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

Executive summary

A report for NHS London

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NHS London

1. Executive summary

1.1 Just after 6pm on Sunday 25 April 2004 Peter Bryan attacked Richard Loudwell in the dining room of Luton Ward, Broadmoor Hospital. Richard Loudwell sustained serious injuries, particularly to his head, and never recovered. He died in hospital on 5 June 2004.

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

mental 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.

1.20 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.

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

Richard Loudwell' s admission to Broadmoor

1.22 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.

1.23 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.

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

1.25 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.

1.26 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.

1.27 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.

1.39 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.

1.40 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

1.41 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

1.42 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

1.43 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.

1.100 Courtesy 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.

1.101 The 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.

1.103 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.

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.