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

Addendum to the report

A report for NHS London

September 2009

NHS London

Introduction

1.1 Following the completion of the report NHS London, the commissioning Strategic Health Authority, indicated that it wished to consider whether the report should be published without any individual to whom it referred being identified by name. The Authority asked the inquiry to express its view on that issue so that it could be taken into account by the Authority in making its decision.

1.2 In the report the inquiry panel expressed the view that it should be published "*in full at the earliest opportunity*".[1] However the panel did not expressly address the issue of anonymisation. The inquiry had assumed that, in view of its terms of reference, it was to submit a report to the commissioning authority "*for publication*", and that it was clear that its report would be published in full, including the names of staff.

1.3 In the light of the matters raised on behalf of the Authority, the inquiry agreed to consider the matter afresh and to place its conclusions in an Addendum to the report.

Submissions on behalf of NHS London

1.4 Through its solicitor the SHA has suggested that the following are factors that need to be taken into account:

- The starting point for this type of inquiry should be that staff are not identified in the public report: staff have rights of privacy and under the Data Protection Act, albeit rights which can be overridden where here is a clear public interest to do so.

- Identification of the staff members involved is unnecessary for compliance with the obligations of the State under Article 2 of the European Convention on Human Rights to hold an independent and thorough investigation.

- The report identified systemic rather than individual errors as directly contributing to the death of Richard Loudwell.

[1] Chapter two paragraph 2.55 and recommendation R4

- The terms of reference do not include a need to ensure accountability in relation to individual staff members.

- There had been media concern about Broadmoor in the past which had resulted in staff being 'door-stepped' by the press: identification of staff in the published report could lead to this being repeated.

- Identification of staff, and any resulting media harassment could deter staff at Broadmoor or elsewhere within the NHS cooperating with any subsequent inquiry.

- Anonymisation would be consistent with what was described as a developing 'culture' (perhaps more appropriately a practice) not to identify staff in reports of this nature.

1.5 We shall set out first the legal context of this inquiry, second the process adopted by it, thirdly a discussion of the relevant factors and finally give our conclusion.

Human Rights obligations

1.6 In the introduction to the report we set out our understanding of the State's obligation under Articles 2, 3 and 8 of the European Convention on Human Rights.

1.7 We remind ourselves that the State's duty in a case such as this includes not only the protection of the lives of detained and vulnerable patients from a real and serious threat to their lives but also to the setting up of an effective investigation where a death occurs in circumstances where a breach of that obligation may have occurred. Thus in *Powell v UK*[2] The European Court on Human Rights said:

> *"…In the Court's opinion, the events leading to the tragic death of the applicants' son and the responsibility of the health professionals involved are matters which must be addressed from the angle of the adequacy of the mechanisms in place for shedding light on the course of those events, allowing the facts of the case to be exposed to public scrutiny – not least for the benefit of the applicants.*

[2] Application no. 45305/99 (emphasis supplied)

The Court has attached particular weight to the procedural requirement implicit in Article 2 of the Convention. It recalls that the obligation to protect the right to life under Article 2, read in conjunction with the State's general duty under Article 1 to 'secure to everyone within [its] jurisdiction the rights and freedoms defined in [the] Convention', requires by implication that there should be some form of effective official investigation when individuals have been killed as a result of the use of force…This obligation is not confined to cases where it has been established that the killing was caused by an agent of the State. Nor is it decisive whether members of the deceased's family or others have lodged a formal complaint about the killing with the relevant investigatory authority. The mere knowledge of the killing on the part of the authorities gives rise ipso facto to an obligation under Article 2 of the Convention to carry out an effective investigation into the circumstances surrounding the death.

The Court considers that the procedural obligation as described cannot be confined to circumstances in which an individual has lost his life as a result of an act of violence. In its opinion, and with reference to the facts of the instant case, the obligation at issue extends to the need for an effective independent system for establishing the cause of death of an individual under the care and responsibility of health professionals and any liability on the part of the latter…

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1.8 In the instructive case of *Edwards v UK*[3], a case of the killing of a detained prisoner by a mentally ill fellow inmate, the Court said:

"56. In the context of prisoners, the Court has had previous occasion to emphasise that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them. It is incumbent on the State to account for any injuries suffered in custody, which obligation is particularly stringent where that

[3] Application 46477/99, 14th March 2002 (emphasis supplied)

individual dies (see, for example, Salman v. Turkey [GC], no. 21986/93, § 99, ECHR 2000-VII)."

1.9 With regard to the need for an effective investigation, the Court said that:

"*69. The essential purpose of such investigation is to secure the effective implementation of the domestic laws which protect the right to life and, in those cases involving State agents or bodies, to ensure their accountability for deaths occurring under their responsibility. What form of investigation will achieve those purposes may vary in different circumstances.*"

1.10 The essential requirements of such an investigation were said by the Court to include:[4]

- Independence from those implicated in the events (para 70).

- Effectiveness (para 71)…

  "*…in the sense that it is capable of leading to a determination of whether the force used was or was not justified in the circumstances…and to the identification and punishment of those responsible. This is not an obligation of result, but of means. The authorities must have taken the reasonable steps available to them to secure the evidence concerning the incident, including, inter alia, eyewitness testimony, forensic evidence and, where appropriate, an autopsy providing a complete and accurate record of injury and an objective analysis of clinical findings, including the cause of death. Any deficiency in the investigation which undermines its ability to establish the cause of death or the person or persons responsible will risk falling foul of this standard.*"

- Promptness and reasonable expedition (para 71).

- A sufficient element of public scrutiny (para 72). This is:

  "*…to secure accountability in practice as well as in theory. The degree of public scrutiny required may well vary from case to case. In all cases, however, the next-*

[4] See also *Jordan v UK* (Application 24746/94) 4th May 2001 para 106 et seq

of-kin of the victim must be involved in the procedure to the extent necessary to safeguard his or her legitimate interests."

1.11 With regard to the degree of public scrutiny it is instructive to note what the Court said in relation to the facts of the case before it (paragraph 83):

"In the present case, where the deceased was a vulnerable individual who lost his life in a horrendous manner due to a series of failures by public bodies and servants who bore a responsibility to safeguard his welfare, the Court considers that the public interest attaching to the issues thrown up by the case was such as to call for the widest exposure possible."

1.12 The Court has also considered, in assessing the adequacy of an inquest, whether effectiveness of the investigation is compromised by anonymity of witnesses: in *Bubbins v UK,* [5] the point is relevant to whether:

"…firstly, the applicant [was guaranteed] a sufficient measure of participation in the investigation into the death of Michael Fitzgerald and, secondly, an appropriate forum for securing the public accountability of the State and its agents for their alleged acts and omissions leading to the death…"

1.13 In the result the Court rejected a submission that allowing anonymity to the police officers compromised the effectiveness of the investigation, because witnesses had been compellable and because the family had, with the assistance of the coroner, sufficient opportunity to examine the witnesses. We observe that while the first factor is present in the case of this inquiry, the second is not.

Domestic law

1.14 In the domestic context the issue of the right of inquiry witnesses to anonymity has recently been considered in the fraught context of police conduct in Northern Ireland by the House of Lords in *Re Officer L and others*.[6] While the case was principally concerned

[5] Application 50196/99, 17th March 2005 paragraph 156
[6] [2007] UKHL 36; [2007] 1 WLR 2135

with a putative risk to the life of witnesses, the broader issues to be taken into account were considered; Lord Carswell said:[7]

> *"The principles which apply to a tribunal's common law duty of fairness towards the persons whom it proposes to call to give evidence before it are distinct and in some respects different from those which govern a decision made in respect of an article 2 risk. They entail consideration of concerns other than the risk to life… It is unfair and wrong that witnesses should be avoidably subjected to fears arising from giving evidence, the more so if that has an adverse impact on their health. It is possible to envisage a range of other matters which could make for unfairness in relation of witnesses. Whether it is necessary to require witnesses to give evidence without anonymity is to be determined, as the tribunal correctly apprehended, by balancing a number of factors which need to be weighed in order to reach a determination."*

1.15 In relation to a risk to life, it was held that the correct test was whether the risk was materially increased by a identification of the witness:

> *"If the risk has not been increased, then it is not unfair on that account to require a witness to give evidence. [The tribunal] went on, again correctly in my opinion, to assess the relevant factors other than actual risk to life which could make it unfair to require witnesses to testify without anonymity, that is, the subjective fears which many of them expressed. It carried out a proper balancing exercise and concluded that the balance came down against allowing the applications for anonymity, then took into account medical evidence in order to determine if that affected its conclusions."*

1.16 The other factors considered in that case included the effect on the public perception of the impartiality of the inquiry and the public's ability to follow the evidence if a grant of anonymity were made.

1.17 Although this inquiry is not governed by the Inquiries Act 2005, having been set up under section 84 of the National Health Service Act 1977 before that provision was repealed, the provisions of section 25 allowing the withholding of parts of an inquiry

[7] Paragraph 22

report may offer some guide. Parts of a report may be withheld if it is considered necessary to do so in the public interest having regard in particular to:

- The extent to which withholding material might inhibit the allaying of public concern.
- Any risk of harm or damage that could be avoided or reduced by withholding any material.
- Any conditions as to confidentiality subject to which a person acquired information that he has given to the inquiry.

1.18 The Data Protection Act is material to this issue. At paragraph 2.63 of our report we explained why we thought that publication is compatible with its provisions. The same factors are relevant to considering whether the names of staff should be disclosed. However, in the case of a description of what staff did or did not do in the course of their employment, the information is not sensitive personal data.

1.19 The identification of staff by their names does amount to the processing of personal data under the Data Protection Act 1998. However in broad terms the processing of personal data for purposes including the prevention or detection of crime is exempt from the first data protection principle (section 29(1) of the Act). A similar exemption applies in respect of processing for the purpose of discharging statutory functions (section 29(2)). Further the processing of personal data is permitted (Schedule 2) where it is necessary for the administration of justice, for the exercise of any function conferred on any person by or under any enactment, for the exercise of any functions of a Minister of the Crown and for the exercise of any other functions of a public nature exercised in the public interest by any person. We have been careful to refer to staff only when necessary and relevant. On that basis, in our view it is probable that the identification of staff in the report is compliant with the Data Protection Act on any one of the above grounds. Taking these grounds collectively we have little doubt that there is no breach of the Data Protection Act arising from the identification of staff by name.

1.20 It is of note that in 2008, the National Patient Safety Agency, in appendix 1 to its Good Practice Guidance on "*Independent investigation of serious patient safety incidents in mental health services*" said:

"As a general rule, the greater the degree of legitimate public interest in the outcome of the investigation, the stronger the argument that public accountability will require that professional staff be named in the report, unless there are particular factors such as police concerns about safety."

1.21 This contrasts with the position taken by the NPSA in the same document when discussing internal investigations preceding the independent investigation:

"Reports may be anonymised. It is not usual for internal trust reports to be put into the public domain (unlike independent investigation reports). Internal reports are usually shared within the trust and with key interested parties, such as families and the SHA. However, they should be drafted on the basis that they may become public, so issues concerning anonymity and consent are important at this stage." (p11)

1.22 The Authority has asked us to consider the issue of privacy. There are aspects of information about a member of staff in respect of which a duty of confidentiality on the part of the employer may arise, contractual terms, pay, health or disciplinary record for example. However we do not consider that any such obligation arises in respect of identification of an individual as an employee or information about what the employee did or did not do in the execution of his or her duties. In any event the members of staff of Broadmoor are exercising on behalf of their employer a public function in detaining, caring and treating a detained patient. Their actions in this regard should not be regarded as private or confidential to them. Any privacy or confidentiality is that of the patient.

Issues

1.23 Taking into account the legal context it seems to us that it is relevant to ask:

- Is the identification of members of staff in principle necessary to ensure, so far as practicable, that this investigation meets the State's obligations under Article 2 having regard to the need for an effective and independent investigation, appropriate involvement of interested parties, enabling those responsible to be held to account, the public interest in the protection of the lives of vulnerable detained patients and maintaining confidence in the inquiry process?

- Is there any good reason individuals should not be named having regard to any materially increased risk to them, or inhibition of the inquiry process likely to result from their being named?

The inquiry context and process

1.24 The terms of reference required us to investigate the facts of the incident leading to Richard Loudwell's death, to review the care and treatment of Richard Loudwell and Peter Bryan, the robustness of hospital policies and other matters, and to consider any wider implications and lessons. We were then to deliver a report for publication. Therefore the intention has always been that a report dealing thoroughly and fairly with these issues should be published.

1.25 The subject-matter of the inquiry involved the death of a vulnerable detained patient at the hands of a very dangerous individual in circumstances where through an accumulation of individual and managerial failings, these two patients were permitted to be together unsupervised, and with no protection afforded to the victim. We would be concerned if the Strategic Health Authority, or any other reader of our report received the impression that there had been no individual failings contributing to this tragedy: any objective reading of it will lead to the conclusion that there were many such individual failings, albeit accompanied by systemic failings as well.

1.26 The persons most closely affected by this incident have been Richard Loudwell himself, Peter Bryan and their respective families. For all of them these events were a tragedy demanding an explanation and satisfaction that lessons would be learned. There is also a legitimate expectation that they will be informed by the process not only as to what happened and why, but who was responsible.

1.27 The public is in our view entitled to be able to form its own judgment with regard to the activities carried in its name behind the closed doors of Broadmoor. The hospital and its staff were performing public functions in the detention, care and treatment of these two patients. The public is therefore entitled to be assured that all appropriate steps with regard to an investigation have taken place. The public, including the health care professional community as well as the general public, need to have confidence in the independence and impartiality of the investigation, and to be able to judge for themselves whether the conclusions we have reached are ones with which they agree.

1.28 Therefore the inquiry and its report have a part to play in ensuring that there is accountability for what occurred: exposure of the facts and any falling short of appropriate standards is an important part of ensuring accountability.

1.29 As part of the procedure of the inquiry it was determined that witnesses should be interviewed in private. We set out the reasons for this in paragraphs 2.22 to 2.27 of the report. We did not consider that the process would be assisted by the presence of representatives of interested parties. We wished to be able to make a judgment about what was relevant to be placed in the public domain having received all the evidence. We did not sit in private because we felt it was necessary to do so in order to protect any witness.

1.30 As described in paragraph 2.27 all witnesses would have understood that what they told us would be used and included in the report to the extent considered necessary, but would otherwise be kept confidential. Virtually all witnesses we met were assisted by a solicitor, but none of them expressed to us any desire that their names be kept confidential or excluded from the report. None expressed any anxiety in that regard. As we observed in the report we did not have to use our statutory powers to compel the attendance of any witness and none sought any conditions in relation to their voluntary appearance.

1.31 Our recommendation that the report be published in full was founded on a consideration of the factors we perceived should be taken into account. We think those factors are relevant to the anonymisation issue.

Conclusion

1.32 This case involves a death of a vulnerable detained patient at the hands of a highly dangerous and mentally disordered fellow patient contributed to by individual, collective and organisational failings on the part of those charged with their care. Article 2 requires an effective and independent inquiry which is sufficient to inform the interested parties and the public of what happened, and whether there were any failures on the part of those charged with the care of the patients leading to the death. The inquiry is also part of the process which should ensure that those who are responsible for any such failings are

held accountable. This does not mean that inquiry itself holds anyone to account; it does not. Rather it informs the process of accountability.

1.33 Therefore we consider that the starting point in relation to publicity is that not only those closely interested in the outcome of the inquiry but the public are entitled to know in full our conclusions, and the evidence and reasoning on which we based them. They are entitled to sufficient material to be able to make their own judgment on whether the investigation has been thorough and effective, and sufficient to bring to account those responsible for the care and treatment. As stated repeatedly by the ECHR the process that achieves this is important as opposed to the outcome. Transparency is needed just as much where individuals are exonerated as where criticisms are made of them.

1.34 We consider there are compelling reasons why members of staff should be identified in the published report:

- Criticisms are made of some staff: we see no reason why the interested parties and the public should not know who they are.

- Even staff who are not subject to direct criticism have been part of a team and an organisation which has been at fault. In so far as systemic failings are identified many individuals had a part to play.

- It is only fair to the staff who are not criticised that this is made clear publicly.

- We have expressed concern about the ability of Broadmoor to respond constructively to adverse experiences and criticism. We consider it is part of the process of accountability and of learning the lessons that the relevant staff be identified.

- We consider that the identification of the staff involved makes it easier for the reader to judge whether our investigation has been an effective one and to be satisfied that there has been no attempt at concealment of material matters.

- Broadmoor is inevitably an institution of which the public know little. We consider the fullest possible transparency following a tragedy such as this can only promote better practice in future.

1.35 Therefore we conclude that identification of staff members is necessary to meet the State's obligations under Article 2.

1.36 With regard to the suggestion that there is a culture or practice of non-disclosure we observe that there have been many ad hoc inquiries in the recent past where staff have been identified, the John Barrett inquiry being one, the Harbour Inquiry into Richard Loudwell's treatment in the community being another. We consider that each case needs to be considered on its individual merits.

1.37 We consider that no witness can have been under the misapprehension that his or her name might be published.

1.38 We have been informed of no specific risks that might arise from identification of staff apart from the possibility of unwanted attention from the media.

1.39 It would obviously be regrettable if the media were to indulge in improper harassment of members of staff. It is to be hoped that the representatives of the media behave in accordance with the Press Council's Code of Practice. We doubt that the risk of inappropriate behaviour is increased materially by publication of names. We would be surprised if the identity of any individuals of potential interest to the press were not known to them in any event. Furthermore, in a democratic society the press have rights under Article 10 to pursue proper investigations into matters of proper public concern, as do the public generally. It should be no part of a public authority's role to seek to inhibit that right by concealing information which should properly be in the public domain without good reason.

1.40 We have considered carefully the argument that identification may deter others from cooperating with future inquiries. We have seen no evidence that any witness was inhibited in this inquiry by the thought that identities would or might be disclosed. Secondly each inquiry is different, and were an inquiry to be made difficult by the reluctance of witnesses in future, then a different approach to identification might be adopted for that inquiry. In each case there needs to be a balance between the concerns

of the individual and the public interest in transparency. We do not think a speculative risk of deterrence justifies non-disclosure in this case

1.41 Therefore we conclude that there are no good reasons specific to this inquiry why individuals should not be named. In our opinion the balance comes down firmly on the side of publishing the report as it stands including the names of staff.

1.42 If it is decided to publish only an anonymised report, we understand that it would not be intended by the Authority to give even the trust management or the Department of Health a copy of the full report. We consider that it would be essential to enable the trust and the Department to respond effectively to the report for them to have a copy of the report which was clear as to the identities of those referred to.

Recommendation

For the reasons given above we recommend that the report is published in full and that individuals other than patients referred to in it continue to be referred to by name.