seclusion it appears that no more than superficial observation was conducted and that no mental state examination or even meaningful engagement took place. The result was that when Peter Bryan left seclusion staff still had no clear picture of what was going on in Peter Bryan’s mind.

Peter Bryan ought to have been treated with the utmost caution when he left seclusion. This was a patient who had been involved in two homicides, the most recent involving highly unusual cannibalistic behaviour. At the very least it ought to have been recognised that Peter Bryan’s behaviour was not yet understood, that he was unpredictable and therefore very dangerous.

It is distinctly possible that by the time of his release from seclusion on 19 April 2004 Peter Bryan was already harbouring thoughts of harming another patient. Had a sensitive and thorough exploration of his thought processes been conducted by a nurse or doctor it is possible that his plans to attack another patient may have been elicited, or at least a specific risk of him doing so identified.

Not all of the care plans for Peter Bryan in his first two weeks at Broadmoor have been kept.

It is extraordinary that a care plan (numbered 6A) dated 20 April 2004 addressed to maintaining a safe environment contains no reference to observation despite Peter Bryan being highly dangerous and unpredictable.

Peter Bryan was initially nursed on level 3 (continuous observations) but on the day of his release from seclusion this was downgraded so that he was observed on the
same level of observation as other patients (i.e. at least every 15 minutes). The decision to downgrade observations was made by RMO2 with the support of nursing staff.

C77 The belief that the normal level of general observations on Luton Ward was adequate to ensure constant monitoring of a patient was unwarranted.

C78 The care plans for Peter Bryan did not adequately reflect the fact that at this early stage of his admission he was an unknown quantity and staff could not be confident that they were able to assess his risk adequately.

C79 Once on the ward Peter Bryan was polite and friendly. His behaviour gave no indication that he might be a risk to other patients or staff.

C80 SHO1’s recollection that he carried out a full mental state examination of Peter Bryan at some time between admission and 25 April 2004 is probably incorrect.

C81 The failure to implement an appropriate observation regime in respect of Peter Bryan is the consequence of broader failings affecting the entire team on the ward at the time and generic cultural and management issues addressed elsewhere in this report.

Recommendations

R18 Every effort should be made on a pre-admission medical assessment for the visiting psychiatrist to see a patient either in their cell or elsewhere but in the same room rather than through a hatch. Where this is not reasonably practicable the fact that the issue has been raised and discussed should be recorded together with the reasons for being unable to interview the patient in the same room.

R19 When patients are admitted directly into seclusion the period during which they are secluded should wherever practicable be used as an opportunity for observation and engagement in order to better understand that patient and to permit the provision of an appropriate care regime once they leave seclusion and join other patients on the ward.

R20 An admission mental state examination must be carried out on admission or otherwise as soon as reasonably practicable thereafter. The mental state examination
must be documented. Doctors and nurses seeing newly admitted patients must check the notes to ensure that a mental state examination has been performed and documented.

R21 It is not enough to manage patients’ risk on the basis of behaviour. Nursing staff should aim to develop as far as possible a working knowledge on a daily basis of how each patient on the admission ward is feeling, thinking and perceiving others.

R22 Further training is required to ensure that care plans adequately reflect the needs of patients and address relevant risks.

R23 Either before or on admission an interim risk assessment should be prepared under the supervision or direction of the RMO and CNM, the intention being to avoid a situation where a patient is at being cared for at Broadmoor without any form of risk assessment in place. The interim risk assessment will then be replaced by a ‘full’ risk assessment prepared soon after admission under existing procedures.

R24 In risk assessments and care planning specific consideration should be given from the outset to risks associated not only with the patient’s known history but also to risks arising from gaps in the clinical team’s knowledge or understanding of a patient’s mental state, subjective thought processes or known dangerous conduct.

10.136 Recommendations regarding Tilt risk assessments, including on admission, are dealt with in the chapter headed “Security and risk assessment”.
11. Luton Ward - observation

Introduction

11.1 When Peter Bryan attacked Richard Loudwell in the dining room of Luton Ward on 25 April 2004 he did so unobserved by staff. In assessing how this could happen it is important to consider the observation policy on Luton Ward at this time. In our view not only was the observation policy itself flawed but many of its requirements were simply ignored by staff.

The Trust’s observation policy

11.2 West London Mental Health NHS Trust has an observation policy. The policy in force at the time of the assault on Richard Loudwell dated from April 2001. The policy was revised in February 2005 ten months after the assault on Richard Loudwell. At that time the policy was renamed “Engagement and Observation”.

11.3 In what follows reference is principally made to the policy in place at the time of the assault but the later version is referred to where appropriate. The introduction to the April 2001 policy states:

“1.1 Supportive observation will be seen as an integral part of a therapeutic plan rather than as custodial care. The purpose of supportive observation is to ensure the sensitive monitoring of the patient’s behaviour and mental state, enabling a rapid response to any change, whilst at the same time fostering positive therapeutic relationships. This may be achieved by establishing good rapport with patients, promoting their coping skills and being aware of their individual needs.”

“1.2 Supportive observation is different from observation that is designed to secure environmental safety and security. Guidance on environmental safety and security is governed by local ward protocols, which take into consideration such variables as ward design and high-risk areas.

“1.3 The aim of this policy is to secure therapeutic engagement between Registered Nurses/ Health Care Assistants/ Nursing Assistants/ Nurses in training and patients. The policy provides a framework for heightened levels of supportive
observation when patients are considered to be at risk of harm to themselves and/ or others.” (underlining added)

Comment

In spite of the specific requirement for local protocols to address environmental safety and security, there was no such protocol on Luton Ward during Richard Loudwell’s time there. For example, there was no ward protocol for the safe use of the dining room which was a high risk area.

11.4 In April 2004 there was a Luton Ward operational policy which set out the philosophy of care on the ward. The 11-page document has five appendices. It provides a description of the ward, the care programme approach and other matters including details of patient community meetings and security searches.

Comment

The document has a sub-heading entitled “Security Issues” which, for example, sets out that there will be routine testing for drugs and alcohol. The document was never intended to be a manual for the management of Luton Ward but it is surprising that there is no mention of requirements for observing patients.

11.5 In 2005 the ward’s operational policy was revised although much of the original text remained. There is no mention in the revised policy of observation requirements. However the safe-use of the dining room was mentioned for the first time. The policy stated:

“The dining room will be locked other than for meal times, and tea times, or when there are sufficient staff for it to be safely monitored.”

11.6 We are not aware of any other document specific to Luton Ward which describes the observation requirements for patients on the ward.

Comment

Before the assault on Richard Loudwell there had never been an assessment of environmental security on Luton Ward. Had there been it is likely that the problems
of observing patients in the dining room, a blind spot on the ward, of which some staff were unaware, would have been addressed.

We further note that neither the Trust’s 2001 nor 2005 observation policies make any distinction between observation at Broadmoor, a high security hospital, and elsewhere.

The Trust’s policy - levels of observation

11.7 The Trust’s 2001 observation policy provided four levels of observation:

- general supportive observation (sometimes referred to as level one)
- intermittent supportive observation (sometimes referred to as level two)
- continuous supportive observation (within eyesight) (sometimes referred to as level three)
- close supportive observation (within arm’s length) (sometimes also referred to as level three)

General supportive observation (level one)

11.8 This was the default level of observation and was routinely referred to by the staff we interviewed as “general obs.”. The policy specified the following requirements for general supportive observation:

“General supportive observation is the minimum acceptable level of observation for all in-patients. The location of all patients should be known to staff, but all patients need not be kept within sight. Once a shift, the patient’s allocated nurse will endeavour to communicate with the patient and an entry of the outcome of any assessment will be made in the patient’s notes.”

11.9 At the time Richard Loudwell was on Luton Ward staff did not know the location of all patients during general observations. This was in breach of the Trust’s policy.

11.10 As Luton Ward is an assessment ward there were large periods of each weekday when patients were not allowed access to their rooms. The idea was that patients should be in the day area unless they were off the ward, for example engaging in occupational
therapy. This gave more time to assess patients than it would if they were spending large periods of each day unobserved in their rooms. When room access was not permitted no record was kept of where patients were on the ward. Unless a nurse could see where Richard Loudwell was, s/he would not know if he was in the main dayroom, the smoking/TV room, the toilet, the games room, an interview room with another member of staff or the dining room.

11.11 During periods when room access was permitted there was a system of checking the corridors off which were the patients' rooms. At the time there were two such corridors at right angles to one another. The corridors would be monitored by three members of staff at any one time. This allowed one member of staff to walk down the corridor in sight of another two at the end of the corridor. If there was a problem one of those staff members could assist leaving the third member of staff to watch the other corridor.

11.12 The staff on corridor duty would record the location of patients on the corridor at 15 minute intervals on a chart. If patients were not in their rooms it was assumed they were in the day area.

Comment

The flaws in this system are obvious. Not only was there no record of where in the day area a patient was, there was a risk that a patient might have left the ward without this being detected. Staff in the day area would assume the patient was on the corridor and vice versa.

The Trust's 2001 observation policy permitted patients to be out-of-sight of staff subject to local environmental risks. We accept this is a reasonable approach for a Trust-wide policy. We question whether it is reasonable on an assessment ward at Broadmoor given the nature of the patients living there. In respect of Luton Ward we consider it inappropriate for patients to be out-of-sight of staff when in association.

The principal purpose of Luton Ward was the assessment and care of patients whose risk had been accepted by the admissions panel to be so great that they could not safely be accommodated in conditions of lower security. Particularly in the first few weeks of their admission such patients were potentially among the least predictable and therefore most dangerous in the mental health system.
In evidence to the inquiry staff repeatedly said it was not safe for a member of staff to be out of sight of other staff whilst in the company of a patient or patients. We agree. However we consider it illogical that it is considered safe for two patients to be out of sight together yet unsafe for a member of staff and a patient. Such a regime places less value on the safety of patients than on the safety of the staff, whereas both are entitled to be kept safe as reasonably practicable. We accept that a staff member might be particularly vulnerable to attack should a patient be seeking a hostage or access to keys. However, as can be seen from the bullying of Richard Loudwell, there may be reasons why individual patients are also vulnerable to assault. In our view, a blanket approach to observation which regards staff as more vulnerable to assault than patients is not justified. There is a balance to be struck between security and therapy. There are disadvantages to nursing patients in an environment where they are aware of being watched constantly. There is, though, a qualitative difference between being watched and being in sight of a member of staff. The latter requires the presence of staff who may be engaged in other activities such as inter-acting with another patient. Those staff would still be aware of any concerning conduct and would be able to take or call for any necessary preventative action. In the circumstances of Luton Ward it is our view that there is no reasonable alternative to all patients being in sight of staff at all times when in association. Had such a policy been in place and followed in April 2004 Peter Bryan might still have assaulted Richard Loudwell but we doubt that he would have been able to sustain such a prolonged and uninterrupted assault. Richard Loudwell would probably not have received fatal injuries.

The 2005 observation policy does not say if patients may be out of sight of staff. This is an unnecessary gap in the policy and a recipe for confusion and danger. The observation policy for assessment wards should require all patients, including those on general observations, to be kept in sight of staff at all times when in association. Thought needs to be given to the best of way of implementing this in practice. There are potential difficulties with the use of toilet areas but it is not clear why access to communal toilet areas could not be restricted to one patient at a time. If that were so, the patient using the toilet would not need to be observed under the revision to the policy that we propose.
This level of general observation would not be instead of existing higher levels of observation. There would still be room for higher levels of observation for specific patients.

Intermittent supportive observation (level two)

11.13 In the Trust’s 2001 policy this was the next level of observation up from general observation. The policy stated (2.3.1):

“Intermittent supportive observation should be used to ensure that patients who have required prolonged continuous or close observation are not subject to immediate disengagement, as this may cause undue distress. This level of observation is appropriate when patients are potentially, but not immediately, at risk of seriously harming themselves or others”

Comment

The wording of this part of the policy is confusing. It is not clear whether intermittent observation was only intended for patients who had previously been on continuous or close observation. This would seem to be the literal reading of the policy. If that were the case a valuable observation tool would have been lost. There might be patients for whom continuous observation was unnecessary but for whom general observations were insufficient. This confusion has been corrected in the 2005 policy which allows for intermittent observation even when there had not previously been continuous observation.

11.14 It is not clear whether Richard Loudwell was ever on intermittent/level 2 observations. The day report for Richard Loudwell’s first day in Broadmoor, 15 January 2004, suggests he was initially on level 3 (continuous) observations. After he was seen by a doctor this was reduced to level 2 (intermittent) observations. However there is an observation record from 4.30pm on 15 January 2004 which records that Richard Loudwell was on continuous observations (level 3).

11.15 Peter Bryan went straight from seclusion to general observations on the ward.
Comment

In our view if it was reasonable for Peter Bryan to leave seclusion and to be in association with other patients then a period of continuous supportive observations should have been followed by intermittent supportive observations before any decision to place him on general observations.

The policy’s explanation of when intermittent observations would be appropriate seems to describe Peter Bryan’s situation:

“This level of observation is appropriate when patients are potentially, but not immediately, at risk of seriously harming themselves or others.”

11.16 The Trust’s 2001 policy set out the following requirements for patients on intermittent observation:

“Patients on intermittent observation must have a specific care plan that clearly indicates:

i) the intervals at which the observations should be carried out (e.g. at 4 minute, 10 minute etc. intervals);

ii) the natures of the therapeutic activity planned;

iii) the need for a mental state assessment on each shift;

and a record of any untoward incidents;

and a summary of the patient’s behaviour and mental state must be entered in the nursing records at the end of each shift and all staff on the shift, who may or may not have been responsible for the intermittent observation are consulted prior to the completion of the nursing records and handover to the new shift.”

Comment

Peter Bryan was an unknown quantity on 25 April 2004. Much more would have been known about him had there been a period of intermittent supportive observations, an appropriate care plan and detailed recording of his behaviour and mental state at the end of each shift.
We also note that the 2001 policy envisaged the use of intermittent observations when a patient is “at risk, but not immediately, of seriously harming themselves or others”. The policy overlooked the patient who is at risk of being harmed by others. Richard Loudwell fell into this category.

The same gap appears in the 2005 policy. In the introduction it states:

“1.2 The key purpose of engagement and observation is to provide a period of safety for people during temporary periods of distress when they are at risk of harm to themselves and/or others...”

“1.3 The aim of this policy is to minimise the risk of potentially suicidal, violent or vulnerable patients from harming themselves or others as part of a broader risk management plan.”

11.17 It is not clear whether staff considered placing Richard Loudwell on intermittent observations to reduce the risk of physical assault on him. Primary Nurse 3’s nursing care plan of 12 April 2004 aimed:

“To keep Richard on general observation and to encourage Richard to tell staff of any verbal abuse he may get from fellow peers. Nursing levels to respond to any untoward incidents.”

11.18 This implies that observation levels could be increased if necessary. This never happened. Between 14 April 2004 and the assault on 25 April 2004 Richard Loudwell told staff on a number of occasions that he was being bullied by patient C but there was doubt, at least on the part of Richard Loudwell’s primary nurse, that the alleged physical assaults were occurring. So nothing was done.

Comment

In April 2004 the Trust’s policy was that it was acceptable for patients to be out of sight of staff, even on Luton Ward. In that context as a minimum Richard Loudwell should have been placed on intermittent supportive observations in response to the bullying he was complaining of. With an appropriate care plan and detailed recording of observations the risk of physical assault would have been greatly reduced.
For a patient like Richard Loudwell intermittent supportive observation is not made redundant by a policy of keeping patients within eyesight since that does not in itself prevent bullying or physical assault. It reduces the opportunity for a sustained assault to be carried out without staff intervention and reduces the overall risk of assault because of the greater likelihood of detection. Even if patients had been kept in sight of staff at all times, Richard Loudwell could still have been subjected to verbal and physical abuse without this always being spotted. Intermittent observation would have been an additional tool for staff because it would have enabled them to focus on Richard Loudwell over other patients who were at less risk.

Continuous supportive observation (within eyesight) and close supportive observation (within arm's length) (level three).

11.19 The Trust’s 2001 policy provided at 2.4.1:

“Continuous (within eyesight) observation is required when the patient could attempt suicide or attempt to seriously harm themselves or others. The patient will be kept within sight at all times, by day and by night...A specific observation care plan is required. An hourly summary of the patient’s condition, care and treatment must be entered into the nursing records. This must include changes in mental state, physical, psychological and social behaviours, pertinent developments and significant events.”

The policy at 2.5.1 provided:

“Close (within arm’s length) observation will be applied when a patient is considered to be in need of the very highest level of observation i.e. the patient is considered to be at a high level of risk of suicide/ seriously harming themselves or others and thus may need to be nursed in close proximity...A specific observation care plan is required. An hourly summary of the patient’s condition, care and treatment must be entered into the nursing records. This must include changes in mental state, physical, psychological and social behaviours, pertinent developments and significant events.”

11.20 The only differences between continuous supportive observation and close supportive observation are the level of risk and the physical distance between the patient...
and an observing member of staff. Neither Richard Loudwell nor Peter Bryan were ever on close supportive (within arm’s length) observation before the assault on 25 April 2004, nor in our view did they need to be. We therefore say no more about close supportive observation.

11.21 Richard Loudwell was on continuous supportive observations (within eyesight) from 4.30pm (within 90 minutes of his arrival on Luton Ward) on 15 January 2004 until the morning of 22 January 2004. The rationale was that he was at risk from other patients having disclosed his index offence.

Comment

The Trust’s policy did not envisage or provide for close observation in these circumstances. The policy envisaged continuous observation where a patient is at risk of harm to themselves or to others, not from others. In this respect, as noted above, the policy was defective. However ward staff cannot be criticised for placing Richard Loudwell on continuous observations.

Under the Trust’s policy a specific observation care plan was required. The policy did not say what the care plan for continuous observation should include. This was a flaw in the 2001 policy that has been corrected in the 2005 policy.

In Richard Loudwell’s case the policy was in any event not followed because there was no specific observation care plan. In fact there was no care plan at all for Richard Loudwell dealing with the risk from other patients until 22 January 2004 when he was taken off continuous observations after a week on the ward.

11.22 We have set out in detail elsewhere in this report, in the chapter “Richard Loudwell - care and treatment at Broadmoor”, the deficiencies in the continuous observation of Richard Loudwell during his first week on Luton Ward. In summary:

- On his first day on Luton Ward, 15 January 2004, Richard Loudwell was subjected to spitting and verbal abuse from other patients, none of which was recorded on the continuous observation record.

- On his second day, 16 January 2004, Richard Loudwell was again subjected to verbal abuse and spitting. The verbal abuse was recorded in the nursing
observation notes and the night report refers to spitting. However neither verbal abuse nor spitting are noted in the continuous observation record.

- On his third day, 17 January 2004, patient J threw a bottle of water over Richard Loudwell and covered him in ash. This was not witnessed by staff despite Richard Loudwell supposedly being on continuous observations. This incident took place between 3pm and 5pm in the afternoon but there is no entry for that period in the continuous observation record. It appears that continuous observations were not being performed in that period.

- On his fourth day, 18 January 2004, patient J was “vocalising threats against Richard Loudwell” saying that if Richard Loudwell sat next to him he would hit him. This was recorded in the day report but there is no mention of such behaviour in Richard Loudwell’s continuous observation record.

11.23 On his fifth day, 19 January 2004, Richard Loudwell’s primary nurse noted in Richard Loudwell’s care planning documentation under “periodic evaluation” that Richard Loudwell was “under verbal assault” and that he was ignoring advice to stay away from the smoking room. In Richard Loudwell’s continuous observation record for 19 January 2004 there is no mention of any trouble.

Comment

The recording of some incidents in the nursing observation notes or the day and night reports is no substitute for proper records in the continuous observation record. If it were it would be unnecessary to have the continuous observation record. The nursing observation notes and the day and night reports are summaries of what has happened on a shift. The purpose of the continuous observation record is:

- to ensure that observation is carried out continuously
- to enable a more detailed picture to emerge of what has happened to a patient over the course of a shift.

On Luton Ward neither goal was achieved. There are gaps in the continuous observation record from which it can be inferred that in some hourly slots no one was attempting to observe Richard Loudwell. When there was a nominated observer it
appears that the quality of their observation of Richard Loudwell and their recording of that observation were both poor.

The nursing staff were correct that Richard Loudwell needed to be continuously observed from the day of his arrival because of the risk from other patients.

One of the reasons why the continuous observation of Richard Loudwell was so poor between 15 and 22 January 2004 was the failure to follow the Trust’s policy. Had there been a specific observation care plan in place in accordance with Trust policy then staff would have had a clearer idea why Richard Loudwell was being observed and what the observation intended to achieve. There would have been a record of any untoward incidents and the scale of the bullying faced by Richard Loudwell would have been more apparent to the nursing team and the rest of the multi-disciplinary team.

It would have been onerous to keep detailed records of the continuous observation of Richard Loudwell in line with the Trust’s observation policy, but the seriousness of the situation faced by Richard Loudwell justified him being properly observed and proper records being kept. Instead, the half-hearted approach to observing Richard Loudwell in that first week became a half-hearted approach to his welfare on the ward for the remainder of his stay.

Principles of supportive observation

11.24 The Trust’s 2001 observation policy set out the basic principles of supportive observation:

“3.2.1 The nurse responsible for carrying out the supportive observation will normally:

iv) be a first level Registered Nurse;

v) know the patient, their history, background and risk factors;

vi) be familiar with the ward, the ward policy for emergency procedures and the potential risks within the environment.”

“3.2.2 The nurse will be familiar with the patient’s social context and significant events since admission.”
“3.2.3. There must be a specific observation care plan, preferably with multi-disciplinary input, written in conjunction with the patient.”

“3.2.4. One to one interaction must be initiated.”

“3.2.5 The nurse must show the patient unconditional positive regard.”

“3.2.6. If the patient is uncommunicative, the nurse must convey a willingness to listen and should initiate conversation as appropriate.”

“3.2.7. The patient must be informed of the reasons for supportive observation…”

“3.2.9 The nurse must reflect on their own thoughts, feelings and attitudes about supportive observation to ensure that this intervention is supportive and therapeutic…”

“3.2.10 The multi-disciplinary team must provide an open and supportive environment, to enable members of staff to discuss their feelings about participating in supportive observation.”

Comment

These principles are sensible and proportionate. Unfortunately compliance with these principles in the observation of Richard Loudwell in his first week at Broadmoor was at best patchy and at worst non-existent.

11.25 A significant amount of the continuous observation of Richard Loudwell was carried out by healthcare assistants rather than registered nurses. For example, on 15 January 2004 three out of five one-hour observation periods were carried out by staff unqualified to do so according to the observation policy; on 17 January 2004 between 8am and 3pm four out of seven one-hour observation periods were carried out by unqualified staff. In addition, there was then no specific observation between 3pm and 5pm or from 7pm onwards. Between 5pm and 7pm the same staff nurse carried out observations continuously for two hours. On 18 January for at least six out of 12 one-hour periods, observation was by a healthcare assistant rather than a registered nurse.
11.26 Staff were aware of Richard Loudwell’s index offence and that he was being targeted for abuse by other patients as a result. But they had little or no understanding that his disclosure of his offence and his refusal to follow advice to stay away from those abusing him might be the result of his underlying condition. Instead it was assumed by many staff that he was deliberately putting himself in danger.

11.27 Because there was no observation care plan in place there were no agreed strategies for dealing with abuse when it took place or for encouraging Richard Loudwell to stay away from trouble.

11.28 There was little one-to-one interaction between Richard Loudwell and the staff observing him.

Comment

Richard Loudwell could be uncommunicative but at Belmarsh it was noted that it was sometimes difficult to make him stop talking. Had Luton Ward staff made an effort to talk to Richard Loudwell it is likely that he would have responded positively. This would have made it more likely that staff could have persuaded or otherwise encouraged him away from the TV room and those who were abusing him.

There is no evidence that staff had the opportunity to reflect on their work with Richard Loudwell. Given his often rude manner and the nature of his index offence we think staff would have benefited from such an opportunity. In our view, it would have made a real difference to the ability of many staff to engage and support Richard Loudwell and to the quality of their supportive observations of him.

The difficulties within the multi-disciplinary team are dealt with elsewhere in this report. The principle that those engaged in supportive observation should reflect on the experience with other members of the multi-disciplinary team is laudable. In reality, many of those observing Richard Loudwell had little or no direct contact with other members of the multi-disciplinary team, let alone an opportunity to discuss this patient and his needs.

The 2001 policy provided the basis for effective observation of Richard Loudwell. The fact that so much of the observation of Richard Loudwell in his first week was ineffective was to a large extent due to a failure to follow that policy.
11.29 After the first week, from 22 January 2004, Richard Loudwell was never again observed at a level other than general observations. Increased observations appear not to have been seriously considered as a way of protecting Richard Loudwell on the ward.

Comment

This was in large part because higher-level supportive observations as carried out on Luton Ward were ineffective and would have made little difference to Richard Loudwell. It is hardly surprising therefore that they were not considered a solution. Increased supportive observation of Richard Loudwell carried out in accordance with the Trust’s policy would however have offered a real opportunity to deal with the bullying and the risk of physical assault he faced.

Review of observation levels

11.30 The 2001 policy said decisions to alter a level of observation “will normally be taken jointly between the patient’s RMO and a first level Registered Nurse”. This applied to decisions to increase or reduce levels of observation.

11.31 There is no record of any discussion within the multi-disciplinary team before the decision to take Richard Loudwell off continuous observations on 22 January 2004. There is no documentary evidence that this decision was the product of any consultation with the RMO.

Comment

The 2001 policy failed to make explicit the requirements for a reduction in observation levels. The 2001 policy was also flawed in not making it clear that a nurse could increase observation levels. A more transparent policy would have encouraged nursing staff to increase Richard Loudwell’s observation levels in the week before 25 April 2004 at a time when he was complaining of being bullied by patient C.

11.32 The 2005 policy provides for increases in the level of observation and engagement at 4.2.1.:
“A nursing decision to increase the level of engagement & observation may be made by the nurse in charge of the ward on his or her own initiative...Staff must feel empowered to raise levels of engagement and observation and be supported in this action (even if this increase is subsequently reduced following a broader team discussion).”

11.33 The 2005 policy also provides for reductions in levels of observation and engagement at 4.3.1:

“The decision to reduce the level of engagement & observation must be a team decision. Generally a minimum of the nurse in charge and a doctor who knows the patient should review the need for an increased level of engagement & observation as appropriate, and as a minimum every 24 hours.”

Comment

Both these changes are to be welcomed. What is important, however, is that they are implemented.

Greater emphasis on engagement

11.34 Greater emphasis on engagement is contained within the 2005 policy compared to the 2001 policy. This is why the 2005 policy was titled “Engagement & Observation Policy”. Paragraph 1.1. of the Introduction states:

“1.1 It must be recognised that observation is only one aspect of caring for people during periods of high distress.”

“It is clearly not enough to simply observe people. The process must be both safe and supportive. People who need this level of help are going through a temporary period of increased need. Whatever the cause of this need they, at that moment, require safety, compassion, understanding and appropriate treatment. Therefore patients must also be engaged in a positive and therapeutic relationship both during and after an increased period of need.” (bold in original)
Comment

This change is to be welcomed. However, given the general failure to follow the 2001 policy we doubt whether greater emphasis on engagement in that policy would have made a difference to the observation of Richard Loudwell. Had the sort of engagement required by the 2005 policy been provided, it would have made a significant difference to his quality of life on Luton Ward. In particular it would have made it more likely that Richard Loudwell would have followed advice regarding his own safety and, by making him less isolated, would have reduced his vulnerability on the ward.

Summary of conclusions and recommendations

11.35 We reach the following conclusions:

C82 At the time Richard Loudwell was on Luton Ward general observations were carried out in such a way that staff did not know the location of all patients. This was in breach of the Trust’s policy.

C83 In respect of Luton Ward it was inappropriate for patients to be out-of-sight of staff during association.

C84 Had there been a requirement for patients to be in sight of staff during association Peter Bryan might have still assaulted Richard Loudwell but it is unlikely the assault would have been as prolonged. In those circumstances, Richard Loudwell may well not have received fatal injuries.

C85 It would have been sensible to observe Peter Bryan with a period of continuous supportive observations followed by intermittent supportive observations before any decision to place him on general observations.

C86 As a minimum Richard Loudwell should have been placed on intermittent supportive observations in response to the bullying he complained of from 14 April 2004. Had this been accompanied by an appropriate care plan and detailed recording of observations, the risk of physical assault would have been greatly reduced.
The period of continuous observation of Richard Loudwell between 15 and 22 January 2004 was carried out half-heartedly and not in accordance with the Trust’s policy.

Increased supportive observation of Richard Loudwell carried out in accordance with the Trust’s policy from the time of his arrival on Luton Ward would have offered a real opportunity to address the issues of bullying and risk of physical assault facing Richard Loudwell.

The 2001 policy was flawed in failing to make explicit the requirements for increasing and reducing observation levels.

The 2001 policy, despite its flaws, should have provided an adequate basis for effective observation of Richard Loudwell. The fact that so much observation in his first week and subsequently was ineffective, was to a large extent due to a failure to follow the Trust’s observation policy.

The sort of engagement required by the 2005 policy, had it been provided, would have made a significant difference to Richard Loudwell’s life on Luton Ward. By making him less isolated, it would have reduced his vulnerability.

**Recommendations**

**11.36** We make the following recommendations:

R25  The Trust’s engagement and observation policy should be reviewed. Consideration should be given to more enhanced engagement and observation protocols at Broadmoor than elsewhere within the Trust.

R26  All wards should have a local engagement and observation protocol which sets out minimum requirements for the observation of patients on that ward to ensure environmental safety and security.

R27  All wards should review how their local engagement and observation practice is carried out to ensure it complies with the hospital’s policy. Each ward must have a system in place which allows staff to know the location of all patients at all times. A named
member of the nursing staff should have the responsibility on each shift for monitoring compliance with engagement and observation policy.

R28 It should be an objective of engagement and observation that staff have a day-to-day understanding of the current mental state and subjective state of mind of each patient.

R29 The requirement for a day-to-day understanding of each patient’s current mental state and subjective state of mind goes beyond assessment solely for the purpose of diagnosis but rather, is intended to ensure the best possible day-to-day care of each patient.

R30 Members of the clinical team need to receive effective training to enable them to carry out such engagement and observation.

R31 Achieving the necessary skill set within the clinical team will require engagement and observation to be a focus of supervision; there should be facility for discussion by staff of the results of their engagement with and observation of individual patients.

R32 The 2005 observation policy should be reviewed in the light of our criticisms in this case.

R33 On assessment wards patients should be kept in sight of staff at all times during association unless there are express reasons for a different regime in respect of individual patients. These should be agreed by the clinical team and documented.

R34 The engagement and observation policy should be revised to take account of the need for engagement and observation when a patient is at risk from others.

R35 Specific training needs to be given to nursing staff with respect to engagement and observation which underpin relational security.

R36 All patient-related information must be recorded in the continuous observation record.
Establishment

12.1 In April 2004 the budgeted establishment for nurses and healthcare assistants on Luton Ward was 51.65 whole-time equivalents and the actual was 51.3. The breakdown was intended to be as follows:

<table>
<thead>
<tr>
<th>Grade</th>
<th>Budget</th>
<th>Actual</th>
<th>Vacancies</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>G</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>F</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>E</td>
<td>14.65</td>
<td>15.65</td>
<td>-1</td>
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<tr>
<td>D</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>C</td>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
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<td>-2</td>
</tr>
<tr>
<td>A&amp;C</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>51.65</td>
<td>51.3</td>
<td>0.35</td>
</tr>
</tbody>
</table>

12.2 In April 2005 the establishment had been reduced to 50.65 whole-time equivalents, but the actual numbers in post amounted to only 42.65 whole-time equivalents with eight vacancies. Patient capacity had been reduced by that time from a maximum of 20 to a maximum of 12 beds.

12.3 Staff turnover in Luton Ward, including transfers to other wards, was higher than an average of Henley, Mendip, Banbury and Taunton Wards taken together in each year between 1 April 2003 and 1 April 2005, but Luton Ward only had the highest turnover in one of these years:
<table>
<thead>
<tr>
<th>Ward</th>
<th>1 Apr 2003 (%)</th>
<th>1 Apr 2004 (%)</th>
<th>1 Apr 2005 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luton</td>
<td>29.0</td>
<td>19.2</td>
<td>18.1</td>
</tr>
<tr>
<td>Henley</td>
<td>10.9</td>
<td>12.9</td>
<td>21.2</td>
</tr>
<tr>
<td>Mendip</td>
<td>6.9</td>
<td>31.3</td>
<td>18.9</td>
</tr>
<tr>
<td>Banbury</td>
<td>15.8</td>
<td>7.6</td>
<td>16.9</td>
</tr>
<tr>
<td>Taunton</td>
<td>7.9</td>
<td>9.2</td>
<td>7.2</td>
</tr>
<tr>
<td>Average of 4 wards</td>
<td>10.4</td>
<td>15.3</td>
<td>16.1</td>
</tr>
</tbody>
</table>

12.4 Ward Manager 1 told us that when he arrived in April 2002 the team leader and seven staff nurses had been on the ward since its creation in 1991. Only two were still in post six months later. He regarded this as significant and an indicator of rapid progress.

12.5 The ward had to be run on occasion with fewer than the planned number of staff because of sickness and other events. For example, Ward Manager 2 told us he sometimes had to work with only five members of staff, instead of seven.

12.6 Team Leader 1 told us that the ratio of qualified nursing staff to unqualified healthcare assistants (HCAs) is roughly 2:3 and that it was hospital policy that there were a minimum of two qualified staff on the ward at one time including the team leader. At the time of the assault on Richard Loudwell there were two qualified staff on duty and seven HCAs. Ward Manager 1 told us that the ideal was to have 60% qualified staff on duty at any one time on Luton Ward because:

“...the patients are on the ward for a relatively short time...and we are required to make key decisions during that time which affect their future and public safety. It is essential to have staff who are trained and who have the right attitudes and experience.”

Patient numbers

12.7 In April 2004 there were 19 patients on Luton Ward. Between September 2003 and April 2004 numbers on the ward fluctuated between about 14 and about 19. The Luton Ward admission policy in force in April 2004 describes the ward as having 25 beds but Ward Manager 1 told us that the capacity had reduced by this time to 20 beds and this is borne out by the figures at appendix F. Overall numbers were reducing. In May 2001 there had been 23 patients on the ward. From May 2004 to September 2004 there were at
various times between 12 and 15 patients. Once the admission wards were split into two (Luton and Churchill) the capacity of each ward was capped at 12 beds.

12.8 At any one time the patients on the ward included a number of personality-disordered patients who had come from prison. RMO3 told us that this had been a particular problem at the beginning of 2004.

Nature of admission ward

12.9 At the time of the incident Luton Ward was the sole admission ward for Broadmoor and therefore took patients from both the London and South of England directorates. This has now changed so that Luton Ward takes patients only from the London directorate. Those from the South of England directorate are admitted to Churchill Ward.

Management and staffing structure

12.10 Originally RMO2 was the only consultant on Luton Ward. In April 2003 he was joined by RMO3 who was appointed to a consultant position split between the Three Bridges Medium Secure Unit in Ealing and Luton Ward. RMO3 had previously been a full time consultant forensic psychiatrist at the Three Bridges Unit. He was responsible for all south of England directorate patients on Luton Ward. RMO2 retained responsibility for all London directorate patients on Luton Ward.

12.11 Ward Manager 1 was appointed ward manager on 1 April 2002. There had been management difficulties in the ward before then and some difficulty in finding an appropriate person to take over. At a meeting to discuss concerns of the Mental Health Act Commission on 5 February 2002 Mental Health Act commissioners had been told by Service Director 2, then the service director, that:

“He saw the major issues as being exacerbated by the lack of consistent leadership at the CNM level...The CNM post has been advertised twice with little response...”

12.12 Ward Manager 1 may not have been aware of this but there had clearly been a reluctance to apply for this post and a corresponding difficulty in filling it. It may be that this had led to drift in the performance of the staff and contributed to the managerial
challenges that undoubtedly faced Ward Manager 1 and the hospital. The choice of Ward Manager 1 for the appointment was explained to the MHAC at a meeting on 11 March 2002. The notes of Commissioner 1 of the Mental Health Act Commission read:

“[The hospital] had felt he was exactly the right person to enforce discipline and commitment within the clinical team. Their only concern was that he wasn’t too ‘Broadmoor’. As a consequence he has been told that, as part of his work, he needs to spend one day per week outside the hospital on either operational or research matters.

12.13 The commission recorded that they were impressed by the quality of thinking that had gone into the appointment.

12.14 Ward Manager 1 had previously been ward manager of Mendip Ward for two years. There he had found it necessary to be “challenging people’s behaviours” and he had found that the ward improved when “the boundaries were clearer”. His perception of his predecessor on Luton Ward was that he had been stronger in his clinical skills than in managerial ones, and that the ward was “stale”. However, he thought staff were too confrontational in asserting the boundaries although they were inconsistent in their approach on a number of issues. He thought he had succeeded in changing much of that by the time he left. He described his management style as follows:

“I have standards I’ve set for myself that I expect to be achieved by the people who are working for me, and I will confront individuals who I believe aren’t working towards achieving those standards, rather than letting it go. The easiest thing to do is to let it go; there are 50 staff and it’s somebody else’s problem. I’m not one for that, I like to lead from the bow of the boat and not the stern...It sounds as if I’m all-controlling, which wasn’t the case. I’m very much a believer that people learn from mistakes, and if somebody makes a decision that I perhaps don’t agree with, we need to work it through to see if there’s a learning curve for me as well. However I had regular meetings with my team leaders and looked for ways where we were working to achieve goals, and challenge those that would disrupt, and I would challenge them in a fact-finding manner to find out why they felt that wasn’t appropriate. If they had good reason I’d try and take that on board, and if they didn’t I would challenge and confront their behaviour.”
“You’re there on a pedestal, you’re there to have things thrown at you...if everyone loved you, you wouldn’t be doing the job properly, that’s for sure.”

12.15 When Ward Manager 1 arrived he thought that most staff were dedicated and competent, but there were “about six” who were not up to an acceptable standard.

12.16 In a subsequent letter to the inquiry Ward Manager 1 described the Luton Ward team that he inherited in April 2002 as follows:

“Following selection at interview I took post on Luton Ward in the April of 2002, the ward had been subject to a number of investigations...The MHAC had raised a number of concerns around culture and the provision of activity.”

“The ward had incurred year on year overspends with senior staff monopolising the most lucrative overtime shifts, the rest of the overtime issue was managed by the ward administrator and seemed to work around staff rather than ward need. The senior qualified staff group consisted of a team leader and 7 staff nurses who had all been present on the ward when or around the time the ward had opened in 1991, the remainder of the staff had little if any experience of working in high security and took their lead from the established senior nurses. Liaison work with receiving units such as RSUs and Prisons had become almost non-existent and a degree of conflict appeared to be ongoing amongst different staff groups and the patients.”

12.17 We heard of complaints about Ward Manager 1’s conduct towards patients and staff. In the chapter “Richard Loudwell - care and treatment at Broadmoor” we consider a complaint by a patient that Ward Manager 1 had sworn at Richard Loudwell. In addition to this complaint, a healthcare assistant told us Ward Manager 1 had sworn at him in the course of a conversation about whether he should work on the ward after the incident. Ward Manager 1 adamantly denied this. We heard conflicting accounts of this matter from Ward Manager 1 and the healthcare worker but it is not necessary to come to a conclusion as to whose evidence we preferred. However, we take the existence of the allegation and the response as indicative of a level of unhappiness and tension between Ward Manager 1 and at least some of his staff.
12.18 RMO3 thought Ward Manager 1 was an effective, charismatic leader, but in the end discovered the extent of the problems on the ward only after the awayday and Ward Manager 1’s departure:

“It was only when the extent of the problems started to become apparent during the awayday once Ward Manager 1 had left... At the time, I had confidence in what the team were doing. We had a very charismatic ward manager, who was very strong, very powerful, knew everything that was going on, was in the thick of it. He was guiding and telling his staff what to do, and he was selling his version of events that all the staff would follow me to the ends of the earth and do anything I wanted of them. That was his view and the image he projected. He was wonderful to have around, especially in a crisis. He seemed to run the place with a rod of iron, and I was of the view at that time that it was a very well run, strong team who knew what they were doing. There were not that many serious episodes that were of great concern. Therefore, at the time, I had a high degree of confidence in the staff.”

“Ward Manager 1 was in control of every aspect of the ward, it was his kingdom almost. The day he left, the entire atmosphere on the ward changed. Staff started making suggestions as to how things could be done differently or better and they were listened to, and people who had not shown any initiative or who had not felt able to discuss a patient psychologically started to do so, and the effect was dramatic. The whole feeling on the ward was that the blanket of control had been lifted, not just from the patients but more obviously from the staff. Somehow there was a feeling of liberation, not in an anarchic sense but in a controlled way. It was only then after staff over the next few months started talking even among themselves dared to talk to me about some of these issues that you realised how hierarchical the ward was, and how every single decision was controlled by Ward Manager 1 from the team leaders downwards. They were all absolutely under his control, and they would not do anything without his sanction. Because he had been there for so long, that was the way in which things were run and it was accepted, certainly by junior members of staff coming onto the ward.”

“You did not say or do anything without permission and I saw a different side to Ward Manager 1. I saw an able, charismatic man who was able to take the

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staff with him, who was very commanding, he knew exactly what was going on. He seemed to be running a very tight ship, the staff seemed to be in awe of him, and I never heard any complaints while he was there from staff that they were not able to function in the way they would prefer. It was not until after he had left that people started to say in respect of the way he managed things that it was not ideal. Therefore, for me his leaving was a bit of a revelation. I managed to see that the staff had some contributions to make in terms of seeing patients psychologically and making suggestions about how they might be managed, doing some things and using their initiative to create much better ways of managing situations. They were able personally to develop and to feel psychologically-minded. It was the control, the custodial feeling that was pervasive on the ward that only really came to light to me once he had gone.”

It was very difficult to question the decisions he made and on a number of occasions I did, but it was uncomfortable and difficult so you chose your battles carefully. He was able to argue his point of view with great persuasiveness and very often he was right. Clinically, by and large, he was a very astute man. He was very bright and in many respects a competent nurse, and I had very little reason to doubt that what he said was true. With hindsight, I recognise that some of the things he told me were not necessarily an accurate reflection of what was going on but, at the time, I had no reason to doubt it.”

12.19 RMO3 maintained that it was only after Ward Manager 1’s departure that it became apparent to him that staff felt bullied and that a hierarchical and custodial culture had been fostered:

“None of the staff ever complained to me about it while he was there. When he had left, a large number, including some very senior members of staff, told me how very difficult it had been working for him and how he would not brook argument, he would not discuss cases with them, he would not be in any way flexible, he would not take their suggestions on board and they felt totally unable to institute any management plan that they wished without his agreement. I knew none of that while he was there…and it came as something of a shock and a surprise.”
“...He was a Broadmoor man who had been trained within Broadmoor to work in a certain way, and that was the Broadmoor way of doing things. It is an old-fashioned, idiosyncratic way of managing a ward and that is how he had come through the hierarchy at Broadmoor. He had seen in his turn ward managers who may or may not have worked in a similar way, and that is the way that things were at Broadmoor. It was a custodial culture, that is how daddy did it, that is how grand-daddy did it and that is how Uncle Tom Cobbley and all did it. That is the nature of a closed institution and the practices were pervasive for generations, this is the way we do things and woe betide anyone coming in off the street who may suggest a modern way of doing things. That is why practices in the hospital at that time were way out of date, which is why we have what we call a modernisation agenda. Most hospitals don’t need one, they are there already, we are 20 years behind.”

12.20 Ward Manager 1 strongly rejected this description and he pointed out that he was not trained at Broadmoor, that none of his family had trained there and he had no links with the hospital before his initial appointment. Ward Manager 1 further insisted that he prided himself on being “an agent of change”. Ward Manager 1 also said that none of the criticisms made of his style by RMO3 was ever put to him as part of his appraisal process. Thus, he said, the criticism was neither accurate nor fair.

12.21 Since Ward Manager 2 arrived nursing staff on the ward team have been allocated specific functional responsibilities. For example one nurse has been allocated responsibility for clinical audit and another service user involvement. In part this has been a response to the dilution of the CNM’s time by his site management duties and in part following decisions taken with team leaders to improve the functioning of the ward.

Shift system

12.22 Luton Ward’s shift system was described by the new CNM, Ward Manager 2, as “archaic and extremely inflexible”. Staff worked four days on, generally two shifts per day, and then two days off. The rotas were set up some months in advance. Ward Manager 2 told us that in most hospitals the shifts were spread over five days followed by two days off, giving greater flexibility. The system required the manager to give six weeks’ notice of any change in the rota, and even then he could not change either the
first or the last shift. Some staff were regular night staff and never worked days. One result of this system was that it was difficult to ensure that all staff could attend clinical team meetings or CPA reviews concerning patients to whom they were allocated. It also meant that staff allocated to the same patient might rarely have the opportunity to meet.

12.23 Some changes have since been made to this system. In particular night staff are now required to work at least three months each year on day shifts, and vice versa for day staff.

Staff breaks

12.24 Where nine staff were on shift together, breaks were taken by three members of staff at a time. This meant that on any shift there would be three periods of half an hour during a seven-and-a-half-hour shift when three members of staff were absent from duty, although still either on the ward or close by in the event of an emergency. Ward Manager 2 preferred this to having two staff on break at once because the greater time involved would lead to a restriction on the activities available to patients.

Appraisal and supervision

12.25 Supervision had always been available, but the take-up was said to have been poor. Ward Manager 2 introduced a system of group supervision in an attempt to gain a wider acceptance of this but individual supervision remained voluntary.

Culture and attitudes

12.26 The Commission for Health Improvement (CHI)\(^9\) reported in November 2003 that:

“Despite the very difficult and challenging nature of their role and some poor working environments the majority of staff are dedicated and committed to caring for service users with dignity and respect...However a small number of staff at Broadmoor Hospital have difficulty in accepting the positive changes that are promoting a therapeutic environment over the old style custodial one.”

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\(^9\) CHI was the predecessor to the Healthcare Commission. *CHI Clinical Governance Review for West London Mental Health NHS Trust* (November 2003).
12.27 The MHAC supported that analysis, which was addressed at the hospital staff as a whole, not specifically those working on Luton Ward, and considered that the development of clinical supervision was a useful remedy in relation to this concern. The Trust action plan accepted that only about half its staff were receiving such supervision and proposed steps to increase that to 100 percent.

12.28 RMO3 maintained that Ward Manager 1 was not in favour of a therapeutic approach on the ward:

“Ward Manager 1 very firmly and openly stated, which I found astonishing, that Luton Ward is not a therapeutic environment, it is not designed to be such, we don’t do anything therapeutic here; we are here for assessment...It is not my understanding of what I want to do and what the hospital is about. We are a hospital, we are not a prison ward within a hospital, it was totally inappropriate.”

Ward Manager 1 denied this:

“As the ward manager, had I heard any of the team state that the ward was not a therapeutic environment I would challenge them as I would expect to be challenged.”

“This is the first time that I have been made aware that the comments have been attributed to me, at best I have been mis-quoted.”

12.29 RMO3 discovered that RMO2 had concerns about Ward Manager 1’s appointment and was attempting to overcome the problems that resulted. RMO3 also felt that Ward Manager 1:

“...was not managed, he was not getting the supervision that he needed, and he developed the management style that he thought worked best and for him was the most appropriate.”

In particular:
“He managed the service manager, she did not manage him. The service manager did not manage him, she did not manage anything. He managed her. He told her what to say, what to think and what to do and she did it."

12.30 The staff turnover on Luton Ward was higher than average but a significant proportion of the staff had worked on the ward for a long time. Ward Manager 2 did not see this as a problem, though he did identify a problem of motivating some such staff (see below).

12.31 After the incident, and when Ward Manager 2 took over as clinical nurse manager, it appears that the nursing team had adopted a defensive method of working: they were reluctant to take decisions on their own and, in Ward Manager 2’s view:

“They did seem to want a lot of micro-management really.”

12.32 He found the main challenge was to give them back responsibility for making decisions. Staff told Ward Manager 2 that his management style was the complete opposite of that of the previous manager, which he took as a compliment. Most of the direction Ward Manager 2 received about what changes were required came from Service Director 3; the Service Manager of the London Directorate, his line manager, had managed him only a little. As something of a laissez-faire manager himself in some ways, he appreciated not being closely managed, but he had raised this with Service Director 3’s successor.

12.33 Ward Manager 2 did not think that morale was any lower on his arrival than on any other ward he had worked on, although there was concern about whether there were going to be many changes. There were, however different groups:

“A number of staff who had obviously worked in the hospital for quite a long time had set ways of doing things and newer staff who were a bit more dynamic...Fortunately they had team leaders who were very open to change in terms of taking the lead.”

12.34 Ward Manager 2 discovered a particular staff culture. It was evidenced by the terminology used by staff, such as “gallery” for corridor, “mess room” for staff room and
so on. He also noted that there was a problem with the motivation levels and attitude of an influential minority of staff:

"[There were] a number of staff who have been on the ward for quite some time and probably were better suited to the way that Luton Ward used to be managed. Therefore they were the ones who had been a little bit resistant to change because they had always done it this way and it works, so why do we need to change?"

12.35 He emphasised that this was not a phenomenon unique to Luton Ward or Broadmoor.

Awaydays

12.36 At the meeting with the MHAC on 5 February 2002 the modern matron with responsibilities for Luton Ward, was recorded as stating that at a recent awayday a “common vision” had been developed between nurses and healthcare assistants in order to deliver high-quality care based on evidence-based practice.

12.37 RMO3 arrived at Broadmoor in April 2003. He spent the first six months or so observing how the ward and its staff worked and came to the conclusion that problems needed to be addressed:

“It came as something of a shock to me to discover that many members of staff had not been supervised for years on end. With some you could see it in their practice but in other instances that took me by surprise. I knew that there were serious problems within the nursing team and I knew that there were some very serious problems in the relationship between the nursing team and the clinical team. The rest of the clinical team were not based on the ward, hence the suggestion in late 2003 that we address this and explore it with an awayday…”

12.38 As noted above, RMO3 had become concerned about the management and culture of the ward. He decided that an awayday was an opportunity to identify the problems, to think about strategy to address them, and the misperceptions of the clinical and nursing teams of each other’s roles.
12.39 At a Luton Ward clinical improvement group meeting on 18 August 2003 it was decided to hold an awayday to address a number of issues which had led to a “lively discussion regarding the therapeutic environment within the ward”. The issues listed were:

- “the atmosphere in the ward
- hospital policies and procedures and how did they impact on the ward
- what are we trying to achieve
- abilities of trained and untrained staff.”

12.40 RMO3 had chaired this meeting of the improvement group, and both RMO2 and Ward Manager 1 were absent.

12.41 Ward Manager 1 told us he was “quite taken aback that it had been arranged without RMO2 and I being involved in the conversation” although he also said he was “reasonably enthused” by the idea. He was “a little apprehensive” at the way it was being arranged, and in particular the idea of discussing the abilities of individuals in a forum such as an awayday. The way problems were defined “got my hackles up”. He saw this as resulting from a lack of understanding on the part of RMO3, who had not been associated with the team for long. However, both he and RMO2 were later recorded as being involved in arranging the agenda.

12.42 The awayday took place on 29 January 2004. A 25-page report about it was later drafted, and on the basis of the oral evidence we heard we accept the report as a fair summary of the views expressed at the awayday. The event was attended by both RMOs, Ward Manager 1, the Deputy Director of Nursing the Service Manager of the London Directorate, and some 30 members of the clinical team. The report described the results of a preparatory survey from which discussion points were taken, and stated that:

“The main motivation for the away day has been the long standing concerns raised by different members of the MDT. Issues concerning the level of therapeutic activity and what was described as ‘fundamental difficulties on the ward and its culture’ were raised...the list of issues also included the therapeutic environment, attitudes of staff, the view of being punitive and even a prison culture....The
underlying feeling of the clinical team was that things had to improve. Hence an away day was planned to focus on what was happening. This would allow the team to get to know each other and provide the structure for ‘team building’. Since then, there have been other levels of dissatisfaction between the team. The lack of clarity regarding roles, the sense of not knowing the different roles within the MDT, and the sense of resentment about colleagues who are viewed as only visitors to the ward.”

12.43 Among the observations recorded as emerging from the day were:

- “Layout of the ward not well suited to the requirements of observations and security.” - Among the comments were that there were too many blind spots, the ward was “geographically too vast”, and that it was possible to “feel isolated when in certain areas.”

- “Poor communication from management” - Among the comments were that there were too many responsibilities, not enough staff meetings, and that “management is a faceless excuse for not knowing something”.

- “Limited consultant time on the ward” - it was stated that patients wanted to see more of the RMO.

- “Boring for patients at weekends” - this comment did not appear to have been accepted as it was stated that patients were offered a number of activities.

- “Staff spend too much time in the office and not enough time in informal interactions” - to this it was suggested by some that more interview rooms and general work space were required, by others only that a bigger office was required.

12.44 Among the recommendations that emerged from the day were:

- a need for better integration of the clinical team meeting and the nursing team
- a need to review the operational management arrangement for Luton Ward
- shared learning for all disciplines and grades of staff
- a review of patient numbers
- a review of the feasibility of housing clinical team members on the ward.
12.45 RMO3 considered that the awayday achieved a lot. It had demonstrated the extent of the problem and brought about the beginning of a recognition that there should be one, not two, teams. However, in his opinion, no improvement in the management style came about until after Ward Manager 1’s departure. Ward Manager 1 represented the nurses at all clinical team meetings and matters were not always fed into the meeting or back to the staff. However, RMO3 found out only later that staff had felt inhibited at speaking at the awayday because of Ward Manager 1’s presence.

12.46 Ward Manager 1 said he had come away from this event feeling “reasonably positive”.

12.47 There is no evidence of any meaningful follow-up of the issues raised at the awayday. We received all the minutes for the service manager/CMN meetings between the date of the meeting and the incident. None of them even mentions the awayday. Ward Manager 1 had no recollection of any action plan being drawn up. There is reference in the minutes of the Luton Ward clinical governance meeting held on 16 February 2004 to discussions between Ward Manager 1 and team leaders:

“Community meetings

Ward Manager 1 informed the meeting that he had a discussion with team leaders following the team planning day on 29 January. Team Leader 2 is in the process of completing a daily structured programme of activities for patients.

A lengthy discussion ensued and the following was agreed:

‘(1) Community meetings should be held fortnightly’.”

12.48 The minutes continue recording the arrangements for these community meetings. We heard no evidence that a change in the daily programme for patients was implemented. As for community meetings, we have seen minutes of meetings held on 1 March 2004 (at which the only member of staff present was Team Leader 2) and 15 March 2004 (attended by Team Leader 2 and HCA7). There was no further community meeting until 26 October 2004 when they appear to have been resurrected by the new CNM, Ward Manager 2.
12.49 The only other reference to follow-up of the awayday is in the Luton Ward clinical improvement group meeting minutes for 19 April 2004 where it is noted that the next meeting will be on 17 May 2004:

“Topic for discussion - follow up of Team Planning Day, 29.1.04.”

12.50 We have not seen any minutes for a meeting on 17 May 2004 and it may well not have taken place, given that at the meeting on 21 June 2004 it was the minutes of the meeting on 19 April 2004 that were approved, with no mention of any meeting in May 2004.

12.51 Ward Manager 2 had not been employed at the hospital when the awayday occurred and became aware of it only when the Service Manager of the London Directorate mentioned it to him and said she was trying to arrange a meeting to tie up what had been discussed. His impression was that some of the criticisms made then were no longer as valid now.

Relations with doctors

12.52 The ward staff expressed differing views about the relationship with the RMOs and the extent to which the nursing staff’s views were listened to.

12.53 Ward Manager 1 found difficulty in working with two consultants on the ward because of the potential for different and conflicting approaches to the management of patients, although he could not recollect any problems arising from this when, for instance, one consultant covered for the other during leave. He also had problems about the availability of RMO3 because of the part-time nature of his appointment. He said that RMO2 had a minimum standard of seeing each of his patients at least three times during the three month assessment period, whereas RMO3 would sometimes see patients only once. However, after he raised the issue with RMO3, he had addressed it and saw his patients more frequently. Ward Manager 1 thought that RMO2’s standard was sufficient so long as the three visits were supplemented by more frequent contacts with junior doctors.

12.54 Ward Manager 2 said:
“There is a difference in approach between the two consultants who work on Luton Ward in the style of their interactions with nursing staff. RMO3 has a more collaborative approach and will, for example, ask everyone’s views on a patient during the course of a CPA meeting. RMO2, on the other hand, tends to lead discussion in relation to his patients.”

“Personally I have always felt that my views have been listened to by both consultants and I have been able to have free discussions with them regarding the care of their patients and other issues relating to the management of the ward. However, I am aware that some members of the staff group still find dealing with other members of the multidisciplinary team, including the consultants, slightly daunting.”

12.55 Ward Manager 2 had found the ward easier to manage since the structural changes which left a single consultant responsible for the patients on the ward.

12.56 Staff expressed concern about the level of medical cover available and in particular the frequency with which patients are seen by consultants. When Ward Manager 2 arrived he became aware this had been a concern and raised it with Service Director 3 who discussed it with the two consultants. He had to raise the issue again with Service Director 3’s successor. As a result he has noticed improvements, although there could still be problems with attendance by junior doctors. Ward Manager 2 considered that RMOs should see their patients once a week but this was not happening. RMO2 considered patients should be seen by the SHO once a week, but Ward Manager 2 had received no explanation why the RMO could not undertake this for himself.

Approach to management of patients

Record keeping

12.57 Ward Manager 2 noticed on his arrival that staff were having regular “one-to-one” interaction with their allocated patients but they were not documenting it. Under Ward Manager 2, team leaders set up systems for monitoring the quality of
documentation produced by nurses, whereas in the past little had been done to improve practice. Ward Manager 2 underlined the importance of this:

“I would say that poor quality documentation is an indication that someone is not doing their job properly and therefore, that they are not nursing as well as they could.”

12.58 When interviewed in 2006, Ward Manager 2 considered that record-keeping had improved but that further improvement was possible. Ward Manager 1 accepted with hindsight that, documentation had not been kept to an acceptable standard, although he noted that it had been a requirement of the team leaders that they audited the documents of the patients for whom they were responsible.

Contact with patients

12.59 At their meeting on 5 February 2002 the Mental Health Act Commission (MHAC) expressed concerns about the approach of staff to their work:

“Commissioners raised a series of concerns. These included the nature of observation on the ward, which included looking at patients without engaging with them, frequent threats of seclusion and a generally repressive atmosphere...[The then CNM] acknowledged that nursing staff were frequently ‘on the back foot’. RMO2 acknowledged that with new and inexperienced staff it was hard to be on the front foot. It was acknowledged there had not been consistency on the ward and there was a need for more confidence in interactions with patients. He said that the staff were trying to overcome these problems to ensure that common sense and fairness prevailed. The Commission highlighted the fact that staff smoking in groups was an indication that the ward was too stressful for the current team. The Luton staff did not deny this assertion.”

12.60 Ward Manager 1 accepted that this description gave a flavour of the ward environment when he arrived. He thought that by the time he left he had succeeded in obtaining a consistency of approach in numbers of staff on duty, standards of documentation, dress code, approach to threats from patients and so on.

“...that suited me and my plans for where the ward was going to go...”

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12.61 Ward Manager 2 explained that contact with patients has been improved. On each shift a named nurse was allocated to each patient and the nurse’s name appeared on a board where patients could see it. This would be the primary nurse or the associate nurse, if on duty. In this way the patient would always know whom to contact.

Patient activities and quality of life

12.62 The MHAC consistently criticised the lack of occupational therapeutic activity for patients and the quality of life offered to them.

12.63 In May 2001 the MHAC reported to the Trust chief executive, Dr Julie Hollyman, its concern at patients being seen to be “sitting around” and being provided with “little meaningful activity”. They had noted “little staff/patient interaction with staff either located in the office or observing patients without engaging with them.”

12.64 The chief executive replied on 29 June 2001 in a letter which appeared to accept the validity of the criticism. She said it was intended to split the ward and that there were proposals to increase significantly the activities on it, subject to funding. RMO2 did not accept in his evidence that there was any significant difference between Luton and other wards. He described the written response as inadequate, although he thought he had been involved in preparing this reply. He pointed out that occupational therapy was available on the ward and that patients could use the sports facilities, but only after the completion of their assessment. However, he accepted that more could have been done. Activity was the first casualty when the nursing staff were under pressure of work. The appointment of Ward Manager 1 had not helped the problem because his approach was more custodial than therapeutic, according to RMO2.

12.65 In December 2001 following two unannounced visits to the hospital by different commissioners, the MHAC repeated these concerns, but more emphatically. The commissioners both found:

“...a considerable number of patients complaining about boredom and lack of activity. It is a regular feature of Luton Ward that four or five patients are to be found at any time of the day asleep in their chairs, with coats over their heads. Most patients described their days as a series of meals interspersed with periods
of sitting around doing nothing. Clearly such a regime is acutely counter-therapeutic for such a difficult group of patients.”

“The Commission recognises that the nursing staff have many formal tasks to undertake and is not writing to criticise their practice. Nevertheless the quality of care on Luton would appear to fall far below an acceptable one for psychiatric patients. While the Commission also recognises that plans to improve the service are in train, it feels that the situation is so serious and urgent that neither a structural nor managerial reorganisation of the ward without a radical investment in therapeutic staff will suffice to change the situation for the foreseeable future.”

12.66 The director of forensic services replied that once a new manager had been appointed other reorganisation would follow and steps were in hand to increase access to activities for patients.

12.67 At the meeting on 5 February 2002 the Modern Matron reported to the commission that she was working towards the appointment of activity co-ordinators to work with patients who could not leave the ward.

12.68 At the meeting of 11 March 2002 the MHAC said it felt little progress had been made on improving patients’ quality of life: it found a lack of use of an activity room, and commented on staff use of the “chill-out room”. Service Director 2 acknowledged that these concerns were significant and undertook to raise them with Ward Manager 1, who had by now been appointed.

12.69 A report of MHAC inspections made between June and December 2003 suggested that the commission did not think much progress had been made:

“The Commission continues to have grave concerns about the management of newly admitted patients on Luton Ward. While the sharing of the consultant load is to be welcomed the number of patients is too great for the maintenance of an active therapeutic regime. We remain unconvinced that an ‘observation and assessment’ function is incompatible [sic] with a busy and active treatment programme...the Commission continues to have concerns about the large numbers
...of patients it regularly sees asleep in chairs or watching television for extended periods of their day... frequently the patients...complain of boredom.”

12.70 Commissioner 1 of the Mental Health Act Commission confirmed to us that “grave concern” was not an expression the commission used lightly.

12.71 A reply by Sean Payne dated 7 April 2004 sought to rebut this expression of concern by pointing to differences between Luton and Bicester Wards to which the MHAC had unfavourably compared Luton. He does not appear to have disputed the central point of the criticism or to have undertaken to find any solution. An action plan was produced dealing with other points in the report, but not this one.

12.72 Commissioner 1, who visited Luton Ward regularly, said in evidence he thought that the commission had particular difficulty in getting acceptable responses from hospital management about this ward:

“Having said we get good answers and good progress, my feeling is that the issues we raised about Luton Ward, we found it very difficult to move on. You can list them very simply: lack of activity, lack of patient involvement, lack of exercise, lack of access to fresh air, an inadequate exercise area at that time. For me throughout this period, we differed from the hospital about the relationship between a ward of observation and assessment and a ward of intervention, because I have never been convinced that you can sit around looking at people and call that observation and assessment. There were patients there for quite lengthy periods who had had an assessment and were waiting for a placement elsewhere in the hospital and were kicking their heels, and there were other patients quite new to the hospital whose mental state would have enabled them to do something. We regularly reported on patients slumped in chairs and so on. We didn’t manage to shift the hospital on that and they talked - as they are talking right to this day - about splitting the ward and it being too big and all those things. We made some progress on levels of activity but I don’t think we radically improved matters, to be honest.”

12.73 Commissioner 1 considered that this lack of response with regard to activity and engagement was directly relevant to the state of affairs, as he understood them to be, on the date of Peter Bryan’s assault on Richard Loudwell:
“My position is very clear that I follow the Nursing and Midwifery Council’s definition of observation, which is about constructive engagement. There was a view at the hospital that the patients were too shocked, too bewildered, too new, they were busy being assessed by the psychologist and the hospital chaplain and everybody else to engage in this process. I was never convinced and there were occasions when I would go in and the nursing staff would be under-involved. If you look at the hospital’s own account of the day on which Mr Loudwell died, they describe three staff on a break, three staff on the corridor, which is fundamentally looking at things, two staff in the office but they couldn’t see out and they couldn’t engage, and one staff in the day room. Which meant that fundamentally, of nine staff on duty there was one staff physically in a position to engage with patients at the time of Mr Loudwell’s death.”

12.74 Commissioner 1 was not impressed by the reaction of staff to commission visits:

“Normally when the Mental Health Act Commission visits your hospital, you will polish your shoes and check your files and jump to attention. I knew we were in trouble when the nurse with his feet up on the coffee table didn’t put his newspaper down, and we challenged them about this.”

Community meetings

12.75 As discussed above at the time of the assault on Richard Loudwell community meetings with patients were meant to be taking place fortnightly. They started again on 1 March 2004 but there were only two meetings before they appear to have fizzled out. Ward Manager 2 re-introduced them in October 2004. In his view:

“They are extremely valuable. You get a lot of insight from the patients and to get their views and their opinions as to what is happening on the ward. We also use it when patients complain about certain issues, to do with security or with the domestic service. We actually get someone in from those departments to answer their concerns. They feel that they are then being taken seriously.”
Care plans

12.76 When we interviewed Ward Manager 2, the ward was working through a draft set of standards for nurses. These proposed the following requirements:

- A requirement to meet the patient at least once a week to review and discuss care plans and document this in the patient’s notes.

- A requirement for all care plans to be re-evaluated at least once a fortnight and for them to be evidence-based and related to CPA risk assessments.

- All care plans to be specific, measurable, achievable, realistic and time-specific.

- The team nurse, primary nurse and associate nurse for any patient to meet once a fortnight to discuss the patient’s care and the discussion to be recorded in the patient’s notes.

Clinical team meetings and CPA reviews

12.77 At a clinical governance meeting on 17 November 2003 a number of problems were identified with CPA arrangements. These included:

- CPA documentation from other organisations such as prisons was rarely available on admission.

- Care coordinators (primary nurses) were routinely not present at pre-CPA and CPA meetings, partly due to the fixed shift system, and partly due to a reluctance to attend multi-disciplinary meetings on the part of some care coordinators.

- The draft risk assessment was not routinely being completed by the care coordinators.

- CPA documentation was not routinely being distributed in line with procedures and was not being prepared in conjunction with the consultants.
There were wider difficulties between the nursing staff and the rest of the clinical team.

12.78 At a service manager/CNM meeting on 16 April 2004 Service Director 3 raised concerns about the way clinical team meetings (not restricted to Luton Ward) were being run. The minutes record:

“There is not enough time given to each patient, in fact she feels that the meetings are sometimes rushing through up to 20 patients. Service Director 3 feels that though the overall aims for the patients are discussed at CPA’s there is no clear treatment plan or objectives discussed between CPA’s. Also that CPA’s are often done quickly because they are at the end of the CTM. Service Director 3 felt they should be discussed in a separate meeting...It was felt that any grade of staff should have the opportunity to attend if they had something they wished to contribute about a patient.”

Conclusions

C92 There is a long-standing history of generic concerns in and around Luton Ward. Some of these may be common across the hospital as suggested by the MHAC, but all impacted on the level and standard of care available at the time of the assault on Richard Loudwell.

C93 The staff/patient ratio was such that staff often found it difficult to find time for interactive engagement with patients, to the extent that they were inclined to undertake this at all.

C94 Ward Manager 1 was brought in in an attempt to make the ward more effective. Reservations were expressed at the time about his appointment, but these in themselves may not have been sufficient reason not to appoint him. He was experienced, confident and capable of firm leadership. He succeeded in difficult and substantial tasks of improving nursing staff organisation. However the difficulty appears to us to have been that he was not more pro-actively supervised and that higher management remained largely unaware of the extent of the problems on the ward as perceived by at least some of the staff there.
C95  The result was that a culture persisted in which active engagement with patients was not given a high priority. The norm was reactive observation rather than engagement with the result that patients were left too much to their own devices.

C96  We sensed there was a lack of purpose and motivation among at least some of the staff. In part this was due to the reactive nature of the nursing regime followed and a lack of definition around the purpose of assessment.

C97  For these among other reasons morale was not high on Luton Ward during the period under consideration. This manifested itself in the concerns which surfaced at the January 2004 awayday and the observations of RMO3 following his appointment.

C98  There was a conspicuous collective failure on the part of management to follow up and address concerns about Luton Ward, whether emanating from ward staff, consultants, or the Mental Health Act Commission. This resulted in there being no real change in the period under review.

C99  There have been improvements on the ward since the death of Richard Loudwell. Patient numbers have been significantly reduced. Under Ward Manager 2’s leadership, there was evidence of a more proactive nursing culture in place. Improvements have also been made to the accommodation in the ward. However, our visits to the ward suggest to us that patients are still left to their own devices a great deal and that there remains a need to improve the availability of therapeutic activity.

C100  We consider that the criticisms frequently made by the MHAC as a result of their inspections were well founded. The contribution such inspections and criticisms can make to the raising of standards is considerable. We are not satisfied that all their concerns were treated with the reaction they deserved, in particular those concerning the custodial culture among some of the staff, and the lack of opportunities for activity on the ward. The MHAC records and reports provide a valuable means of auditing the management’s efforts to raise standards. We are concerned that the recent changes in the MHAC arrangements may have resulted in a reduction of the number of commissioners allocated to Broadmoor, and accordingly in a diminution in its ability to monitor the hospital.
Recommendations

R37 The MHAC and its successor The Care Quality Commission, should review the new arrangements for inspecting Broadmoor in accordance with our recommendation R84. If possible, this should be at the same level of inspection that was routine before 2005, including visits arranged in response to issues raised by patients.

R38 In light of the history of specific concerns about the lack of therapeutic activity on Luton Ward priority needs to be given to the consideration of this issue, specifically on this ward.

R39 The care plan for each patient on Luton Ward should include a plan for daily and periodical activities to be offered to him throughout his stay on Luton Ward.

R40 Regular staff meetings should be held on Luton Ward to discuss practice, management and patient welfare issues. Such meetings should be attended by directorate level representatives who should monitor concerns raised and ensure that these concerns are addressed.

12.79 We note that recommendations regarding management are set out at the conclusion of the chapter “Hospital management”.
13. Security and risk assessment

13.1 In 1997 a Royal College of Psychiatrists working party made the following observation about mental hospital security\textsuperscript{10}:

“It is people and policies that provide the main elements of security in a psychiatric unit, rather than bricks and mortar. Security considerations must be built into operational policies and procedures, into staffing and training and into the philosophy of care.”

Tilt

13.2 In February 2000 Sir Richard Tilt reported and made recommendations on the maintenance of security in high security hospitals. The report was commissioned in response to the Fallon inquiry.\textsuperscript{11} It observed that such hospitals face a challenging task because of the variety of patients they have to serve and the high level of danger posed by them. The report identified their objectives as follows:

“The high security hospitals have clear twin security and therapeutic objectives. The security objectives include the protection of the public, by seeking to ensure that patients do not escape or abscond, and the provision of a safe environment for staff and patients within the hospitals. The therapeutic objectives include the need to do everything possible to provide therapy for patients so that their illness/disorder can be treated and their behaviour made less dangerous for others and themselves. It was clear to the Review Team from the outset that security and therapeutic issues were so closely interrelated that security could not, and should not, be dealt with in isolation. It is also important to state clearly that maintaining high levels of security is the responsibility of all staff in a high security hospital, not just the security staff, and that good security and therapy will be seen as integrated concepts rather than opposite ends of a spectrum.”


\textsuperscript{11} The Report of the Committee of Inquiry into the Personality Disorder Unit, Ashworth Special Hospital.
13.3 To achieve these objectives Sir Richard Tilt’s review team made recommendations with two main thrusts:

- increase in therapy and activity for patients
- upgrading physical and procedural security to safeguard the public, staff and patients.

13.4 The Tilt report recommended improvements in procedural security particularly in relation to the risk presented by patients to the public, staff and other patients. Tilt considered but rejected recommending the construction of special units for particularly dangerous patients. The report concluded this would not be necessary as the recommended procedure would be adequate to safeguard security. The report also observed that staff attitudes to security procedures were important.

13.5 It is crucially important that high security hospitals have appropriate security policies and procedures in place, that these are made known to staff in an accessible way. It is also important that staff receive the necessary advice and training on implementation and that there are appropriate mechanisms for monitoring implementation.

13.6 In each of the hospitals, the Tilt review team noted an element of discontent among staff and their representatives about the way information, including security related information, was given to them and an alleged lack of consultation about significant security changes. Whilst the review team accepted that it was not always appropriate to consult staff in advance they believed that the manner in which security changes were introduced had an important bearing on the attitude of staff to implementing them. It was therefore beneficial for security information to be made known in the most user-friendly manner possible.

13.7 As a result of the Tilt report mandatory security directions were amended for high security hospitals.\(^\text{12}\) Risk assessments were required as follows\(^\text{13}\):

\(^{12}\) *The Safety And Security In Ashworth, Broadmoor And Rampton Hospitals Directions* 2000 as amended.

\(^{13}\) Emphasis supplied to indicate parts of the regulation particularly relevant to Richard Loudwell and Peter Bryan. Paragraph 30 is shown as amended by the 2003 directions, but the amendments have not materially affected the italicised passages.
“(1) Each hospital authority shall ensure that as soon as is practicable after this paragraph comes into force each patient has a risk assessment carried out by his clinical team provided he has not had an equivalent assessment in the previous three months, and every newly admitted patient shall have a risk assessment by his clinical team as soon as is practicable after admission to the Hospital.

(2) The clinical team shall use the risk assessment to determine whether the patient presents a high risk of
(a) immediately harming others;
(b) committing suicide or self harming;
(c) being assaulted;
(d) escaping; or
(e) subverting security and safety, or organising action in collaboration with others to subvert security and safety.

(3) When making or reviewing a risk assessment the clinical team shall decide on a risk management plan for the patient and that risk management plan shall, where appropriate, cover the matters set out in paragraphs 29(1) and 31.

(4) If the patient’s clinical team decide that the patient presents a high risk
(a) of escaping and of harming others or
(b) of organising action in collaboration with others to subvert security and safety
the clinical team must consult a member of the security department before finalising a risk management plan for the patient.

(5) When the clinical team carries out a risk assessment they must-
(a) record their reasons for concluding that the patient presents any of the high risks specified in sub-paragraph (2);
(b) record the risk management plan for the patient, including any decision made on the matters specified in sub-paragraph (3);
(c) decide and record the date on which the risk assessment is to be reviewed; and
(d) decide and record the date on which any decision to monitor the patient’s telephone calls while in progress, or lock the patient in his room at night, is to be reviewed.
The clinical team shall review the risk assessment of each patient and the patient’s associated risk management plan as necessary and at least once a year.”

13.8 Guidance on the directions was issued by the Secretary of State. It stated the intention that:

“...their implementation will, in contributing to the provision of a safe environment for patients and staff, enhance rather than provide a barrier to the therapeutic activities of the hospitals.”

13.9 Annex C of the guidance set out a protocol for the required risk assessment:

“In accordance with the Safety and Security in Ashworth, Broadmoor and Rampton Hospitals Directions 2000 (the Directions), a comprehensive multi-disciplinary risk assessment will be undertaken and recorded to ensure that all risks are identified. These fall into four main categories

- risk of harm to self (suicide or self injury)
- risk of harm to others
- risk of escape
- risk of being assaulted (i.e. high vulnerability)

In any category, risk may range from ‘no risk’ to ‘high risk’ and this is a matter for clinical judgement. The underpinning reasons for the conclusion must be documented.

The risk assessment protocol must be used to assess patients at least annually but frequencies will be set for individual patients in the light of their clinical condition and security intelligence (see paragraph 30(6) of the Directions). A further risk assessment will be appropriate after any occasion where a patient threatens or is involved in violence to others or behaviour which could facilitate escape.”

13.10 Both the directions and the guidance include the risk of being assaulted as one of the risks requiring assessment. In the guidance this is further explained as meaning “high

14 Guidance Annex C para 4
vulnerability”. We are concerned to note that paragraph 5 of the guidance does not require a repeat assessment where a patient has been subjected to violence, but only where a patient has posed a threat to others. By implication, and probably unintentionally, this means the protection of vulnerable patients from risk is given a lower priority than the protection of others from risk posed by patients.

13.11 We think there should be an express requirement to repeat a risk assessment for any patient who has been the victim of actual or threatened violence. We have considered whether the directions and the guidance are the most appropriate place to address the protection of vulnerable patients. In Luton Ward the directions - in so far as they are considered by staff to have any practical application - were seen as addressing security matters at the hospital perimeter. This is understandable since the Tilt review did not give particular consideration to the needs of vulnerable patients. In our view the issues arising from this case and the lack of appropriate management planning to protect Richard Loudwell suggest higher priority should be given to the protection of vulnerable or potentially vulnerable patients. We think the security directions are the appropriate place in which to require the appropriate level of attention be paid to the protection of such patients.

13.12 The guidance contains a “decision tree”. This relates to the issue of whether patients should be locked in their rooms or be allowed to lock themselves in if they are vulnerable. This needs to be reviewed to give greater emphasis to the issue of whether vulnerable patients are capable of making appropriate decisions to protect themselves. Richard Loudwell’s case demonstrates such patients are not always able to do this.

13.13 The guidance also contains a summary of management strategies for vulnerable patients:

- “Enhanced levels of observation (refer to the hospital’s observation policy).

- Geographical manipulation such as moving the patient away from individual(s) posing a risk.

- Risk or restrict access to such individual(s).
Voluntary locking into room for periods of day or night. Many of these patients will cooperate with measures to enhance their safety, including agreeing to remain in their rooms for specified periods. Voluntary exit from rooms should be retained.”

13.14 The statement may be true but the guidance needs to remind hospitals that because of their disorder or for other reasons some patients may be unable or unwilling to cooperate. Those patients are no less entitled to protection than patients who are capable of assisting in their own protection.

13.15 West London Mental Health NHS Trust has a policy on high risk patients. The version relevant to the events under consideration was published on 2 June 2003. It sets out a process for identifying high risk patients:

“A comprehensive multi-disciplinary risk assessment will be undertaken and recorded to ensure that all risks are identified:

- risk of harm to self
- risk of being assaulted (i.e. high vulnerability)
- risk of escape
- risk of immediate harm to others
- risk of subverting security and safety
- risk of organising action in collaboration with others to subvert security and safety”

13.16 The responsibility for this assessment was placed on the clinical team, including the security liaison nurse and required them to:

“Consider whether each patient presents an identified risk of harmful behaviour which is greater than can be managed by the ward’s regime which normally contains or manages the risk(s) presented by other patients.”

13.17 We are concerned about the application of the high risk policy only to patients who present a greater risk than Broadmoor’s “normal” patients. We think this may encourage the widespread attitude we found among ward staff that they could cope with almost anyone because they routinely dealt with difficult and high risk patients. This can lead to
a complacent attitude and a failure to consider the risks or manage individual patients appropriately.

### 13.18 A high risk of immediate harm to others could, it was suggested, be dealt with by:

- **“Locking into room until judged safe to end such locking in...**
- **Locking into room for identified high risk periods only (e.g. night time)**
- **Geographical manipulation i.e. consider moving patient to a higher staffed location or away from provocation, or restrict access to a more confined area of the ward**
- **Enhanced levels of observation**
- **Enhanced restrictions on access to risk items**
- **Enhanced search/drug screening procedures**
- **Enhanced monitoring of visits (including closed visits) or temporary suspensions of visits”**.

### 13.19 A patient who is vulnerable to assault by others will be more at risk in the company of some patients than others. We think the policy should make it mandatory that management plans for vulnerable patients should include reviews to identify patients who are at risk of harming vulnerable patients, whether or not they present a high risk of harming others. The current policy can be understood to suggest any restriction of liberty should involve only the vulnerable patient not his potential attackers.

### 13.20 The policy required the risk status of all patients to be assessed on admission and thereafter at least annually:

> “But frequencies must be set for individual patients in the light of their clinical condition and security intelligence. A further risk assessment may be required after any occasion where a patient threatens or is involved in violence to others of behaviour which could facilitate escape or subvert security or safety, either alone or in collaboration with others. Similarly events leading to a change of ward may trigger a review of risk...”

### 13.21 This did not expressly require a risk status review after incidents in which patients were the victim of threats or violence. We consider the policy should do so. We also think
there should be a requirement for a risk status review on discharge from any period of seclusion, and on any occasion when the patient’s care plan is reviewed.

13.22 The policy also sets out a procedure for identifying high risk patients. This required patients to be reviewed “as part of the regular ward review”. This part of the policy should be consistent with the main body of the policy: risk status should be considered on admission and on discharge from any period of seclusion as well as on regular ward reviews of the care plan.

13.23 The Trust also has a risk management strategy. The date of the document we have seen is April 2001 amended in October 2004. It emphasises the need for a proactive risk assessment programme in clinical risk management among other areas. The director of estates and capital was on the risk management committee but we could find no reference in the policy for the need to proactively review the risks presented by the estate. Given the defects in the dining room exposed by this case this issue should be placed explicitly within the remit of the risk management committee.

13.24 We note that the health and safety policy, dated April 2001, includes the following aim of the Trust in its introductory service statement:

“The provision of a safe living and working environment for all patients, staff, visitors and contractors who have access to the hospital…”

13.25 Paragraph 5 of the policy refers to monitoring arrangements and includes at 5.2.1. under the heading “Active arrangements” the following:

“Comprehensive risk assessments of all hazards, risks and incidents and frequent audits of health and safety practice and standards, carried out by the Risk Manager and supporting staff.”

13.26 Then at 5.2.4. there is provision for:

“Regular inspection of environment and practices to measure the achievements of objectives and specified standards.”

13.27 Appendix 2 provides a “Health and Safety Inspections Check List”. It says:
“The following items should be covered in any health and safety inspection and observations recorded on a ‘Safety Inspection Report’ form:

Environment

- *Is the area in acceptable decorative order?*
- *Is lighting adequate and suitable?*
- *Is the temperature level acceptable for the type of work (sic)?*
- *Is the noise level acceptable?*
- *Are staff adequately protected from a noisy environment?*
- *Are staff in danger from overcrowding of either persons or equipment?*
- *Are there any tripping hazards e.g. trailing cables, loose carpets etc?*
- *Is pest control carried out effectively?*
- *Are there adequate sanitary and washing facilities?*

13.28 We can find no reference in this policy to the effect of the environment on the risk presented by patients to one another or to staff.

The security department

13.29 The security department at Broadmoor Hospital was under the management of the Trust’s director of security, Alistair McNicol. He was a police chief superintendent before retiring in 1995 and joining Broadmoor Hospital as director of security. He was appointed director of security for the whole Trust when it was created in 2001. He estimated that he spent 60 percent of his time managing security at Broadmoor and the rest of his time dealing with issues elsewhere in the Trust.


Managerial structure

13.31 As security director, Alistair McNicol was an associate member of the Trust board. The director of security’s deputy at Broadmoor is the Security Operations Manager. The Security Operations Manager also has duties across the Trust, although his principal focus is at Broadmoor. There is also an assistant manager responsible for intelligence. The security directorate has 125 staff and a budget of £3.5
million. The responsibilities of the directorate include search procedures, the reception area, security intelligence, escorting contractors, the control room, perimeter security, photography, post, telephone and risk assessments for patients’ leave.

13.32 Alistair McNicol’s role, and therefore that of his department, was advisory, not executive. If there was a disagreement with a clinical team on a security matter he would advise the director of forensic services and, if necessary, the Trust chief executive. He expressed concern that if his department were more integrated into the overall management structure, with formal accountability to the director of forensic services, there would be a loss of objectivity and independence in the security advice given. He accepted there was a tendency for security to be thought of as separate from clinical decision-making, relating to matters outside the ward rather than being an integral part of ward life.

General security issues

13.33 When interviewed in 2006 Alistair McNicol identified problems setting up a new security intelligence computer package which he was confident were now being addressed. There has also been reluctance on the part of consultants to share clinical information with the security department, particularly its non-clinical members. Externally there had been difficulties obtaining intelligence information from prisons although Alistair McNicol was confident this would now be addressed. The ease with which information was obtained varied from one prison to another, largely because of differences in perception regarding confidentiality. The spasmodic operation of arrangements for sharing information in Service Level Agreements was commented upon.

13.34 Alistair McNicol described good relations with the local police and provides information for multi-agency public protection arrangements (MAPPAs) when requested. He had not explored whether the local MAPPA provided a forum through which useful information about patients could be obtained from police sources.

13.35 Alistair McNicol told us that a considerable amount of the department’s resources are taken up with internal escort duties and assessments for leave of absence. Alistair McNicol thought the lay-out of the buildings restricted the activities the hospital could engage in:
“Some nursing staff tend to use security as a reason for not getting patients off the ward. The current layout of the Broadmoor site is extremely problematic from a security point of view. The escorting of patients to off-ward activities requires escorting staff from the wards and this often poses a problem due to a lack of sufficient numbers of staff to carry out the escort. This results in the patients not being taken to the off-ward activities. A major reconfiguration of existing buildings and far more extensive use of CCTV cameras will be necessary to remove this problem. The redevelopment of the hospital which is planned will address this. In my view the buildings which we have at Broadmoor Hospital are not fit for delivering the kind of service which we would like to deliver to patients.”

Security liaison nurses

13.36 Broadmoor has six security liaison nurses, all of whom were supervised by their line manager the Security Liaison Manager.

13.37 Luton Ward had a security liaison nurse, who at the time of the attack on Richard Loudwell was Security Liaison Nurse 1. He was a qualified registered mental nurse who worked as a staff nurse until moving to the security department in 2000. Security Liaison Nurse 1 was responsible for four wards including Luton Ward and had specific responsibilities in three other areas. He attended clinical team meetings where he presented the known security history of each new patient. He also participated in the review of existing patients at these meetings. He had worked on Luton Ward since then.

13.38 According to Alistair McNicol the role of the security liaison nurse was:

“...to give objective and focused advice to the clinical team in relation to security issues; this includes the assessment of risk in relation to patients.”

13.39 Security Liaison Nurse 1 told us that the basic job of the security liaison nurse was to:

“...be the link between the security department and clinical practice. We give support to the clinical team on the ward, advise on security matters and carry out teaching and auditing of security matters.”
All such nurses have clinical experience and, in his view, this:

“...helps us to be alert to the risks which patients may present from a security point of view.”

13.40 Alistair McNicol thought the role was difficult as the nurses tended to be “subservient” to the RMOs and found it hard to be assertive. He found it necessary to constantly advise security nurses to document disagreements with clinical teams and report them to himself or the Security Operations Manager. He was also doubtful whether the post should be restricted to nurses. He worried that nurses would prioritise therapeutic considerations over security. There had also been difficulties with their line management through changes in personnel. He agreed that liaison nurses had a responsibility to offer a different, wider and objective perspective to the clinical team on the risks associated with a patient.

13.41 The Security Operations Manager thought the relationship between security liaison nurses and the wards was good and that they made a positive contribution.

13.42 There is no specific training for security liaison nurses although they are encouraged to attend relevant courses. Alistair McNicol thought there would be merit in rotating staff between a security post and mainstream nursing for a minimum of two years, and preferably three. The Security Operations Manager identified lack of training as a weakness although a service level agreement with the Prison Service College for access to some of their training had recently been arranged.

Risk assessment

13.43 Alistair McNicol expressed doubts about the role of Tilt risk assessment at Broadmoor:

“In my opinion almost all the patients who arrive on the admissions ward at Broadmoor could be categorised as ‘Tilt high risk’. Categorising someone as ‘Tilt high risk’ on the admissions wards at Broadmoor makes little difference to their management during the initial admission assessment period, save for the fact that if considered necessary, it would permit their phone calls to be monitored.”
But he also said:

“There is a view that on admission all patients should be categorised as high risk for a period until such time as the clinical team and ward staff have gained a better knowledge of the patient. This would remove any uncertainty which may exist amongst staff as to the patients risk status.”

13.44 Alistair McNicol thought patient risk needed to be assessed as higher at Broadmoor than elsewhere to be classified as Tilt high risk. He also thought there were variations in application between different teams in the hospital.

13.45 We were told that deciding whether or not a patient was Tilt high risk was normally made after the patient had arrived at the hospital. That would usually be between one and six days after their arrival depending on when the next clinical team meeting was, although in exceptional cases the team might discuss a case before the patient’s arrival. Security Liaison Nurse 1 told us there were occasions when this delay caused a problem and he had to raise concerns to be considered before the next available meeting.

13.46 Security Liaison Nurse 2 attended the immediate aftermath of the attack on Richard Loudwell. When interviewed by the inquiry he was asked about the patient risk assessment. He said that formal risk assessment did not necessarily take place until the “admission” CPA three months after actual admission. Before then risk assessment came from the security department’s analysis of pre-admission information, together with whatever emerged at clinical team meetings. His personal view was that:

“…we should do a full risk assessment prior to the CPA, or otherwise have other things in place to ensure safety.”

13.47 Before team meetings were held the only information available to the security liaison nurse was a summary of the case prepared from intelligence sources. This would generally be brief and would not contain the wealth of information available in the clinical records. The security liaison nurse did not have access to the pre-assessment reports written on patients. If the security information summaries on Richard Loudwell and Peter Bryan were the norm, there was nothing in them which clinical staff would not have been able to glean from clinical sources. Security Liaison Nurse 1 accepted this put him in a weak position at clinical meetings. He said:
“I’m not happy about it. As I say, that’s the only information I receive. I don’t know anything about the patient at all.”

13.48 He accepted he could raise concerns if he had them, but on occasion it “feels like it has been brushed aside.”

“Quite often I would raise my concerns and quite often the clinical team wouldn’t support my views at all and quite often I felt I was standing by myself and wasn’t paid any attention to.”

13.49 It was his perception that the doctors did not see any value in the Tilt classification: it might highlight risks but it did not have an impact on the care of the patient. He understood the doctors’ point of view. He thought that one of the consultants was more reluctant to classify a patient as Tilt high risk. Security Liaison Nurse 1 considered that all patients should be classified as high risk on arrival until the staff had got to know them.

13.50 At the time of the assault it appears there was little emphasis on the consideration of risk to patients from others. The pre-admission assessment on Richard Loudwell by Nurse Consultant 1 did not even have a heading for harm from others. Security Liaison Nurse 2 accepted that from a security point of view the hospital was primarily concerned with the risk of harm to others:

“From what I see here and some of the reports I’ve seen looking back at patient’s histories, there isn’t much attention paid to harm from others.”

13.51 The pre-assessment nursing template in use since this incident does include provision for the assessment of risk of harm from others.

The dining room and physical security

13.52 As already noted the layout of the dining room is such that no one outside the room can see all of the inside so it is not obvious from the outside what any patients in the dining room might be doing. This appears to have been known by some staff, including members of the security department, but nonetheless the use of the dining room became
normal practice even if no staff were in the room observing activity. This practice may not have been known to all members of the security department.

13.53 In his written statement Security Liaison Nurse 1 said he remembered that the use of the dining room was discussed at some point and it had been locked off, but he could not remember when that was. In oral evidence he said he was unaware of the blind area in the dining room being discussed as a security issue. If it had, his view would have been that there should always be staff in the room if it was open. He did not consider he had any responsibility to advise ward staff about blind spots on the ward.

13.54 Alistair McNicol expressed a different view:

“If it had come to the attention of the security liaison nurse on Luton Ward that a patient(s) was unobserved in the dining room, I would have expected the security liaison nurse to have taken immediate action to notify the senior person on the ward that this was inappropriate and posed a risk. I would also expect him to have submitted an incident record and to have raised it with the clinical team. I personally was unaware that the dining room was being used by patients unobserved by ward staff.”

“We failed the victim and Mr Bryan himself; organisationally we failed them both and I would like to place that on record. As far as the security directorate is concerned, with hindsight if I personally had known the dining room was being used by patients, as it appears, unobserved, I would have been advising immediately that that be stopped...Because I don’t think it is appropriate that patients on an admission ward should be alone in a communal room such as a dining room unobserved.”

“If I or a member of my directorate...if any of us had observed that we should be taking some immediate action to advise whoever is in charge of the ward at the time that this wasn’t acceptable.”

“The reason for the incident occurring on 24 April 2004 (sic) unobserved by staff is difficult to explain. There was clearly a serious failure on the ward at that time to ensure the safety of the patients.”
“I don’t know whether the security liaison nurse observed or knew this was happening. You would have thought that because this room had been in use for that purpose for some time that he must have, but I don’t know that directly.”

13.55 The Security Operations Manager did not know if any specific security concerns about Luton Ward had been raised with the security department. He had not been aware of any discussions within the clinical team. He believed the department, if asked, would have advised that the dining room should be supervised whenever it was in use. The department had not been asked to assess the use of any Luton Ward rooms.

13.56 The dining room is not the only physical space in Broadmoor which is difficult to observe. Our own visits to other parts of the hospital suggested there are many areas where observation is difficult. This is probably inevitable in buildings largely from a different age with a different concept of care and management. It may not be practical to have enough members of staff to monitor such locations by direct vision, yet it appears such observation is what Broadmoor principally if not exclusively relies on for internal security. Alistair McNicol raised the possibility of improving safety by the introduction of CCTV monitoring in ward areas. He recognised that there were privacy issues but noted that such technology was now a common tool in the policing of public places.

Risk assessment of buildings

13.57 Security Liaison Nurse 2 thought one or two members of the security team had done a risk assessment course but that did not include training about risks presented by ward design. When asked if security staff would have been involved in a review or audit of security arrangements on the ward before the incident he said:

“It’s something we would be involved in, I think. We are now doing security audits so we’re probably more aware now, in the last two years, looking at a theme, and part of a theme could be the ward environment itself.”

13.58 When expressly asked if there was a systematic way in which security staff inspect the building he said:

“We do look out for things and we will discuss them with the ward manager. We have been involved in a number of wards that have had refurbishing done,
especially in the older building, and we were involved in discussions about better observations. We had some input into that but that is partly more as a clinical team, but we were also involved in upgrading the dining rooms on several women’s services wards.”

13.59 There was a physical audit of the perimeter carried out by the Prison Service but there was no audit of the physical security of the internal buildings, unless there were proposals to refurbish or change use.

Richard Loudwell

13.60 On 16 January 2004 Resource and Intelligence Manager of the security department originated an information sheet on Richard Loudwell’s admission to Broadmoor. It contained a brief summary of his index offence and previous convictions and the following three lines:

“Abusive to staff
Sexually disinhibited
Inappropriate touching of staff”

13.61 This sort of form is prepared as a matter of routine and distributed to the security operations manager, the security liaison manager, the security liaison nurse for the ward concerned, and the clinical nurse manager for the ward. Resource and Intelligence Manager told us he distributed these forms because he was instructed to. The ward did not tell him if the form was useful or not. The form is not updated if new information comes to light.

13.62 Security Liaison Nurse 1 remembered meetings at which the bullying of Richard Loudwell was discussed. In his witness statement, he said he thought Richard Loudwell should have been “Tilted”, registered as being at high risk of harm, but he did not suggest he had expressed this view to ward staff. He said he doubted it would have made any difference to Richard Loudwell’s treatment. He did not think reports of a patient being bullied would ever lead to a re-assessment of a patient’s risk as what generally happened was that the patient would be put on an enhanced level of observations. Security Liaison Nurse 1 had not received training in the management of patient vulnerability. If he had been asked about a patient such as Richard
Loudwell who was vulnerable and being bullied he would have advised that he should be registered as Tilt high risk.

Peter Bryan

13.63 The security department acquired brief details of Peter Bryan’s index offence at or before his admission. Alistair McNicol wrote a note to Security Liaison Nurse 1 asking if the clinical team had discussed whether or not Peter Bryan was a high risk patient, and reminding Security Liaison Nurse 1 he needed to be involved in those discussions”.

13.64 Security Liaison Nurse 1 replied in a memorandum dated 21 April 2004 that the clinical team meeting did not consider Peter Bryan to be high risk. It does not appear that Peter Bryan was registered as Tilt high risk until 26 May 2004, after the incident and after his transfer to Isis Ward. Security Liaison Nurse 1 remembered that Peter Bryan’s risk status had been discussed at the clinical improvement group meeting on 19 April 2004. The minute of that meeting contains no mention of Peter Bryan and does not record Security Liaison Nurse 1 as attending. Security Liaison Nurse 1 said it was not unusual for his name to be omitted. He said he would be surprised if the determined risk status of the patient had not been recorded somewhere. The security department was not sent copies of the clinical risk assessment when it was done.

Serious incident reports

13.65 It was part of the security department’s role to receive and, if necessary, initiate an incident record (Form IR1). The only one on Richard Loudwell’s file relates to the incident on 25 April 2004. There are none relating to the many incidents of bullying or harassment that had occurred previously and which were documented in the patient’s clinical records.

Critical incident review

13.66 The security department was not invited to, or represented at, the critical incident review which took place on 26 May 2004. Security Liaison Nurse 1 felt
someone from the department should have been present, as did Alistair McNicol and the Security Operations Manager. Similarly, the security department was not invited to contribute to the table top review nor the serious untoward incident review.

Conclusions

C101 Security has to be an integral part of all activity in a high security hospital. It is necessary to protect the public, staff and the patients themselves. A secure environment is the reason patients are admitted to high security hospitals as opposed to those offering a lesser degree of security. Patients in high security hospitals are - or should be - patients who present a serious risk to the public. They are just as entitled to protection from the danger presented by other patients as any other member of the public or staff. It is not a function which can be separated from the business of managing and caring for patients. Above all security can never be merely a matter of walls, locks and guards. As we were told time and again relational security, that is a close and watchful relationship between staff and patients, is the best guarantee of safety. This is not to say there is no role for security expertise over and above that expected of all trained staff in the hospital. In the busy routine of a ward the danger of unsafe practises and poor habits developing is ever present: a relative outsider may be in a better position to detect something going wrong than the ward insider. In the words of Alistair McNicol, using a boxing analogy:

“If you don’t keep your gloves up in terms of high security policies, procedures and observation and all the rest of it, you will end up, sadly, with an incident such as this.”

C102 An external department can focus on gathering and analysing intelligence in a manner not possible in the ward setting. However security advice from outside the ward will only be effective if it is sought, respected, listened to and applied. It needs to be accepted as an integral part of the day to day working of the ward.

C103 We noted that physical security in the ward common areas in Broadmoor consisted of direct visual monitoring and nursing management techniques such as periodic location checks. No automated or remote monitoring was available. We think it would be helpful to consider CCTV monitoring of particularly difficult areas. Such monitoring is no substitute for direct observation but could be a support for staff especially if direct observation was inadvertently or unexpectedly removed. It might also be useful in providing retrospective
information about incidents, and act as a deterrent to the use of monitored locations for violent or other illegal activity. However, we recognise there are wider issues in this area than we have been able to explore within our terms of reference.

C104 We found a number of inadequacies in the way Luton Ward security issues were handled:

- The purpose and use of the intelligence summary produced on admission had not been thought through or developed. The opportunity for producing a tool which would be mutually useful and acceptable to the security department and clinicians was not taken up.

- The security department did not ensure that the role of security liaison nurse was regarded by ward staff as important. The liaison nurse was not included in patient reviews to a sufficient extent.

- The legitimate view that security was a clinical matter led to the importance of external (to the ward) specialist security advice being disregarded.

- The liaison nurse was not treated as a full member of the clinical team and was not therefore listened to or respected to the extent necessary.

- Without intending personal criticism of any member of staff, we have the impression that staff were transferred to the security liaison nurse role if they were not succeeding in front line nursing rather than being regarded as the best person for the job even though this may not have been the intention of the Trust.

- The role of security liaison nurse in individual risk assessment was insufficiently emphasised. We are not satisfied the nurse was present at the clinical improvement group at which he believed an assessment of Peter Bryan had taken place. It is more likely that he gained an impression from conversations that the assessment had taken place and then relayed that impression to Alistair McNicol.

- It appears no provision was made for proactive observation of the ward to look for unsafe practices and uses of the building. It should have been part of the security

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liaison nurse’s job to draw attention to the potentially unsafe use of the dining room.

- There was insufficient exchange of information between the ward and the security department about individual patients. In particular:
  
  - Critical incident forms should have been completed and submitted to the department in respect of each incident of reported harassment of Richard Loudwell. The only such form submitted related to the last fatal assault. Reports of the previous incidents would have highlighted to the security department the level of risk to which Richard Loudwell was exposed.
  
  - Pre-assessment reports were not shared with the security department. This resulted in the department often having only basic information on each new patient. This compromised the department's ability to contribute to the risk assessment from a security point of view. We do not consider the obligation to respect confidentiality should prevent relevant clinical information being shared with the security department. We regard sharing this information as essential.

- The requirements of the Tilt directive were not implemented in full. Patients who were objectively high risk were therefore not registered as such because of the belief that Broadmoor could handle such patients. Only patients thought to present an exceptional risk by Broadmoor standards were designated high risk. We consider this practice could lead to complacency and lack of vigilance.

- The requirements of the Tilt directive regarding the protection of vulnerable patients as part of risk assessment were not given the same priority as those regarding patients who were dangerous to others. Vulnerable patients should be given the same priority in risk assessment.

- The security department and issues of security were too often marginalised and seen as peripheral to the therapeutic business of the hospital.

C105 These observations arise from our examination of the events leading to an incident on one ward but we have no reason to believe the problems we have identified are not common throughout the hospital.
Recommendations

R41  The security department and the forensic services directorate should review the policy for, and use of, intelligence summaries whether circulated in hard copy or electronically. They should improve the quality and extent of risk related information they contain and ensure they are updated in response to new information.

R42  We are told that a national review of the role of security liaison nurse is underway across the three high secure hospitals. We recommend that whether as part of this process or following it, the hospital should conduct a review of the role of security liaison nurse and try to reach agreement with clinical staff about the contribution this post should make to the management of patients on the ward.

R43  The hospital should review the job specification and criteria for the appointment of security liaison nurses with a view to improving the competency and skills of those appointed.

R44  The hospital should consider adopting a policy whereby appointments to the post of security liaison nurse are for no more than five years and are rotated between ward staff and security department staff.

R45  Within the parameters of the NHS Code of Practice on Confidentiality and other national and professional guidance the hospital should initiate a protocol or policy for ensuring the routine exchange of security related information between the security department and the ward which should include access for the security department to relevant clinical information.

R46  The security department should collect and disseminate intelligence on all Tilt risk factors, including patient vulnerability to harm by others.

R47  A Tilt risk assessment on each patient should be prepared and in place at the time of admission, regardless of the amount of information available on the patient at the time. The assessment should be reviewed by the clinical team and the security department regularly, that is to say at least once a month. This could be more frequent if any member of the clinical team or security department thinks new information suggests the need for such a review.
R48  Management should ensure the Tilt risk assessment includes all risk factors. All factors, including vulnerability to harm from others from assault or harassment, should be given equal priority.

R49  A representative of the security department should be present at all clinical team meetings, and the security department’s view as to the risk status of any patient should be recorded in the minutes. If the decision as to risk status is contrary to the expressed view of the security department representative the reasons for the decision should be recorded and communicated to the director of security.

R50  The security department should receive a copy of relevant minutes from any clinical team meeting at which the risk status of a patient has been discussed.

R51  Management should ensure that reports of any incident of bullying or harassment are sent to the security department.

R52  The security department should arrange for periodic ward inspections to assess risks posed by physical structure, equipment, and the way structure and equipment are being used by staff and patients. Ward managers should receive the results of such inspections in writing.

R53  The Trust policies on health and safety and risk management should be reviewed in the light of our recommendations, particularly in relation to the assessment of risk from the working environment.

R54  The security department should be consulted on any proposal to change the use of a room or premises, whether or not the change involves refurbishment or rebuilding.

R55  The Trust should initiate a review to consider introducing CCTV or other remote monitoring particularly for areas of the hospital which are difficult to observe.

R56  Management should ensure that the security department is notified of any serious untoward incident review and given an opportunity to contribute to the review.

R57  The Trust should consider re-organising the management structure at Broadmoor so the security department is integrated into the directorate of forensic services and the
manager with operational responsibility for security reports directly to the director of forensic services. In the event of a disagreement on a matter of security between that manager and the director, the matter must be reported to the Trust chief executive and/or the Trust’s director for security.

R58 The Trust is invited to draw the attention of the Department of Health and the Ministry of Justice to the comments we make about the Tilt report and the need to give the protection of patients from other patients the same priority as the protection of the public from patients. Specifically we recommend that the directions be amended:

- to require re-assessment of a patient’s risk status whenever s/he is the victim of actual or threatened violence

- to require the re-assessment of the risk status of any patient who has used or threatened violence towards another patient or member of staff.

R59 The “decision tree” in the Tilt guidance should be reviewed to give greater emphasis to consideration of whether vulnerable patients are capable of making appropriate decisions to protect themselves.

R60 The guidance should be amended to remind hospitals that for reasons of their disorder or other reasons, some patients may be unwilling or unable to cooperate.

R61 The Trust should initiate a review of the way clinical and security information about patients is obtained from the prison service to ensure uniformity of practice. The aim should be the disclosure of such information within as short a time as possible and ideally before admission to Broadmoor. Unless there are security reasons otherwise, all such information should be made available to the clinical team. Any clinical information relevant to security, as assessed by a properly trained security liaison nurse, should be made available to the security department.

R62 With local and national police the Trust should initiate a review of arrangements to obtain police intelligence and other relevant information about the risks presented by or to patients.
R63 The health and safety policy should be revised to ensure risk assessment of the environment in which patients are cared for has adequate regard to the risk presented by patients to one another, to staff or to themselves.
14. Support for families

14.1 The loss of a close relation to detention in a high-security hospital after a horrific killing is highly traumatic for the family concerned. For that to be followed by the death in hospital of that relation at the hand of another patient is even more dreadful. The family of the victim are and should be treated as victims of the homicide and are entitled to all appropriate support from the authorities.

14.2 Indeed, one of the principal duties of an inquiry such as ours must be to inform the bereaved family of what happened and provide them with the small consolation that the death has led to the learning of lessons which will minimise the chances of such a tragedy occurring again.

14.3 In the context of a hospital the family of the perpetrator of the homicide should not be forgotten either. They are entitled to expect that their mentally ill relative has been detained in a high security hospital to protect him from the consequences of his illness until such time as it is safe for him and others to be discharged to less secure surroundings. Where the system so fails a patient that while mentally ill he seriously injuries and kills a fellow patient in hospital, his family may also be regarded as victims and are entitled to all appropriate support.

14.4 Therefore the inquiry has examined what was done to assist the families both of Richard Loudwell and Peter Bryan. The families are, of course, accountable to no-one and are not responsible for anything that occurred. It would be wrong to interfere with their privacy more than absolutely necessary. Some of what follows will therefore be expressed in more vague language than might otherwise have been the case.

Policies

14.5 The hospital had a policy on the death of a patient in Broadmoor. The version in operation at the time of Richard Loudwell’s death had been published in 1998 and was revised in September 2000. This policy is striking in that it offered no guidance on liaison with a deceased patient’s family.

14.6 West London Mental Health Trust published a further draft policy on the death of a patient in October 2004. This lays down requirements for offering information and support.
to patients, friends and staff. So far as the family is concerned, an “appropriate person” must be identified to coordinate and maintain all contact with the patient’s relatives to “ensure that they are given support from the time the death occurs until the funeral and to continue offering support at least until the date of an inquest”. Managers of different sites are required to develop local procedures.

14.7 Pursuant to this policy, Broadmoor also drafted a policy in October 2004 with detailed guidance about the help available to families in relation to funerals and other matters. It also provides for the duty doctor in consultation with other staff to decide who is the most appropriate person to contact the next of kin. This is usually the consultant or the duty doctor. The on-call manager is to ensure this has been done. The consultant is to be available to deal with the relatives’ inquiries. Where the death has taken place in another hospital, there should be a detailed care plan in the patient’s records of what to do and who to contact in the event of death.

14.8 Policy U1 on serious untoward incidents, drafted in December 2003, contains little on support:

“Suitable arrangements may be required to provide support to relatives, carers, or friends of the individual concerned.”

14.9 We note and welcome the introduction of a revised policy, I8 Incident Reporting and Management Policy introduced in April 2008 which contains detailed guidance on the need for family liaison following serious incidents and during subsequent investigations. The following advice appears within this guidance:

“5.5 Communicating with and Supporting Relatives

5.5.1 It is essential to ensure relatives are always kept informed of progress of the review and related events; this will be as appropriate but must happen following any death or serious incident.

5.5.2 Good communication is vital to allay the anxiety and fears of relatives and carers. Communication must be open, honest and accurate, ensuring that the right information is given to the right people and that they have ample opportunity to ask questions.”
5.5.3 Face to face contact is always preferable to other indirect communication media in these circumstances.

5.5.4 Sharing of information about the incident and subsequent investigation is important to reassure relatives and carers that the incident is being investigated and that measures are being taken to ensure that a recurrence of the incident is prevented.

5.5.5 The principles and concepts of Being Open - communicating patient safety incidents with patients and their carers (NPSA, 2006) should be considered. This document is available on the Risk and Safer Services Page of the Exchange.

5.5.6 It is both natural and desirable for those involved in the care which produces an adverse outcome to sympathise with the person’s relatives and to express sorrow and regret at the outcome. Such expressions of regret do not normally constitute an admission of liability, either in part or full, and this policy does not prohibit them.

5.5.7 As part of apologising it is the intent of this policy to encourage the sharing of information related to the incident with relatives whether informally, formally or through mediation. The NHS litigation authority is clear that it will not take a point against anyone offering a factual explanation offered in good faith before litigation is in train. They consider that the provision of facts, as opposed to opinions to constitute good practice, should form the basis of any explanation.

5.5.8 Immediately after a death or serious incident the responsibilities for communicating with relatives is described above in section 4.5.1.

5.5.9 In the event of a death a letter of condolence must be considered. This should be signed by the Chief executive.”
Support during admission at Frimley Park Hospital

14.10 There appears to have been no bar to the family visiting Richard Loudwell whenever they wanted but logistical problems made this difficult. However, they were able to keep in regular contact by telephone with staff on the ward and were given information about his condition and prognosis, although the quality and content of this depended on whom they spoke with. Some staff were unduly optimistic at a time, when as they subsequently discovered, a “do not resuscitate policy” had been agreed.

14.11 On 26 April, the day after the incident, a clinical team meeting discussed the incident in detail. During the meeting Social Worker 2 telephoned a member of Richard Loudwell’s family who had been informed of the assault by the police. She undertook to contact them again after visiting Richard Loudwell with RMO3.

14.12 Neither the commissioners for secure services, the West Kent NHS and Social Care Trust nor the Trevor Gibbens Unit, which had referred Richard Loudwell to Broadmoor, were told of the incident. They had not been told by 18 June 2004, over two weeks after Richard Loudwell had died. Many staff who might have had to field inquiries in Kent learned of events only from the media. It emerged that whilst the Trust’s policy required commissioners to be informed the procedure sheets followed by staff after Richard Loudwell’s death omitted this requirement and so this was not done. This has been rectified.

14.13 RMO3 and Social Worker 2 visited Richard Loudwell at Frimley Park the day after the incident. Both spoke to several members of his family by telephone that day. RMO3 was shocked by Richard Loudwell’s condition and formed the view that he would not survive. However, there was no firm diagnosis and the facts of the incident were not fully known. Therefore he found it difficult to know what to say to the family:

“I knew there would be a possibility of further action. So while expressing sympathy and shock, which is what we all felt, it was difficult to go much further.”

14.14 By “further action” RMO3 meant the possibility of litigation by the family:
A. The full facts were not known, it wasn’t known quite how they would react, but their elderly vulnerable relative comes into hospital and is assaulted by another patient. It is obvious that there would be potential action.

Q. Why would that inhibit anyone from telling the next of kin what is known about what had happened?

A. Absolutely nothing about that. It is just about the extent to which I felt I could admit liability or say sorry.

Q. Did you feel constrained in that it was your inclination to say, ‘I am terribly sorry, this should never have happened’?

A. Of course, that is a natural human response and I felt awful about the whole thing. Then they did not seem to be looking for that from me. Because they had been liaising quite a lot with others, they seemed to know quite a lot about what happened. Most of them seemed to know more than I did initially, but they did not seem to be looking for that.

14.15 The nursing observation notes record visits by RMO3 and Social Worker 2, on 26 April and 26 May only, but RMO3 told us he visited his patient on three or four occasions. We could find no entry in the Broadmoor clinical records of RMO3’s visits.

14.16 RMO3 did not meet Richard Loudwell’s family. He told us management had asked him not to meet them unless they requested it. The reason he says he was given was the perceived need to monitor the information given to them and to ensure that it was properly recorded. RMO3 regretted that he had not seen the family:

“I would like to have met them, they could have confronted me and perhaps felt better if they needed to. I was never informed about what their views were really and I was kept in the dark, maybe on purpose, about how they felt about circumstances, what they felt about the hospital and about me in particular. In a way, I can understand that, and I have not had any feedback from them at all.”

14.17 The Trust denies that there was any instruction to RMO3 not to meet the family, but they accept that greater effort should have been made to meet the family. It was clearly unfortunate that RMO3 was left under a misapprehension with regard to what he should or should not do in these for him, novel, and distressing circumstances.
14.18 Social Worker 2, as noted above, visited Richard Loudwell with RMO3 the day after the assault. She also facilitated a visit from a close relative on 11 May 2004 and gave that relative a lift to Frimley Park.

14.19 On 30 April 2004 a member of Richard Loudwell’s family wrote to Social Worker 2 thanking her for the consideration she had shown to the family but complaining that the family had not been given details of the assault which had appeared in the press. The letter went on to say that the family did not seem to have been given full details about Richard Loudwell’s medical condition and prognosis; they would rather know the truth than be left in ignorance; Social Worker 2 was asked to ensure that the family were given:

“...all information past and future accurately and honestly in the best interests of everyone, so that our level of trust does not get affected.”

14.20 Social Worker 2 replied on 6 May 2004 regretting that the family felt that she had withheld information and asking them to understand that she had tried to answer all their questions within the limits of the duty of confidentiality and the existence of a police investigation, but that the press were not so restricted. As for information about Richard Loudwell’s medical condition she understood that medical staff were still not able to offer an opinion.

14.21 There appears to have been no contact between Social Worker 2 and the family between 12 May and 3 June 2004, when there were telephone conversations about Richard Loudwell’s condition and arrangements for further visits.

14.22 On 19 May 2004 a member of Richard Loudwell’s family wrote to the chief executive, Simon Crawford. The letter expressed the family’s surprise and amazement that he had not been in contact with the family with an explanation since the assault. No reply was sent before Richard Loudwell’s death. Sean Payne accepted that with hindsight early engagement and communication with the family would have been beneficial. The Trust had “struggled with” knowing what level of support to offer when it was “probable the concerns of the family would be expressed legally...against the Trust or the hospital”. He wondered whether it was right for the Trust to provide the support or whether the strategic health authority should take on that responsibility to ensure objectivity and sensitivity. He accepted that it was natural for the family to question why the hospital had
not been in touch rather than relying solely on individuals with background knowledge to make personal approaches, especially as they might have personal difficulties about the legal consequences of the incident. This view was echoed by Simon Crawford who agreed that the Trust could have been more proactive sooner with more input for the family and should have answered the family’s letter sooner. Simon Crawford denied that the lack of communication had been motivated by concern over litigation:

“Clearly we wanted to do the right thing and it is the prerogative of the family if they wanted to pursue legal action per se anyway, but it doesn’t mean we shouldn’t try and do the right things in supporting them in this tragic incident.”

14.23 On 1 June 2004 Social Worker 5, team manager for forensic social work service of Ealing Social Services, wrote to Sean Payne requesting a review of the procedure for informing families about patients taken out of Broadmoor with serious illness or injury. In her view there was a danger of such a transfer occurring without the family’s knowledge. Sean Payne asked Service Director 3 to ascertain the nature of the concerns and to review the procedure.

Comment

It was appropriate and indeed essential that RMO3, as RMO, visited his patient at Frimley Park even if there was in fact little he could contribute to the patient’s care at that stage. It was necessary if only to help him in his and other staff members’ contact with the family and the information they could pass on. It is unfortunate that his visits were not more widely and thoroughly recorded.

RMO3 is to be commended for contacting members of the family as soon as he had seen his patient. However, his feeling of being inhibited in what he said by the possibility of further action, while understandable, is concerning. It is also of concern that Social Worker 2 felt that the information given to the family before and after Richard Loudwell’s death was incomplete. She was critical of the process by which information was given to the family, a matter she had raised in supervision and with the director of forensic services. There does not appear to have been a system for ensuring proper contact with the family and an adequate and co-ordinated flow of information to them.
It is natural that there should be some reservation in offering apologies and explanations when the facts are unclear and there is a possibility of further action including complaints or litigation. This should never inhibit a senior medical practitioner who is primarily responsible for the care of the patient from expressing sympathy, giving such limited explanations as possible and offering and organising appropriate support. As with any adverse incident in a hospital, possible consequences should never inhibit a humane and helpful response. Indeed, such a response may reduce the sense of grievance which may motivate action of this sort.

A balance is required between the patient’s rights to privacy and confidentiality and the obvious need of his next of kin and close family to know what has happened and what is being done. Such a balance can be difficult to achieve where there is or has been conflict or alienation between a patient and the family complicating their relationship, although no such complication appears to have existed here.

We are concerned that RMO3 was clearly discouraged from offering to meet the family. There is obviously a need to ensure that consistent and accurate information is given to family members and that what has been said is properly recorded but we see no reason why in this case the RMO would not be an appropriate person to undertake a leading role in contact with the family.

We think it is almost always appropriate after an incident as serious as this for the responsible medical officer to make prompt contact with the patient’s close family and provide as much information and support as possible. Where for any reason information has to be withheld, the family should normally be told why.

Any communication with a patient’s family in these circumstances should be fully recorded in a note accessible to and read by any other member of staff or management who also makes contact with family members.

Courtesy required that a swift reply be given to the letter the family sent to the chief executive on 19 May 2004. As it was, no reply was sent for nearly three weeks, by which time Richard Loudwell had died. As the letter had complained of lack of contact, we find this failure even to send a swift acknowledgement deplorable. Indeed, we would have expected the chief executive to have written on his own initiative to Richard Loudwell’s next of kin as soon as possible after the assault,
given its gravity. Failure to do so will have given the erroneous impression that the hospital and the Trust did not truly care about this incident and will have added to the family’s distress. The understandable lack of complete information about the incident and Richard Loudwell’s prognosis does not excuse the omission to demonstrate to the family the seriousness with which the organisation as a whole was treating the matter. We were not impressed by the reaction of either the chief executive or the director of forensic services to this omission. They did not display an appropriate level of concern.

There was a lack of co-ordination of the process of informing interested professionals and agencies of what had occurred, both before and after Richard Loudwell’s death. According to the extant policy for serious untoward incidents, the responsibility for deciding which agencies were to be informed lay with the chief executive.

The handling of vital communication of information to family, colleagues and agencies was left to the initiative of a conscientious social worker and the RMO who did their best in difficult circumstances but without any adequate guidance or help at a time of considerable anxiety and stress for both of them. The extant policy for serious untoward incidents required the senior clinician present or his/her delegate at the incident to inform relatives of what had happened but made no provision for what should happen where no clinician was present.

The communication strategy and its coordination should be part of the patient’s care plan so that responsibilities are clearly allocated and a record kept of what information has been disseminated and to whom. Social Worker 2 and Richard Loudwell’s family were both entitled to feel aggrieved at the way this was handled, in spite of the former’s best efforts.

Notification of death and aftermath

14.24 Mr Loudwell died on 5 June 2004 at about 10.40pm. Broadmoor nursing staff informed management immediately.

14.25 RMO3 informed the inquiry that he contacted Richard Loudwell’s family to express his sorrow and that of the care team as a whole. On 8 June 2004 he wrote letters
expressing his sympathies and expressing his willingness for the family to contact him if they wished to. He did not visit the family personally as a result of discussions with hospital management. At a later date he received a letter from a member of the family outlining concerns and questions, and he replied.

14.26 Social Worker 2 accompanied members of the family to the formal identification of Richard Loudwell’s body and provided support at this difficult time.

14.27 On 11 June 2004 the chief executive finally replied to the family’s letter of 19 May, at the same time briefly expressing his condolences on Richard Loudwell’s death. An explanation was given of the arrangements for contacting the family immediately after the incident and subsequently. The letter contained no apology for any distress caused and described the assault as “regrettable”. Simon Crawford was asked whether there was not scope in this sort of letter to express the view that the Trust and the hospital had let the family down. Simon Crawford did not think so:

“At that stage that probably isn’t the sort of thing I would put in that type of letter. The sort of thing I would be saying is I am extremely sorry for what has happened and we clearly need to look and understand fully the facts around how this has happened and we will keep you abreast of the inquiry process. I don’t think at that stage I would be saying we had let anyone down per se.”

Comment

We have already commented on the time taken to write this letter. When it was finally sent, it contained no apology for the delay, for the incident or for any further unintended distress caused by any difficulties in contact. To a less understanding family, this letter might have been seen as provocative, increased their distress and generally been counter-productive. We disagree with the chief executive’s view of the limit of what should have been included in a letter at that time. We consider that the sketchiest consideration of the known facts would have led to the conclusion that Richard Loudwell had been let down. A seriously ill patient in need of and entitled to the protection of the hospital from danger had not been protected, and a serious and sustained assault had not been prevented or even noticed until it was over. It is right that it was too early to know why this had happened but that there had been a failure to protect Richard Loudwell was already indisputable. It is of even greater
concern that the chief executive appeared to be unable, even in June 2006 when he gave evidence to the inquiry, to accept that there had been a collective failure on the part of Broadmoor which had led to Richard Loudwell’s death:

Q. It may be that you would think it would be premature at this stage to have any opinion as to whether there has been a collective failure on the part of Broadmoor which led to Mr Loudwell’s death. What is your reaction to that? Is it too early to say or do you have a view?
A. There are lessons for us to learn, which I have acknowledged as we have gone through on a couple of occasions. The overriding reason for Mr Loudwell’s death is the assault by the patient Peter Bryan. There were no indications that I can tell from what I have seen or understood that Peter Bryan was likely to be assaultative, had Richard Loudwell in his sights to be assaultative of, and it couldn’t reasonably be foreseen at that particular moment on that particular occasion that that severity of assault was going to take place resulting in the kind of outcome that it did. That is not to say that, with the benefit of hindsight and looking at the incident, there weren’t other things we could have done differently.

Giving evidence in June 2006, Simon Crawford then described these events as:

“…a tragic incident, it was a bit of a shock to the system. As an organisation we are extremely disappointed that it happened within Broadmoor. Sympathy clearly goes to Richard Loudwell’s family, and we are concerned to learn the lessons from the incident.”

It was put to the Trust executive that it is a matter of concern that the Trust, as represented by its chief executive, took the view that a fatal attack of a patient in the circumstances of this case can properly be treated as unforeseeable, and therefore an unavoidable, if tragic, incident. This might be thought to display an attitude to risk which is somewhat complacent and suggests that at least as of June 2006 senior management of the hospital did not adequately appreciate the lessons of this tragedy. In response the Trust stated that the chief executive would like to apologise to the panel if he gave the impression in June 2006 that the Trust did not accept there had been a “collective failure on the part of Broadmoor which had led to Richard Loudwell’s death”. Simon Crawford on behalf of the Trust accepted that
there was a collective failure of the hospital’s duty to provide a safe and therapeutic care environment for patients Richard Loudwell and Peter Bryan.

14.28 Two events caused particular distress to the family. The first concerned Richard Loudwell’s watch. The family wanted this and his glasses to be returned. There were considerable difficulties in finding the watch, but it was eventually given to Social Worker 2 in a sealed bag to give to the family. It had probably been taken off Richard Loudwell at Frimley Park, placed in a bag and sent back to Broadmoor. Most regrettably, when Social Worker 2 handed the bag to the family who opened it, the watch was seen to be blood stained. Social Worker 2 had not thought it right to open the bag before handing it over as she did not want it to look as if the bag had been tampered with. Social Worker 2 told the inquiry she felt personally responsible for this distressing event. Of apparently less significance to the family, the glasses could not be found, only the case.

14.29 Second, among the property returned to the family were letters from his solicitor and other documents relating to his impending trial. The family were distressed by the uncertainty of whether they should have such documentation or indeed knowledge of the contents. Arrangements were made for the police to collect some of the material.

Comment

We consider that Social Worker 2 is being over-critical of herself. The fault lies not with her but with a system which allows property to be stored and handed back to the relatives of a deceased patient without it being checked and, where necessary, cleaned. It also appears that the system for logging the whereabouts of a patient’s property was incapable of managing a patient’s property after a transfer from Broadmoor for physical medical treatment.

There was clearly a failure to inspect Richard Loudwell’s correspondence and other documentary material before handing it to his family. Confidential legal papers concerning criminal proceedings should be passed back to the patient’s solicitor as only they are qualified to judge what should be done with privileged and confidential legal material.
14.30 A meeting took place on 28 June 2004 between Social Worker 2 and Sean Payne to discuss the arrangements for contact with the Richard Loudwell family. Sean Payne accepted that this was probably the first time there had been formal agreement about who the principal contact point for the family should be and the arrangements until then had been ad hoc.

14.31 On 18 August 2004 Social Worker 2 and her manager visited members of the family and discussed their concerns, providing them with information about the circumstances of the assault and ward routine. The arrangements for the funeral were discussed and confirmed in a follow-up letter by Social Worker 2 on 23 August 2004.

The funeral

14.32 Richard Loudwell’s funeral was arranged with the help of hospital management. The chaplain officiated. RMO3 did not attend for the reasons considered above, although he would have liked to do so. He regretted that he had not gone and had not done more to see if it was acceptable for him to have gone.

14.33 Social Worker 2 expressed concern at the nature of the financial support offered by the hospital for the funeral. The cost of a basic funeral was underwritten, but monies held at Broadmoor on Richard Loudwell’s account were used as a contribution to costs. Social Worker 2 felt this was inappropriate in the circumstances. However, it seems that the family understood and accepted this arrangement.

Comment

It is clearly appropriate that the hospital should offer financial support for a funeral but there is no reason why the estate of the deceased, if in funds, should not be expected to contribute or pay for a funeral, as would be the case for anyone dying in this country.

Conclusion

C106 Attacks like this are rare, so it is not entirely surprising that there was uncertainty about how to approach the important issue of supporting Richard Loudwell’s family. It is
an area where it is hard to lay down general rules as each family and each patient has different needs and circumstances. However, it is in just such cases that senior management should take an immediate and proactive role in the planning, coordination and monitoring of the support and information supplied. As has been shown above, management failed to ensure that this occurred, leaving individuals to do their uncoordinated best when they had no informed idea what they were permitted to say or do. Even when not only the family but the responsible social worker registered their concerns there was no adequate and timely response. In particular, the inability of the hospital to expressly recognise even the possibility that there had been a failure of its systems to keep Richard Loudwell safe is likely to have added to the hurt the family felt and to reduce its confidence in what they were being told.

Recommendations

14.34 The hospital’s policy D6 (“Death of a patient”), drafted after this incident, contains no reference to the need to provide family support in the event of a death or any guidance to how this should be organised. Policy U1 on serious untoward incidents referred vaguely to the need for “suitable arrangements”. The policies should be amended to provide a procedure for:

R64 The identification of one or more professionals to be responsible for liaison with and support of the family.

R65 Planning what information is to be released to the next of kin and other appropriate family members.

R66 Planning what support is to be offered to the family.

R67 Recording the information and support given in a form accessible to the clinical team and hospital management.

R68 Planning and managing the dissemination of information concerning the death to other responsible healthcare professionals.

R69 Ensuring that these arrangements are made part of the care plan.
R70  In the case of the death of or life-threatening injuries to a patient, the assumption by the chief executive, in conjunction with the director for forensic services and the RMO, of responsibility for ensuring that the appropriate arrangements for support are in place.

R71  Giving priority to the needs of the family of a seriously injured or dead patient for support over the perceived needs of the Trust or its staff with regard to potential, threatened or actual litigation.

R72  Unless there are exceptional circumstances making a meeting inappropriate, the RMO should never be prevented by management from meeting such members of the family of a seriously injured or dead patient as he/she sees fit.

R73  The system for preserving and recording the location of patient’s property should be reviewed with particular reference to the property of patients who are transferred to another hospital for medical treatment.

R74  Any confidential legal documents belonging to a deceased patient should be the subject of consultation with the patient’s legal adviser, if any, and, where necessary, the Trust’s legal adviser, before a decision is made as to who such material should be transferred.

R75  Procedures should be implemented to ensure that property of a deceased patient is inspected to ensure it is in an appropriate condition.
15. Incident investigation

15.1 Aside from this inquiry there have been the following investigations into the assault on Richard Loudwell by Peter Bryan on 25 April 2004:

- A critical incident review (CIR), held on 26 May 2004
- A ‘table top’ review of the CIR, held on 18 October 2004
- A ‘root cause’ analysis, conducted by Sean Payne in March 2005
- A serious untoward incident inquiry, chaired by Professor Kennard, which reported in March 2006.

15.2 In this chapter we briefly review these investigations and comment on their findings. We will also consider the effectiveness of these investigations and what lessons can be learned for future investigation of the most serious incidents at Broadmoor.

Policy

15.3 The relevant Trust policy for investigation of the assault on Richard Loudwell was “U1: Serious Untoward Incidents and Resulting Inquiries”.

15.4 The definition of a serious untoward incident includes a case of death or serious injury. It was clear from the outset that Richard Loudwell had been seriously injured.

Reporting requirements

15.5 Section 3 of policy U1 provides for the reporting of a serious untoward incident:

“3.1 All incidents whether requiring individual investigation or not should be reported using the Trust’s procedures for accidents/incidents, security reports and RIDDOR. 

3.2 Serious untoward incidents will require individual investigation and should be notified by the person immediately in charge of the area to the relevant Senior Manager and/or Clinical Director, Head of Department, or out of office hours to the Duty Manager. Via the Manager or Head of Department, the appropriate

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15 Reporting of injuries, diseases and dangerous occurrences regulations 1995.

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Executive Director (out of normal hours the Executive Director on-call) should be informed who will in turn inform the Chief Executive. Each Director should ensure this pathway is clear within his/her Directorate. The Chief Executive will decide how and when to inform the Chairman and other Board members. Clinical incidents will always be reported to the Medical and Nursing Directors usually on the next working day but immediately if very grave...”

15.6 Service Director 1 was the on-call manager. Her evidence, which we accept, was as follows:

“Sunday, 25th April 2004 fell during the period for which I was the on call duty manager. I was called at about 6.20pm by the Nurse Manager from Broadmoor’s Nursing Administration office.”

“When I spoke with the Nurse Manager we agreed that this was such a serious incident that I had to attend. At this early stage it was being reported that Mr Loudwell may have sustained life-threatening injuries. I also agreed with the Nurse Manager that he would contact the other relevant personnel whilst I was travelling to the hospital in order to save time. This included:

- The on call executive director (Simon Crawford)
- The on call PR manager
- The Clinical Nurse Manager for the ward (Ward Manager 1), and
- The Clinical Director (RMO2)
- Thames Valley Police”

15.7 Service Director 1 also asked for the duty security liaison nurse, Security Liaison Nurse 2, to be notified.

Actions to be taken

15.8 Section 4 of the Trust’s policy U1, provides for the following “Immediate actions to be followed once a serious untoward incident is identified”:

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“4.1 Where a patient is involved in a serious untoward incident the appropriate medical and nursing staff must make comprehensive entries in the case notes as soon as possible after an incident. It is the Senior Manager or Head of Department’s responsibility, or the Duty Manager out of hours, to ensure that these individuals are relieved of other responsibilities to allow this to happen…”

“4.4 Staff on duty and directly involved in an incident will be required to provide a written statement of their involvement in the incident prior to going off duty unless medically unfit to do so.”

“4.5 The Senior Manager to whom the incident was reported by the person immediately in charge of the area should produce, within 72 hours, a report of the incident covering the prima facie facts (including who, what, where, when and how), a description of the action taken following the incident and any initial assessment of the causes of the incident. Any information sought but not available in the timescale should be identified in this report. This prima facie report should be reviewed by the relevant Director and forwarded immediately to the Chief Executive. A check list for immediate action is attached at Appendix 2…”

15.9 Each of these steps was complied with. There are extensive entries in the notes of both Richard Loudwell and Peter Bryan. Eight of the nine members of staff on duty on Luton Ward at the time of the incident made brief written statements about their involvement. The only member of staff who apparently did not make a statement was HCA5 who had been on duty at the relevant time on the corridor. The statements were all brief; none was more than three paragraphs long.

15.10 Service Director 1 produced a report dated 26 April 2004 which she handed that day or the following day to Service Director 3, the service director of the London directorate.

The critical incident review/ serious untoward incident inquiry

15.11 Section 5 of the policy requires a decision on whether to hold an inquiry within five working days. We accept the evidence of Sean Payne, director of forensic services, who explained to us how it came about that there was a critical incident review and an SUI:

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“Once the immediate situation had settled the next step was to ensure a review of what had occurred took place. The critical incident review was intended to be an initial response by the clinical team to the incident to try to identify any immediate issues which needed to be addressed. From the outset it was anticipated that there would be a far more detailed and thorough serious untoward incident review in due course.”

“RMO2 and RMO3 were provided with a copy of the draft terms of reference which I had drafted for the serious untoward incident review, and I requested that they use these as a framework for the critical incident review.”

15.12 The SUI itself was not commissioned until 7 June 2005, a year after Richard Loudwell’s death. We accept that it was reasonable to postpone the SUI pending completion of the criminal investigation given the steer that was given by the police and the fear on the part of the Trust that its own investigations might compromise the police investigation.

15.13 In the absence of an immediate SUI a critical incident review was held. CIRs are provided for in section 7 of policy U1, which states at paragraph 7.1:

“Clinically focussed critical incident reviews must be carried out by clinical teams as a matter of good practice. All such reviews should incorporate peer review, either by involving fellow clinicians from outside the immediate clinical area or by seeking external clinical input. However where a serious and untoward incident has led to the convening of an inquiry team there is no obligation for the clinical team to undertake a critical incident/ peer review.”

15.14 There was very little assistance for Trust staff in policy U1 (Serious Untoward Incidents and Resulting Inquiries) or policy I1 (Incident Reporting) as to how a CIR should be conducted. We note that in May 2008 more detailed guidance was given in Policy I8 ‘Incident Reporting & Management’ and I8 ‘Undertaking Incident Reviews - Management Guidelines’.
The critical incident review (CIR)

15.15 This took place on Luton Ward on 26 May 2004, a month after the assault on Richard Loudwell and while he was still alive. The review took the form of a group discussion, led by RMO2. All the participants were present throughout. A report, dated 27 May 2004, was prepared by RMO2 following the meeting.

Attendees

15.16 The following attended the meeting:

- RMO2
- RMO3
- Ward Manager 1
- Team Leader 1
- Nurse 1
- HCA1
- HCA6
- Student Nurse
- Service Director 3
- the Service Manager of the London Directorate
- Social Worker 2
- Manager of Occupational Therapy
- Occupational Therapist 2.

15.17 A significant absentee was Security Liaison Nurse 1, security liaison nurse. He told us he had not been aware of the meeting and would have attended if invited. It seems to us striking that a CIR into this incident could be contemplated without input from the security department and in particular the ward’s security liaison nurse. RMO3 could not explain why Security Liaison Nurse 1 had not been invited. He accepted the omission was regrettable. The failure to involve the security department indicates the poor standing of the security liaison nurse role at the time. It may be that at the time of the CIR it was assumed there was no significant ‘security’ issue and therefore...
no need for a security department representative to attend. In our view there is a clear need for input from the security department in this type of serious incident review.

15.18 A second significant absentee was Primary Nurse 3 who was Richard Loudwell’s primary nurse. As the member of staff with the lead role in the management of the victim it is difficult to see how a comprehensive CIR could be conducted without involving him.

15.19 Service Director 3, then service director of the London directorate, told us she had not been invited to the meeting but insisted on attending when she heard it was taking place. Again we find it surprising that she was not invited or at least formally notified. We think this failure points to a lack of understanding on the part of senior members of the Luton Ward clinical team as to what was required after an incident of this gravity.

Methodology

15.20 The CIR had the benefit of the Trust’s terms of reference for a serious untoward incident inquiry but the CIR was hampered by general inhibitions and lack of clarity as to its remit. It was not intended to be a serious untoward incident inquiry. This was planned to take place after the completion of any criminal investigation. At the time of the CIR RMO2 believed the police had instructed that there should be no formal investigation, and no further witness statements should be taken from staff (i.e. in addition to those prepared by staff on the evening of 25 April 2004). He thought that if the hospital held a formal SUI, or took witness statements this might prejudice the criminal investigation and jeopardise any prosecution. This view appears to have been shared by management at Broadmoor.

15.21 The intention was therefore to hold an informal meeting to see whether there were any steps that needed to be taken urgently to address the safety of staff or patients in the light of what had happened on 25 April 2004.

15.22 We heard from a Detective Chief Inspector, who was the senior investigating officer on the case for Thames Valley Police, that neither he nor any of his colleagues, to his knowledge, had issued any prohibition on the hospital investigating what had happened. He did accept that police
might have told the hospital not to conduct an inquiry in a manner which could prejudice the criminal investigation. For instance, if statements were taken from potential witnesses there was the possibility of a prosecution being complicated by any inconsistency between statements taken by the hospital and any taken by the police.

15.23 In the experience of at least one member of the panel, there is widespread belief amongst NHS management that it is not possible to interview staff or take statements about an untoward incident which is under investigation by the police. We recognise the potential for prejudice to a police investigation or subsequent prosecution if an organisation such as the West London Mental Health Trust takes witness statements and holds an investigation without due regard to the requirements of the criminal justice system. However there will be cases where a serious incident might be repeated if the reasons behind it are not quickly identified and addressed. If an incident may only be investigated informally while a criminal inquiry is in process this will sometimes increase the risk of further, avoidable serious incidents. It will also make it more difficult to obtain the information necessary to ensure good management of the hospital.

15.24 In the circumstances prevailing following the assault of Richard Loudwell we accept Broadmoor had little option but to follow what they understood to be the steer given by the police.

15.25 We note that in February 2006 a Memorandum of Understanding was agreed between the Department of Health, the Association of Chief Police Officers and the Health and Safety Executive to assist with the investigation of unexpected deaths and serious incidents involving National Health Service patients. This Memorandum would now apply to incidents such as the assault on Richard Loudwell. It provides for the creation of an Incident Coordination Group within five working days of a referral of an incident to the police. This Group would provide a forum for agreeing how to manage parallel investigations by police and a Trust in order that safety may be maintained without prejudicing the criminal process.

Consequences of methodology adopted at CIR

15.26 On the night of the incident Service Director 1, the on-call manager, asked those staff who had been on duty to write a brief outline of what had happened and where they had been. This was in accordance with paragraph 3.1 of policy U1. Aside from
this no further statements were taken from staff until after the police investigation was complete. No witness statements were taken for the CIR and any views offered by staff at the CIR had to be expressed in front of all of those attending. This significantly restricted the ability of the CIR to get to the bottom of what happened on 25 April 2004. Unwittingly it appears a ‘received’ line emerged and was allowed to perpetuate. For example on page 2 of the CIR report the following is written about Richard Loudwell:

“During his time on Luton Ward he had informed other patients of the nature of his index offence and had been the victim of intimidation from other patients. He had declined to accept advice about keeping himself safe on the ward and had at times been placed on increased nursing observations because of concerns about his safety. However immediately prior to the incident on 25th April 2004 there had been fewer concerns about his vulnerability as a result of changes in the patient population on the ward.”

15.27 In fact Richard Loudwell had been placed on increased observations on the day of his arrival on the ward (15 January 2004) and remained on this level of observation for one week until 22 January 2004. Thereafter he was never placed on increased nursing observations. The summary in the CIR is therefore incorrect or misleading in this respect.

15.28 It is not clear that there was a consensus amongst staff about Richard Loudwell’s vulnerability decreasing before the assault. Examination of the nursing observation notes for the two weeks before the assault shows repeated allegations by Richard Loudwell that he was being subjected to physical abuse.

15.29 In early February 2004 one of the main perpetrators of abuse against Richard Loudwell (patient J) left the ward but there is no evidence this affected the abuse he received. On 8 March 2004 patient C arrived on the ward. Richard Loudwell identified him on many occasions as subjecting him to physical and verbal abuse. The summary in the CIR is again incorrect or misleading to suggest the risk to Richard Loudwell reduced as a result of changes in the patient population.

15.30 The CIR makes no mention of RMO3’s risk assessment, prepared for the admission case conference on 30 March 2004, which said it was likely that Richard Loudwell would be physically assaulted by other patients.
15.31 The CIR makes no mention of the fact that three days before the assault Richard Loudwell had spoken to the MHAC about the abuse that he was suffering on the ward.

15.32 These matters are evident from a thorough read of Richard Loudwell’s nursing and medical notes. In our view the CIR’s review was superficial and therefore missed the true picture to be gained from the records.

15.33 A crucial question for the CIR ought to have been “how could this have happened without a member of staff witnessing the assault”. The CIR failed to discover the important fact that at the time Richard Loudwell was assaulted there were no staff in either the dining room or the dayroom.

15.34 The CIR described the location of staff as follows:

“At the time of the incident there were nineteen patients on the ward and nine nursing staff (a team leader, a staff nurse and seven HCAs). Three staff were on break on the ward, three staff were observing the corridor to the patient bedrooms, one member of staff was in the day room and two members of staff were in the ward office. The dining area (and toilets in the day room) cannot be directly observed from the ward office but form part of an environmental check by nursing staff of the ward twice an hour. It appears that other patients were creating a noise at the time of the incident and may have been aware that an assault was taking place.”

(underlining added)

15.35 This description was incorrect. There was no member of staff in the dayroom. Three members of staff were in the ward office. The CIR may have accepted too uncritically the accuracy of notes made by Service Director 1 in her report. At page 7 of her report of 26 April 2004, she set out the location of the nine members of staff on duty at the time of the assault. She reported that HCA1 was in the dayroom, and Team Leader 1 and HCA2 in the office from where, she noted, they were able to observe the dayroom. It is not clear what her source for this information was. HCA1 had provided her with a short statement in which he said HCA4 came to the ward office to say Peter Bryan was in the toilets hitting the wall. HCA2, in his short statement, placed

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16 See chapter 3: The attack on Richard Loudwell

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himself in the office. Team Leader 1 made no reference to the whereabouts of herself or other members of staff, even though Service Director 1 told the inquiry she would have asked members of staff to write down where they were at the time of the incident. She thought she might have obtained the information in her report about HCA1’s whereabouts by asking Team Leader 1.

15.36 We are not critical of Service Director 1’s error which comes in the context of an otherwise well-prepared report, written 24 hours after the incident and intended to be a provisional summary for management of what had happened. Paragraph 4.2 of the policy required Service Director 1’s report to be produced within 72 hours of the incident. However it is often the information that is collected immediately after an incident that is the most important. The later a detailed account is obtained the more likely it is that memories will have faded or become influenced by conversations with others. Obtaining information and statements in the difficult circumstances of this case requires experience and training.

15.37 In our view the CIR was deficient in not re-examining where staff had been at the time of the incident. HCA1 told us he was in the ward office when the alarm was raised. He was present at the CIR although wrongly described in RMO2’s report. In our view it is likely that HCA1 would have said he was in the ward office if he had been asked that question during the CIR.

15.38 Given the perceived constraints on interviewing potential witnesses during criminal proceedings it is understandable that no formal statements were taken. However, as a review requires a thorough investigation and understanding of what happened, this type of critical incident review should ensure relevant members of staff are asked about important matters as soon as possible, and a list of the important questions to be pursued should be included.

15.39 We think the failure to identify that no member of staff was in the dining room or dayroom at the time of the assault on Richard Loudwell is a clear example of the serious consequences that follow if an investigation like this is unable to obtain statements or interview members of staff.
15.40 Even allowing for the perceived restriction on obtaining further evidence from staff we believe there were flaws in the CIR's methodology. One important issue which should have been apparent to the review was why two patients were unobserved in the dining room with staff unaware of their whereabouts. It should have been clear that this required a detailed investigation into the whereabouts of individual members of staff at the time of the incident. Service Director 1’s interim report did not establish these facts and this should have been apparent to those conducting the critical incident review. This failure indicates to us that the hospital needs to review the methodology for such reviews. Those undertaking this review doubtless believed - with justification - there would be a more detailed investigation in the near future, but this type of review should give the most thorough and critical consideration to the issues arising as is possible in the circumstances. We appreciate this may not be easy for even the most experienced healthcare professionals as few will have experience of this sort of investigation, but in future the Trust should provide assistance on how to run a review. With an incident of this gravity consideration should be given to obtaining external assistance. When something as serious and shocking as this incident occurs it may be asking too much of the staff who were responsible for the care of the patients concerned, even senior and experienced consultants, to review calmly and objectively what occurred.

Recommendations of CIR

15.41 The CIR made a number of very sensible recommendations:

- That the weekly CTM be extended to permit adequate discussion of all patients, particularly new patients.

- That when risk was discussed by the CTM this should always be documented.

- That when a patient had not yet had an admission case conference (CPA and pre-CPA meetings) they should be seen medically at least once per week and their mental state documented.

- That the primary nurse, or deputy, would interview all patients and document their mental state within a week of admission.
• That an action plan would be drawn up to tackle what the review reported to be a culture of bullying on the ward.

• That the skill mix for each shift should be assessed prior to the shift.

• That the medical cover provided by the SHOs on the ward should be improved.

• That the number of patients on the ward be reduced to between 12 and 15.

15.42 The action plan to tackle bullying took until November 2004 to devise. It would have been better if the plan had been drawn up sooner but we appreciate that a considerable amount of work may have been required to produce a worthwhile plan. During the course of work on the anti-bullying strategy it was discovered that Woodstock Ward had developed its own anti-bullying policy. Woodstock’s policy was used to devise the Luton strategy but no one could tell us if Luton Ward’s strategy was drawn to the attention of other wards.

15.43 It was put to the Trust that this might be a good example of a failure at Broadmoor at the time to share good practice, thereby causing unnecessary duplication of effort. The Trust responded that since 2003 there has been an annual clinical governance event when each directorate in the forensic division presents the lessons to be learned from its most significant critical incident review. Since the summer of 2006 the Trust has additionally held bi-monthly CIR follow-up meetings at both West London Forensic Service and at Broadmoor. Whilst acknowledging that this arrangement was not in place in 2004 the Trust contends that its clinical governance arrangements continue to evolve.

15.44 The Trust further explained that the CIR in question was not presented at a time when it was felt to be sub-judice during the criminal investigation and that by the time this criminal investigation had been completed the immediacy of the CIR had been lost and it had been superceded by other investigations. A number of other initiatives have been taking place in relation to bullying, including in the DSPD service. In November 2007 there was a presentation on bullying at the divisional clinical governance meeting by a professor who had worked on the anti-bullying strategy at Ashworth Hospital. We are told that work is underway to draw on this and other best practice to produce a Broadmoor/Trust-wide policy.
15.45 Whilst we welcome the clinical governance initiatives identified in the Trust’s response we believe that more can still be done. In our view it would be sensible if the results of all Critical Incident Reviews be shared with other wards and throughout management promptly. We understand from the Trust that the Incident Monitoring and Review Group does facilitate the sharing of CIRs and actions and that the Trust will work to improve on this in the future.

15.46 The findings and recommendations in the review do not seek to compare what happened with what might have been expected under existing good practice. We would have thought that an important task of such a review, when it finds that some change of practice is required, is to ask “why are we not doing this already?”. We think this indicates that those with management responsibility who took an active part in the review did not, as they should have, seek out the lessons to be learnt in relation to the management of the ward. The standard of management performance appears to have gone unquestioned. It is not only healthcare professionals who should be required to audit their own performance but also those in management positions. The team undertaking this review cannot be criticised for this omission to examine management issues as paragraph 7.1 of the policy refers to “clinically focussed critical incident reviews” and does not even mention management.

15.47 There is no recommendation about keeping patients in sight of staff at all times during association or about the distribution of staff on a shift to ensure this can happen. The recommendation about the dining room (see below) suggested the opposite. Given the circumstances of the case we find this omission surprising.

15.48 There was a recommendation about the use of the dining room. It said the dining room could be used again subject to there being twice hourly environmental checks by staff. That was the same regime the CIR describes as being in place at the time of the assault. It is of great concern to us that the CIR appears to have seen no link between the inability to watch Peter Bryan and Richard Loudwell because of the dining room design and the assault. RMO3, one of the signatories of the review admitted he had been “worried” about this. His recollection of the reasoning behind this recommendation was:

“I think the perception was that the risk of closing it would be greater, due to the effect that that would have on a reduction of spaces for that number of patients in that single room without places where patients could go off-ward, if you like,
with the patient mix at that time. That was very firmly the ward manager’s view. He was very vociferous in that.”

15.49 RMO3 had no confidence that he could have changed that view:

“...I was concerned about the dining room not being observed, but the case was made which seemed, on the face of it, to be a justifiable one. In any event, I am not sure what power and influence I would have had if I had strongly objected to the dining room being open, I think I would have been told to get stuffed!”

15.50 In our view the CIR was wrong to conclude that the dining room could be used without being observed continually by members of staff. Whatever the balance of perceived risk before this incident, the experience of this terrible incident should have made it clear that practice had to change. It is of serious concern that even a senior member of the clinical team felt an objection to current practice would be met with a hostile and negative reaction.

15.51 Despite this recommendation by the CIR from what was reported at the subsequent table top review (see below) it appears that the dining room was not re-opened other than on specific occasions when supervised by staff. In other words this recommendation of the CIR was ignored.

15.52 RMO2 had not been aware that the recommendation had not been implemented. In an email of 19 November 2004 RMO2 expressed concern that there had been no team discussion about not implementing this recommendation, when in fact the opposite may have occurred. He told the inquiry:

“I am somewhat surprised that the recommendation of the critical incident review had not been acted upon, given that there had not been any subsequent discussion of the clinical team about that recommendation. No-one had come to the clinical team and said we need to go back and speak about this again. It appears that it was locked off without any discussion taking place with the clinical team about that recommendation of the critical incident review.”
15.53 RMO2 could not explain why he had not been aware of this for some six months although, as he agreed, this was an issue for himself as RMO and the whole clinical team. It indicated, he accepted, a communication problem on the ward.

15.54 It seems to us that the fact that the Luton Ward clinical team appears to have ignored the recommendation of its own review may be understandable if viewed from the perspective of what was the safe course to take, but it also gives some insight into the staff culture on the ward. We make allowance for the fact that Ward Manager 1 left shortly after the CIR. There was no ward manager until about September 2004 when Ward Manager 2 took over. In the interim period it may well be that team leaders were not comfortable with the dining room being used unsupervised. It is nevertheless surprising that the nursing staff on the ward appear to have been able to ignore the decision of the CIR without discussing this with RMO2. It is also surprising that this appears not to have been known by RMO2 or, possibly, RMO3. At the very least we would have expected the issue to have been discussed further but this does not appear to have happened.

Table top review

15.55 On Monday 16 August 2004 a meeting was held at Victory House, London, with North West London SHA, North East London SHA, Metropolitan Police and Thames Valley Police to discuss arrangements for serious untoward incident inquiries in northwest and northeast London. Broadmoor was represented by Sean Payne, director of forensic services.

15.56 The minutes refer to discussion at which:

“...it was agreed that it was problematic to commence an inquiry before criminal proceedings had been completed. Any information offered to the inquiry panel e.g. interviews with Peter Bryan or other witnesses would have to be made available to the police. Any deviation between statements to inquiry and Police could then compromise the criminal case...”

“JM [barrister, Chair of NELSHA inquiry] also cited draft guidance on public inquiries, which states that parallel inquiries are not recommended as this may prejudice the outcome of the criminal proceedings...”
“TP [Thames Valley Police] reiterated the concerns that even an internal NHS inquiry could compromise the criminal proceedings...”

“SP [Sean Payne] advised that a clinical/management review had taken place immediately following the incident resulting in some changes to practise.”

15.57 Jane Mishcon (JM) was not advising that there could not be an internal investigation. Her view was simply that if the police investigation was a murder inquiry then an independent inquiry looking at Peter Bryan’s mental health might prejudice any subsequent prosecution.

Comment

While the sort of advice given to the Trust by the police accords with a commonly held view of the requirement of criminal investigations and prosecutions, we find it unfortunate that the fear of prejudicing such proceedings resulted in a more or less blanket ban on any investigation which involved taking statements from or interviewing potential witnesses. We find it difficult to accept that investigation of the facts by an authority responsible for the security and safety of a highly vulnerable group of patients should be obstructed. The fear is that witnesses may become open to the suggestion that they made inconsistent statements or that their evidence may become “tainted” by the influence of a person or a body with an interest contrary to one which might uphold the original evidence offered by the witness. Any statement taken from a potential witness would be required to be disclosed to both the prosecution and the defence. Clearly the requirements of the criminal justice system are highly important and should normally take priority. However we think that the requirements of safety and security in a hospital are legitimate public interests which should also be taken into account.

15.58 Following the meeting, the Head of Mental Health Performance at North West London SHA, sent Sean Payne an email stating:

“I attach the notes of our meeting with the police. Given the fact that we have been given a clear indication that we can not proceed as we had hoped, we do need to ensure that the management review that was conducted immediately after the incident is seen to be robust. It would therefore be very helpful if you
could send us a copy of the review, with indication of any actions that were implemented as a result of the review.”

15.59 This in turn led to Sean Payne commissioning a table top review. The review was carried out as a purely paper exercise by the Associate Medical Director and a Project Manager for the DSPD unit.

15.60 The table top review was carried out in October 2004 and presented to the Trust board in November 2004. It provoked an angry response from the two ward consultants, RMO2 and RMO3 who appealed directly to the Trust chairman, Professor Smidt, that the exercise was unfair. They felt there was no logic in excluding from the process those who might be involved in a subsequent fuller investigation or inquiry. They felt that the whole exercise risked damaging team morale and undermining the position of the consultants on the ward.

15.61 Their letter to Professor Smidt led to an email from Simon Crawford, Trust chief executive, to both doctors. He wrote expressing his support but tried to explain why the review had happened in the way it had:

“I appreciate the review was not conducted in the normal way and yes we should have ensured you knew it was taking place and on what basis. We have been given a very clear steer from the police and CPS that we cannot re-interview any staff re the incident in advance of the criminal proceedings concluding. On the other hand we know we only conducted an initial management report and local CIR, originally in the expectation of conducting a Trust led SUI. As a result of Mr Richard Loudwell’s death this could not then take place and the subsequent steer from the police etc. What was agreed with the police and expected by the SHA was that we would conduct a table top review of the existing findings/ facts/ evidence pertaining to the incident, independent of any staff involved and this is the report of the Associate Medical Director and Project Manager.”

15.62 In practical terms there is no doubt that the table top review was organised clumsily and in such a way that unnecessary alarm was caused to the consultants. They should have been told what was being done and why. They were not.
15.63 The process also revealed a concerning absence of communication between different levels of management and ward staff. Had there been closer communication between ward staff, the RMOs, and more senior management then the relevant recommendations of the CIR and any SUI would have been implemented and there would have been no need for a table top review.

15.64 The future use of the dining room is an example of the absence of a ‘joined up’ approach between different layers of management operating in the hospital. As we noted above the CIR recommended the dining room continue to be used unsupervised as before. This was ignored by staff at ward level who left it locked. RMO2, and possibly RMO3, did not know this recommendation was being ignored. When the table top review took place the Associate Medical Director and Project Manager were shocked by the recommendation which permitted the continued use of the dining room. They directed that if the dining room could not be supervised then it could not be used. They do not appear to have known that in fact the dining room was not being used.

15.65 We question what would have happened if the dining room been put back in use as the CIR recommended. It appears it would have taken six months for more senior management to realise this was happening and put a stop to it.

15.66 These problems would have been avoided if there had been senior management input, for example from the Associate Medical Director or Project Manager, into the initial CIR. In addition, if the CIR report been circulated at service director level and more widely via the professional firms within the hospital, this would have provided a ‘fail-safe’ in case of obvious problems with the CIR’s findings or recommendations which would probably then have been queried. Wider circulation would also have been a method of sharing good practice and the lessons learned. It may be that there are other wards at Broadmoor with similar problems to the use of the dining room on Luton Ward. If so then it makes no sense for a CIR to take place which does not share its findings with other wards.

The recommendations of the table top review

15.67 The table top review made a number of sensible recommendations. Had the Associate Medical Director or Project Manager been involved in the original CIR we anticipate the same recommendations could have been made in May 2004.
rather than waiting until November 2004. Because Broadmoor investigated the assault on Richard Loudwell with a CIR then a table top review it meant there was an unnecessary delay in identifying the lessons to be learnt.

15.68 The table top review made the following recommendations:

- That joint notes are prepared following clinical team meetings (CTMs) which are circulated to both clinical teams.
- That where a CTM cannot take place because of a bank holiday it is rescheduled for a different time in the same week.
- A more comprehensive review of the incident should be undertaken pending the SUI.
- At least brief notes should be obtained prior to admission for all patients.
- All admissions should have a nursing assessment prior to arrival in hospital.
- The admission policy should be revised to require explicit consideration of risk to potentially vulnerable individuals consequent upon admission to high security.
- Responsibility for ensuring that risk assessments are completed at the first clinical team meeting should be clarified.
- SHO absences should be anticipated and cover arranged at each week’s CTM.
- That an action plan on bullying be developed.
- That the dining room should not be available for use unless supervised.
- There should be a limit on the number of staff taking breaks simultaneously.
- The minimum skill mix on the ward should be clarified and explicit instructions given as to what the nurse in charge should do if this mix is not achieved on a particular shift.

Chapter fifteen: Incident investigation
When there is a serious incident there should be an automatic temporary moratorium on admissions.

15.69 In addition to these recommendations the table top review identified the failure of the CIR to establish where each member of staff was at the time of the assault. At paragraph 4.1 the table top review stated:

“4.1 The description of the incident in the CIR does not include a clear statement of where each member of staff was at the critical time. It does not identify which members of staff were on a break, who was observing in the day room, and who was observing in the corridors...”

“4.3. A number of these issues were considered in Service Director 1’s initial manager’s report, but the level of detail regarding who was where, who what and at what time, was inevitably limited. There needs to be a clearer understanding of exactly what happened on the ward that evening. It is however, probably inevitable that the necessary interviews with staff and patients cannot take place before the conclusion of criminal proceedings: they should nonetheless be part of the subsequent inquiry.”

15.70 The table top review therefore believed that nothing could be done to remedy this omission. For the reasons set out above we are sympathetic to this conclusion but hope that in the light of the Memorandum of Understanding (MoU) between the NHS, the Association of Chief Police Officers and the Health and Safety Exective this situation will not rise again.

Follow-up of the table top review

15.71 Sean Payne, director of forensic services, presented the table top review to the Trust board in November 2004 together with an action plan (see appendix G).

15.72 It can be seen from the action plan that almost all of the table top review’s recommendations were either implemented by the time the report was presented to the Trust board or significant progress was being made.
15.73 In our view the response of Broadmoor management to the recommendations made by the table top review was impressive. However the measures taken relatively easily between the time of the table top review in October 2004 and the November 2004 Trust board meeting, could have been taken in May or June 2004 if the initial response of the Trust to the incident had been quicker and more thorough.

15.74 We also note, presumably because the table top review failed to identify that no staff had been in the dayroom or dining room when the assault took place, that this fundamental issue remained unnoticed and unaddressed in either Sean Payne’s report to the Trust board or the action plan that accompanied his report.

15.75 It is apparent from the action plan that the Trust was again hampered by the belief that staff could not be interviewed. It is stated:

“Trust advised not to undertake any internal inquiry that would involve interviewing staff. An independent inquiry will commence following Peter Bryan’s criminal proceedings being concluded and agreed.”

Interim root cause analysis

15.76 Root cause analysis is a set of tools that can be used to assist with a systematic investigation process. It is a methodology for identifying and understanding the fundamental causes of a problem or problems. Health Circular HSG(94)27, concerning the conduct of investigations in mental health services, advocates the use of a process such as root cause analysis when carrying out internal management reviews.

15.77 A root cause analysis was recommended in Sean Payne’s November 2004 action plan. This was in response to the table top review suggestion that there be further consideration of the lessons to be learned from the incident. This was pending completion of the criminal process and subject to the limits the criminal process imposed.

15.78 The result was an interim root cause analysis (RCA) presented to the Trust board in April 2005 by Sean Payne. The root cause analysis was carried out in March 2005. By April 2005 the criminal process was completed when Peter Bryan pleaded guilty to the manslaughter of Richard Loudwell. In his report to the Trust board RMO2 recommended that a full root cause analysis review be carried out. This was the internal inquiry, also
referred to as the SUI, chaired by Professor Kennard. Professor Kennard’s team first met in June 2005.

15.79 The interim root cause analysis adopted a process which it described as a “review of existing reports”. It included a “mapping exercise” of the incident carried out by a patient safety manager of the National Patient Safety Agency, at a meeting which was also attended by RMO3 and RMO2. There was no examination of the notes of either Peter Bryan or Richard Loudwell and no staff were interviewed about what had happened on the day of the assault. The interim root cause analysis did not pick up on the fact that no staff had been in the dayroom or the dining room at the time of the assault. This is perhaps unsurprising given this was a review exercise, no further evidence was obtained and the criminal process was still ongoing. At page 7 of the RCA it is once again recorded, incorrectly, that there was one member of staff in the dayroom at the time of the assault.

15.80 The interim RCA appears to have accepted that it had reached no positive conclusions. At page 8, in the final paragraph of the report, it is written:

“It is too early in the process to reach any definitive conclusions with regard to the root causes of this incident. The Trust, staff and patients will benefit if the process is completed in an open and inclusive manner.”

Professor Kennard’s inquiry

15.81 The final stage in the internal investigation of the assault on Richard Loudwell was the inquiry chaired by Professor Kennard. His report was presented to the Trust board on 28 March 2006. This was a serious untoward incident inquiry report, as envisaged by policy U1. It was not commissioned until 7 June 2005, just over a year after Richard Loudwell’s death and some 13 months after the incident.

15.82 The SUI adopted the earlier root cause analysis and interviewed the following staff:

- RMO3 -Luton Ward
- RMO2 -Luton Ward
- Team Leader 1 - Luton Ward
- Team Leader 3 - Luton Ward
15.83 We find it surprising that no member of the security directorate was interviewed. We would have thought it sensible for the SUI to have heard the views of the director of security and asked for input from Security Liaison Nurse 1.

15.84 We note that the SUI did not hear evidence from SHO1, who had a number of dealings with Peter Bryan and who was asked to assess his mental state but did not do so. The SUI may have felt they could not interview SHO1 as he no longer worked for the Trust. We think it would have been sensible to ask SHO1 if he was prepared to be interviewed or to provide a statement. If this was done we have not seen any evidence of it.
15.85 The SUI’s report is 18 pages long and has seven appendices. We find it a well presented and helpful document. It is accessible and provides what would have been a useful ‘immediate’ response to the incident. Apart from the view that staff could not be interviewed pending completion of the criminal investigation, there is nothing in the SUI report that could not have been investigated and reported on within one or two months of the incident itself. The report is useful but it would have been far more useful if it been prepared closer to the incident.

15.86 We make no criticism of the view that the SUI could not take place until the conclusion of the criminal process. However, it is interesting that in our view there is nothing in either the evidence given to the SUI or its report which would have been prejudicial to any prosecution of Peter Bryan. This conclusion is necessarily provisional and a detailed analysis of the issue is beyond the scope of this inquiry. However, we make the point since the assumption that parallel internal investigations compromise criminal inquiries may be too widespread.

The SUI’s recommendations

15.87 The SUI makes a number of recommendations nearly all of which we are happy to adopt (the numbering reflects the original paragraph numbering in the SUI report):

“4.1 New admissions should receive a full mental state assessment upon admission. From this, a detailed plan of care should be devised and recorded in the CPA documentation.

4.2 Upon termination of seclusion, a thorough assessment will be completed within 36hrs by a member of their treating team.

4.3 There will be a comprehensive plan as part of the CPA documentation for post seclusion care and assessment upon the determination of seclusion.

4.4 All newly admitted patients will have an agreed risk management plan, specific to their particular risks. This plan will be recorded in the CPA documentation. It will highlight any and all unusual factors, e.g. cannibalism.
4.5 All new admissions to Luton Ward, and wards with a similar remit, will have an agreed multi-disciplinary plan at the time of admission, outlining milestones in the admission process, for example “seen by doctor”, “seen by OT”, etc. This plan will be completed by the assessing team and the primary nurse.

4.6 A meeting of the clinical team should occur upon, or prior to, the admission of new patients. This meeting will focus on the immediate management and plan of engagement. It will be clearly documented in the CPA documentation.

4.7 Care plans will be reviewed by the multi-disciplinary team as part of the CTM.

4.8 Entries in the clinical notes should be linked to the relevant care plan, with each care plan being referred to. For example, in the notes, entries relating to Care Plan 1 will be written under the heading “Care Plan 1”. This will describe information relevant to this plan, including interventions and any changes.

4.9 The CPA process should be followed in line with WLMHT policy.

4.10 The dining room will be locked unless there is a constant staff presence.

4.11 The use of CCTV cameras should be reviewed by West London Mental Health Trust.

4.12 Each professional discipline will review their line management and supervision structure to ensure that each member of staff is regularly supervised.

4.13 Each clinical area should have a clear remit and evidence based model of care.

4.14 A member of each patient’s nursing team, ideally the primary nurse, will attend the clinical team meeting.

4.15 A weekly progress record will be completed by the primary nurse and discussed at the relevant clinical team meeting.
4.16 The panel were informed of a new method of approaching staff support that is now present in the Dangerous and Severe Personality Unit (DSPD) in Broadmoor hospital whereby all staff must attend regular staff support sessions. The panel suggests that advice is sought from the DSPD unit regarding the implementation and efficacy of this system so that it is implemented throughout the hospital.

4.17 The panel are aware that an anti-bullying strategy is now in place. The panel recommend that this is evaluated for effectiveness. If beneficial, it should be widely canvassed and implemented.

4.18 A strategy of post incident support should be developed, outlining the process relating to incidents of differing severity.
4.19 After such an incident, staff may be traumatised, with delayed reaction. A strategy should be developed which puts the onus on the organisation to ensure that staff are supported as opposed to simply informing them of its availability.

4.20 This strategy should describe the individuals’ roles in the process.

4.21 The plans for the process of any review should be communicated in writing to the team in question. This may take the form of a description of the process, including the terms of reference and the methods employed.”

15.88 We draw attention to the recommendation in paragraphs 4.7 and 4.14. It seems to us care plans need only be reviewed by the multi-disciplinary team in the case of a new patient (for example Peter Bryan) or in the event of a particular issue with a patient which requires the input of the multi-disciplinary team (for example Richard Loudwell and the issue of bullying).

15.89 With respect to paragraph 4.14 we think it could be impractical for each patient’s primary nurse to attend each CTM. However we do agree with the aim of this proposal which is to encourage greater involvement of nursing staff within the multi-disciplinary team. We think that members of the nursing staff should regularly attend CTMs on a rotation basis. In addition, when a new patient is admitted or when a patient has a particular issue that patient’s primary nurse should if possible attend the CTM.
Shortcomings of the SUI

15.90 We were generally impressed with the SUI but thought there were two significant related shortcomings. Firstly the SUI failed to ask or answer the question of where all the staff were at the time of the assault. We say “failed to ask” because although the appropriate members of staff were interviewed the SUI appears not to have appreciated that at the time of the assault there were no members of staff in the dayroom. Instead, three were in the ward office, three were on the corridors and three were on a break. If staff were asked where they were, we are surprised this is not included in the report.

15.91 We note the ward map at appendix F of the SUI report shows that the three staff responding to the incident came from the office. This implies their location had been ascertained so it is more surprising that there is no comment in the body of the SUI about the fact that no staff were in the dayroom.

15.92 At appendix G the SUI annexes the “First Stage Root Cause Analysis” documents. These, as we saw above, wrongly put one member of staff in the dayroom. This error is not commented on or corrected in the SUI.

15.93 The second shortcoming, which may flow from the first, is that the SUI does not appear to have asked how the attack happened without being witnessed by staff. It recommends that the dining room be locked off in future but it does not question the more fundamental point about how, and how often, patients were observed.

Conclusions

15.94 We make the following findings:

C107 The Trust complied with its untoward incident investigation policy, U1, in that it recognised the assault on Richard Loudwell was a serious untoward incident, the reporting requirements were complied with and a SUI commissioned. This was reasonably postponed until the completion of the criminal investigation and subsequent prosecution.

C108 The CIR was not a substitute for an SUI, nor was it intended to be.
C109  There were significant omissions in the list of those invited to take part in the CIR, in particular Service Director 3, who attended anyway and Security Liaison Nurse 1, who did not.

C110  The CIR failed to identify the key fact that at the time of the assault on Richard Loudwell no member of staff had been in the dining room or the dayroom.

C111  The CIR accepted too readily a ‘received’ view that the bullying of Richard Loudwell had diminished prior to the assault and failed to take sufficient care to review the many entries in his nursing and clinical notes which suggested the opposite was true.

C112  The CIR made a number of sensible recommendations but was wrong to recommend that the dining room be reopened subject only to twice hourly environmental checks.

C113  The arrangements for the table top review were such that ward staff were justifiably concerned that they were being excluded from the process.

C114  The recommendations of the table top review were nevertheless largely sensible.

15.95  The interim root cause analysis appears to have reached no additional conclusions about the incident.

C115  The SUI, chaired by Professor Kennard, was a useful exercise and produced a helpful report but did not address the underlying issue of how this incident could have happened without being witnessed by staff.

Recommendations

15.96  We make the following recommendations:

R76  Further consideration should be given at government level to building on the Memorandum of Understanding to enable thorough internal inquiries to run in parallel with criminal investigations. It is unsatisfactory for internal inquiries to be placed on hold pending a criminal investigation. Avoidable incidents could occur because lessons are not learned quickly enough following a serious incident.
R77  That the Trust’s policy U1 is revised to give clearer guidance on how to conduct a critical incident review.

R78  That the Trust ensures that members of staff involved in incident investigations are properly trained in the importance of obtaining accurate statements.

R79  That the results of critical incident reviews be shared with management and other wards promptly.

R80  That a template be introduced for use following all inquiries, CIR’s and similar to ensure recommendations are followed up or actioned within a reasonable timeframe.

R81  That the recommendations of the Kennard SUI be implemented save for 4.7 (care plans to be reviewed at clinical team meetings) and 4.14 (primary nurses to attend clinical team meetings) both of which recommendations we believe to be impracticable.
16. Hospital management

Introduction

16.1 In the preceding chapters we have made critical findings not only to the standard of care provided to Richard Loudwell and Peter Bryan, but also to the general running of Luton Ward in relation to care planning, observation, physical and environmental security and support for families. These findings have led us to consider the extent to which these matters are symptomatic of management weaknesses within the hospital.

16.2 We must emphasise that we have not investigated whether the defects we have identified on Luton Ward are to be found elsewhere in the hospital and it would be wrong to infer that they are. The evidence we have does not enable us to say one way or the other. The evidence tends to suggest that a weakness in the structure and performance of management at all levels may have contributed to a context which permitted the deficient performance in Luton Ward at the time.

16.3 As with other criticisms we make in this report, we do not suggest that any of the deficiencies we identify would have avoided the tragedy of 25 April 2004.

Overview

16.4 We consider that generally, and in the case of Richard Loudwell in particular, there are indications that the standard of performance on Luton Ward was deficient in the period leading up to the incident. Our findings in previous chapters highlight a number of deficiencies including (in no particular order):

- the lack of an effective anti-bullying policy
- a failure to ensure safe observation practice
- a failure to ensure that appropriate care plans were recorded and implemented in a commonly understood way
- a failure to engage proactively with patients
- a failure to respond effectively or promptly to concerns expressed by the MHAC about Luton Ward
- a failure effectively to integrate security policy and practice into the operation of Luton Ward
• a failure to respond to staff concerns about the ward.

16.5 We must consider, in trying to explain how these circumstances arose in a hospital of such longstanding expertise, whether there were any deficiencies in management at the time. We consider we have identified evidence of such deficiencies:

• Higher management appears to have known little of the difficulties being experienced in Luton Ward at the time.

• After the appointment of Ward Manager 1 the ward appears to have been managed internally in some isolation from the management structure and without a sufficient degree of external managerial supervision and support. This is of particular concern because Ward Manager 1 was not the selection panel’s first choice and was appointed against the wishes of the ward RMO, RMO2.

• The ward was run under the shadow of an impending change of directorate structure with no apparent strategy for managing the effect on the ward of waiting for the change.

• There was tension between the clinical and non-clinical management of the ward which led to a lack of integration of these two functions.

• Management, clinical governance and audit processes were not sufficiently robust to detect issues concerning the ward performance of key workers.

16.6 We review the evidence that leads us to identify these weaknesses, after a description of the management structure.

Management structure

16.7 Broadmoor Hospital is managed by the West London Mental Health Trust. Its catchment area is London and the south of England. The Forensic Services Division of the Trust is comprised of the Three Bridges Regional Secure Unit and the Local and Specialist Secure Services (both on the Ealing site) and Broadmoor Hospital High Secure Services. There were four directorates at Broadmoor: Men’s London, Men’s South of England,
Women’s Secure Services (until September 2007) and Dangerous and Severe Personality Disorder Patients (DSPD) (from 2005).

16.8 The structure of the organisation of the clinical services is set out in Figure 1 below. Sean Payne, the director of forensic services is responsible for all the clinical directorates and the forensic services at the Ealing site, under the overall management of the chief executive, Simon Crawford. The Associate Medical Director undertook the role of medical director for Broadmoor Hospital as well as having clinical governance and overall medical responsibility for forensic services at St Bernard’s Hospital, comprising the Three Bridges Regional Secure Unit and the Local and Specialist Secure Services on the Ealing site. The London directorate is managed by a service director and a clinical director, RMO2, who was also RMO for London patients on Luton Ward. Between March 2004 and March 2005 the service director of the London directorate was Service Director 3, now associate director of forensic services. At the time of the incident the service and clinical directors reported direct to Sean Payne. We were told that they will report to the associate director in due course.

16.9 Non-clinical services, such as security, have a different management structure. They report direct to the chief executive. This had occasionally led to problems. For instance, security liaison nurses’ working practices and hours of work could be changed without reference to the clinical services. The Broadmoor Operational Meeting, a forum in which clinical and non-clinical management could discuss operational issues of mutual interest, was bypassed at times.

16.10 Luton Ward was managed within the London directorate, even though it took south of England and London patients. The line of management from the service and clinical directors ran down through a service manager,17 to the RMOs,18 and the ward manager.19 Figure 2 below shows the London directorate management structure. The south of England directorate had no managerial line of responsibility for Luton Ward.

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17 At the time the Service Manager of the London Directorate
18 RMO2 and RMO3
19 At the time Ward Manager 1, now Ward Manager 2
Figure 1 - organisation of clinical services

WEST LONDON MENTAL HEALTH NHS TRUST

FORENSIC SERVICES DIVISION

Chief Executive Officer
Simon Crawford

Director of Forensic Services
Sean Payne

- Head of Psychology (Forensic Division)
- Deputy Director of Nursing (Forensic Services)
- Associate Medical Director
- Head of Allied Health Professions
- Service Head – Social Work Forensic Mental Health

High Secure DSPD Service
Service Director
Clinical Director

High Secure Services Men – London
Service Director
Clinical Director

High Secure Services Men – South
Service Director
Clinical Director

Women’s Integrated Secure Services
Service Director
Clinical Director
Associate Clinical Director

West London Forensic Services
Associate Director
Clinical Director - Men’s West Directorate
Clinical Director – Men’s Central Directorate
Clinical Director
Secure Adolescents

BROADMOOR
BROADMOOR & EALING
EALING
Figure 2 - London directorate management structure
16.11 Before the incident the catchment areas of each high security hospital had been changed and, locally, it had been decided to base clinical directorates on catchment areas with a view to developing separate wards. The position in Broadmoor now is that there are separate wards for London and the south of England. It has taken time to repatriate patients within Broadmoor so that they are located within the clinical directorates commensurate with their originating catchment area (i.e. Men’s London and Men’s South of England). RMO3 is responsible for south of England patients who are now admitted to Churchill Ward for assessment. RMO2 remains as RMO in Luton Ward, caring for the London patients.

16.12 We were told that plans for managing and staffing these separate wards were evolving. It is now proposed that there should be a separate clinical team consisting of a consultant, junior doctor, occupational therapist, psychologist, social worker and a senior clinical nurse, as well as a clinical nurse manager. Previously it had been thought to be a problem that the clinical team in each directorate had not included the senior doctor. There were difficulties for management in ensuring that information was shared. Thus Service Director 3 told us:

“When I first arrived at Broadmoor it took me about six months even to be shown minutes of the south of England patients’ meeting discussions because there was a process going on in people’s minds of, these are south of England directorate patients, therefore the south of England issues will be shared with the south of England and the London issues will be shared with the London side. That was one problem that did occur, that people split information-sharing for a while because there was this split of directorate.”

16.13 She found it bizarre that separate minutes were taken for each directorate even though the relevant discussions took place at the same meeting.

16.14 We understand that discussions continue about the changes to be made.

Service manager

16.15 We interviewed the Service Manager of the London Directorate in March 2006. She told us that her role was to oversee the running of
three wards in the London directorate, Luton, Banbury and Dunstable. She dealt with problems as they arose and referred issues up the management chain as appropriate. She was required to attend a variety of committees and other regular meetings, including clinical team meetings, clinical improvement groups, patient community meetings, clinical nurse manager/service manager meetings, and child protection meetings.

16.16 The Service Manager said her role in attending clinical team meetings was to know more about the patients, to help with information about bed availability when a patient needed transfer, and to provide information about hospital wide issues. She had not attended many meetings in early 2004 because she was absent from work for health and personal reasons.

16.17 She tried to spend some time on Luton Ward each day, but because of personal circumstances between January and April 2004 she was unable to spend as much time there as she would have liked. She would normally have expected to spend about five hours on the ward, including attendance at the clinical team meeting.

16.18 The Service Manager did not know what could have been done to avoid the incident. She thought it was easy to say with hindsight that the dining room should have been locked, but at the time they had to balance risk with therapy. She said:

“The dining room is a room which runs directly off the dayroom, you cannot see it directly from the office, but it is certainly nearer than the dining rooms on other wards are to the office.”

16.19 At the time she would have gone into the dining room to speak to a patient and would not have been concerned about it, but:

“I wouldn’t have gone into the dining room with a patient on my own, because we don’t tend to go into areas that are not observed on your own, but - no, providing the cutlery is locked away, I was no more concerned about the dining room than other areas.”

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20 She was appointed in 2001 and the wards for which she was responsible changed from time to time, but she was the manager for Luton Ward except for a period of 12 to 8 months in about 2002.
16.20 She said that she ‘had not been fully aware’ that the dining room could not be observed from outside, but:

“Personally, if it was down to me, I would have had the dining room locked off. I would on most wards, because most dining rooms aren’t the best of areas to observe and I can’t see the point in using them unless you are dining in there, really. But the dining rooms were opened up and different wards have different policies; in the high dependency unit it is locked there all the time unless it is dining, and Luton chose not to.”

16.21 She thought the decision to use the dining room in this way would have involved discussions with management, but it does not appear to us that any such discussions involved the Service Manager or that she felt it to be part of her role to comment on the decision once it was made. She said that, even without the benefit of hindsight, if there had been more than one patient in the dining room she would have expected members of staff to be in there as well, but it does not appear that she suggested that this should happen.

16.22 The Service Manager’s evidence suggests that neither she or Ward Manager 1 followed the consultants’ recommendation in the critical incident review that the dining room could remain in use subject to twice hourly environmental checks:

“...it was locked off but most certainly from my point of view, and I think Ward Manager 1’s point of view as well, we weren’t comfortable with the dining room being open and decided that it should be locked off, but it could be open if staff were available...We would have in this case implemented it and then told [the consultants] and explained the rationale behind it...In this instance [it was] our [decision] as we felt the risk was too great to keep it open.”

16.23 This decision does not appear to have been documented until it was noted at the tabletop review that the critical incident review recommendation had not been implemented.

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21 See chapter 15: Incident investigation
16.24 At around the time of Richard Loudwell’s admission to the ward the Service Manager of the London Directorate thought that morale there had been “very low”. She described the staff as feeling “quite battered and bruised”:

“Staff were very professional in doing their job but they were very busy. They appeared to me to be quite stressed. There was one issue after another - nothing major, but if you were to compare it for instance with the ward as it is at the moment...the ward atmosphere is lovely, and they can get on with the job in hand, i.e. looking after the patients’ care plans, whereas at the time when Richard Loudwell was on it seemed to me it was fire-fighting. You went from one thing to another...”

16.25 She was surprised at the extent of staff feeling about the perceived lack of communication and other issues that emerged at the awayday in January 2004. She had not been aware before of the extent of the division of opinion among staff about the managerial style of Ward Manager 1.

16.26 The Service Manager met Ward Manager 1 about once a month or six weeks. Many minutes that were taken were not kept. She was unaware at these meetings of the difficulties staff were having with him. She would have raised them if she had been. She was unable to pursue these issues because shortly after matters came to light at the awayday her absence for personal reasons began. During that time Ward Manager 1 was acting up for her.

16.27 The Service Manager was aware of some individuals’ concerns that they were not encouraged to attend or contribute to CPA meetings. She said that they tried to encourage and support these members of staff, but she could not see the point of making them come to CPA meetings if they did not want to because it would “stress them out so much”. The shift system made it very difficult to arrange for some people to attend clinical meetings.

16.28 One concern of the staff before the awayday was an anxiety about completion of the risk assessment part of the CPA documentation. The Service Manager of said a basic risk assessment should have been completed on the day of a patient’s admission. The clinical improvement group minutes for 17 November 2003 recorded that it was agreed that the draft CPA documentation of the risk assessment be completed within two
weeks of admission. This does not appear to have happened in the cases of Peter Bryan or Richard Loudwell, and there could be a number of practical problems preventing the completion of a comprehensive risk assessment in such a short time. The Service Manager observed that the CPA process “scared” rather than helped staff. Matters are more settled now. However the Service Manager was unable to say when most staff received training in CPA documentation and became comfortable with it.

16.29 The Service Manager said she had great difficulties fixing a meeting to follow up the recommendations coming out of the awayday and, on 7 March 2006 this had still not occurred, over two years after the event.

16.30 The role of service manager to Luton Ward seems to have been more one of a spectator than a leader. We find little evidence of any steps to manage Ward Manager 1 or the ward staff about their performance or concerns. We recognise that there are many different styles of management, but the combination of a passive style of service management and a strong personality in the post of clinical nurse manager resulted in the relative isolation of the business of the ward from the general management structure. This was exacerbated by the frequent absences of the service manager.

Service director

16.31 When Service Director 3 arrived as service director she knew there were issues requiring attention, including some of those identified above. For example the minutes of a service manager/CNM meeting on 16 April 2004 show that she raised concerns about the way clinical team meetings were run. She thought that insufficient time was given to discussion of each patient and that treatment plan objectives were not clearly discussed at meetings between CPA reviews. She said there should be more consistency in the way nursing staff presented information and felt that all staff should be able to attend a clinical team meeting if they wished to contribute something about a patient. While she had such concerns about a number of wards she thought that insufficient time was spent discussing each patient on Luton Ward.

16.32 Service Director 3 also said that the ward was run in a hierarchical manner:
“Certainly at the first clinical team meeting I attended it was apparent to me there were stronger personalities in the team who dominated more of the team than others, and that was very obvious to me on my first viewing of it. It was medical, psychology and the CNM who were more dominant than any other members of the clinical team, which I discussed with the clinical director at the time about how you engage everyone in a multidisciplinary team. That would have been my first view in terms of problems with the multidisciplinary team, that there were clearly people who had been there a long time, had strong views, strong personalities and able to impose. People operated in quite a hierarchical way so the OTs didn’t feel they could speak until they were spoken to.”

16.33 She knew there had been an awayday\textsuperscript{22}, but it took her months to find out what happened at it. However she said it demonstrated a split between the nursing staff on the ward and the multi-disciplinary team. It appeared to her that there had been very little follow-up:

“My first impressions of Luton Ward and its clinical team meeting were that there were issues around the multidisciplinary team functioning and a split between the team and the ward-based staff. It was quite apparent to me quite quickly when I came here that there were issues, which is why after a while I asked a lot of questions, and eventually I discovered this had happened and then eventually received the paperwork to look at the issues that were being discussed.”

16.34 It was difficult for Service Director\textsuperscript{3} to find out what had been happening in terms of service management before she arrived. She was unaware for example of the correspondence between the Mental Health Act Commission and the Trust about Luton Ward. This was partly because her predecessor had emptied the office of all documentation.

16.35 Service Director\textsuperscript{3} became aware from the Deputy Director of Nursing that there had been problems with the behaviour and attitude of some members of staff on Luton Ward. She knew that one of the strategies for tackling these problems was to separate the patients from the two directorates. She said that, although this was not a problem specific to Luton Ward, the mechanisms were not in place to address this type of issue.

\textsuperscript{22} See chapter 15: Luton Ward - management for a description of this.
“One of the things I tried to do as service director was put in place a much clearer and robust supervision and performance management process between the service manager and CNM to understand what was happening. I also introduced a number of other things in the directorate that weren’t specifically aimed at Luton but across the board. Nobody ever monitored sickness and things like that particularly well, so we put in place things like sickness monitoring procedures. One of the early things I did was an audit of appraisals around are appraisals happening with nursing staff across the directorate. It wasn’t just about Luton but I was concerned that the appropriate mechanisms weren’t in place to address when these issues are raised about culture, about what is happening, who is doing what and what were we doing as a response, so I kicked off a number of things. I also did a session with the CNMs about recruitment and retention: what are we doing to retain the good staff we want to keep, how are we dealing with it, what are the initiatives we want to put in place to try and keep staff, i.e. their secondary induction, training appropriately and things like that.”

16.36 Service Director 3 found that there was a long-standing problem with transferring patients from Luton Ward once their assessment was completed. The problem had been identified in management meetings since at least October 2003. The first management intervention recorded was at a meeting on 16 April 2004 when Service Director 3 wrote to consultants to ask if they could move patients on. She agreed that:

“I don’t think people had run with it as they should have...There was no point in just recording in the minutes if action isn’t taking place.”

16.37 She did not obtain the impression on her arrival that a great deal had been done to address the other problems she found:

“It felt like I was starting from scratch. It didn’t feel there was a lot happening to try and address what this has described. There had been some things happening, getting the appointment of a new CNM being one of those key things, and getting two consultants to share the workload, and that happened in order to address some of these things. I wasn’t particularly aware that a lot of work had gone on around the therapeutic environment and engagement specifically relating to Luton
Ward. There was work in the Trust around revising the engagement and observation policy, because people get very hung up on observation and forget the fact that it is called the engagement and observation policy. There has been some work around that but not specifically in relation to Luton Ward.”

16.38 Service Director 3 felt that the Ward Manager 1, was managing the service manager rather than the other way round. It was clear to us that she did not intend to single out the Service Manager for criticism in this regard, so much as to identify a culture prevalent at Broadmoor:

“There is a real culture at Broadmoor that I walked into, which was if you don’t get the answer from the person immediately above you, you go past that and ask the next person, which is not my style of working at all. I found very quickly that if a CNM asked a service manager something or discussed something with them and didn’t like the answer, they would come running to me to try and get me to undermine what had already been discussed. I think that particular relationship had gone on, whereby if the service manager had not done what Ward Manager 1 wanted he would go to the previous service director, he will circumvent it in the end and not go through the service manager at all. That meant he was given fairly free reign on what he was doing on Luton Ward.”

“There is an issue about the supervision of CNMs and making sure they are part of the corporate direction, and that is why we have service managers who are best placed to manage a group of services together to make sure we have sharing of ideas, sharing of policy and ensuring the commonality of approach.”

16.39 Soon after her arrival, albeit after the incident, Service Director 3 found that ward record keeping for patients was inadequate. At a meeting on 18 June 2004 it was minuted that:

“Service Director 3 felt that the ward recording keeping for patients is not currently adequate. We need to look at what is currently being done to get a picture of what is happening with patients, what they’re doing etc. We need a more informative and consistent way of recording this information and a standard is required around frequency of recording in the nursing notes which is consistent
across all wards. It was agreed a form for recording the information should be devised and Clinical Nurse Manager 1 agreed to lead on this issue.”

16.40 Service Director 3 told us that it had not taken her very long in post to work out that this problem existed:

“There were a number of things that threw it up to me quite quickly. One was that I was asked to have a look at a critical incident review of an incident that occurred before I joined the Trust, and in doing so I looked at the nursing notes and the records of observation and was a bit worried. A couple of other things cropped up that made me concerned also about the qualitative nature in particular of our observation of patients. It is all very well ticking a box to say you have seen somebody, but the policy we have is about engagement and observation, it is not just about sitting and staring at people. It is particularly called engagement and observation because it is about trying to engage with patients. Quite quickly I was concerned that staff had got into a very mechanistic routine of running round with a clipboard and ticking that they had seen everybody but not engaging in a way I would expect, and not recording what they were engaging with.”

“Again I was using the experience of where I had worked before, where we had a fairly comprehensive and robust observation process, which meant if someone was on general observations you saw them hourly and you would record something about what you had seen hourly. If they were on intermittent observations you would record something about what you had seen in that intermittent observation. If they were on constant observations you would regularly record something around constant observations, but you would record something qualitative, not just a tick about where they were at what time. That is what was concerning me from what I saw.”

16.41 The directorate has now, we were informed, designed a better observation form and launched a new engagement and observation policy which distinguishes between engagement and presence checks.

16.42 In summary Service Director 3 thought that there had been a difficulty in the flow of information about problems up the management structure:
“I think there were blockages at certain levels in the system, and I said earlier that certain information was contained at CNM level, for various reasons. Some of it is this belief that the individual was a senior CNM therefore he ought to be able to manage certain things; some of it is about information is power. At the next level things weren’t necessarily perceived as issues that should have been raised higher, so at service manager level things were caught because of the perception of what was the problem. Take the issue of bullying, and did anyone raise with me about bullying before the incident happened, no, not a word. And yet that would be an issue I would expect the CNM and service manager ought to be discussing in their monthly supervision, and that ought to be flagged up at the directorate management level for the service director and clinical director to address. There are fairly clear lines of accountability in the structure. What I am not sure we have got right is the structure.”

“The service management structure at Broadmoor could work if it was really about service management, but I think it has actually been about nurse management a lot of the time, and managing nurses and managing certain parts of the process, which would normally lead you down a structure of nursing line management and not service management. We have not necessarily supported the service managers in terms of their skills and competence to deliver what we want, so we get into very much an inward focusing, very hands-on approach to dealing with issues that CNMs ought to be dealing with and ought to be managed at a lower level. We are currently looking at how we revise the service management role to be about service management and, instead of managing wards, service managers managing a group of clinical teams and the disciplines within that clinical team that therefore deliver a whole service to the patient rather than being specifically nursing focused, which is what they largely are. In the south of England directorate one of the service managers also manages the psychology service. They don’t really because the head of psychology still jumps them to report up much higher. What they are actually managing is the day-to-day operation; they don’t manage the people. We are trying to shift that to be much more about the service management.”
16.43 Service Director 3 said more work needed to be done to disseminate information and organise meetings between service managers and service directors. She suggested:

- There should be an annual audit of Tilt high risk decisions to monitor how high risk policy was being applied.

- Steps were required to ensure that ward based policies and other good practice are shared actively across the organisation.

- There would be advantages to having one person responsible for both clinical and non-clinical services (including estates and facilities) at Broadmoor.

16.44 Service Director 3 provided an outsider’s insight into the problems of management at ward level in Broadmoor. They were obvious to her but may have been less obvious to those who had been in the system for some time. She confirmed the impression we have of Luton Ward being run by its nurse manager without enough objective information about its performance being fed to more senior management, and without sufficient attention to problems which were obvious to an objective observer, whether a newly appointed service director, or a visiting Mental Health Act commissioner.

Clinical director

16.45 Throughout the period that this inquiry is concerned with, the clinical director for the London directorate was RMO2, who was also Peter Bryan’s RMO. He was appointed in 2000, and allocated two sessions a week for the role, but in practice took two to two and a half days a week. He tended not to become involved in management issues about non-medical staff, but consulted the service director about clinical governance and strategy. However on issues arising out of the ward, its environment and the way it was run he would mainly deal with the ward manager.

16.46 RMO2 does not appear to have received a great deal of training or supervision on this important managerial aspect of his job. He told us:

“There have been a variety of different things run by the Trust to deal with specific aspects of management such as supervising SHOs, disciplinary procedures,
performance procedures in relation to doctors in general - those sorts of pragmatic issues. What has been difficult, and my colleagues will find this difficult as well, is finding the time to do some of the more developmental, leadership stuff. We are not very good at identifying and setting aside time to do that but I have done some of it.”

16.47 The role was clearly time-consuming and may have had an impact on his ability to manage his patients:

“I am sure it does impact because there is less time available in the week to see patients and deal with them. At times it concerns me but not consistently so, otherwise I would be arguing in appraisals and job plans that something needs to be done about it. There are times that are particularly busy managerially when it does have an impact but most of the time, given the input from the other medical staff on the ward, I am no different to my colleague and other clinical directors.”

16.48 RMO2’s effect on the running of the ward seems to have been limited:

- As a member of the appointment panel when Ward Manager 1 was selected, RMO2 had concerns that he was not the right person for the job, largely, we infer, because of his approach to the balance between custody and therapy. However, he was outvoted by the other two members of the panel, Service Director 2 and the Deputy Director of Nursing. He considered that his concerns were borne out by experience.

- He expected to be involved in commenting on the drafting of responses to the critical observations made between 2001 and 2003 by the Mental Health Act Commission. He felt for example, that the response to the letter of 2 May 2001 was not “particularly adequate”. He could not remember much about the commission’s criticisms or about the Trust’s response to them. This suggests that higher management did not involve him much in the response to them, or that he did not think the criticisms very important. He accepted that it was his role to make sure that the ward staff were addressing the criticisms and were seen to be doing so. It is probably a mixture of both: RMO2 told us that he thought that some

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23 See Chapter 12 : Luton Ward - management
of the criticisms were “misplaced” and “overstated”, but also that the hospital could have done better in its provision, for example of activities. He said that they had never been able to sustain an increase in the time the nursing staff spent with patients.

- Following Ward Manager 1’s appointment, RMO2 was unhappy with the culture being fostered on the ward it was only after the arrival of RMO3 that he felt better able to address this.

- The staff revealed their concerns about the running of the ward at the awayday in January 2004. RMO2’s explanation for the failure to respond to these concerns was partly that:

  “There was not an obvious way forward.”

- He said there had been discussions with the service director but did not say what they were about.

Conclusions on directorate level management

16.49 At the time of this incident management at directorate level responded passively to known issues. Ward Manager 1 was a strong personality with his own definite way of running Luton Ward. While concerns were harboured about his approach, ward culture and other issues we have seen little evidence of effective direction and management at directorate level. We identify an approach of merely observing matters of concern rather than addressing or communicating them. Matters relevant to good practice do not seem to have been shared. Luton Ward was run semi-autonomously, rather than as a fully integrated part of the whole organisation. This was a consequence of the competing styles of those managing it.

16.50 This is an observation of what happened, not a criticism directed at individuals. A number of factors contributed to the weakness in management at this level:

- Managers lacked appropriate support. Insufficient training or managerial supervision was provided or taken up. It is insufficient to make training available; steps must be taken to ensure that it is used.
- The clinical director’s role lacked sufficient authority to affect matters on the ward. Team-working is of course essential, but the point of having a medically qualified director is to bring clinical perspective to management. It is essential when balancing custodial and therapeutic elements of care and management that clinicians are empowered to ensure that the approach is acceptable clinically. On matters such as this, the clinicians’ voice needs to be listened to. It is surprising that the clinical director’s strongly expressed reservations about the appointment of a ward manager were overridden. This was likely to undermine the director’s confidence and ability to participate in the difficult task of contributing to the management of this ward.

- The Service Manager’s management style and her absences from work made it difficult for her to challenge the ward manager’s strong personality. It is not clear to us that she received the required support and supervision to ensure that she was sufficiently assertive and effective in this role. It is likely that the ward manager largely ignored her and communicated directly with others in the management hierarchy. The Service Manager appears to have had little authority.

16.51 Staff at ward level may have felt they had to put up with things as they were, meaning that their concerns did not reach higher management. The ward manager did not share the concerns of some of those around him and probably did not communicate them to those above him.

16.52 There are different management styles and different approaches to the challenges of an organisation as complex as Broadmoor. However, there was a lack of cohesion which was fostered by passive management. The combination of management structure, personalities and styles in place at the time resulted in a failure to address issues of concern.

Senior management

16.53 The Associate Medical Director of the Trust was unaware of problematic issues concerning Luton Ward before Richard Loudwell’s death. When he was asked if he was aware it was a “problem ward” he told the inquiry:
“It was not a ward that came to my attention as far as I was concerned. There were other areas of the hospital that were more a cause for concern and that occupied more of my attention.”

16.54 He had not had many dealings with the ward, and he could not remember having the criticisms in the MHAC report for the period July to December 2003 being drawn to his attention. Much of the criticism made about this ward by the commission passed him by. For example he was unaware of the meeting on 5 February 2002 when the commission expressed their concerns to RMO2 and the service director, Service Director 2. The Associate Medical Director said that he might have been told about this meeting but he could not remember. His main concern then was covering staff shortages. He was not aware of the Luton Ward awayday in January 2004 at which staff expressed a number of concerns.

16.55 We note that the Associate Medical Director had many responsibilities in addition to Broadmoor. He said he spent most of his time there. He also retained a clinical workload. The clinical directors were responsible to him for professional and clinical matters. He saw his role as “to a large extent advisory, rarely dictatorial” and largely dependent on the experience of the relevant director. He did not appreciate that there were causes for concern about Luton Ward which required attention. There seems to have been no managerial system which informed him about such matters unless he was approached directly by another manager or professional colleague. His style was reactive and advisory rather than one of leadership. Such a personal style is not in itself a matter for criticism. However we criticise the system for not ensuring that he was told of the concerns about Luton Ward in a manner indicating the need for leadership, action and follow-up.

Director of forensic services

16.56 Sean Payne was appointed director of forensic services for the Trust, on the creation of the present Trust in 2001. He was accountable directly to the chief executive and was a member of the Trust board. He spends 75-80% of his time at Broadmoor. He was confident that the integration of Broadmoor into a wider Trust was beneficial in particular in opening the practices of a high secure hospital to the scrutiny of the wider Trust and the influence of the wider profession. He felt that staff fears about the merger had been allayed over the intervening years.
16.57 Sean Payne had been aware of issues about the performance of the service manager over some three years and that these were being worked on with the support of the service director, first Service Director 2 and then Service Director 3. He agreed that the extensive absences of the service manager impacted on the way Luton Ward was run and the support available. However he did not know of her difficulties in managing the ward manager.

16.58 Sean Payne knew of the problems with the ward before the appointment of Ward Manager 1 - and in particular that there were issues about the role of the clinical nurse manager on the ward. Sean Payne also knew that Ward Manager 1 was the appointment panel’s second choice, the first having declined the offer of the job, and that RMO2 was the only one to oppose Ward Manager 1’s appointment. Sean Payne felt that no single member of an appointments panel could have an automatic veto. He pointed out that if Ward Manager 1 had not been appointed, the post would have remained vacant and would have had to be re-advertised. Sean Payne said that he had taken no specific steps to monitor the relationship between Ward Manager 1 and RMO2 after Ward Manager 1’s appointment.

16.59 Sean Payne felt that the caseload of up to 25 beds was inconsistent with developing modern practice and that competent managers were needed to change this. However he saw this as a hospital-wide problem, not one specific to Luton Ward. He told the inquiry that in 2001 he started, with others to formulate some strategy on this. He said that the dramatic reduction in the overall number of patients after 2001 provided an opportunity to reduce caseloads and ward size:

“...and to start to put together some clear plans for the future about what we felt would be appropriate to ease the management issues within the ward environment, and Luton Ward was part of that.”

16.60 Such plans were in an embryonic stage in 2002-2003 and were implemented from 2004 onwards.

16.61 He recalled the concerns of the Mental Health Act Commission in 2001 about the lack of activity on Luton Ward, and their statement, in that context, that the quality of
care on Luton Ward appeared “to fall far below an acceptable one”. He accepted this was a serious matter, but:

“It was not different from the view I had...concerns overall about engagement of patients within wards at Broadmoor...It was a consistent issue across the hospital that we needed to address...Indeed the commission will have expressed similar concerns about other wards over the course of that period and the following year or two.”

16.62 He thought the problem of inactivity in Luton Ward was the same in wards across the hospital.

16.63 Sean Payne believed that Ward Manager 1 would tackle particular problems on Luton Ward. In retrospect he might have had a different perspective on that. He was unaware that in March 2002 the Mental Health Act Commission was informed that Ward Manager 1 was “exactly the right person to enforce discipline and commitment within the clinical team”. Sean Payne said this is not language he would have used about patient care.

16.64 Sean Payne said the reason for the commission’s statement in December 2003 that it had “grave concern” about the management of Luton Ward was that the ward was still too large. This was being addressed but could not be implemented because of the capital demands of other projects such as the development of the DSPD unit.

16.65 On 7 April 2004, Sean Payne responded to the commission. He sought merely to refute the commission’s criticisms by highlighting differences between Luton Ward and Bicester Ward, with which the commission had compared it. His response did not address the concerns expressed by the commission. Sean Payne accepted that the Commission had continuing concerns and that it was dissatisfied with the steps taken to address them. He did not suggest that the commission was mistaken about this. He accepted that he would have liked to see earlier progress on the points of concern, in particular the engagement of patients in activities. He said that the hospital was “still a little way off from that”. While the resources were now available there remained the task of shifting the culture and underlying attitudes of the staff.
16.66 Sean Payne accepted that after the attack on Richard Loudwell, there could have been more discussion within the hospital about the impact the incident was going to have rather than putting in place the normal processes after a serious untoward incident. It was difficult to find any reference to the incident in the records of hospital-wide meetings.

Chief executive

16.67 Simon Crawford has been chief executive of the West London Mental Health NHS Trust since January 2004, having been appointed deputy chief executive in June 2002. He was director of finance and information of the ‘shadow’ Trust from November 2000 and before that had spent four years as director of finance of the Broadmoor Hospital Authority.

16.68 The chief executive is the accountable officer for the Trust and, among other duties has to ensure that it has sound governance processes which identify and manage organisational risk, and maintain clear lines of accountability and appropriate leadership for all its clinical services. Given the Trust-wide nature of his responsibilities it is impossible for him to know everything that goes on at the hospital. However, he is informed of key issues at monthly one-to-one meetings with the directors of forensic services, security, human resources and estates & capital in addition to other meetings, including those of the research and clinical governance group, which receives the minutes of the forensic executive group meetings and information on issues identified by the Broadmoor operational meeting. He also spends one day a week on average at Broadmoor when he meets staff and visits wards.

16.69 Simon Crawford accepted that there had been shortcomings in the delivery of a therapeutic regime in Luton Ward in 2004. He thought that the same was probably true of a number of other wards. He was more aware of those shortcomings since the incident than before it. He was unaware of any particular concerns about Luton Ward before the incident. He expected concerns to be drawn to his attention by the director of forensic services or through the clinical governance structure.

16.70 Simon Crawford was unaware of the Mental Health Act Commission complaint in January 2002; this pre-dated his appointment as deputy chief executive. He said the issues outlined in it warranted attention over and above that routinely given to other wards.
Today he would expect that sort of concern to be dealt with by the director of forensic services, but the commission had access to him if a problem persisted.

16.71 The response to the concerns expressed by the commission in December 2003, was sent out in his name, but was drafted and signed on his behalf by Sean Payne. He did not discuss the issues with Sean Payne although he would normally have expected to. He accepted that the letter did not give a full response to the commission’s concerns. He was not aware that the commission had been expressing concerns about Luton Ward since 2001.

Subsequent developments in policy and practice

16.72 Since the commencement of this inquiry inevitably there have been developments in policy and practice both locally at the hospital and within the West London Mental Health Trust and nationally. In particular, as is to be expected, the Trust has implemented an action plan to address many of the points which we have identified as requiring attention. The strategic health authorities responsible for the oversight of high security hospitals have agreed a new performance framework\textsuperscript{24}. The Health and Social Care Act 2008 has been enacted (but not yet brought into force) under which the Mental Health Act and Healthcare Commissions will be merged with the Commission of Social Care Inspection to form the Care Quality Commission. While we will note some of these changes in this report it is not part of our remit to evaluate their efficacy in bringing about the improvements at Broadmoor we have identified as being required. In essence this report is designed to give our evaluation of the standards of care which were in place at the time of the incident we were appointed to investigate.

An overview of management

16.73 Luton Ward was a cause for concern for a significant period of time before the attack on Richard Loudwell.

- A report by Professor Appleby into a spate of suicides at Broadmoor (see below) highlighted the need for changes on Luton Ward particularly regarding numbers and the need for a therapeutic approach.

\textsuperscript{24} Terms of reference for the National Oversight Group for the High Security Hospitals were published by the Department of Health in July 2008.
The Mental Health Act Commission signalled concerns to the Trust in 2001 and again in 2003.

There were issues with the management of the ward before the appointment of Ward Manager 1.

The appointment of Ward Manager 1 was known to be opposed by the clinical director.

The awayday highlighted significant discontent among staff.

16.74 It is clear that these concerns were not addressed effectively at any level of management. Senior levels of management may have been unaware of at least some of these concerns. Various factors caused this:

- From the time Ward Manager 1 was appointed, if not before, Luton Ward was managed on an independent basis with minimal intervention from senior management.

- Those who worked at ward-level did not convey concerns up the management chain, or did not do so effectively.

- Although more senior managers may have thought their formal and informal systems for monitoring performance were effective they were not in this instance. Senior managers remained unaware of the extent of the issues relating to Luton Ward until after the attack on Richard Loudwell, and in some instances until this inquiry.

- Any change under consideration was part of wider changes undertaken throughout the hospital. There were delays caused by resource and other global issues.

- Notwithstanding that the hospital board and, from 2001, the Trust may not have been in a position to implement a more permanent solution to the difficulties faced by Luton Ward there appears in the interim to have been little or no attempt
at a senior management level to support and monitor Luton Ward in the light of the particular difficulties that had been identified there.

16.75 Management structures were ineffective in alerting senior management to the existence of problems before the incident. This continues to be the case since the incident as is demonstrated by the way in which the incident has been considered in those structures.

- A medical advisory committee meets monthly. The first meeting of this committee after the incident was on 17 May 2004. We found no mention of the incident in its minutes.

- The Broadmoor operational meeting of clinical directors and non-clinical managers under the chairmanship of Sean Payne meets monthly. The incident was raised at the meeting on 1 July 2004 at which Sean Payne reported on the planned reviews and how staff should deal with approaches from the police. There is no record of further discussion until August and September 2005 when updates were given about this inquiry. It is striking that there appear to have been no discussions about the problems on Luton Ward that might be indicated by the incident.

- The forensic division has a clinical and research governance group. The minutes before October 2004 do not refer to the incident. There was no reference to the incident in the Trust’s clinical and research governance group minutes before November 2004. Simon Crawford said it was not mentioned because it was so serious an incident that everyone knew about it anyway. He said that the Trust should have ensured that this sort of issue was fed into these structures and dealt with directly through the chain of managers.

16.76 The apparent absence of this sort of corporate response to this serious incident, probably one of the most serious incidents to have occurred in Broadmoor in recent times, alarmingly mirrors the lack of response to the concerns that had been expressed about Luton Ward before the incident.

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25 The most recent minutes presented to us.
26 The most recent minutes presented to us.
Proactive management was more difficult because of the reorganisation of the clinical directorates around geographical catchment areas, which coincided with a national reorganisation of the catchment areas of the high secure hospitals. As part of this re-organisation Luton Ward was to be split into two wards, each serving one directorate. It may be that the expectation of this change, delayed discussion of important issues. The change was not completed until 2006. It is a considerable challenge for hospital management to direct these changes while at the same time focusing on the existing service.

Other incidents

Towards the end of our inquiry a number of other serious incidents involving patients assaulting other patients came to our attention. While it is beyond our remit to investigate these, we present a summary of evidence from the reports and reviews conducted at the time.

Assault on Henley Ward on 24 December 1997

One patient attempted to set another alight by pouring polish over him and setting it alight using a deodorant can as a flamethrower. This happened in the ward TV room late one evening but was unobserved by staff. The victim suffered minor injuries. The critical incident report said the incident was ‘well-managed’ and made no comment on the lack of observation of the TV room or the patients.

Assault on Henley Ward 10 March 1997

The assailant attacked the victim in the victim’s room during the afternoon with such ferocity that the victim lost sight in one eye. The location was not observed by staff and the incident, which was not witnessed by staff came to light only after the assailant was observed later to have blood on his shirt. The circumstances indicate the complicity of other patients. Staff thought the assailant unsuitable for the ward, but there had been no formal nursing assessment before his transfer there. Although staff considered him to be exceptionally dangerous no continuous or close observations were prescribed. The internal review report said of the victim “an attempt on [his] life was entirely predictable. The nature of [his] offences make him a prime target for an attack on his life. [He] is not safe anywhere, inside or outside Broadmoor”.

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Internal review of incident of 10 March 1997

16.81 W, a non-executive director of the hospital authority, and L, an independent nursing consultant, conducted an internal review of the above incident. This report was presented to the hospital management board on 11 September 1997. The report made a number of criticisms and recommendations which resonate with some of those made here, including:

- “We are amazed that continuous or close observations were not prescribed immediately on [the assailant’s] admission to Henley Ward.”

- “[The assailant] was able to choose his time because staff were absorbed and busy. Even deafening music did not attract attention.”

- The review recommended that a medical and nursing assessment of a patient should be performed on the day of transfer to the ward irrespective of assessments done previously.

- A risk assessment piloted on Dover Ward was recommended for consideration for use throughout the hospital.

- It recommended that “regular observations of ward corridors be undertaken without fail”.

- “The difficult layout of the ward and the observation standards required should be taken into account when reviewing staffing levels for the ward.”

- The review found “a rule-bound culture rather than a therapeutic culture dominating”.

- It found “no real clarity on the role, function, membership, accountability and leadership of the Clinical Management Team and the requirement of members to attend CMTs”.

- The review concluded that “measures that would have reduced the risk of a violent attack on [the victim] to the lowest possible level were not implemented”.

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• The report noted that the position of the director of security was weakened because he was advisory and not a board member; it said that “accountability for security should be clear”.

• It recommended that viewing mirrors be placed wherever they would improve observation.

• It recommended that the role and function of clinical teams and their members should be clarified and standardised across the hospital.

• The review drew attention to the “lack of consistent and applied standardised frameworks for the management of patient care. The nature of the hospital is such that unless these omissions are remedied a high risk environment will remain. The existence of autonomous wards contributes to the fragmentation of policies and procedure. We draw the attention of the new Chief Executive to this”.

• It recommended that the security classification and observation required for vulnerable patients should be reviewed regularly by the clinical management team and the director of security. The security plan drawn up should then be monitored regularly.

Assault on Harrogate Ward on 19 December 2000

16.82 In a female ward, one patient attempted to strangle another in a day-room in the middle of the afternoon. Staff did not see the beginning of the incident and it was drawn to their attention by other patients. The critical incident review commented on the absence of a “culture of learning”, training or a “culture of supervision”, among the staff on the ward and the absence of determined effort to formally manage the risk presented by the assailant who was known to pose a risk to other patients. The review also criticised the failure to manage the risk the victim presented to herself. The ward operated “in isolation from contemporary mental health nursing practice”. The review made no specific comment about the observation of patients or communal areas.
Assault on Banbury Ward on 3 June 2002

16.83 One patient assaulted another in the doorway of the victim’s room with a pen borrowed from another patient. The victim sustained large gouges in the back of his neck, a deep puncture wound to the front of the neck, and other more superficial injuries. This occurred at 10.45am but was not seen by staff. Their attention was drawn to it when the victim activated an alarm. The victim had been on the ward for less than two weeks and had not wanted to transfer there for fear of being assaulted by other patients. The assailant had a history of threatening sex/child offenders, and of multiple assaults on patients and staff. Among the recommendations of the critical incident report was a review of ward observation policy and of access to corridors.

Assault on Taunton Ward on 30 March 2003

16.84 A patient lured the victim to the assailant’s room in the early evening. The victim was attacked and sustained bruises and cuts. Staff did not see the incident which was reported by the victim who came to the ward office for help. The assailant had a history of violence towards other patients and the victim was known to be at risk of assault because of his behaviour. The report said the ward was difficult to observe and that a plan developed for the ward had not yet been “accepted”. The report identified staff numbers as an issue along with the need to reduce patient numbers.

Incident on Taunton Ward on 8 April 2003

16.85 At 9pm in the ward dining room the assailant poured hot liquid over the victim and then punched him. Staff did not see the beginning of the incident but a noise alerted them to it. The assailant had a history of assaulting patients with a history of sex offending and the victim’s index offence had involved the sexual torture of an old lady. The assailant was placed on the ward even though there was not enough space for him. The report again identified lack of staff. The report did not expressly point to the need for observation of all communal areas.
Common themes arising from previous incidents

16.86 These are probably not the only incidents in the seven years before the assault on Richard Loudwell, but the reports of them make depressing reading. A number of common themes are obvious:

- Serious incidents involving patients assaulting other patients occur without being observed by staff.

- This despite the patients involved being known to be at high risk of assaulting others, or being assaulted, as the case may be. Two of the incidents involved assaults on sex offenders by patients on the same wards who had made previous threats to attack such individuals.

- Observation policies seem consistently to fail to take into account the layout of wards or the interactions between patients.

- Staffing issues in relation to the numbers available, culture, and attitude persist.

- Care and risk assessments of patients are unsatisfactory.

- Wards are run on a semi-autonomous basis without consistent good practice through the hospital.

16.87 The report referred to in paragraph 16.81 above deserved and still deserves particular attention. If lessons from the report were learned and recommendations implemented, many of those we set out here would not have been necessary. The similarity between them is striking, particularly as we made our initial recommendations without knowledge of the earlier report.

16.88 The Trust was asked to comment on the incidents and themes we identify above. They responded that while they accept the inquiry’s findings they regret they did not receive earlier our request for information about the assaults on previous patients, particularly that of March 1997. If they had managers and clinicians could have been asked questions about these incidents when giving their evidence to the inquiry in 2005 and 2006.
16.89 The Trust were adamant that appropriate action was taken in response to the report on the March 1997 incident at the time. The report was presented to the board in September 1997 and a detailed discussion took place over each of its recommendations. It was agreed that whilst some of the recommendations could not be actioned quickly owing to financial and staffing resource implications all the recommendations would be accepted as best practice to strive for. At the next board meeting in October 1997 an action plan was presented to the board and in April 1998 a further updated regarding implementation was presented to the board.

16.90 The Trust assert that the hospital has changed significantly since 1997 and that care has been transformed from that described in the report. In a letter to the inquiry the chief executive states:

“The number of patients admitted has been significantly reduced from about 60 patients (including women) annually in the mid 1990’s to about 25 patients annually in the mid 2000s. This has significantly reduced pressure on admission and high dependency beds, so that the unplanned transfer between wards or patients which was such a feature of the 1997 case no longer occurs.”

“We have reduced the numbers of patients on the high dependency wards from 25 on Henley, Abingdon, Banbury and Luton in the 1990s to 15 on the high dependency wards (Henley, Banbury and Milton) and 12 on the admission wards (Luton and Churchill) now - the ceiling on high dependency wards in 2004 was 18.”

“We have increased staffing so that on Henley ward, for instance, the usual number in 2004 would be 8/8 rather than the 6/6 described in the W/L report. By 2004 this includes constant monitoring of the corridors.”

“We have moved away from the system of patients “bouncing” between wards as described for patient X between January 1996 and the assault in March 1997, and by 2004 this was in the process of development with the establishment of geographical directorates with pre-determined care pathways: wards were no longer able to refuse to take patients...”
“The question of how to best ensure the safety of individuals who may be targets from other patients is a complex one, where there has been limited research, and the best we have is practice-based evidence rather than evidence based practice.”

16.91 The chief executive went on to point out the particular vulnerability of the patient attacked on Henley Ward in 1997 and the particularly violent nature of his attacker who had identified his victim well in advance. Both patients remain at Broadmoor but have not met again since 1997 as a result of a care strategy adopted by the hospital.

16.92 The chief executive went on to address 3 specific issues arising out of the Henley Ward incident:

- Care planning: the care planning process (CPA) was in its infancy in 1997, when the Trust was created in 2001 it inherited diverse risk management systems from Broadmoor, from Ealing, Hammersmith and Fulham NHS Trust and subsequently from Hounslow services. Considerable investment took place which led to the introduction of a common CPA process across the Trust in April 2003. It is acknowledged that the process is in need of review. Nonetheless say the Trust, all patients across the hospital are now regularly (and were in 2004) assessed at each CPA every 6 months for their risk to self, to others, of escaping or absconding and of seeking to subvert the organisation either alone or with others.

- Poor observation: the chief executive asserts that the Trust could not now countenance operating with the staff-patient ratios described in the 1997 report. The possibility of realistic observation with such numbers is remote. He asserts that matters were better in 2004 on Luton Ward with all of the corridors being constantly observed and with 9 staff on duty, albeit not all at the same time. He acknowledges that there was a weakness in the operational policy insofar as this did not require the dining room to be under constant observation. This has since been addressed and close circuit television has been introduced on the ward. Further the Trust introduced its engagement and observation policy in 2005 to emphasise that the task was not simply one of observation but engaging with patients with a view to anticipating and remedying those situations where untoward incidents might occur.
Wards operating in isolation: the chief executive rejects this charge in 1997 let alone 2004. He asserts that the very fact that patients were moved from ward to ward in 1997 showed that wards were not isolated from each other. As for practice and culture he asserts that as long as wards have distinct roles this may be inevitable.

16.93 We agree with the Trust that it would have been better had the information about previous incidents been available at the time that clinicians and managers were giving their evidence. This would have given individuals a better opportunity to address the issues arising. We also acknowledge that our requests for information about previous incidents were dealt with in a timely manner. It is of some concern that the Trust found it very difficult to locate a copy of the full report on the March 1997 incident which was eventually retrieved from a computer disk with the assistance of the former board secretary and the Trust’s IT department. We do acknowledge that at least part of the reason was that when this report was prepared there was an understandable concern that the report might be leaked to the press and therefore very few copies of the full report were made.

16.94 It is right to point out however that not a single clinician or manager referred at any time in their written or oral evidence to these previous incidents. The inquiry only discovered that these incidents had taken place as a result of its own further investigations when they had almost finished writing this report.

16.95 Many of those who gave evidence to the inquiry did not have direct knowledge of the incidents but the current chief executive, Simon Crawford, was on the hospital board or the Trust board at the time of each of these incidents as were a number of other senior managers.

16.96 We do not criticise any individual for failing to tell the inquiry about these incidents, but that no one at Broadmoor thought it relevant to mention them does indicate:
A concerning failure to appreciate that the assault on Richard Loudwell was not just an unpredictable ‘one off’ event but occurred in the context of wider failures which had existed on Luton Ward and to some extent, other parts of the hospital for years;

That the Trust, at least at Broadmoor, is not as much of a ‘learning organisation’ as it ought to be. It is right to acknowledge that each of the incidents referred to was investigated and that in the case of the Henley Ward incident in 1997 which was by far the most serious, a detailed action plan was drawn up and the hospital board kept informed of progress made in addressing the issues that arose. We acknowledge also that Broadmoor in 2004 had changed in many ways from 1997. We remain concerned however at the ability of the Trust to learn from past incidents or mistakes and to apply such lessons to future practice. The senior management of a true ‘learning organisation’ would have recognised the relevance of these previous incidents to the assault on Richard Loudwell and would have told the inquiry about them without being asked. We have identified common themes arising from the previous incidents, particularly that on Henley Ward in 1997, and the assault on Richard Loudwell. It is of concern to us that these themes appear not to be recognised by the hospital management. For example, the assault on a patient in Henley Ward in 1997 occurred in part because a dangerous patient and another, vulnerable patient were left unobserved despite the known risks. It is clear that on Luton Ward in 2004 Richard Loudwell was frequently left unobserved by staff. This was not just down to a specific weakness in the operational policy concerning observation of the dining room. To give another example, at the time of the assault on Richard Loudwell he had been assessed by his RMO as being at risk of physical assault from other patients and it was thought by his RMO that such an assault was ‘likely’. Peter Bryan, despite his offending history, had not been the subject of a risk assessment from the time of his admission ten days earlier.

16.97 The Trust point out that in 1997 there were significant pressures on the hospital: numbers of patients often exceeded the number of funded beds, there was a significant waiting list, a significant number of vacancies, for examples in RMO posts with some RMOs having caseloads in excess of 40 patients. Significant capital expenditure was required on the estate. There was also considerable pressure to reduce the hospital’s budget and make efficiency savings. Between 1997 and 2001 the board at Broadmoor were working with potential suitors to merge Broadmoor with another NHS Trust. This lead to the
merger with Ealing, Hammersmith and Fulham NHS Mental Health Trust in 2001. In 2002 an original statement of case for the redevelopment of the hospital was produced and received positively by the then London SHA which accepted the need for a re-build. There were then the further pressures already mentioned, such as Tilt, re-patriation of patients and the accelerated discharge of patients.

16.98 The Trust is correct that this is all important context within which to consider not only the previous incidents but also the steps taken in response to those incidents. However, regardless of what was happening at a strategic level there was a need for improved observation and risk assessment of patients, a higher standard of patient care and greater consistency of practice by staff throughout the hospital. We fail to see why those concerns, which stand out from the reports of the incidents, could not be given a higher priority even with the challenges the Trust were experiencing.

Report by Professor Appleby into suicides at Broadmoor

16.99 The Associate Medical Director, in his oral evidence to the inquiry, drew our attention to a report by Professor Louis Appleby into a spate of suicides at Broadmoor in the late 1990's. The relevance of this report to our inquiry is that Professor Appleby, who reported in 1999, was concerned by conditions on Luton Ward and the effectiveness of observation within the hospital.

16.100 Professor Appleby recommended that Luton Ward (then capacity 24 beds) should be divided into two smaller wards. He expressed concern about Luton Ward in particular because it had to deal with more patients at high risk of suicide and had too many patients generally. He said:

“I believe that Luton Ward has too many patients and that this makes observation difficult, creates a counter-therapeutic sense of over-crowding, and leads to a case mix of acute, recent admissions with recovering pre-transfer patients which would stretch the resources of the most competent nursing teams. There are a number of ways of dividing the ward according to the stage of care...by treatment needs...or by simple division into two. The senior clinical staff on the ward are in the best position to advise on these options.”
16.101 Despite this, it appears that the issue of ward size was considered only part of a hospital-wide issue.

16.102 We asked the Trust about the response to Professor Appleby’s report and received the following explanation for the way in which the hospital board (Professor Appleby’s report pre-dated the creation of the Trust) and, subsequently, the Trust dealt with Luton Ward following the report:

“The concerns set out by Professor Appleby were accepted and shared by the then hospital management team and indeed were a focus for change through the period 1999 to 2004. The pressure on bed numbers at Broadmoor Hospital in the late nineties was considerable. There was growing evidence of increasing referrals and demand for admissions from referring agencies such as medium secure units and prisons. There was a growing sense from referrers that it was becoming increasingly difficult to secure an admission to the hospital and that Broadmoor would only admit the most severely ill patients. This was the outward reflection of the intense pressures on Luton Ward, the single admission ward. These pressures were known within the hospital and would have been known to commissioning agencies in relation to their overview of the hospital.”

“In addition to these pressures, there continued to be within the 3 high secure hospitals, some 400 inappropriately placed patients detained as identified by the Tilt Review 2000. The continuing detention of these individuals resulted in significant difficulties in the onward movement of patients from the admission ward resulting in inconsistent care pathways throughout the hospital for patients. Between 2002 and 2006 some 150 patients inappropriately detained at Broadmoor were transferred to newly created long term medium secure services...the reduction in patient numbers over this period reduced the patient numbers per ward, enabling the hospital to develop alternative models of care and to critical review care pathways. The Broadmoor Hospital Board did attempt to address these known pressure points with the support of commissioning agencies during this period, with some success around funding and patient numbers…”

“The period from 1999 to 2004 was a period of intensive activity and both structural and organisational change within the organisation of the three secure...
hospitals. The Fallon Report had reported in 1998, quickly followed by the Tilt Review of Security in 2000, Professor Appleby’s report in 1999 followed by the Trust merger process in 2001. These change agendas required a significant amount of management time to progress and there were limitations in relation to the environment of Broadmoor itself and the management capacity to progress those changes in an ordered and planned manner alongside other priorities...In addition to the above reviews the Commission for Health Improvement (CHI) undertook a review of the Trust in 2003. The CHI Review identified the poor quality of the hospital buildings environment and asked for the urgent completion of the Strategic Outline Case which had commenced following the Appleby Review in 1999 but because of the structural and organisational changes of the high secure hospitals, changes to High Secure Commissioning arrangements...and the changes to Strategic Health Authorities and creation of Primary Care Trusts the Broadmoor Strategic Outline Case was not prioritised by external agencies. It took the CHI Review in highlighting the deficits in patient accommodation to focus all the stakeholders on the urgent need to progress this work...”

“...It remained difficult to identify a relocation for Luton Ward, due to environmental constraints and bed pressures within the hospital. A number of options were considered during this period, the building of a new ward on site, extending Luton Ward but each option carried significant financial costs and did not have the support of commissioners. So it was not that the observation by Professor Appleby was ignored it was that it was difficult to progress in the immediate aftermath of his report in 1999 which was provided to the previous hospital authority.”

16.103 It exceeds our terms of reference to investigate in any detail the response to Professor Appleby’s report. We accept that there were considerable financial and logistical difficulties in dividing Luton Ward and that nationally a significant reorganisation in high secure services was underway. Nevertheless we would have thought that for as long as a more permanent solution to the evident difficulties faced by Luton Ward could not be implemented, the hospital board and, from 2001, the Trust, would have given a high priority to monitoring conditions on Luton Ward and to giving that ward as much managerial support and attention as it needed. We find little evidence of this approach over the years.
16.104 We acknowledge that, unlike the reports into previous incidents referred to above, Professor Appleby’s report was drawn to our attention by a senior member of the Trust the Associate Medical Director. At the same time it is right to note that no one else referred to this report in their evidence. Again, in our view, this says something about Broadmoor as a learning organisation.

The 1997 Donovan Report

16.105 For the sake of completeness we also mention the Donovan Report. This report was prepared in March 1997 at the request of the Secretary of State following widespread media coverage of allegations that security at Broadmoor was at breaking point. The review found that there had been considerable advances at Broadmoor in the overall aim of providing quality patient care in a secure environment. A number of recommendations were made, particularly in respect of improvements to security. The Donovan Report did not focus specifically on either patient observation or the risk of attack by patients against each other. Its scope was wider than that of this inquiry and we do not therefore intend to analyse further its findings and recommendations.

Conclusions

C116 No particular manager or level of management is responsible for the weaknesses we identify in relation to the attack on Richard Loudwell, and the issues arising from it. We see a collective failure in the organisation at virtually all levels to address legitimate concerns about the standard of service provided on Luton Ward. These were either not communicated or were not addressed if they were. The evidence suggests that this organisation has been unable to detect such problems, or to effect appropriate change when it has known about such matters. This situation requires a self-critical analysis, not the pillorying of individuals. The failure of the organisation to absorb and implement the conclusions of the W/L report in 1997 and the Appleby Report in 1999 cannot be repeated.

C117 Broadmoor should be a leader and an example of excellence in forensic in-patient care in the same way it is a leader in the forensic assessment of patients. We are concerned to find in the areas examined in our inquiry that the management has apparently failed for a number of years and through a number of changes to deliver this standard with any degree of consistency.
Recommendations

R82 The Trust board should review all critical incident reports, internal and external reviews since 1997 and prepare an analysis of the recommendations and observations of general relevance to the organisation and management of the hospital. This should be periodically updated, disseminated to staff and included in induction arrangements for new staff.

R83 The Trust should review the organisation of the management of the hospital with a view to ensuring that:

- It aspires to and attains a standard of excellence in the care provided to the hospital’s patients.
- The hospital becomes more responsive to experience learned within it, and to good practice developed outside it.
- Management are accountable for the implementation of necessary change.
- Concerns of staff, patients and others are listened to and addressed.

R84 The relevant regulatory bodies for health and adult social care (Mental Health Act Commission, the Healthcare Commission, or, from April 2009, their successor, the Care Quality Commission) in consultation with relevant professional organisations such as the Royal College of Psychiatrists and the Royal College of Nursing, as appropriate, should be invited to inspect Broadmoor on a regular basis, including a programme of unannounced visits, to review the performance of the management of the hospital, monitor progress towards improvement and to publish reports of their inspections.

Postscript

16.106 Critical as this chapter has been we wish to make it clear that we do not see the remedy to the concerns we have expressed being wholesale change of management personnel, or indeed the replacement of any individual managers. As we hope we have made clear we see the fault being a collective one, and that the management as a whole, from the board downwards, must work as a team to restore the standards of excellence that are required at every level.
17. Recommendations

We list for ease of reference all of the recommendations listed in the report.

Chapter two: Introduction

R1 This report should be considered not only by the board of West London Mental Health Trust, but also by NHS London, by the Mental Health Act Commission and its successor body, the Care Quality Commission and by the Department of Health.

R2 The board of the Trust should produce an action plan addressing the recommendations in this report. The plan should contain details of action already taken and an updated version should be reviewed on a regular basis by the bodies mentioned above.

R3 Each of the bodies referred to above should review, in a manner appropriate to their functions, the report and the action plan and consider whether the action taken by the Trust is sufficient and what, if any other, action ought to be taken to address the issues raised in this report.

R4 This report should be published in full at the earliest opportunity.

Chapter seven: Richard Loudwell - care and treatment at Broadmoor

R5 The Trust should review its procedures for carrying out pre-admission nursing assessments to ensure that the lessons of Richard Loudwell’s case are properly learnt and incorporated into future practice including by the development of assessment tools, training, peer review and audit of assessments to ensure that the highest standards are maintained.

R6 Agreement should be sought with referring bodies such as the prison service as to what sources of information will be routinely made available to staff from Broadmoor carrying out pre-admission assessments; in particular those carrying out such assessments ought to have the same access to a patient’s IPR and IMR as their colleagues, whether nurses or prison officers, in the prison service. Those carrying out assessments should not
feel restricted from discussing a patient with members of prison staff for the purposes of carrying out a more thorough assessment.

R7  All incidents believed by staff, or perceived by the victim, of serious or persistent harassment and victimisation should be the subject of an incident report and review by senior management.

R8  Any allegation of verbal or physical abuse of a patient should be treated as having substance unless there is persuasive evidence to the contrary, and the RMO agrees that the allegation may safely be rejected.

R9  When an incident of abuse by one patient on another occurs, the perpetrator must be managed on the basis of the threat posed to other patients on the ward.

R10  Any incident of abuse between patients must be reviewed by the team and a joint management plan in relation to both the victim and the perpetrator agreed and implemented.

R11  When a patient is the victim of more than one incident of verbal or physical bullying the second and any subsequent incidents must be reported to security and logged as a serious incident regardless of whether any injury is sustained.

R12  Patients must be given information in an accessible form about the anti-bullying policy and their rights to complain about harassment, victimisation and bullying and to have their complaint recorded.

R13  The anti-bullying policy of the Trust should be reviewed to take into account the findings of this inquiry.

R14  A system of ‘flagging’ should exist in order to identify any critically important care plans that all staff on a ward need to be aware of.

R15  Where a care plan is of critical importance the ward manager and team leaders ought to have an input in its creation and direct involvement in any review of it.
R16  A system of supervision of practice in nursing should be in place to include care plan formulation and implementation.

Chapter nine: Peter Bryan - events before admission to Broadmoor

R17  Prison authorities should advise their staff of the constant need for sensitivity and training on the effect that insensitive or inappropriate remarks may have on mentally ill prisoners.

Chapter ten: Peter Bryan - care and treatment at Broadmoor

R18  Every effort should be made on a pre-admission medical assessment for the visiting psychiatrist to see a patient either in their cell or elsewhere but in the same room rather than through a hatch. Where this is not reasonably practicable the fact that the issue has been raised and discussed should be recorded together with the reasons for being unable to interview the patient in the same room.

R19  When patients are admitted directly into seclusion the period during which they are secluded should wherever practicable be used as an opportunity for observation and engagement in order to better understand that patient and to permit the provision of an appropriate care regime once they leave seclusion and join other patients on the ward.

R20  An admission mental state examination must be carried out on admission or otherwise as soon as reasonably practicable thereafter. The mental state examination must be documented. Doctors and nurses seeing newly admitted patients must check the notes to ensure that a mental state examination has been performed and documented.

R21  It is not enough to manage patients’ risk on the basis of behaviour. Nursing staff should aim to develop as far as possible a working knowledge on a daily basis of how each patient on the admission ward is feeling, thinking and perceiving others.

R22  Further training is required to ensure that care plans adequately reflect the needs of patients and address relevant risks.

R23  Either before or on admission an interim risk assessment should be prepared under the supervision or direction of the RMO and CNM, the intention being to avoid a situation
where a patient is at being cared for at Broadmoor without any form of risk assessment in place. The interim risk assessment will then be replaced by a ‘full’ risk assessment prepared soon after admission under existing procedures.

R24 In risk assessments and care planning specific consideration should be given from the outset to risks associated not only with the patient’s known history but also to risks arising from gaps in the clinical team’s knowledge or understanding of a patient’s mental state, subjective thought processes or known dangerous conduct.

Chapter eleven: Luton Ward - observation

R25 The Trust’s engagement and observation policy should be reviewed. Consideration should be given to more enhanced engagement and observation protocols at Broadmoor than elsewhere within the Trust.

R26 All wards should have a local engagement and observation protocol which sets out minimum requirements for the observation of patients on that ward to ensure environmental safety and security.

R27 All wards should review how their local engagement and observation practice is carried out to ensure it complies with the hospital’s policy. Each ward must have a system in place which allows staff to know the location of all patients at all times. A named member of the nursing staff should have the responsibility on each shift for monitoring compliance with engagement and observation policy.

R28 It should be an objective of engagement and observation that staff have a day-to-day understanding of the current mental state and subjective state of mind of each patient.

R29 The requirement for a day-to-day understanding of each patient’s current mental state and subjective state of mind goes beyond assessment solely for the purpose of diagnosis but rather, is intended to ensure the best possible day-to-day care of each patient.

R30 Members of the clinical team need to receive effective training to enable them to carry out such engagement and observation.
R31 Achieving the necessary skill set within the clinical team will require engagement and observation to be a focus of supervision; there should be facility for discussion by staff of the results of their engagement with and observation of individual patients.

R32 The 2005 observation policy should be reviewed in the light of our criticisms in this case.

R33 On assessment wards patients should be kept in sight of staff at all times during association unless there are express reasons for a different regime in respect of individual patients. These should be agreed by the clinical team and documented.

R34 The engagement and observation policy should be revised to take account of the need for engagement and observation when a patient is at risk from others.

R35 Specific training needs to be given to nursing staff with respect to engagement and observation which underpin relational security.

R36 All patient-related information must be recorded in the continuous observation record.

Chapter twelve: Luton Ward - management

R37 The MHAC and its successor The Care Quality Commission, should review the new arrangements for inspecting Broadmoor in accordance with our recommendation R83. If possible, this should be at the same level of inspection that was routine before 2005, including visits arranged in response to issues raised by patients.

R38 In light of the history of specific concerns about the lack of therapeutic activity on Luton Ward priority needs to be given to the consideration of this issue, specifically on this ward.

R39 The care plan for each patient on Luton Ward should include a plan for daily and periodical activities to be offered to him throughout his stay on Luton Ward.

R40 Regular staff meetings should be held on Luton Ward to discuss practice, management and patient welfare issues. Such meetings should be attended by directorate...
level representatives who should monitor concerns raised and ensure that these concerns are addressed.

Chapter thirteen: Security and risk assessment

R41 The security department and the forensic services directorate should review the policy for, and use of, intelligence summaries whether circulated in hard copy or electronically. They should improve the quality and extent of risk related information they contain and ensure they are updated in response to new information.

R42 We are told that a national review of the role of security liaison nurse is underway across the three high secure hospitals. We recommend that whether as part of this process or following it, the hospital should conduct a review of the role of security liaison nurse and try to reach agreement with clinical staff about the contribution this post should make to the management of patients on the ward.

R43 The hospital should review the job specification and criteria for the appointment of security liaison nurses with a view to improving the competency and skills of those appointed.

R44 The hospital should consider adopting a policy whereby appointments to the post of security liaison nurse are for no more than five years and are rotated between ward staff and security department staff.

R45 Within the parameters of the NHS Code of Practice on Confidentiality and other national and professional guidance the hospital should initiate a protocol or policy for ensuring the routine exchange of security related information between the security department and the ward which should include access for the security department to relevant clinical information.

R46 The security department should collect and disseminate intelligence on all Tilt risk factors, including patient vulnerability to harm by others.

R47 A Tilt risk assessment on each patient should be prepared and in place at the time of admission, regardless of the amount of information available on the patient at the time. The assessment should be reviewed by the clinical team and the security
department regularly, that is to say at least once a month. This could be more frequent if any member of the clinical team or security department thinks new information suggests the need for such a review.

R48  Management should ensure the Tilt risk assessment includes all risk factors. All factors, including vulnerability to harm from others from assault or harassment, should be given equal priority.

R49  A representative of the security department should be present at all clinical team meetings, and the security department’s view as to the risk status of any patient should be recorded in the minutes. If the decision as to risk status is contrary to the expressed view of the security department representative the reasons for the decision should be recorded and communicated to the director of security.

R50  The security department should receive a copy of relevant minutes from any clinical team meeting at which the risk status of a patient has been discussed.

R51  Management should ensure that reports of any incident of bullying or harassment are sent to the security department.

R52  The security department should arrange for periodic ward inspections to assess risks posed by physical structure, equipment, and the way structure and equipment are being used by staff and patients. Ward managers should receive the results of such inspections in writing.

R53  The Trust policies on health and safety and risk management should be reviewed in the light of our recommendations, particularly in relation to the assessment of risk from the working environment.

R54  The security department should be consulted on any proposal to change the use of a room or premises, whether or not the change involves refurbishment or rebuilding.

R55  The Trust should initiate a review to consider introducing CCTV or other remote monitoring particularly for areas of the hospital which are difficult to observe.
R56  Management should ensure that the security department is notified of any serious untoward incident review and given an opportunity to contribute to the review.

R57  The Trust should consider re-organising the management structure at Broadmoor so the security department is integrated into the directorate of forensic services and the manager with operational responsibility for security reports directly to the director of forensic services. In the event of a disagreement on a matter of security between that manager and the director, the matter must be reported to the Trust chief executive and/or the Trust’s director for security.

R58  The Trust is invited to draw the attention of the Department of Health and the Ministry of Justice to the comments we make about the Tilt report and the need to give the protection of patients from other patients the same priority as the protection of the public from patients. Specifically we recommend that the directions be amended:

- to require re-assessment of a patient’s risk status whenever s/he is the victim of actual or threatened violence

- to require the re-assessment of the risk status of any patient who has used or threatened violence towards another patient or member of staff.

R59  The “decision tree” in the Tilt guidance should be reviewed to give greater emphasis to consideration of whether vulnerable patients are capable of making appropriate decisions to protect themselves.

R60  The guidance should be amended to remind hospitals that for reasons of their disorder or other reasons, some patients may be unwilling or unable to cooperate.

R61  The Trust should initiate a review of the way clinical and security information about patients is obtained from the prison service to ensure uniformity of practice. The aim should be the disclosure of such information within as short a time as possible and ideally before admission to Broadmoor. Unless there are security reasons otherwise, all such information should be made available to the clinical team. Any clinical information relevant to security, as assessed by a properly trained security liaison nurse, should be made available to the security department.
R62 With local and national police the Trust should initiate a review of arrangements to obtain police intelligence and other relevant information about the risks presented by or to patients.

R63 The health and safety policy should be revised to ensure risk assessment of the environment in which patients are cared for has adequate regard to the risk presented by patients to one another, to staff or to themselves.

Chapter fourteen: Support for families

The hospital’s policies D6 and U1, on procedures following the death of a patient and following untoward incidents, should be amended to provide a procedure for:

R64 The identification of one or more professionals to be responsible for liaison with and support of the family.

R65 Planning what information is to be released to the next of kin and other appropriate family members.

R66 Planning what support is to be offered to the family.

R67 Recording the information and support given in a form accessible to the clinical team and hospital management.

R68 Planning and managing the dissemination of information concerning the death to other responsible healthcare professionals.

R69 Ensuring that these arrangements are made part of the care plan.

R70 In the case of the death of or life-threatening injuries to a patient, the assumption by the chief executive, in conjunction with the director for forensic services and the RMO, of responsibility for ensuring that the appropriate arrangements for support are in place.

R71 Giving priority to the needs of the family of a seriously injured or dead patient for support over the perceived needs of the Trust or its staff with regard to potential, threatened or actual litigation.
R72  Unless there are exceptional circumstances making a meeting inappropriate, the RMO should never be prevented by management from meeting such members of the family of a seriously injured or dead patient as he/she sees fit.

R73  The system for preserving and recording the location of patient’s property should be reviewed with particular reference to the property of patients who are transferred to another hospital for medical treatment.

R74  Any confidential legal documents belonging to a deceased patient should be the subject of consultation with the patient’s legal adviser, if any, and, where necessary, the Trust’s legal adviser, before a decision is made as to who such material should be transferred.

R75  Procedures should be implemented to ensure that property of a deceased patient is inspected to ensure it is in an appropriate condition.

Chapter fifteen: Incident investigation

R76  Further consideration should be given at government level to building on the Memorandum of Understanding to enable thorough internal inquiries to run in parallel with criminal investigations. It is unsatisfactory for internal inquiries to be placed on hold pending a criminal investigation. Avoidable incidents could occur because lessons are not learned quickly enough following a serious incident.

R77  That the Trust’s policy U1 is revised to give clearer guidance on how to conduct a critical incident review.

R78  That the Trust ensures that members of staff involved in incident investigations are properly trained in the importance of obtaining accurate statements.

R79  That the results of critical incident reviews be shared with management and other wards promptly.

R80  That a template be introduced for use following all inquiries, CIR’s and similar to ensure recommendations are followed up or actioned within a reasonable timeframe.
R81 That the recommendations of the Kennard SUI be implemented save for 4.7 (care plans to be reviewed at clinical team meetings) and 4.14 (primary nurses to attend clinical team meetings) both of which recommendations we believe to be impracticable.

Chapter sixteen: Hospital management

R82 The Trust board should review all critical incident reports, internal and external reviews since 1997 and prepare an analysis of the recommendations and observations of general relevance to the organisation and management of the hospital. This should be periodically updated, disseminated to staff and included in induction arrangements for new staff.

R83 The Trust should review the organisation of the management of the hospital with a view to ensuring that:

- It aspires to and attains a standard of excellence in the care provided to the hospital’s patients.
- The hospital becomes more responsive to experience learned within it, and to good practice developed outside it.
- Management are accountable for the implementation of necessary change.
- Concerns of staff, patients and others are listened to and addressed.

R84 The relevant regulatory bodies for health and adult social care (Mental Health Act Commission, the Healthcare Commission, or, from April 2009, their successor, the Care Quality Commission) in consultation with relevant professional organisations such as the Royal College of Psychiatrists and the Royal College of Nursing, as appropriate, should be invited to inspect Broadmoor on a regular basis, including a programme of unannounced visits, to review the performance of the management of the hospital, monitor progress towards improvement and to publish reports of their inspections.
Appendix A

Terms of reference

North West London Strategic Health Authority

Independent Inquiry into the care and treatment of Peter Bryan & Richard Loudwell in Broadmoor Hospital and the circumstances of the fatal assault on Richard Loudwell by Peter Bryan.

Commissioner

The Inquiry is commissioned by North West London Strategic Health Authority and is set up under Section 84 of the NHS Act 1977

Terms of Reference

1. To establish the facts of the incident on April 25th 2004, leading to the death of Richard Loudwell.

2. To review:

   - the plans in place to care for Peter Bryan, including the management of his mental state and behaviour following his arrest for the murder of Brian Cherry in February 2004. This includes looking in particular at any assessments made by the prison and health authorities of the risk of Peter Bryan harming others;

   - the plans in place to care for Richard Loudwell and the management of his mental state and behaviour following his detention in HMP Belmarsh in December 2002 and his subsequent admission to Broadmoor. This includes looking in particular at any assessments made by the prison and health authorities of the risk of him being harmed by others;

   - any concerns expressed following Peter Bryan’s arrival at Broadmoor Hospital and prior to the incident on April 25th 2004, along with any action taken;

   - the action taken subsequent to the assault by Peter Bryan on Richard Loudwell;

   - the robustness and application of policies in Broadmoor Hospital relating to:

     the management of recently admitted patients;

     violent or potentially violent patients;
the supervision of patients and
patient protection

- the management and staffing arrangements in place on Luton admissions ward at
the time of the incident;

- the particular arrangements for consultant responsibilities and its impact on
individual care plans on Luton admissions ward;

- the arrangements in place between the local health services, Broadmoor Hospital
and the criminal justice system for the sharing of information, specifically with
regard to the management of risk;

- any other matters arising during the course of the inquiry which, in the opinion of
the panel, are relevant to the occurrence of the incident or might prevent a
recurrence.

3. To consider whether the matters raised by the inquiry have implications and lessons
beyond West London Mental Health NHS Trust and if so, what these are.

4. To submit a report for publication to North West London Strategic Health Authority.

Sharing of Information

This inquiry will be running alongside a second Independent Inquiry concerning Peter
Bryan, commissioned by North East London Strategic Health Authority on behalf of
Newham Primary Care Trust and Newham Social Services Department. Information
obtained by this Inquiry may be shared with the second Inquiry, where in the opinion of
the Chair it is reasonably necessary for the purposes of the second Inquiry to do so.
Similarly, the Chair may request the Chair of the second Inquiry to share information with
this Inquiry on the same basis.

15 July 2005
Biographies of panel members

Robert Francis QC has been in practice at the Bar since 1973, and took silk in 1992. He is a Recorder, and a past Chairman of the Professional Negligence Bar Association. He specialises in medical law. He is joint head of 3 Serjeants’ Inn Chambers. He has been involved in a number of NHS related inquiries, including the independent inquiry into the care and treatment of Michael Stone which he chaired.

Granville Daniels has a long and distinguished career in mental health nursing and management. Prior to his retirement in 2007 he was an executive director at Nottinghamshire Healthcare NHS Trust. He has experience in undertaking a number of reviews and investigations, notably an inquiry into the personality disorder unit at Ashworth Hospital.

Dr John Baird was, until his retirement this year, consultant forensic psychiatrist at Leverndale Hospital, Glasgow. Prior to this, he worked for many years at the State Hospital, Carstairs. (Dr Baird retired from the panel on 7 February 2007)

Supporting the panel:

John de Bono was counsel to the inquiry. He has been in practice at the Bar since 1995. John specialises in medical law and has a particular interest in mental health law. He is a member of 3 Serjeants’ Inn Chambers.

Dr Adrian Grounds provided expertise and specialist advice in forensic psychiatry. He is a university senior lecturer at the Institute of Criminology, Cambridge with research interests in the needs of mentally disordered prisoners and the provision of secure psychiatric services. He is responsible for providing an NHS forensic psychiatry service in the Huntingdon locality of Cambridgeshire, including Littlehey Prison.

Derek Mechen provided the secretarial and administrative support. He has been involved in healthcare in a variety of settings for over 30 years. He has held senior positions in operational management in the NHS and the independent sector, as well as the National Audit Office. He is currently the director for client work at Verita.
Plan of Luton Ward

The plan of Luton Ward has been deleted for security reasons.
The plan of Luton Ward has been deleted for security reasons.
Appendix D: Corridor check form from 25 April 2004
# Appendix E: Staff on duty on 25 April 2004

<table>
<thead>
<tr>
<th>Name</th>
<th>Post-grade</th>
<th>Start time</th>
<th>Finish time</th>
<th>Breaks</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morning shift</strong></td>
<td></td>
<td>7am</td>
<td>1.40pm</td>
<td>15 min tea break and one hour for lunch.</td>
<td></td>
</tr>
<tr>
<td>Team Leader 1</td>
<td>RMN F</td>
<td>7am</td>
<td>12.30am</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse 10</td>
<td>RMN D</td>
<td>7am</td>
<td>12.30am</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA2</td>
<td>HCA A</td>
<td>7am</td>
<td>1.30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA11</td>
<td>HCA A</td>
<td>7am</td>
<td>10.30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Nurse 9</td>
<td>RMN E</td>
<td>9am</td>
<td>11.30am</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ward Manager 1</td>
<td>CNM H</td>
<td>9am</td>
<td>11.30am</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA12</td>
<td>HCA B</td>
<td>7am</td>
<td>10.30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse 1</td>
<td>RMN E</td>
<td>7am</td>
<td>10.30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA7</td>
<td>HCA C</td>
<td>7am</td>
<td>10.30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse 8</td>
<td>RMN E</td>
<td>7am</td>
<td>10.30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA13</td>
<td>HCA B</td>
<td>7am</td>
<td>10.30pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Afternoon shift</strong></td>
<td></td>
<td>1.40pm</td>
<td>9.20pm</td>
<td>15 min tea break and one hour for lunch.</td>
<td></td>
</tr>
<tr>
<td>HCA4</td>
<td>HCA A</td>
<td>7pm</td>
<td>9.20pm</td>
<td></td>
<td>Came on duty after incident; not on ward</td>
</tr>
<tr>
<td>Nurse 11</td>
<td>HCA A</td>
<td>7pm</td>
<td>9.20pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Team Leader 1</td>
<td>RMN F</td>
<td>7am</td>
<td>12.30am</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA2</td>
<td>HCA A</td>
<td>1.40pm</td>
<td>9.20pm</td>
<td></td>
<td>Came on duty after incident; not on ward</td>
</tr>
<tr>
<td>HCA5</td>
<td>HCA B</td>
<td>1.40pm</td>
<td>9.20pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse 12</td>
<td></td>
<td>7.15pm</td>
<td>8.45am</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA6</td>
<td>HCA B</td>
<td>1.40pm</td>
<td>9.20pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA1</td>
<td>HCA A</td>
<td>7.15pm</td>
<td>9.45am</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse 1</td>
<td>RMN E</td>
<td>7am</td>
<td>10.30pm</td>
<td></td>
<td>15 hours 30 mins</td>
</tr>
<tr>
<td>HCA7</td>
<td>HCA C</td>
<td>7am</td>
<td>10.30pm</td>
<td></td>
<td>15 hours 30 mins</td>
</tr>
<tr>
<td>Nurse 5</td>
<td>RMN E</td>
<td>7.15pm</td>
<td>8.45am</td>
<td></td>
<td>11 hours; came on duty after incident</td>
</tr>
<tr>
<td>HCA3</td>
<td>HCA B</td>
<td>2.15pm</td>
<td>7am</td>
<td></td>
<td>10 hours 45 mins</td>
</tr>
<tr>
<td><strong>Night shift</strong></td>
<td></td>
<td>9.20pm</td>
<td>7am</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse 13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not on ward</td>
</tr>
<tr>
<td>Team Leader 1</td>
<td>RMN F</td>
<td>7am</td>
<td>12.30am</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA2</td>
<td>HCA A</td>
<td>9.20pm</td>
<td>11pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA6</td>
<td>HCA B</td>
<td>9.20pm</td>
<td>11pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA1</td>
<td>HCA A</td>
<td>9.20pm</td>
<td>11pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA14</td>
<td>HCA C</td>
<td>9.20pm</td>
<td>11pm</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nurse 5</td>
<td>RMN E</td>
<td>7.15pm</td>
<td>8.45am</td>
<td></td>
<td>11 hours</td>
</tr>
<tr>
<td>Nurse 16</td>
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<td></td>
<td></td>
<td>Not on ward</td>
</tr>
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<td>Nurse 17</td>
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<td></td>
</tr>
<tr>
<td>HCA3</td>
<td>HCA B</td>
<td>2.15pm</td>
<td>7am</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HCA15</td>
<td>HCA A</td>
<td>2.15pm</td>
<td>7am</td>
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</tbody>
</table>

Total shifts = 24 hours 50 minutes = 20 minute handovers x 3
## Appendix F

Luton Ward patient numbers from 1 September 2003 to 30 September 2004

<table>
<thead>
<tr>
<th>Week Commencing Monday</th>
<th>Number of Patients</th>
<th>Average Patient No. Per Month</th>
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<tbody>
<tr>
<td>01-Sep-03</td>
<td>17</td>
<td>17</td>
</tr>
<tr>
<td>03-Sep-03</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>15-Sep-03</td>
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<td>22-Sep-03</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>29-Sep-03</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>06-Oct-03</td>
<td>18</td>
<td>17.25</td>
</tr>
<tr>
<td>13-Oct-03</td>
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<td>20-Oct-03</td>
<td>17</td>
<td></td>
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<tr>
<td>27-Oct-03</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>03-Nov-03</td>
<td>18</td>
<td>17.75</td>
</tr>
<tr>
<td>10-Nov-03</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>17-Nov-03</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>24-Nov-03</td>
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<td>02-Feb-04</td>
<td>18</td>
<td>17.75</td>
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<td>07-Jun-04</td>
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<td>28-Jun-04</td>
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<td>05-Jul-04</td>
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<td>12-Jul-04</td>
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<td>02-Aug-04</td>
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<td>15</td>
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## Action plan presented to Trust board in November 2004

<table>
<thead>
<tr>
<th>Source of recommendation</th>
<th>Action</th>
<th>Progress</th>
<th>Timescale</th>
</tr>
</thead>
<tbody>
<tr>
<td>CIR 1 26 May</td>
<td>CTM on Luton Ward to be extended to 3 hours to allow adequate time to discuss new patients and the local Clinical Improvement Group.</td>
<td>Meeting now extended to discuss all patients weekly. <strong>Completed</strong></td>
<td>Mar 05</td>
</tr>
<tr>
<td>CIR 2 26 May</td>
<td>To document all risk when discussing new patients. Clinical Teams to complete CPA documentation.</td>
<td>Clinical Team completing CPA documentation at first meeting after admission. <strong>Completed</strong></td>
<td>Jan 05</td>
</tr>
<tr>
<td>CIR 3 26 May</td>
<td>All patients prior to CPA meetings to be seen by medical staff and their mental state documented.</td>
<td>Now part of SHO duties. <strong>Completed</strong></td>
<td>Dec 04</td>
</tr>
<tr>
<td>CIR 4 26 May</td>
<td>Patient’s Primary Nurse or deputy to interview patients and document their mental state within one week of admission.</td>
<td>CNM to monitor standard. Reviewed in the monthly performance meeting with Service Managers. <strong>Completed</strong></td>
<td>Jan 05</td>
</tr>
<tr>
<td>CIR 5 26 May</td>
<td>Clinical Team to draw up an Action Plan to change the culture of bullying on the ward.</td>
<td>A strategy for the prevention of bullying has been prepared. Subject to final agreement, a Lead Nurse has been identified to lead on implementation and ensure all staff and patients are aware. This will be incorporated into the ward operational policy. Final strategy to be completed in December and circulated (shared) with all wards. <strong>Completed</strong></td>
<td>Jan 05</td>
</tr>
<tr>
<td>CIR 6 26 May</td>
<td>The dining room will remain in use for patients but will be subject to twice hourly environmental checks and will be locked off during staff breaks.</td>
<td>Initially post-incident the dining area is only used when staff are available to supervise. This remains the case and this recommendation has not been auctioned.</td>
<td></td>
</tr>
<tr>
<td>CIR 7</td>
<td>26 May</td>
<td>The skill mix for each shift needs to be assessed prior to the shift and a decision taken that the skill mix is adequate for the shift.</td>
<td>New CNM appointed. Skill mix built into key objectives. It has been agreed a minimum of 3 qualified staff per shift will be on duty.</td>
</tr>
<tr>
<td>-------</td>
<td>--------</td>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CIR 8</td>
<td>26 May</td>
<td>When there are two SHO’s allocated to the ward they should be from different training schemes and have different training days in order to improve medical cover on the ward.</td>
<td>New SHOs now in post.</td>
</tr>
<tr>
<td>CIR 9</td>
<td>26 May</td>
<td>The future development of the hospital should incorporate the need for 2 smaller male admission wards, each of 12-15 beds.</td>
<td>Proposals development for all ward configurations as part of the modernisation work. To include one additional admissions ward.</td>
</tr>
<tr>
<td>Table Top Review Oct 04</td>
<td>Audit on the completion of presentation at risk assessment on new admission of the first Clinical Team meeting.</td>
<td>Revised practice subject of audit. See CIR Recommendation 2.</td>
<td>Jan 05</td>
</tr>
<tr>
<td>Table Top Review Oct 04</td>
<td>Dining room not to be available for use by patients unless supervised at all times. Protocol to be written. To be included in operational policy.</td>
<td>Protocol in preparation. Access to dining room only under staff supervision.</td>
<td>Jan 05</td>
</tr>
<tr>
<td>Table Top Review Oct 04</td>
<td>Review of allocation of staff breaks</td>
<td>CNM has carried out a review and agreed with Service Director. Evening breaks, commence after patients’ evening meals, i.e. 5.30 p.m. Following review the current practice is for maximum of 3 staff taking on-ward breaks.</td>
<td>Completed</td>
</tr>
<tr>
<td>Table Top Review Oct 04</td>
<td>Review of the skill mix of staff to ensure not less than 40% qualified staff on any shift.</td>
<td>New CNM appointed. Skill mix built into key objectives. Budget establishment is set at 48% qualified staff.</td>
<td>Completed</td>
</tr>
<tr>
<td>Table Top Review Oct 04</td>
<td>Automatic temporary moratorium on admission until safe to resume. Guidelines to be agreed.</td>
<td>Following incident, admissions were slowed. Following CIR, normal practice reviewed and ward capacity reduced to 18 beds.</td>
<td>Jan 05</td>
</tr>
<tr>
<td>Table Top Review</td>
<td>Joint CTM notes to be prepared following CTM’s which deal with all patients weekly. Joint CTM</td>
<td>Meeting now extended to discuss all patients weekly. Joint CTM</td>
<td>Feb 05</td>
</tr>
</tbody>
</table>

**Appendix G: Action plan presented to Trust board in November 2004**

426
<table>
<thead>
<tr>
<th>Date</th>
<th>Task Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct 04</td>
<td>the patients on the ward and are circulated to both Clinical Teams, and to others in the respective directorates in order to provide an overview of issues on Luton Ward.</td>
<td>Completed</td>
</tr>
<tr>
<td>Table Top Review Oct 04</td>
<td>To review whether Clinical Team meetings should continue to take place on a Monday morning and if they should, alternative arrangement set in place to ensure that 2 weeks do not go by on the admission ward without a CTM.</td>
<td>On going.</td>
</tr>
<tr>
<td>Table Top Review Oct 04</td>
<td>A more comprehensive review to take place addressing the concerns of the Table Top Review.</td>
<td>Trust advised not to undertake any internal inquiry that would involve interviewing staff. An independent inquiry will commence following PB’s criminal proceedings being concluded and agreed.</td>
</tr>
<tr>
<td>Table Top Review Oct 04</td>
<td>At least brief notes to be obtained prior to admission, of any new patient, with full notes to follow on as soon as possible.</td>
<td>To be addressed in review of Admissions Policy.</td>
</tr>
<tr>
<td>Table Top Review Oct 04</td>
<td>All new admissions to have a nursing assessment prior to arrival at the hospital, in order to better prepare nursing care plans. Admission Policy to be reviewed to include this.</td>
<td>Review of Admissions Policy.</td>
</tr>
<tr>
<td>Table Top Review Oct 04</td>
<td>Admission Policy to be revised to require explicit consideration of risk to potentially vulnerable individuals consequent on admission to High Security.</td>
<td></td>
</tr>
<tr>
<td>Additional Management Actions</td>
<td>To do a Review and Risk Assessment of Luton Ward to look at identifying all areas not in natural eyesight of staff and to write a Management Plan for all isolated areas on the ward when not in functional use. The Review and Risk Assessment to be shared once completed with all Service Directors, Clinical Directors, and Heads of Professions</td>
<td>Review commissioned by Service Director.</td>
</tr>
<tr>
<td>Additional Management Actions</td>
<td>Review the process by which Critical Incident Review reports are presented by the directorate management teams to avoid any delays in implementing action plans and sharing lessons learned.</td>
<td>Process under review and will be incorporated into Trust-wide Root Cause Analysis Strategy. In the interim independent panel to undertake CIR internally.</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Additional Management Actions</td>
<td>Review the recording system to monitor the location of each patient on the ward at agreed intervals during a shift.</td>
<td>Recording system reviewed to include detailed location of patient. Completed</td>
</tr>
<tr>
<td>Additional Management Actions</td>
<td>Maintain regular contact with Mr RL’s family through designated contact.</td>
<td></td>
</tr>
<tr>
<td>Additional Management Actions</td>
<td>Agree clinical notes to be disclosed to Police on both Mr RL and Mr PB. Police have requested the Trust to review the clinical notes of all patients on Luton Ward on 25 April 2004 and disclose any information relating to the incident.</td>
<td>On going.</td>
</tr>
</tbody>
</table>
### List of interviewees

#### Luton Ward

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title at time of incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant psychologist</td>
<td>Consultant Clinical Psychologist</td>
</tr>
<tr>
<td>HCA1</td>
<td>Healthcare assistant</td>
</tr>
<tr>
<td>HCA2</td>
<td>Healthcare assistant</td>
</tr>
<tr>
<td>HCA4</td>
<td>Healthcare assistant</td>
</tr>
<tr>
<td>HCA5</td>
<td>Healthcare assistant</td>
</tr>
<tr>
<td>HCA6</td>
<td>Healthcare assistant</td>
</tr>
<tr>
<td>HCA7</td>
<td>Healthcare assistant</td>
</tr>
<tr>
<td>Manager of Occupational Therapy</td>
<td>Head occupational therapist</td>
</tr>
<tr>
<td>Nurse 1</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>Nurse 2</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>Nurse 4</td>
<td>Acting team leader</td>
</tr>
<tr>
<td>Nurse 6</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>Nurse 8</td>
<td>Team leader</td>
</tr>
<tr>
<td>Occupational Therapist 2</td>
<td>Occupational therapist</td>
</tr>
<tr>
<td>Primary Nurse 3</td>
<td>Registered nurse</td>
</tr>
<tr>
<td>Primary Nurse 9</td>
<td>Acting team leader</td>
</tr>
<tr>
<td>RMO2</td>
<td>Consultant forensic psychiatrist</td>
</tr>
<tr>
<td>RMO3</td>
<td>Consultant forensic psychiatrist</td>
</tr>
<tr>
<td>Security Liaison Nurse 2</td>
<td>Security liaison nurse</td>
</tr>
<tr>
<td>SH01</td>
<td>Senior house office</td>
</tr>
<tr>
<td>Specialist Registrar 4</td>
<td>Forensic psychologist and Specialist Registrar</td>
</tr>
<tr>
<td>Team Leader 1</td>
<td>Team leader</td>
</tr>
<tr>
<td>Team Leader 2</td>
<td>Team leader</td>
</tr>
<tr>
<td>Team Leader 3</td>
<td>Team leader</td>
</tr>
<tr>
<td>Ward Manager 1</td>
<td>Ward manager (clinical nurse manager)</td>
</tr>
<tr>
<td>Ward Manager 2</td>
<td>Clinical ward manager (based on Woodstock Ward)</td>
</tr>
</tbody>
</table>

**Appendix H: List of interviewees**

429
**Other staff at Broadmoor**

<table>
<thead>
<tr>
<th>Name deleted</th>
<th>Class 3 technical instructor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name deleted</td>
<td>Manager, Mental Health Act office/health records</td>
</tr>
<tr>
<td>Name deleted</td>
<td>Assistant psychologist on Dangerous and Severe Personality Disorder unit</td>
</tr>
</tbody>
</table>

**Author of neuropsychology report**

<table>
<thead>
<tr>
<th>Name deleted</th>
<th>Clinical neuropsychologist</th>
</tr>
</thead>
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**Clinical Nurse Manager 2**

<table>
<thead>
<tr>
<th>Clinical Nurse Manager 2</th>
<th>Clinical nurse manager, Isis Ward</th>
</tr>
</thead>
</table>

**Consultant Psychiatrist 1**

<table>
<thead>
<tr>
<th>Consultant Psychiatrist 1</th>
<th>Consultant psychiatrist, Isis Ward</th>
</tr>
</thead>
</table>

**HCA3**

<table>
<thead>
<tr>
<th>HCA3</th>
<th>Healthcare assistant, Taunton Ward</th>
</tr>
</thead>
</table>

**Nurse 18**

<table>
<thead>
<tr>
<th>Nurse 18</th>
<th>Registered nurse, Woodstock Ward</th>
</tr>
</thead>
</table>

**Nurse Consultant 1**

<table>
<thead>
<tr>
<th>Nurse Consultant 1</th>
<th>Nurse consultant</th>
</tr>
</thead>
</table>

**Resource and Inteligence Manager**

<table>
<thead>
<tr>
<th>Resource and Inteligence Manager</th>
<th>Resource/intelligence coordinator</th>
</tr>
</thead>
</table>

**Security Liaison Nurse 1**

<table>
<thead>
<tr>
<th>Security Liaison Nurse 1</th>
<th>Security liaison nurse</th>
</tr>
</thead>
</table>

**Social Worker 2**

<table>
<thead>
<tr>
<th>Social Worker 2</th>
<th>Social worker</th>
</tr>
</thead>
</table>

**Social Worker 3**

<table>
<thead>
<tr>
<th>Social Worker 3</th>
<th>Social worker</th>
</tr>
</thead>
</table>

**Specialist Registrar 3**

<table>
<thead>
<tr>
<th>Specialist Registrar 3</th>
<th>Specialist registrar</th>
</tr>
</thead>
</table>

**The Security Operations Manager**

<table>
<thead>
<tr>
<th>The Security Operations Manager</th>
<th>Security operations manager</th>
</tr>
</thead>
</table>

**Directors at West London Mental Health NHS Trust**

<table>
<thead>
<tr>
<th>Alistair McNicol</th>
<th>Director of security</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Deputy Director of Nursing</th>
<th>Deputy director of nursing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sean Payne</th>
<th>Director of forensic services</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Service Director 1</th>
<th>Service director, Women’s Secure Services</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Service Director 3</th>
<th>Assistant director of forensic services</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Simon Crawford</th>
<th>Chief executive</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>The Associate Medical Director</th>
<th>Associate medical director</th>
</tr>
</thead>
</table>

| The Service Manager of the London Directorate | Service manager of the London directorate |
### Appendix H: List of interviewees

#### Staff at Belmarsh Prison
- Head of Healthcare: Head of healthcare
- Prison Officer: Prison officer
- RMO1: Consultant psychiatrist

#### Other interviewees
- Commissioner 1: Regional director, Mental Health Act Commission
- Commissioner 2: Area commissioner, Mental Health Act Commission
- Peter Bryan: Patient
- Social Worker 4: Forensic social worker, Ealing Social Services Department

#### Staff from Broadmoor who were not interviewed but gave written statements
- [Name deleted]: Clinical risk advisor
- [Name deleted]: Technical assistant, Department of Sport and Leisure
- [Name deleted]: Staff counsellor and support adviser
- Clinical Nurse Manager 3: Clinical nurse manager, Dover Ward
- GP: General practitioner
- HCA11: Healthcare assistant, Luton Ward
- HCA13: Healthcare assistant, Luton Ward
- HCA15: Healthcare assistant, Luton Ward
- HCA16: Healthcare assistant, Luton Ward
- HCA17: Healthcare assistant, Luton Ward
- HCA18: Healthcare assistant, Luton Ward
- HCA19: Healthcare assistant, Luton Ward
- HCA8: Healthcare assistant, Luton Ward
- Nurse 10: Registered nurse, Luton Ward
- Nurse 13: Bank registered nurse
- Nurse 19: Registered nurse, Banbury Ward
- Nurse 20: Registered nurse, Luton Ward
- Nurse 21: Registered nurse, Luton Ward
- Nurse 22: Registered nurse, Luton Ward
- Nurse 5: Registered mental nurse, Luton Ward
- Nurse manager: Nurse manager
- Speech and Language: Speech and language therapist, a professor
<table>
<thead>
<tr>
<th>Role</th>
<th>Position/Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist</td>
<td></td>
</tr>
<tr>
<td>Student Nurse</td>
<td>Healthcare assistant, Banbury Ward</td>
</tr>
<tr>
<td>Team Leader 4</td>
<td>Team leader, Glastonbury Ward</td>
</tr>
<tr>
<td>Social worker 6</td>
<td>Senior social worker, HMP Belmarsh</td>
</tr>
</tbody>
</table>

Mrs Loudwell, Richard Loudwell’s mother, and other members of his family were also seen by the panel and kept up-to-date on the inquiry. The panel were sad to learn that Mrs Loudwell died during the course of the inquiry. The panel also interviewed members of Peter Bryan’s family.
## List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>CASS Unit</td>
<td>Facility offering access to various therapeutic activities</td>
</tr>
<tr>
<td>CHI</td>
<td>Commission for health improvement</td>
</tr>
<tr>
<td>CIR</td>
<td>Critical internal review</td>
</tr>
<tr>
<td>CNM</td>
<td>Clinical nurse manager</td>
</tr>
<tr>
<td>CPA</td>
<td>Care programme approach</td>
</tr>
<tr>
<td>CTM</td>
<td>Clinical team meeting</td>
</tr>
<tr>
<td>DSH</td>
<td>Deliberate self-harm</td>
</tr>
<tr>
<td>DSPD unit</td>
<td>Dangerous and severe personality disorder unit</td>
</tr>
<tr>
<td>F2052SH</td>
<td>Regime initiated for prisoners at risk of self-harm</td>
</tr>
<tr>
<td>GBH</td>
<td>Grievous bodily harm</td>
</tr>
<tr>
<td>HCA</td>
<td>Healthcare assistant</td>
</tr>
<tr>
<td>HMP Belmarsh</td>
<td>Her Majesty’s Prison, Belmarsh</td>
</tr>
<tr>
<td>HMP Elmley</td>
<td>Her Majesty’s Prison, Elmley</td>
</tr>
<tr>
<td>ICA</td>
<td>Intensive care area</td>
</tr>
<tr>
<td>IMR</td>
<td>Inmate medical records</td>
</tr>
<tr>
<td>IPR</td>
<td>Inmate personal record</td>
</tr>
<tr>
<td>MDT</td>
<td>Multi-disciplinary team</td>
</tr>
<tr>
<td>MHA</td>
<td>Mental Health Act</td>
</tr>
<tr>
<td>MHAC</td>
<td>Mental Health Act Commission</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td>RIDDOR</td>
<td>Reporting of injuries, diseases and dangerous occurrences regulations</td>
</tr>
<tr>
<td>RMO</td>
<td>Responsible medical officer</td>
</tr>
<tr>
<td>SHO</td>
<td>Senior house officer</td>
</tr>
<tr>
<td>SIR</td>
<td>Security intelligence report</td>
</tr>
<tr>
<td>SPECT</td>
<td>A nuclear imaging test to show how blood flows through to tissues and organs</td>
</tr>
<tr>
<td>SpR</td>
<td>Specialist registrar</td>
</tr>
</tbody>
</table>
## Appendix J

### List of all those mentioned in the report

<table>
<thead>
<tr>
<th>Name</th>
<th>Job title at time of incident</th>
</tr>
</thead>
<tbody>
<tr>
<td>[Name deleted]</td>
<td>Manager, Mental Health Act Office</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Author of a review of suicides at Broadmoor Hospital</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Author of mapping exercise, root cause analysis review of death of Richard Loudwell</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Author of neuropsychology report</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Author of post-mortem report</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Author of psychiatric report</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Author of psychological report</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Author of psychiatric report on Richard Loudwell</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Consultant, Queen Elizabeth Hospital</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Consultant neuropsychiatrist, Maudsley Hospital</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Consultant neurologist, BUPA Alexandra Hospital</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Locum associate specialist, Medway Hospital</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Produced dental report</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Produced fingerprint report</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Produced post-mortem report</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Professor, Ashworth Hospital</td>
</tr>
<tr>
<td>[Name deleted]</td>
<td>Chadwick Lodge</td>
</tr>
<tr>
<td>Alistair McNicol</td>
<td>Director of security, West London Mental Health NHS Trust</td>
</tr>
<tr>
<td>Anthony Harbour</td>
<td>Chair of the independent inquiry into the care and treatment of Richard Loudwell</td>
</tr>
<tr>
<td>Assistant Psychologist</td>
<td>Assistant psychologist, dangerous and severe personality disorder unit</td>
</tr>
<tr>
<td>Associate Specialist</td>
<td>Associate Specialist in Forensic Psychiatry, Broadmoor Hospital</td>
</tr>
<tr>
<td>Barrister 1</td>
<td>Richard Loudwell’s barrister</td>
</tr>
<tr>
<td>Barrister 2</td>
<td>Barrister</td>
</tr>
<tr>
<td>Chief Executive, Mental Health Act Commission</td>
<td>Chief Executive, Mental Health Act Commission</td>
</tr>
<tr>
<td>Clinical Nurse Manager 1</td>
<td>Clinical Nurse Manager, Taunton Ward</td>
</tr>
<tr>
<td>Clinical Psychologist</td>
<td>Principal Clinical psychologist, Broadmoor Hospital</td>
</tr>
</tbody>
</table>
Appendix J: List of those mentioned in the report

Commissioner 1
Regional director, Mental Health Commission

Consultant Psychiatrist 1
Consultant psychiatrist, Isis Ward

Consultant Psychiatrist 2
Consultant psychiatrist, Medway Hospital

Consultant Psychiatrist 3
Consultant forensic psychiatrist, Trevor Gibbens Unit

Consultant Psychiatrist 4
Consultant psychiatrist, Broadmoor Hospital

Consultant Psychiatrist 5
Consultant psychiatrist, Kneesworth House

Consultant Psychiatrist 6
Consultant psychiatrist, Kent Psychiatry Service

Consultant Psychiatrist 7
Consultant forensic psychiatrist, HMP Belmarsh

Consultant Psychiatrist 8
Locum consultant forensic psychiatrist

Consultant Psychologist
Consultant Clinical Psychologist

Detective Chief
Detective Chief Inspector, Thames Valley Police

Dr Julie Hollyman
Chief executive, West London Mental Health Trust

GP
General practitioner

HCA1
Healthcare assistant, Luton Ward

HCA2
Healthcare assistant, Luton Ward

HCA3
Healthcare assistant, Taunton Ward

HCA4
Healthcare assistant, Luton Ward

HCA5
Healthcare assistant, Luton Ward

HCA6
Healthcare assistant, Luton Ward

HCA7
Healthcare assistant, Luton Ward

HCA8
Healthcare assistant, Luton Ward

HCA9
Healthcare assistant, Broadmoor Hospital

HCA10
Healthcare assistant, Broadmoor Hospital

Head of Mental Health Performance
Head of mental health performance, North West London SHA

Jane Mishcon
Chair, Independent inquiry in the care and treatment of Peter Bryan

Joan Smythe
Richard Loudwell’s victim

L
Independent consultant and author of internal review into an assault

Manager of Occupational Therapy
Head occupational therapist
Appendix J: List of those mentioned in the report

Modern Matron

Nisha Sheth

Nurse 1

Nurse 2

Nurse 4

Nurse 5

Nurse 6

Nurse 7

Nurse 8

Nurse Consultant 1

Nurse Consultant 2

Nurse Manager

Occupational Therapist 1

Occupational Therapist 2

On-call PR Manager

Peter Bryan

Primary Nurse 3

Primary Nurse 9

Professor Kennard

Professor Louis Appleby

Professor Smidt

Project Manager

Resource and Intelligence Manager

Richard Loudwell

RM01

RM02

RM03

Sean Payne

Security Liaison Nurse 1

Security Liaison Nurse 2

Service Director 1

Modern Matron, West London Mental Health Trust

Victim of Peter Bryan

Staff nurse, Luton Ward

Registered nurse, Luton Ward

Acting team leader, Luton Ward

Registered mental nurse, Luton Ward

Registered nurse, Luton Ward

Registered nurse, Broadmoor Hospital

Team Leader, Luton Ward

Nurse consultant, Broadmoor Hospital

Nurse consultant, Women’s Services, West London Mental Health NHS Trust

Broadmoor Nursing Administration Office

Occupational therapist, Broadmoor Hospital

Occupational therapist, Luton Ward

On-call PR manager, Broadmoor Hospital

Perpetrator

Registered nurse, Luton Ward

Acting team leader, Luton Ward

Chair, root cause analysis review of death of Richard Loudwell

Author, Suicide prevention at Broadmoor Hospital

Chair, West London Mental Health NHS Trust

Project manager, PSPD unit

Resource/intelligence coordinator, Broadmoor Hospital

Victim

Consultant psychiatrist, HMP Belmarsh

Consultant forensic psychiatrist, Luton Ward

Consultant forensic psychiatrist, West London Mental Health NHS Trust

Director of forensic services, West London Mental Health NHS Trust

Security liaison nurse, Broadmoor Hospital

Service director, Women’s Secure Services, West London Mental Health Trust

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Service Director 2  
Service director, Broadmoor Hospital

Service Director 3  
Assistant director of forensic services, West London Mental Health NHS Trust

Service Director 4  
Service director of high secure services men, London, West London Mental Health Trust

Service Director 5  

SHO1  
Senior house office, Luton Ward

SHO2  
Duty medical officer, Broadmoor Hospital

SHO3  
Ward senior house officer

Simon Crawford  
Chief executive, West London Mental Health Trust

Sir Richard Tilt  
Author of report on security in high security hospitals

Social worker 1  
Richard Loudwell’s social worker

Social Worker 2  
Social worker

Social Worker 3  
Social worker, Broadmoor Hospital

Social Worker 4  
Forensic social worker, Ealing Social Services Department

Social Worker 5  
Team manager, forensic social work service, Ealing Social Services

Specialist Registrar 1  
Psychiatrist, HMP Belmarsh

Specialist Registrar 2  
Specialist registrar, Broadmoor

Specialist Registrar 3  
Specialist registrar, Broadmoor Hospital

Specialist Registrar 4  
Forensic psychologist and Specialist Registrar

Speech and Language Therapist  
Speech and language therapist

Student Nurse  
Student nurse, Broadmoor Hospital

Team Leader 1  
Team leader, Luton Ward

Team Leader 2  
Team leader, Luton Ward

Team Leader 3  
Team leader, Luton Ward

The Associate Medical Director  
Associate medical director, West London Mental Health NHS Trust

The Deputy Director of Nursing  
Deputy director of nursing, West London Mental Health Trust

The Head of Healthcare at Belmarsh  
Head of healthcare, HMP Belmarsh

The Medical Director  
Medical Director, Kneesworth House

The Security Liaison  
Security liaison manager, Broadmoor Hospital

Appendix J: List of those mentioned in the report

437
<table>
<thead>
<tr>
<th>Manager</th>
<th>Security operations manager, Broadmoor Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Security Operations Manager</td>
<td>Service manager of the London directorate, West London Mental Health NHS Trust</td>
</tr>
<tr>
<td>the Service Manager of the London Directorate</td>
<td>Non-executive director, Broadmoor Hospital Authority and author of internal review into assault an assault</td>
</tr>
<tr>
<td>W</td>
<td>Ward manager, (clinical nurse manager), Luton Ward</td>
</tr>
<tr>
<td>Ward Manager 1</td>
<td>Clinical ward manager (based on Woodstock Ward)</td>
</tr>
</tbody>
</table>