

An independent investigation into the circumstances surrounding two separate but related incidents involving Norbury patients on Spring Ward on the night of 1st October 2012

Commissioned by South London and
Maudsley NHS Foundation Trust

FINAL REPORT

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1. Introduction

This is the report of an Independent investigation commissioned by South London and Maudsley NHS Foundation Trust, following two separate but related patient incidents on the night of 1st October 2012, involving Norbury patients on Spring Ward.

This report refers to ten patients, whom for the purposes of confidentiality have been anonymised (referred to as patients A to J), as have staff and other individuals referred to in this report.

The Independent investigation was guided by the Terms of reference, agreed in November 2012, the Trust's Incident Policy, September 2011 (including Management and Reporting Processes for Incidents and Near Misses), the Policy for Investigation of Incidents, Complaints and Claims, September 2011, and other relevant policies listed in the appendices to this report.

2. Executive Summary

On the night of the 1st October 2012, two days after Norbury Ward had moved to Spring Ward, two separate but patient-related disturbances occurred on Spring Ward, where Norbury patients had been temporarily relocated as part of a phased programmed of planned ward moves, to facilitate essential health and safety works being carried out in River House (RH).

In the first incident, four patients besieged the nursing station where staff had retreated, causing damage to property, whilst at the same time making threats to kill and rape staff. This necessitated intervention from the RH Rapid Response team, The Bethlem Royal Hospital (BRH) Emergency Team, various on-call managers from the Behavioural and Developmental Psychiatry (BDP) Clinical Academic Group (CAG), an On-Call Executive Director, three divisions of the Metropolitan Police, the London Ambulance Service, and the presence of the London Fire Brigade.

The first incident began at approximately 2200, when one patient, as part of his recurrent delusional state, accused the designated ward-based security nurse on the night shift of stealing designer wear and trainers which he believed his mother had brought to RH for him.

Attempts to deescalate this incident were unsuccessful. Although a decision was taken to offer the patient prn medication, a second patient destabilised the intervention and two other patients subsequently became involved. Staff considered the situation to be unsafe and retreated to the nursing station.

Assistance from the Metropolitan Police was first requested at 2244 and the first police officer from Bromley Police Station arrived promptly at 2247.

The police contend that on arrival they were unable to access key information about the patients involved in the first disturbance which frustrated their ability to risk assess the situation.

The Unit Coordinator (UC), along with other nursing staff, were trapped in the nursing station where grab packs were located which contained vital information to be used in specific situations. This information was available on the hard drive and could have been accessed in RH Reception, albeit

there was no senior clinician present in this area to govern release of this confidential material, which formed part of an agreed protocol between the Trust and the Metropolitan Police.

In the course of approximately three and a half hours, somewhere in the region of forty police officers were on-site, comprising the entire Bromley Borough Night Response team, the Territorial Support Group (TSS) – Commissioner's reserve, three police dog units and Trojan (specially trained armed officers).

With the assistance of the Metropolitan Police and the first on-call CAG manager, three of the four patients were, after several hours, placed in supervised confinement (SC) on other wards. The clinical environment was restored at approximately 0230.

In the second incident which occurred at approximately 0250, one patient challenged staff with regard to decisions which had been taken about the management of the four patients involved in the first incident. He accused them of discrimination, believing that there had been a racist motive and that staff had assisted the police to pursue this line of action. He threatened to kill staff and one of the white perpetrators, who he declared had been treated differently to the black perpetrators. This resulted in nursing staff losing control of the ward for a second time when they retreated to the nursing station.

This incident also required intervention from on-call managers and the Metropolitan Police. The clinical environment was finally restored at 0500.

Staff that had been trapped in the nursing station and in the intensive care area (ICA) were emotionally and physically shaken by the first incident, however, they returned to duty following time spent in RH Reception, where they were seen by paramedics from the London Ambulance Service.

One patient sustained injury to his hand during the second incident. No physical injuries were sustained by staff.

The care and treatment of ten patients, five of whom were identified as perpetrators and five who were referred to during examination of events was examined specifically for the month of September 2012, leading up to incident 1 and incident 2 on the night of 1st October 2012. The time frame was extended either side when it was considered to be relevant to do so.

The Independent team found that for all ten patients there was a completed ePJS risk assessment in place that ranged from satisfactory to excellent, completed by a range of disciplines. As at 1 October 2012, the average age of those ten patients' risk assessments was 40 days exactly.

In contrast, it is of note that no 'risk event' entry was made for the night of 1 October for any of the ten patients identified as being involved.

Of the ten patients, seven had HCR20 risk assessments. The three patients that did not have HCR20 risk assessments had been admitted to hospital for less than three months.

The Independent team was very impressed with the scope and depth of the HCR20s and with the risk scenarios. They went well beyond the standard and rather categorical approach.

There was quite a range of ages of HCR20s, with the oldest (on 1 October 2012) being 435 days old. The average age of the seven completed HCR20 risk assessments was 244 days, or eight months and one day.

The Forensic Inpatient Emergency Transfer protocol recommends the inclusion of a current and complete HCR20 at the time of patients transferring between wards. The Independent team found that transfers went ahead more often than not without transfer forms (i.e. clinical summaries) in place. It found also that HCR20s are not updated for this purpose and did not accompany transferring patients.

The Independent team was impressed with the good intention behind the running of the HCR group and the principle that lay behind it - the involvement of the patient in risk management.

Of the clinical notes examined, the Independent team was impressed with the quality of the OT entries in particular, by the thorough and regular CT-grade doctor entries for secluded patients, and by the contribution made to the record by gym instructors.

One of the features that really stood out, however, was the reduced amount of senior medical entries on ePJS and the reliance instead on Ward Round minutes to record clinical changes and decisions that had been made. The Independent team is clear in its finding that during the timeframe when care and treatment was reviewed there were fewer entries made by senior doctors setting out clinical information relevant to treatment than would be expected.

The Mental Health Act Code of Practice states that If the patient is secluded for more than 8 hours consecutively or for 12 hours or over a period of 48 hours, then a multi-disciplinary review should be completed by a senior doctor or suitably qualified approved clinician, and nurses and other professionals who were not involved in the incident which led to the seclusion. In a number of cases there was significant deviation from the Mental Health Act Code of Practice.

Care planning practice was variable. The Independent team was impressed by the OT care plans in particular but found that there was an inconsistent overall picture.

The prescribing practice on Norbury Ward is up-to-date and is evidence-based. However, the Independent team did not find good evidence of medication changes always being discussed with patients and recorded and that is of note.

The Independent team was impressed with the reliable pattern of consent always being obtained at the three-month point for newly admitted patients as Section 58 of the Mental Health Act requires it to be. However, the situation concerning valid Consent to Treatment procedures for patients who were already in River House but had moved on to Norbury Ward needs attention.

One hugely impressive feature of Norbury Ward is the Family Surgery which the RC operates (and which is a feature of a very busy Monday, alongside the Management Round). The Independent team was very impressed that the Management Round was used as an opportunity to ensure that invitations were made to others to attend this.

While substance misuse groups are available in the central therapies department in RH, in practice Norbury Ward patients have restricted access. However, the ward-based assistant psychologist runs

a substance misuse group. There is no dual diagnosis practitioner as part of the RH establishment. Given the prevalence of substance misuse, support to clinical teams with regard to dual diagnosis and access to substance misuse groups should be reviewed.

As part of the security review a range of policies were reviewed to examine quality, with reference to their contribution to the overall security envelope of River House, and the translation of these policies into practice.

The operational policies for both RH and Norbury Ward offer a clear vision and structure for the service. They are aspirational in nature, realistic and achievable. They are presented clearly and concisely, and provide a logical progression; setting out appropriate objectives for the care and management of patients within a Medium Secure Service. The policies offer a baseline for service audit through which organisational assurance can be tested.

Despite the comments above, there is serious disconnection between excellence in policy and translation of policy into practice and serious concern on the part of the Independent team that assurance testing of agreed policies is not rigorously and consistently applied.

Relational security is poorly understood by some staff. The attitude and behaviour on the part of some of the nursing staff, observed during this Independent investigation is counterproductive to safe clinical practice.

It is clear from interviews with staff, particularly the UC on the night in question that a problem arose with following the Emergency Response Protocol.

The Lock Down procedure was implemented on instruction of the first CAG on-call manager at some point after her arrival, having been advised to do so by the second CAG on-call manager. The Lock Down policy stipulates that for a major incident the Bronze, Silver and Gold command structure should be established.

The police adopted this modus operandus, but despite the fact that several managers became involved throughout the night, four of whom came on-site at various times, there is no evidence that the Bronze, Silver or Gold command roles were assigned to Trust staff to work with the police accordingly.

Staff entering clinical areas are expected to collect and return Ascoms from RH Reception, although in the case of the Rapid Response Ascoms, these are kept on the wards, for which charging units are available. Ascoms are tested by reception staff on every occasion prior to allocation.

Ascom is a global positioning system providing staff with a means of summoning help in an emergency from colleagues working in the same location or from the wider RH Rapid Response Team drawn from each of the wards, where there is a designated member of staff on each shift.

Some staff told the Independent team that they had little confidence in the Ascom system and that it was not uncommon for there to be systems failure, as opposed to incorrect usage by staff. However, when the Independent team met with the Security Team Leader and Risk Management Portfolio Lead, the Clinical Service Leader – Service Line One, the RH Customer Services Manager and

representatives from Ascom it became clear that the main problem lay with staff, as opposed to systems failure (soft or hardware).

At interview and during visits to Norbury Ward, there was a surprising number of staff who gave incorrect information, when asked to explain how the Ascom units worked, especially with regard to the means by which they could summon help in an emergency. This is something which has been identified previously in a number of internal investigations, but not addressed sufficiently to secure a high level of compliance and confidence in the system.

There were examples of user failure on the night of 1st October 2012. Some of this may have been the result of human error arising from 'panic- scramble' on the part of individuals. However, even allowing for this as a factor, the evidence presented to the Independent team indicates serious failings across RH as well as Norbury Ward. The root cause appears to be a culture of no confidence in the Ascom system, with ineffective controls assurance.

There is evidence of very good and consistent training for staff on security and particularly the use of Ascoms.

See Think Act – Your guide to relational security, published by the Department of Health 2010, was used as marker, with specific reference to team functioning, boundary setting, therapy, patient mix, patient Dynamic and physical environment.

The Chair of the Independent Investigation spent most of one day in RH Reception, shadowing different members of the team in the execution of their duties and responsibilities. This demonstrated a high level of policy being delivered in practice.

The Independent team visited Norbury Ward on three occasions and Spring Ward twice. During the first visit to Norbury Ward (a planned visit), the SC rooms, in the opinion of the Independent team, were unfit for clinical purpose. The Trust took immediate steps to decommission the two SC room on Norbury Ward, whilst remedial works took place before the SC rooms were put back into clinical use. In addition, new measures with regard to monitoring the safety of SC rooms were immediately implemented.

The poor design of the SC rooms on Norbury, their constant use and fabric, present on-going and costly problems for the Trust. The constant destruction of these rooms contributes to reduced confidence on the part of ward staff that patients with severely challenging behaviour cannot be safely nursed within them.

The lack of awareness of the risks outlined above and the ease with which these were quickly identified by the Independent team, suggests a less than optimal grip on environmental security in which safe clinical practice takes place.

The Independent Team understand that the Trust is planning a further review and re-provision of supervised confinement facilities in RH.

The daily ward-based security checks on Norbury Ward were not up to date; the last one available was from June 2012.

Two impromptu visits to Spring Ward were made on 10/12/12 and 28/01/13. The first visit examined the exact location where the incidents on the night of the 1st October 2012 had taken place.

The second visit examined the lay-out of the ICA and access to the fire-road (the position the police adopted to monitor the ward before making a decision as to when to go in).

The internal door leading from the ICA into the airlock, through which access to the fire road is possible, was found to be unlocked, as was the outer door from the airlock to the fire road. This door can only be opened from the fire road and is controlled by RH Reception.

In the course of five visits, the Independent team found on three occasions, at best perfunctory attitudes and practice towards physical, procedural and relational security.

The importance of shared understanding and mutual respect between patients and staff is vital in the maintenance of relational security, as advocated in See Think Act.

Some of the evidence associated with this Independent Investigation demonstrates that there are times when control of the shift passes from the nursing team to some of the most challenging patients on Norbury ward, rendering the clinical environment to a level of suboptimal safety.

It is important to recognise the impact of change in circumstances which effect how people feel. Although the Independent team found one example of a one-to-one session with one patient with reference to their move from Norbury to Spring Ward, this was not consistently the case across the cohort of patients considered as part of this investigation.

Norbury Ward requires their patient mix to be fully appreciated at all levels in the service and subjected to continual impact and risk assessment. The very nature of Norbury ward means that patient mix is a continual challenge and something which requires robust clinical and managerial leadership to secure, as far as is possible, a clinical environment which is within the competency of staff allocated to work on this ward across all shifts, including nights and at weekends.

There is no documentary evidence to demonstrate that in the period leading up to Norbury patients moving to Spring Ward that patient mix was adequately assessed, either at ward level, Pathways or by the Senior Management Team.

Although there is a weekly Pathways meeting, usually chaired by the Clinical Service Leader - Line One Forensic Services, the record of such meetings is produced in such a way that concerns with regard to patient mix are not identifiable. For this reason, and from what some staff have said about Pathways meetings, the Independent team is concerned that the clinical implications of decision making, both admissions and internal transfers, is not given a consistent level of priority.

See Think Act captures the very essence of why patient dynamics are a critical feature in safe and effective service provision: 'The mix of patients and the dynamic that exists between them has a fundamental effect on our ability to provide safe and effective services – the whole group can be affected by the arrival or departure of just one patient'.

During September 2012, three patients arrived on Norbury Ward, two of whom played a part in the incidents on the night of 1st October 2012, namely: Patient C, who transferred from BDU on 07/09/12, and Patient A, who transferred from Thames Ward on 24/09/12; having perpetrated a

serious assault on a member of staff. It is also worth noting that Norbury Ward received three other patients during late August 2012, whilst the RC was on annual leave.

There were known dynamics between named patients, for example, between patient B and patient D. However, there is no documentary evidence that patient dynamics were fully assessed in preparation for Norbury patients moving to Spring Ward on 29/09/12.

The physical environment on Norbury Ward is such that there is no separation of the ward immediately between the main airlock and the main ward. This could be easily rectified. There is no safe egress from the nursing station which has, on more than one occasion, led to nursing staff being trapped in this area, requiring police assistance. This requires urgent resolution. The staff room and the staff toilet are not adjacent to each other which means that if staff go on break in the staff room, they have to re-enter the ward to go to the toilet. The acoustic is such that the noise factor is significant. Noise is a well-known exacerbating trigger, adversely affecting people's mental wellbeing. This too is resolvable. Internal investigations have raised concerns about ward design but to date a definitive course of action has not been agreed.

Very considerable resources were consumed both on the part of the Trust and the emergency services, especially the Metropolitan Police.

Whilst the management on-call arrangements were successfully and appropriately initiated, the on-call arrangements, with regard to the on-call RC were not.

There was significant service disruption from 02/10/12. Norbury Ward, in particular, faced difficulty in covering shifts. This was exacerbated further by other bank staff cancelling shifts.

There was a constellation of factors which, to a greater or lesser extent, played their part in some of the patients gaining control of the ward on two separate but linked occasions on the night of 1st October 2012, namely:

- Patient mix.
- Patient acuity.
- Disengaged staff from the process of management
- Sub-optimal senior clinical involvement in the planning process with reference to Norbury patients moving to Spring Ward, despite there being provision for this.
- Insufficient management oversight.
- Imperceptible clinical leadership.

Linked together, these factors represent systemic failure, which on the night of 1st October 2012, resulted in the destabilisation of the care environment which could have had catastrophic consequences.

Systems and safety culture are the root cause of the majority of incidents and no less so in relation to what took place on the night in question.

There was a departure from risk management protocols in fully assessing the risks of Norbury patients moving to Spring Ward and this too had a direct bearing on the night of the 1st October 2012.

Once the incidents took hold, there was impulsive and deliberate intention to harm on the part of the perpetrators, three of whom (Patients B, C and D), were very unwell. There is no evidence that either incident was premeditated.

The Independent team considered whether substance misuse, at least in the form of cannabis, may have played its part with some of the perpetrators. However, the RC is of the view that the patients did not require cannabis to be disinhibited. Patient B at the time, according to the RC, had been very unwell, but was improving mentally. His significant mood disorder would account for his disinhibition. Moreover, when urine samples from the perpetrators were tested for cannabis they proved to be negative. Nevertheless, Patient B is known to be a dealer. His nursing management plan written by patient B's Primary Nurse to manage his physical aggression and his drug taking/dealing activities dated 11/08/12, does not contain any specific therapeutic intervention, distraction techniques or focused work around drug issues. It does, however, insist that he must not have any access to private calls, other than his solicitor and benefit agency.

The RH management and service culture appears to place less than optimal emphasis on standards of professional practice, practice development, clinical leadership, risk management and impact assessment, which creates anxiety and stress amongst some staff. Some of the nursing staff have adopted 'distancing' as a means of coping.

Seven out of the twelve factors cited in the Contributory Factor Taxonomy (National Patient Safety Agency, Root cause analysis – 2004) feature generally in this investigation, namely: patient factors, individual factors, task factors, communication factors, team and social factors, working condition factors and organisational and management factors.

Recurrent factors, previously identified as areas of concern by internal investigations carried out by the Trust and cited in an Organisation with a Memory (Department of Health, June 2000), are also relevant to this investigation, namely: institutional context, organisational and management factors, work environment, team factors, individual (staff) factors, task factors, patient characteristics.

This Independent investigation raises a number factors highlighted in the Francis Inquiry (Final Report February 2013) with specific reference to:

- A lack of impact assessment.
- Staff disengagement from the process of management.
- Leadership.

The appointment of a new BDP CAG Service Director creates a fresh opportunity for transformational leadership of forensic services. The Independent team suggest there are three priorities:

- I. A review of management costs and arrangements, including medical and other professional engagement in the management process, and investment in supporting and developing clinical practice.
- II. A forensic service review which examines patient flow through RH, including: case-mix, triage, assessment and the management of patients who require forensic intensive care.
- III. Development of an agreed protocol which specifies the core competencies and behaviours necessary for effective clinical leadership and multidisciplinary working at ward level, for which the RC and Team Leader have accountability to deliver.

It is evident that the BDP CAG commits itself to thoughtful initiatives, as can be evidenced in the examples provided by the BDP CAG in section 17 of this Independent report. Furthermore, comprehensive action plans are generated as and when required.

Successful implementation of action plans aimed at securing maxim impact with regard to relational security, pathways, risk reduction, improving patients and staff safety, the physical environment and service delivery in its broadest sense, is crucially dependent on transformational leadership which engages all staff in the process of leadership and management, and in particular a collective medical responsibility from within the forensic service for the service as a whole system.

Arguably, if clinical leadership and managerial oversight at every level had been stronger in the preceding months, this would have reduced the likelihood of occurrence of the incidents which have been subjected to examination by the Independent Team.

3. The Incidents

- 4. Incident 1:** escalated to a riot (as defined by BDP CAG - Major Incident Protocol and Procedures, February 2012), involved four patients who opportunistically placed staff under siege in the nursing station which required police intervention before nursing staff could regain control of the clinical environment. The antecedent to this incident stemmed from one patient, referred to as patient D, focusing his delusional ideas, initially on the designated ward-based security nurse, during the early part of the night shift on the night of 1st October 2012. This incident resulted in damage to property but no physical injury to staff. Three patients (patients A, B, and D; all black) out of the four patients involved were placed in SC. The fourth patient, (patient C; a white patient), was initially left on the ward, despite concerns raised by staff that this could lead to further disturbance.
- 5. Incident 2:** followed on almost immediately from the first incident, when patient E (a black patient) approached staff demanding an explanation as to why patient C had remained on the Ward. Patient E believed that there was a racial motive which led to staff assisting the police to place three black patients in supervised confinement, whilst a white patient was treated more favourably. Notwithstanding explanation from staff, patient E became increasingly agitated and hostile and threatened to kill staff and patient C. This led to a second siege when staff lost control of the Ward for a second time. Police assistance was required again before staff could

regain control of the clinical area. This incident also resulted in damage to property. Patient E sustained minor injury to his hand. There were no physical injuries to staff.

6. Acknowledgements

The Independent team would like to thank all those who contributed and supported this investigation, namely:

- ❖ Staff of the South London and Maudsley NHS Foundation Trust.
- ❖ The Metropolitan Police.
- ❖ The London Ambulance Service.
- ❖ The London Fire Brigade.
- ❖ Fiona Shipley Translation Ltd.

7. Terms of reference

The scope of this investigation required the Independent team to:

- ❖ Produce a chronology of events to assist in the identification of strengths and good practices and care and service delivery problems so that lessons could be identified.
- ❖ Summarise and comment on the mental health history and care and treatment of patients directly involved in the disturbance.
- ❖ Summarise and comment on procedural and physical security management.
- ❖ Review liaison with the emergency services.
- ❖ Review action following the two incidents.
- ❖ Consider findings from any parallel reviews commissioned, relevant to Norbury or RH.
- ❖ Make SMART recommendations which can be used to improve and develop services and reduce the risk of recurrence of similar incidents.

The full Terms of reference governing this Independent investigation can be found at **appendix 1**

8. The Independent team

Paul Beard Consulting was appointed by the Trust to Chair and project manage the investigation.

The team comprised:

- ❖ [REDACTED] – a registered nurse, formerly the Director of Nursing and Patient Services [REDACTED], working as an independent consultant in health and social care since 2002.
- ❖ [REDACTED] – Consultant Forensic Psychiatrist, [REDACTED], West London Mental Health NHS Trust.
- ❖ [REDACTED], Consultant Forensic Nurse, [REDACTED], Oxleas NHS Foundation Trust.

9. Patient Consent

Given the size of the cohort of patient records which needed to be reviewed and the difficulties this presented with regard to obtaining patient consent, members of the Independent team were issued with honorary contracts by the Trust for the sole purpose of accessing the Electronic Patient Journey System (ePJS).

10. Approach

The Independent team conducted its work in private and took as a starting point the Trust's Fact Finding Report signed off by the BDP CAG Deputy Director Clinical Service Delivery on 3rd October 2012 – Incident form number WEB5346. This was supplemented by other resource documents, a full list of which can be found at **appendix 3**. In addition, interviews with relevant staff, past employees and other sources were held.

Root cause analysis (RCA) methodology was applied to examine the circumstances so that lessons could be identified. The Independent team followed established good practice in the conduct of interviews, ensuring that interviewees were offered the opportunity to be accompanied and asked to comment on the factual accuracy of their transcript of evidence.

11. General Background

RH opened in 2008, on a phased basis (phase one and two) with 89 beds. The unit had been under discussion for over a decade. The Trust commenced work on an outline business case in 2001, in response to initiatives by the then London Regional Office of the NHS Executive, aimed at reducing reliance on the private sector. The full business case was agreed by the Trust, the Primary Care Trust and the then Strategic Health Authority in 2005, when full planning permission was granted.

Different service cultures and practices associated with the former interim medium secure units at the Dennis Hill Unit (BRH) and Cane Hill Hospital were amalgamated, following a protracted and challenging planning process which required intervention, in the final instance, from the Secretary of State.

RH is a medium secure unit with six wards. Since October 2010, RH formed part of the BDP CAG, comprising six service lines. Norbury Ward is part of Service Line One. Each service line has a designated Clinical Service Leader.

RH is situated within the grounds of the BRH. It operates, to a large extent, independently from the main site.

The policies and procedures which underpin the service have been well crafted and there is a cycle for reviewing and updating such documents.

RH was a Design and Build project and once commissioned significant flaws in the building were incrementally identified. In 2011/12, a statutory notice was served on the Trust with regard to fire safety and a programme of planned remedial works was agreed. This programme of works was managed in accordance with Prince Methodology.

Provision was made for Consultant medical staff, Team leaders, security staff and other staff to be centrally involved in the project, given the complexity of ward moves and the associated risks this presented. The designated Project Manager held weekly 'Decant Meetings' during the lifetime of the project.

Individual patient risk assessments, specifically in the context of Ward moves, were a stated requirement in the project plan. The plan specified that 'all patients require decant care plans to manage risk'.

Weekly Pathway Meetings are chaired by the Forensic Clinical Service Leader for Service Line One, comprising Norbury Ward, Thames ward, Brook Ward, Spring Ward, William Blake and community forensic psychiatry.

12. Chronology of events from 26th September to 2nd October 2012

The following sources have been used to collate this integrated chronology:

- Written statements from named staff, some of whom were on-duty or on-call on the night of 1st October 2012.
- Transcripts of evidence given at interview with named sources.
- The Trust's fact finding report and other supplementary notes and logs.
- The Metropolitan Police Incident Management Log-book 198.
- Confirmation of attendance report from the London Fire Brigade.
- Incident reports from the London Ambulance Service.
- Ascom diagnostic report following the night of 1st October 2012.
- Various responses to requests for further and better particulars.
- Re-enactment event with key staff held on 22nd January 2013.

Although every attempt had been made to capture the sequencing detail of events as accurately as possible, it should be noted that due to considerable variation of timing of some events, the absence of a single detailed contemporaneous critical incident log and variation in evidence a margin of error exists.

It took eight weeks to secure material from the Metropolitan Police. Requests for further and better particulars have been unsuccessful, despite several reminders on matters which were explored at interview with an Inspector from Bromley Borough Police.

On the 26/09/12, the weekly Pathways Meeting was held, chaired by [REDACTED]. An apology for absence from [REDACTED] was recorded. There is no record of [REDACTED] being present at this meeting or any other representative from the Norbury team.

The minutes of this meeting record the transfer of patient A from Thames Ward to Norbury Ward, following a serious assault on a member of staff whilst on Thames Ward. The transfer date (admission to Norbury ward) is dated as 26/09/12 but according to ePJS the transfer date was 24/09/12.

There were two vacant beds and 13 occupied beds on Norbury at this point in time, with two patients awaiting transfer from prison. There was no evidence of any recorded discussion with regard to risks in the context of Norbury patients moving to Spring Ward on 29/09/12.

On 29/09/12, Norbury Ward patients, with the exception of patient F who was in SC, moved to Spring Ward to allow for essential planned works to commence on 01/10/12.

Although, according to some evidence, an agreement had been reached with Bromley Police Station that there would be police presence at the point of patient F's transfer. When this was requested on 29/09/12, it was not forthcoming. Patient F remained in SC on Norbury Ward over the week-end, with staff allocated accordingly.

On 01/10/12, scheduled works were due to start on Norbury Ward but were delayed until the afternoon due to patient F's transfer from SC on Norbury Ward to SC on Spring Ward not being possible on 29/09/12.

There were reports of disturbances from patients on Thames Ward and Norbury patients over the week-end and on 01/10/12.

Incident 1

On the night of 1st October 2012, the designated UC for the night shift took handover from the UC on the late shift. She was informed that there had been some disruption during the day on Thames Ward and from some of the Norbury patients (now on Spring Ward).

The night shift UC got the distinct impression that events during the day might continue into the night, so after the handover she started to prepare for potential incidents.

Whilst in reception, the UC took the telephone numbers of the BRH Night Site Manager/ Emergency Team Leader (ETL), BRH Duty Doctor, and the first on-call BDP CAG Manager. In addition, she established who the fire warden was from RH Reception.

The UC went to Spring Ward to leave her coat and bag. She then went over to the vacated Norbury Ward in an attempt to assess the condition of the ward and the two SC rooms, in case access to SC was required throughout the night, as the only SC room on Spring Ward was occupied by patient F.

The entrance airlock to Norbury Ward was inaccessible, as the entry door and electronic key panel barrels had been removed and the airlock door barrel had been replaced with a different lock, pending remedial works which were due to start on 01/10/12. The UC did not have the key to the new locks, so she planned to call the first on-call manager about this to discuss other possible options for SC. Essentially Norbury Ward had been taken out of commission and was now a designated building site.

The UC visited each ward within RH to ensure that all ward teams were settled and to get an update of the night statistics for the unit (patient numbers, staffing levels, observation levels and response team members). In addition, the UC conducted radio checks to all wards and reception, receiving audible responses from all.

At 2100 the night shift took over from the late shift on Spring Ward. The nurse-in-charge (NIC) of the night shift (Band 5) allocated staff to various duties, including designation of the ward-based security nurse, who was a Band 3 employee.

Shortly after the NIC had allocated specific duties, patient D approached the ward-based security nurse, asking him where his five Nike trainers and designer clothes were, which he believed his mother had brought for him. This was overheard by a Band 2 member of staff and overseen by a Band 5 nurse. This behaviour, on the part of patient D, was considered to be an on-going delusional trait and according to witnesses patient D had been asking the same question repeatedly over the past few days.

Although patient D was informed that his mother had not brought trainers or designer clothes to RH for him, patient D refused to accept the explanation.

The ward-based security nurse explained to patient D that staff on the early shift had checked and rechecked but these items were not in Reception. Initially patient D went away but returned and made further demands that staff go to Reception to collect these items. When patient D was told that this was not going to happen, he became verbally aggressive, and according to staff statements, used offensive language, verbally abusing the ward-based security nurse, threatening to assault him and challenging him to a fight.

There is evidence from interview to indicate that the response from the ward-based security nurse towards patient D exacerbated the situation, although this is denied by him.

Comment: [REDACTED] had devised a behavioural plan to distract patient D from his recurrent delusional idea with regard to the trainers and designer wear, whereby staff try to engage him in discussion about football. However, some nursing staff report that this intervention is ineffective and had distanced them from it. There is no evidence that this was tried on this occasion.

At approx. 2200 the ward-based security nurse activated the panic alarm button.

The UC returned to Spring Ward during the altercation. As patient D was focusing his anger at the ward-based security nurse, the UC decided that he should be removed from the situation. He was therefore asked to go into the nursing station initially, although he subsequently relocated to the hand-over room, where he remained for approximately 1.5 hours.

The UC summonsed the Rapid Response team to Spring Ward. She assigned roles to members of the Response Team, in case promoting safer therapeutic (PSTS) approved techniques were needed

The UC made contact with the Maudsley switchboard to establish who the on-call consultant was. The switchboard operator informed the UC that the on-call consultant was not answering his phone and that there was no SpR as they were off sick and no cover arrangements had been made.

Comment: reference was being made to the RC on-call rota which had expired at the end of September 2012. The Independent team understand that the rota is now distributed in hard copy form as well as being available on the shared hard drive. It therefore should replace previous displayed rotas as soon as it arrives in the internal mail system.

A member of the Rapid Response team and another member of staff facilitated a smoking break in the ward garden, so that there would be fewer patients on the ward when staff approached patient D with medication. However, patient D then focused his fixation on this member of the Rapid Response team, so the UC asked him to remain in the nursing station, whilst other staff attempted to deescalate patient D.

Deescalation was attempted to no avail, so the UC asked all staff to meet in the nursing station so that they could discuss a plan of action. A decision was taken to prepare oral prn midazolam 10mg as well as to draw up 7.5mg of midazolam for intramuscular injection. This was because the team determined there be to be a likelihood of patient D refusing oral medication. This was based on previous knowledge of him.

Comment: Preparing intramuscular medication at the same time as oral medication falls outside the ideal standard of practice. Whilst the Trust policy does not give guidance on this matter, NMC guidance (Standard 14: Standards for medicines management (NMC 2007)) is clear. However, under the circumstances and on balance, the Independent Team acknowledge that the specific situation required a degree of flexibility and staff initiative. The Independent Team accept that in some circumstances both oral and injectable medicines can be prepared simultaneously but that the injectable form of the medicine should then be stored in a readily accessible place and not handled in front of the patient at the same time that the oral medication is handled.

Attempts to encourage patient D to be escorted to his room were unsuccessful. On his way to his room, patient D diverted and entered patient A's room.

When staff went to patient A's room, he and patient D came out when prompted by staff to do so.

Patient D was very aroused. He was smoking a cigarette. Patient D cooperated with staff and extinguished his cigarette.

Comment: Possession of lighters by Norbury Ward patients is not permitted.

Patient A was observed to have a belt with a metal head around his neck but according to one witness he did not show any overt signs of violence at this point.

Staff continued to encourage patient D to retire to his room so that staff could try to establish and address his concerns, but he continued to present in an extremely agitated and threatening manner.

One member of the Rapid Response team suggested that another nurse ([REDACTED] from Waddon Ward who was on night duty) be asked to attend Spring Ward, which he did.

The Rapid Response team approached patient D in a semi-circular or arrow formation (interview evidence differs) to gain his compliance with medication. At this point the UC and the NIC were talking to patient D.

Patient D initially agreed to take the oral medication, however, patient B (known by staff to dislike the use of medication) started to interfere, becoming extremely aggressive and threatening, making a clenched fist and attempting to jab at some staff faces, screaming and shouting and ranting at the nursing staff, telling patient D not to take the medication and arousing and encouraging other patients to get involved in the act of defiance.

Then, in response to a wink from patient A, patient B smashed the oral medication out of the hand of the UC, spilling all the medication and water on the floor, along with the intramuscular medication, which according to some statements was concealed out of sight when it had been taken as a contingency measure, should patient D refuse oral medication.

Patient B accused the staff of bullying patients.

Attempts were made to prevent any further altercations from patients D and B, but the situation rapidly escalated and both patients D and B continued to attempt to attack staff.

Patient B took a ball point pen to use as a weapon.

Patient A, who initially attempted to support staff in deescalating the situation, placed himself between staff and patient D, when male staff attempted to disable D and B.

In addition, patient C, who had been transferred from Whitley 1 Ward following an incident when he went absent without leave, came out of his room, having heard the disturbance. He was advised to return to his room and lock the door from the inside, but he became aroused and verbalised threats towards staff, making suggestions that he would slit the throats of staff by using his finger and drawing a line with it across his neck. Patient C was on 'within eyesight (enhanced) observations' (Engagement and Observation Policy, 2011) but had retired to bed early.

Patient B then became highly aroused, abusive, confrontational and aggressive towards members of staff.

The UC advised some staff to withdraw and to assemble in the nursing station for safety, as the situation was getting out of hand. Three staff, including a member of the Rapid Response team were located in the Intensive Care Area (ICA) area where patient F was in SC.

Comment: Although staff retreated to the nursing station as a place of safety there is no means of egress, other than back into the main part of the ward.

Comment: Patient F who was being nursed in SC was not involved in either incident under investigation, however, as the ward environment destabilised his vulnerability posed risks.

Staff in the ICA were advised to lock the door between the main ward and the ICA, so that nobody could get through. Patients D and C tried to enter the ICA, but as the connecting door had been locked they were unable to do so.

As staff retreated to the nursing station, patient B kept following the staff. He was at this time shouting and taunting staff. Patients D and B began banging and kicking the windows and doors of the nursing station in an attempt to gain entry. Patient B and D challenged staff to a fight. Whilst staff were in the nursing station, they observed patient B to be playing his music system extremely loudly and pouring a bottle of fizzy drink on himself. Patients D and B continued to pace up and down the ward.

One of the Healthcare Assistants (HCA) was called on his Ascom by a male member of staff who by now was in the nursing station, informing the HCA that he was now the only staff member in the main part of the ward, advising him that he should go to the nursing station for his own safety, as his 'life could be at risk'.

According to the HCA, this message was audible and was possibly overheard by patient D. The HCA told the Independent team that as the 'triggers' associated with incident 1 were known to staff, that arguably, it was possible to foresee what would happen, once a decision was taken to offer patient D prn medication and how patient B would react to this. Patient B is known to object to the use of medication and tends to act as an intermediary between a patient and a staff member, often to try to 'whip' the situation up. In the opinion of the HCA, the situation could have been pre-empted and the police should not have been called.

Patient D began shouting at one of the staff in the ICA, using sexually explicit language and threatening to rape her.

Patient C was also pointing at this member of staff and then running his finger across his throat, indicating that he was cutting her throat.

Patient B was observed to be pressing all the alarms in the corridor and the moon-shaped structure in front of the nursing station. He was also threatening to kill one of the staff trapped in the nursing station if he came out.

Patient B was observed breaking some plastic strings inside the alarm key hole in the moon-shaped structure to prevent staff turning the alarms off with a key.

Patient A remained in the corridor near his room and was observed to be interacting intermittently with patients D, B, and C.

The UC made contact with the BRH Night Site Manager/ ETL to inform her that a riot was about to start on Spring Ward.

The ETL advised the UC to call her on-call manager, which she confirmed she had done but was waiting for her to call back.

The UC sought clarification as to vacant male SC rooms on the BRH site which were as follows:

- Monks Orchard House was identified but when contacted by the UC was informed that it was out of use/not fit for purpose, due to problem with the door.
- One room on the Denis Hill Unit - the room was reserved by the ETL for potential transfer of a RH patient during the night.
- One room on PICU (Gresham House) but overnight guesting was not permitted, unless arrangements to do so had been agreed during the day - in any case it was discovered later that this SC room was occupied.

The ETL offered her assistance but the UC indicated that she was ok and that she would ask for assistance when she needed it.

Patient B took a heavy metal bin from the communal day area and patients B, D and C took it in turns to throw the bin with sheer determination against the windows of the nursing station, in an attempt to break the windows and gain entry. The windows were damaged in the process, albeit not broken.

The ward, according to one statement, was turned into a 'war zone' within a few minutes.

Patients were asked to go to their bedrooms until the situation was under control but patient C decided to join patients B and D in the threatening and indecent behaviour.

Patients D, B and C were all making specific threats to kill and rape staff.

Patients B and C were indecently exposing themselves and patient B was spitting, whilst patients D, B and C continued to attempt to breach the security of the nursing station.

Patient C stripped naked exposing his penis, showing it to staff through the window. After masturbating vigorously several times over, patient C urinated on the floor just outside the nursing station door.

Patient B took a heap of serviettes out of the main dining area containers and urinated on them to soak them, before pasting them on the nursing station windows.

Staff considered this to be a biological hazard, considering the known medical presentation of patient B and his hepatitis status.

Patients A, C and D tried to tamper with the lights to create darkness, possibly to perpetrate their acts.

One member of staff in RH reception recalls that somewhere around 2210-2220 that alarms were going off and that false alarms were given over the radio. She also recalls that at around 2225, an Ascom was sounded as a test. She sounded the panel and called the Ascom which she thought was 40088. She spoke to a female member of staff and asked her if assistance was needed but was advised, according to her statement, that this was a false alarm, so she cleared the panel.

Comment: Ascom 40088 is the Rapid Response number for Chaffinch Ward which is used on a 24 hour basis. This Ascom is stored in Chaffinch and its frequent use requires a higher level of maintenance, according to the Lead Security Nurse/Security Team Leader.

At approximately 2220, the UC made calls to the BDP CAG first on-call manager, to update her on the current situation and the Maudsley switchboard, to enquire who the on-call Consultant Psychiatrist was.

At 2244 the first call for police assistance, CAD number 9657, was made. It was recorded on the police log that police were needed, as staff were being attacked by patients. RH Reception was informed that the police had been called. However, at 2245, RH reception received a telephone call from one of the staff trapped in the nursing station, asking for the police to be called, so a second call was made at 2245, CAD number 9665. This was recorded on the police log that several patients were attacking staff and that a few police units were required.

██████████ at Bromley Police Station had already been alerted by the time the second call came in to the central control centre. Between 2247 and 2252, the first police officers from Bromley Police Station arrived on site (██████████). One of the two Reception staff was asked what kind of facility RH was, in addition to other questions which she endeavoured to answer.

Comment: The police contend that they were unable to access key information which they required in order to risk assess the situation. Grab packs were available on all wards but staff were unable to provide the relevant packs as they were trapped in the nursing station. However, this information is available on the hard drive and could have been accessed in RH Reception, albeit there was no senior clinician in RH Reception to govern release of this confidential information at this point.

The police spoke with the UC to clarify the nature of the incident and support required regarding danger to life.

At some point one of the staff (a member of the Rapid Response team – ██████████) left the nursing station and went to RH reception. He told the Independent team that he had done so because he felt unsafe on the ward, having been targeted by patient D. He did not consider the nursing station to be a place of safety.

On his arrival he, along with one of the two Reception staff on duty, escorted the police to the fire gate, opening and closing them and locking them behind people who were entering and leaving.

At 2253 further back-up police officers from Bromley Police Station and a Dog van unit were requested by a police officer on-site. RH Reception was informed of the pending arrival.

At 2305 ██████████ from Bromley Police Station arrived on scene.

According to a statement from an Inspector from the Metropolitan Police, numerous requests were made to ascertain the names of those involved and risk assessment details, but there were no staff on duty able to provide such information, with no contingency plan, other than calling the police for dealing with such a disturbance. There was discrepancy between this statement and the evidence given by the UC.

██████████ requested the TSG, Commissioner's Reserve.

At approximately 23.10 the first on-call CAG manager received a call from Lambeth Switchboard asking her to call the RH UC which she did. She was informed of the incident on Spring Ward, and that ward-based nursing staff, along with the Rapid Response team were trapped inside the nursing station. The first on-call CAG manager ran through some procedural issues to ensure that the police and the BRH ETL had been notified. In a second call, shortly after the first conversation, she informed the UC that she was making her way to RH to help coordinate the situation. The UC informed her that at least three to four patients were now attacking the nursing station with weapons and threatening violence. The UC was worried that one nurse (the designated ward-based security nurse) was isolated in the conference room and others in the ICA.

RH Reception was advised of the first on-call CAG manager's pending arrival.

At approximately 2315 one of the Reception staff returned to Reception to collect a large torch as the fire road was dark. She then returned to the fire gates to allow access in and out of the fire road. New lights in this area had been installed but at this juncture were not commissioned into operation.

At 2317 a third call was made to request 'riot police support' - CAD 9864. This was recorded on the police log as three patients had started rioting in the first instance and that all thirteen (patients) had now joined in; that suspects had metal poles and were trying to break the windows where the staff had retreated for security and that if the patients broke the windows, the staff would all be killed because patients had committed murder before.

Comment: This account is inaccurate, either because of what the police were told or because it was misconstrued in the translation. Most of the patients were sleeping or at least in their own bedrooms. There were no metal poles involved, although three patients were continually throwing a large metal bin with force at the window of the nursing station.

At 2319 the police requested two further Dog vans.

At 2330 a member of the maintenance team received a call from RH reception, informing him that there was a problem on Spring Ward and a problem with the RH sliding gate. He was asked if the lights in the fire road were in working order. He informed the caller that there was a flood light in the loading bay in working order but that the fire road lights were not working at this point in time, as previously described above.

Also at 2330 the second CAG on-call manager received a voice mail message from the first on-call CAG manager with regard to the situation on Spring Ward.

At 2337 [REDACTED] at Bromley Police Station was made aware of situation.

At 2345 more police had gathered in the fire road outside of the ICA of Spring Ward, which is accessed from the fire road through an airlock into the ICA. The external door can only be opened outwards and is controlled by Reception staff.

At 2346 [REDACTED] from Bromley Police Station declared the situation to be a Critical Incident. When this occurs, the Bronze, Silver, Gold command structure is invoked.

Comment: although several Trust managers were involved throughout this incident, there is no evidence that Bronze, Silver, or Gold roles were assigned during the night to operate in partnership with the police.

At 2347 the incident was considered by [REDACTED] to be “otherwise so dangerous” that Trojan (armed police officers), Dog Units and London Ambulance Service (LAS) were requested.

The entire Bromley Borough Police Night Response Team stood immediately outside Spring Ward in case patients managed to breach the room where staff had retreated to, whilst the Bromley Response team waited the arrival of TSG.

The plan (if required before the arrival of TSG) was to enter the ward in “quick time” and for the police officers to form a bubble around staff, escorting them to safety.

It is noted that if this had been necessary (before arrival of TSG) it would have been at considerable risk to the Police Response team.

At some point patient A discovered the whereabouts of the ward-based security nurse which made him feel panicky.

Staff had tried to contact him on Ascom number 40034 to update him on what was happening and to check if he was all right, as he had been on his own in the hand-over room for over an hour and a half, but his Ascom did not respond. He later told staff that he had also tried a few times to use his Ascom to contact them but that his Ascom was showing no signal to enable him use it.

Comment: The use of Ascom will be discussed later in the report.

Having noticed that there were no staff in sight, the ward-based security nurse exited the ward through the main airlock and relocated himself initially to Thames Ward. When he telephoned Spring Ward he was informed that the staff had been taken “hostage”.

Comment: several staff referred to incident 1 as a hostage situation, whereas according to the Trust Policy (Major Incident Protocol), it is defined as a riot.

The Spring Ward ward-based security nurse was subsequently relocated to Waddon Ward, as two of Waddon staff were trapped on Spring Ward.

The first on-call CAG manager informed the second on-call CAG manager that staff were trapped in the nursing station on Spring Ward, besieged by four patients and that the police and fire brigade were in attendance. She was advised to do a ‘situation report’ on arrival and to call the second on-call manager back.

At approximately 2350 the first on-call CAG manager arrived at RH. She picked up a hand held radio and Ascom on her arrival and informed the UC of the police presence.

The UC informed the BRH Night Site Manager/ETL of the first on-call CAG manager’s presence and that emergency services were also on- site.

The first on-call manager made herself known to several police officers who she thought might be in charge.

Staff in the ICA on Spring Ward could see that there were people outside through the frosted glass window. Although unable to tell who they were, they assumed that they might be police officers.

By this time three police vans and three police cars had arrived. Two police cars were blocking the road leading to the RH car park. The vans were parked in the secure car park facility leading to the fire road.

At 2352 the police requested the presence of the LAS.

At 0052 there were in excess of 20 police officers on site; some in standard police uniform and others in tactical wear, carrying Tasers, shields and batons.

On entry to the ICA, the police considered it unsafe for them to enter the main ward at this juncture. They had poor sight-lines and several patients were running amok, making threats and taunts towards the police.

The Police Response team was separated from the patients by a door, although they could see the nursing station through a glass panel. The police observed patients making threats to staff and one patient being sexually aroused.

At some point, one of the Reception staff returned to Reception with a small pane of glass believed to have fallen out of the lower section of the fire door leading from the ICA between the air-lock and the external door leading to the fire road.

The UC confirmed that patients A, B, C, and D were involved and that prominent amongst these patients was patient C. Patient A was seen sitting calmly but directing the activities of others. Patient D mostly stood at the door between the main part of the ward and the ICA, with his shirt off and was either dancing or making boxing/karate type gestures.

Patient D removed himself from the door between the main part of the ward and the ICA and joined other patients in the TV lounge, who had gathered to watch what some staff had described as being a pornographic programme showing on Freeview at that time.

Some of the patients were openly aroused and masturbating in the TV area, as a result of watching this program. Staff had no way of controlling it.

Comment: Access to pornographic material, including specific TV channels, should be restricted through the use of a PIN where possible.

Whilst staff were trapped in the nursing station, they observed some patients pacing around the ward, whilst others had come out of their rooms, having been woken by the constant sound of the alarms, looking distressed and asking for the alarms to be silenced.

Patients B and C emptied all the paper and rubbish from the rubbish bins and scattered it around the nursing station door and the half- moon area.

Staff knew that at least one patient had a lighter and also that a known arsonist was hovering around the day area.

As the police continued to assemble and risk assess the situation, patient C made several telephone calls from the patients' telephone kiosk to the emergency services, informing them that patients had escaped and were attempting to stab nurses. Bogus names were given for patients and staff.

The first on-call CAG manager gave several assurances to the police that these calls were being made by patient C, who had a history of doing this. The police requested the patients' phone be cut / turned off but were informed by the on-call CAG manager that the hospital did not have this facility. The on-call CAG manager gave the police the number of the patients' telephone which they checked with their central control room. This confirmed that it was the number of the patients' phone which had been used.

Comment: The patients' phone is housed in a kiosk which is lockable but staff were unable to leave the nursing station to restrict access to the telephone.

Because of the threatening behaviour of the said patients, the police called for more support, though they continued to risk assess the situation through the glass panel and to monitor the threat towards staff in the nursing station.

At some point after the arrival of the first CAG on-call Manager, the Lock Down Policy (May 2012) was invoked and the wards at RH were informed by RH Reception that staff and patients were to remain on their wards.

The police and first on-call CAG manager kept in regular telephone contact with the staff trapped in the nursing station.

In total, eleven staff were on Spring Ward at this juncture, nine of whom had no means of escape. Of this total, four were members of the RH Rapid Response team, including the RH UC and [REDACTED] who had been requested to attend the incident from Waddon Ward where he was working the night shift.

Comment: The RH Rapid Response Team and the RH UC, given that they were trapped in the nursing station on Spring Ward were unable to fulfil their duties should a further incident occur within RH.

02/10/12

At 0020 both the London Fire Brigade (LFB), incident number 119907121, and the LAS, CAD 54, responded.

One report by LAS refers to "support to stabbing incident". This is probably based on one of several hoax calls made by patient C.

At 0027 the LFB arrived.

One of the Reception staff accompanied a fire officer to the fire panel as the alarms were sounding and because he wanted to check to make sure that it was not a false alarm.

The Fire Brigade silenced the panel from Reception area, but remained on-site just in case there was a fire and that it was not just the smoke detector set off from patients smoking in their bedrooms.

At 0030 the second on-call CAG manager received a bleep asking him to phone the first on-call CAG manager which he did at 0035. The first on-call CAG manager updated the second on-call CAG manager.

At 0034 and 0036, the two LAS crews arrived on scene. On arrival they were met by the police and a member of the RH Reception staff who led them down the fire road to the external door to Spring Ward.

A member of the Reception staff went to Reception to collect some high visibility coats as there were staff outside who were cold.

At 0040 the second on-call CAG manager had a telephone call with [REDACTED]. It was agreed that the first on-call CAG manager would manage the on-site situation. It was agreed that [REDACTED] should be informed of the situation.

At 0045 the second on-call CAG manager made a telephone call to [REDACTED]. As there was no reply, he left a message and sent texts later on as there was still no response.

At 0050 the second on-call CAG manager called the Trust Executive on-call Director, to inform her of the incident, advising her that the first on-call BDP CAG manager was on-site and that everything was in hand.

Out of frustration at the perceived delay by the police to come to the aid of staff, an HCA on Spring Ward felt compelled to phone Scotland Yard, using a direct line which he had been given access to [REDACTED]. He asked to speak to the Operational Officer on duty for the night. In all likelihood this was CAD number 84540. He was asked to explain the kind of patients on the ward, so he gave them a brief explanation of what, 'in his limited view', forensic mental health patients are.

The police officer at Scotland Yard asked if any of the current patients had committed murder as part of their index offence, and if so how many.

The HCA explained that he had no immediate knowledge of the index offence of patients but that he was aware that at least one of them had a previous conviction for murder, without going into details.

Comment: Grab packs situated in the nursing station contain vital key information, such as that which was being requested by Scotland Yard.

According to this HCA, he was asked if he felt that SO19 (Specialist Fire Arms Command) would be a good idea to be deployed. He saw no reason to disagree with that suggestion. He was informed that 'riot police' had already gathered outside the ward and that it was showing on their system that a senior officer was on the way to take command of the situation. He was also assured that SO19 had been 'scrambled' and should be on site in a few minutes and that due to the staff's fear of fire, that the fire brigade had been informed and that a contingent of the LAS service would also be in

attendance. He was, according to him, assured that he could call again with a specific CAD number if threats mounted and the patients resumed attempts to break into the nursing station.

Comment: Arguably this call should not have been made, although it was born out of fear, given the distressing nature of the situation.

At 0052 TSG arrived under leadership of [REDACTED].

On arrival of Trojan (unspecified in the police log), tactical advice was given, as per standard practice, with regard to use of fire arms. However, Trojan was stood down, as was the Bromley Borough Response team, as TSG would take the lead in entering Spring Ward.

The First on-call CAG manager discussed the situation with [REDACTED], who asked her to check if the two SC rooms on Norbury Ward could be put back in to use, bearing in mind that the ward had been decommissioned. On inspection of the ward, work tools were found to be in situ. The two SC rooms, though not ideal in cleanliness, were deemed to suffice as a temporary place of safety.

The first on-call CAG manager picked up left items and placed them in the main part of the ward and locked the dividing doors, leaving only the ICA accessible. Her main concern was that the locks to the main entrance were not on RH keys but on contractor cores to prohibit staff entry.

The first on-call manager made a quick assessment as to which patients should be placed in SC and who should stay on the main part of Spring Ward. She concluded that patients B and D should go to SC on Norbury, that patient C should be placed on 2:1 observations on Spring Ward, and that patient A should be placed in SC in DHU.

Patients B and D were observed by the first on-call CAG manager and the police to be more vocal, active, threatening and hostile throughout the incident. Their proposed transfer to SC on Norbury Ward was only a short distance walk along the fire road.

Once the above plan was formulated, the first on-call CAG manager informed the police that places of safety had been found.

The police were at first reluctant to assist in placing these patients in the aforementioned areas, as they saw this to be the responsibility of the staff. However, the first on-call CAG manager agreed to either remain with them throughout or for a member of staff nominated by her to accompany the patients.

The police are also described as being reluctant to assist with the transfer of patient A to DHU but agreed to do so, although, they would not enable this transfer to take place in a police van.

The first on-call CAG manager agreed at this point that the RH security van would be used and nominated a HCA (an authorised driver) to drive, as long as the police remained with the patient until he was safely placed in SC in the DHU.

From 0105 to 0226 a series of telephone calls took place between the first and second on-call CAG managers, when the second on-call manager was updated on tracking the police entry to Spring Ward. He was informed that police had riot gear and Tasers, that three fire engines, three

ambulances and, four to five police vans were on site, and that police were planning to enter Spring Ward once they had risk assessed the situation and the management plans for the perpetrators.

At 0114 [REDACTED] decided to text [REDACTED] to inform him of events.

0119 The LFB closed the incident from their perspective. In their incident report they referred to RH as a prison and that the incident was coded as a 'false alarm – good intent'

At 0120 [REDACTED] asked switchboard to bleep [REDACTED] but got no response.

At 0126 she also bleeped [REDACTED] to brief him but got no response.

At 0130 she telephoned switchboard again as she had received no response from [REDACTED].

At 0135 [REDACTED] telephoned [REDACTED] to verbally brief him regarding the situation.

At approximately 0210/0252 (according to the police log and statement) or 0130/0140 (according to Staff statements) TSG entered Spring Ward from the fire road entrance via the airlock leading to the ICA and to the main ward in "strict compact riot formation (regimented crowd control)" armed with shields, visors, batons and Taser guns. Taser guns were not used.

Comment: According to some statements, patients who were already asleep and who were in no way connected to the disturbance were forced to leave their bedrooms by police officers, even though staff kept signalling to the officers that the real culprits were in the corridor and in the TV lounge.

Police moved patients into the lounge area, clearing bedroom after bedroom. Staff remained in the nursing station/ICA, whilst police were stabilising the situation.

Once all the patients were accounted for, the police told staff in the nursing station that it was safe for them to leave the ward.

On leaving the ward, staff were escorted to RH Reception, where they underwent a series of physical observations conducted by the paramedics. No serious medical conditions were declared. Staff requested that their blood pressures were recorded. Further observations and hospitalisation was declined.

Patient F remained unsupervised in SC once staff in the ICA and the nursing station had been evacuated from the ward. The first on-call CAG manager (a Registered Nurse) saw patient F on two brief occasions, with a police escort, to establish that he was breathing and not in too much distress.

Comment: Most patients played no part in the riot. Nevertheless they were forced to leave their rooms (with the exception of patient F who was SC) as part of the tactical intervention made by the TSG. Some patients subsequently reported their sense of distress to [REDACTED] but there is nothing recorded in the notes to this effect, even though there were potential safeguarding

issues at stake. Attempts to secure further and better particulars about the methods used by the TSG have been unsuccessful.

The first on-call CAG manager was asked to enter the ward to identify the patients for removal to SC.

Patient B, had by this time, calmed down considerably and although remained verbally threatening and abusive, obeyed police instruction, sitting on the floor with his arms above his head allowing the police to handcuff him. The police placed a clear plastic cover over his head to prevent him from moving his shoulders and elbows. He was initially ignored by the police until several promptings by staff. He was escorted by the first on-call CAG manager and the police to SC on Norbury Ward.

Patient D, whose presentation had not changed throughout the period, returned to his room and was later brought out in handcuffs before he was escorted by the police and the first on-call CAG manager to the other SC room on Norbury Ward.

Patient C was left sitting in the day area, as if he had played no part in the riot, despite all earlier insistence from staff that he had been a significant player in the disturbance. He was not handcuffed, as patients B and D had been and he was not taken off the ward. He was allowed to continue to remain in the TV lounge.

Patient A was considered by staff to be a behind-the-scenes orchestrator and manipulator.

According to staff statements, the police, after entering the unit, ignored the request of staff to treat patient C (a white patient) the same way as they had treated the other three black patients.

Staff state that the police made no attempt to coordinate their actions with staff as is standard practice during a siege, to gain information and to help them plan their strategy in order to minimise disruption to the unit.

Comment: Although there is evidence that the first on-call manager was actively liaising with the police, there is no evidence of anyone working in partnership with the Bronze, Silver and Gold command structure, which the police had put into operation and which forms part of the Trust's protocol once Lock Down is invoked.

According to staff, most of the patients who were unnecessarily woken up were visibly angry and later said so. They had nothing to do with the disturbance and some were unable to return to sleep after apparently struggling very hard to fall asleep.

The first on-call CAG manager met staff in reception to inform them that the situation was now under control and that patient A had been transferred to SC on DHU and that patients B and D had been transferred to SC on the temporarily closed Norbury Ward.

Staff expressed their concern with regard to patient C remaining on Spring Ward.

At 0150 [REDACTED] telephoned [REDACTED], as there was no response from [REDACTED]. She subsequently spoke with [REDACTED], who informed her that he would go to BRH. At this juncture [REDACTED] decided to go to BRH and advised [REDACTED] accordingly.

At 0210 [REDACTED] telephoned the second on-call CAG Manager to inform him that she was going to travel to BRH. She also bleeped [REDACTED] but got no response.

At 0218 [REDACTED] sent a text to [REDACTED] to advise him that she was travelling to BRH. At 0220 she updated [REDACTED] verbally.

A series of three conversations took place between [REDACTED] and [REDACTED].

At approximately 0230 the police began to enquire as to when they could leave. However, it became evident at this point that there was no-one to replace staff. This was due to all available staff being deployed from four wards to help support incident 1. This left four wards with below minimum staffing throughout the night.

The first on-call CAG manager went to Reception to discuss the situation with staff. After a period of reflection, and against the advice of the paramedics, they agreed to return to work, although they were offered the opportunity to go home. Two staff were deployed to the ICA on Norbury Ward where two patients had been transferred to SC. One staff member remained with patient A in SC on DHU, and two staff recommenced observations on patient F in SC on Spring Ward.

Just before the police finally retired staff complained again about patient C remaining on Spring Ward. Therefore, a decision was taken to nurse patient C in the ICA on Spring Ward and to offer him prn medication. Two staff were deployed on 2:1 observations with this patient. The rest of the staff started clearing up Spring Ward. The police left Spring Ward some time after 0230.

At 0240 the BRH ETL received a call from a staff nurse on the DHU, informing her that patient A had been transferred from Spring Ward. The ETL advised her that patient A should be placed in SC. The staff nurse informed the ETL that the HCA who had brought the patient to the DHU was about to leave. The ETL stated that the accompanying HCA should not leave the DHU until Spring Ward had replaced him. The ETL spoke to the HCA. He informed the ETL that he was [REDACTED] who had driven the patient to the DHU with the police, and that he needed to take the van back. The ETL instructed the HCA to remain with the patient until such times as he could be replaced. The ETL went to the DHU to sign the SC initiation document and 30-minute SC review forms.

As the police and emergency services left, the first on-call manager was informed by RH Reception that the security gate was not closing. She asked that on-call maintenance be contacted as the wall alarm on Spring Ward required deactivating. Repairs were also required to the nursing station door.

At 0254/0300 the LAS crews left the BRH site.

Incident 2

Three members of staff were preparing tea, snacks and a smoking break for the remaining Norbury Ward patients on Spring Ward, shortly after the closure of incident 1.

Patient C, who was now being nursed in the ICA on Spring Ward started to resist this arrangement. He was offered but refused 50 mg prn promethazine to help calm him down, so staff 'rushed' into the ICA to assist.

It was during patient C's refusal to stay in the ICA that drew attention to him still being on the ward. Some of the other patients, mostly black, were furious that patient A (a white patient) was still on the ward.

These patients asked staff why one of the main activists (patient C) in the earlier incident, was left on the unit, while three other patients (all black) had been handcuffed and taken off the unit, accusing them of being racist for transferring three black patients into SC and leaving the white patient on the ward.

Patient E (a black patient) approached staff around the nursing station demanding an explanation as to why patient C remained on the ward. Notwithstanding explanation from staff, patient E believed there to be a racist motive in the way black patients had been treated, accusing staff of assisting the police.

Patient E accused white staff of being racist. He called black staff 'coconuts' and 'niggers' and accused them of being agents of white racists. He then dared staff to either remove patient C from the unit, or bring back at least one of the black patients or allow him to beat up patient C and that if staff refused he would kill them all.

Patient C, on noticing that patient E and other patients wanted to attack him, decided to cooperate with staff and go to his bedroom.

The UC and one of the HCAs tried to deescalate the situation, explaining that they were unable to discuss such matters, as they had not been present on the ward when these patients had been removed.

Patient E became increasingly agitated and hostile and threatened to kill patient C. He charged towards the ICA.

The UC and three other staff retreated to the nursing station to summon help. Patient E punched the windows of the nursing station causing injury to his hand. He also kicked the nursing station doors causing damage to the door nearest to the staff toilet.

The other five nurses barricaded themselves in the ICA to prevent patient E from gaining access. One of the HCAs took down all the fire extinguishers and prepared to use them as defensive instruments as a last resort, should patient E manage to break down the door and gain access.

Patient E told staff that he was a martial arts expert and said that none of the staff could stand in his way. He went to his room to change into white martial arts clothing and started pacing up and down, demanding the whereabouts of patient A and also access to patient C.

Comment: The Independent team would have expected patient E's access to martial arts wear to have formed part of his care plan, especially given the inherent risks to others caused by a patient skilled in martial arts.

Patient H took part in what patient E was saying and was ready to fight but he was discouraged by staff.

Patient J just stood looking on and waiting to see what would happen. He was considered by staff to be someone who would join in with anything which challenged the staff.

The UC contacted the first on-call manager on the radio to inform her of the situation.

At 0251 the first on-call manager informed the second on-call manager of the second incident.

At 0300 the BRH ETL received a call from RH Reception informing her that the first on-call manager had requested that the ETL attend RH with the Emergency Team, comprising [REDACTED]. The ETL also contacted two BRH duty doctors to brief them on what was happening. The Emergency Team waited in RH for further instruction from the first on-call manager.

At 0305 the second on-call manager arrived. He held discussions with the first on-call manager and telephoned [REDACTED].

[REDACTED] based himself in RH Reception and assisted with various administrative tasks.

The first on-call manager informed the ETL that the fire road gates were broken, so she asked the BRH Emergency Team to guard the fire gates until the arrival of the on-call maintenance. The Emergency Team was subsequently told they could return RH reception to wait for further instructions.

At approximately 0305 the second on-call manager arrived at RH. He went to Monks Orchard House to explore the possibility of using SC, which was not available, so he returned to RH.

At 0306 the first on-call manager requested police assistance. Approximately 11 police officers from Bromley Police Station arrived quickly and dealt with the situation promptly. They were clear that they would enter the ward and give staff safe passage to exit, but that they would not touch or remove patient E.

By this time, patient C's observations had been increased to 3:1 as he was refusing to remain in his room and had become more aroused and threatening.

[REDACTED] was informed.

At 0310 [REDACTED] arrived at BRH. She went to RH where she was informed by [REDACTED] that a further incident had occurred.

[REDACTED] liaised with the police who were questioning why patient E had access to martial arts clothing.

At 0315 [REDACTED] telephoned [REDACTED], to discuss the situation surrounding the second siege and the difficulty [REDACTED] was having contacting the RH on-call RC or the Croydon on-call RC.

Comment: It would appear that RH Reception did not have an up-to date list of the on-call RC for RH. In the absence of the October on-call rota, Reception staff wrongly identified who the RC was. Although this information had not been printed, it was available on the hard drive. (See above.)

The on-call RC for the night of 1st October 2012 was in fact [REDACTED].

Comment: When [REDACTED] was interviewed by the Independent team, she stated that she was surprised that no one had called her, even though they had the wrong rota, as she was often called when there were issues with Norbury Ward patients, whether she was on-call or not. Given the severity of the situation and the recent move from Norbury to Spring Ward, [REDACTED] should have been informed of event once control of the ward was lost.

From 0318 the second on-call manager had a series of three telephone conversations with the first on-call manager with regard to the management of the second incident. A plan was agreed that the second on-call manager would accompany first on-call manager to the front door of Spring Ward in order to reconnoitre the situation on the ward.

[REDACTED] made a telephone call to [REDACTED] but there was no response so he left a message on the voicemail. At 0321 [REDACTED] contacted another Consultant psychiatrist ([REDACTED]) who agreed to attend the unit if required to do so.

Comment: Given the severity of the situation the presence of an RC would have been appropriate. There was no senior medical presence for either incident 1 or 2.

The Independent Team were provided with an initial Fact-Finding Report signed off by the CAG Deputy Director Clinical Services Delivery dated 3rd October 2012 which specified that at 0315 [REDACTED] had phoned [REDACTED] informing him of the second siege and the difficulty [REDACTED] was having contacting [REDACTED]. This version of the Report also states that at 0321 [REDACTED] contacted [REDACTED] who agreed to attend RH if required to do so.

On 20th November 2012, the Independent Team was provided with an updated version of the Fact Finding Report, although the date of this newer version remained 3rd October. The Independent Team was informed at the time that this was not normal Trust practice. In this updated version, the aforementioned reference to [REDACTED] differed to the initial version by the addition of a sentence. This read:

“It would appear that RH reception did not have an up-to-date list of on call RC for the unit. In the absence of the October on-call rota, reception staff wrongly identified [REDACTED] instead of [REDACTED].”

[REDACTED] was the on-call RH consultant for 1st October 2012 according to the October rota which the Independent Team obtained.

However, the Independent Team heard evidence from [REDACTED] that he had contacted the correct consultant [REDACTED] because he knew that person to be on-call but

received no reply. The Independent Team also obtained the September on-call rota and cannot reliably determine from it reasons why [REDACTED] was contacted in error. The September on-call rota identifies another consultant [REDACTED] as being the consultant on-call for 1st September which presumably would have been the date mistakenly referred to if the wrong rota was the source of the problem and that Reception were unaware they were working from the wrong rota. However, if Reception were aware that they had an out-of-date rota then they may have contacted [REDACTED] because he was on-call for 30th September – the last date on the September rota.

At approximately 0345 the police re-entered Spring Ward via the fire road entrance leading to the ICA. By this time patient E was in his room. The police escorted the UC and two of her colleagues from the nursing station to the ICA to join the other five staff.

Staff remained in this area with no means of exit, other than a door leading into the main ward which staff considered to be unsafe. There is a door leading from the ICA to the ICA garden and one through the fire door into an airlock, but access through this door to the fire road is controlled by Reception staff and can be opened from the outside only.

From approximately 0345 to 0420 the main ward environment was unstaffed, although staff in the ICA had visual sight of the main ward corridor. Eight patients, including patient I, deemed very vulnerable, were left without access to any staff or care.

At approximately 0355 to 0420 the first and second on-call managers, accompanied by two members of the maintenance staff, went to the front door of Spring Ward. At first glance there was no presence of patients in the main communal part of the ward, so the above named entered the main airlock. There was a discussion regarding further risk assessment, but this was not possible without entering the ward.

Staff could be seen through the glazed panels of the double doors at the far end of the ward leading to the ICA. Rubbish was observed to have been strewn about and the alarms were sounding.

As no one was visibly present in the main part of the ward it was agreed that the first and second on-call managers, accompanied by the two maintenance staff, would enter the ward. Once in the ward, no patients were present in the main communal areas. Staff in the ICA were beckoned to, indicating that it was safe for them to re-enter the main part of the ward. Staff were asked to check patients' bedrooms, and to check that patients were present.

Maintenance staff attended to the damaged nursing station door and wall mounted panic alarm. A foreign object (a matchstick) had been inserted into the wall alarm in the communal day area which had caused the alarms to continuously ring from 2200 until 0430.

At 0400, the BRH ETL received a call from the first on-call manager requesting the Emergency Team to go to Spring Ward. On arrival all patients were in their rooms so the Emergency Team helped to sweep up the ward, tidy the nursing station and clear all of the debris.

The first on-call manager asked RH Reception to ring available (off-duty) staff to come in early to assist if they could. Two members of RH staff came in early to assist, one of whom relieved a BRH Emergency Team member who needed to go back to her ward to assist with personal care. In

addition, Chaffinch Ward sent a member of staff to help on Spring Ward, so that the Chaffinch emergency bleep holder could return to her ward.

The first on-call manager, with one of the BRH duty doctors, undertook three SC reviews within RH for patients F, B and D.

At 0414 the second on-call manager had a series of two telephone conversations with [REDACTED], informing her that the ward had been secured and that any staff waiting in reception could now return to Spring Ward.

[REDACTED] arrived at RH at 0445.

Staff gathered for an initial debrief in the conference room on Spring Ward, facilitated by the first on-call manager, which was variously attended by staff.

During this time, Patient E came out of his room in an aroused state and was demanding a cup of tea. The BRH ETL asked the staff to leave the debriefing session until the patient returned to his room. Patient E was very confrontational with staff, making various insults and accusing staff of racism. The first on-call manager skilfully defused the situation and helped patient E to make a cup of tea. He returned to his room and the staff debriefing continued.

At 0500 full control of Spring Ward was restored.

At 0530 the first on-call manager deployed two BRH ET members to relieve Spring Ward staff who were carrying out observations in the ICA, so they could attend a debriefing session.

All members of the BRH Emergency Team left Spring Ward when it was considered safe to do so. The Norbury Ward staff took over observations.

At approximately 0600 staff were seen and supported by [REDACTED] that at approximately 0610 [REDACTED] and the second on-call manager met the Norbury staff for a further debrief.

After the debriefing sessions, it was agreed that patient C should be transferred to William Blake Ward, Bridge House and placed in SC, due to his unpredictable behaviour. Four staff assisted with his transfer, using the Trust's secure van.

At 0630 the first on-call manager met [REDACTED] to inform her of events.

Once the day staff had relieved the BRH Emergency Team members, the ETL went to review patient A in SC on DHU, following which she wrote her notes for the night.

The first on-call manager telephoned [REDACTED], who came in early to take a briefing of events and to discuss decision making processes.

At 0700 the BRH ETL handed over to the BRH morning ETL who was based on Tyson West 2 Ward.

At 0730 [REDACTED] went to Norbury Ward. It took some time to gain access. She was let in by builders who were already on-site, walking past patients B and D, who were in SC.

At 1200 an emergency crisis meeting chaired by [REDACTED] was held to take stock of the two incidents and recommend immediate actions to prevent recurrence, support staff on duty, and advise on measures to consolidate physical and relational security.

Systems checks were carried out on 02/10/12, as there were concerns that patients had interfered with security systems during the incident.

There was no interference to the fire alarm on the wards or interference with CCTV systems. With regard to wall alarms, the maintenance team established that objects had been stuck inside the push buttons which meant the alarms could not be reset during the incident.

All Ascom devices were remotely tested late on the night of 02/10/12 and reported to be in working order.

The Fact Finding report acknowledged that there was no headcount throughout the night of 1st October 2012.

The incidents were rated as category B Serious Incidents (Incident Policy, September 2011).

There was a breach of SC policy with regards to patient F, in that circumstances prevented staff from conducting reviews for a period of time when staff were escorted from Spring Ward to RH Reception and until the police were able to stabilise the situation.

13. Patient Care and Treatment.

Background

When Norbury Ward became operational in 2008, it opened with thirteen beds. However, bed numbers were subsequently increased to fifteen in late 2009. In doing so, this removed two de-escalation rooms within the intensive care area (ICA), removing a critical therapeutic option associated with the management of PICU (Psychiatric Intensive Care) patients, without securing alternative strategies for the clinical management of patients.

Norbury Ward takes direct admissions (new patients), in addition to accepting inter-ward transfers (PICU function) when patients on other wards (except Spring Ward) become acutely unwell or deemed too disturbed and cannot be managed on Thames Ward.

[REDACTED] reports that during the past twelve months Norbury Ward has accepted 50% of the total admissions to the Trust's forensic services, of which PICU patients accounted for 50% of all admissions to the ward. Moreover, fifty nine patients were admitted to Norbury Ward between January and September 2012.

The very nature of Norbury Ward means that turnover and acuity is often high. According to [REDACTED], Norbury Ward has at times been over-occupied, with 16 or 17 patients – although this is disputed in the BDP CAG response to the draft report.

On average, during the month of September 2012, 13 out of a complement of 15 beds were occupied. [REDACTED] described the ward at this time as being especially busy with

an intensive level of admissions, transfers and discharge activity, and at the time when Norbury patients moved to Spring Ward on 29/09/12, there was a significant number of challenging patients, high staff sickness levels and regular use of bank and agency staff.

In addition, Norbury ward has been the main ward responsible for the Lewisham Triage Assessment Model; an innovative approach to managing and assessing patients over a twelve week period, during which thorough assessment and initial treatment is expected. This placed additional strain on all members of the ward team.

The Independent team understands that this was a very successful model in that it saved the Lewisham PCT £1.5 million. However, the nature of the contract meant that there was an expectation of four-weekly reports to the Commissioners, in addition, to the quarterly reporting to the Commissioners for local patients and monthly reporting for national patients. There does not appear to have been any documented impact assessment associated with the Triage Assessment Model.

Approximately half of Norbury Ward's patients are admitted from remand prisons whilst they are awaiting trial. This involves a considerable amount of paperwork as they are often at the stage where their fitness to plead is being called into question. Moreover, some of these patients contest their detention in hospital under the Mental Health Act, necessitating a Mental Health Tribunal. Once fitness to plead is established, patients go to trial and if convicted a psychiatric disposal is often considered.

The multidisciplinary team comprises:

- A General Adult Consultant Psychiatrist with a community and PICU background, who took up post in [REDACTED]
- Core Trainees: a CT-grade doctor and a senior trainee (a Specialist Registrar- SpR - also known as an ST 4-6 grade doctor). The ward has been without a SpR since July 2012. [REDACTED] [REDACTED] has been working under the supervision of [REDACTED] [REDACTED] since October 2012.
- A Team Leader, [REDACTED] with an adult community mental health and PICU background, whilst the substantive post holder was on maternity leave. He was (at the time of the incident) supported by three Deputy Team Leaders (DTLs) and one acting DTL (Band 6 nurses). A team of six nurses / support workers are provided for each shift.
- A Forensic Psychologist, supported by an assistant psychologist.
- An Occupational Therapist, supported by two part-time OT technicians.
- A Social Worker.

The RC has a full-time contract. One day per week (two PAs) is spent at the Institute of Psychiatry where she has teaching responsibilities for [REDACTED]. A further day (mentioned when interviewed) is spent working from home or at the Institute, while remaining on-call for the ward.

The most recent job plan was signed off in February 2013 by [REDACTED] [REDACTED]. The job plan makes provision for ward-based activities on three days of the week,

including a Clinical Management Round, Risk Management Meeting, a Family Surgery for relatives, a Care Delivery System Meeting, individual sessions with patients, and a Ward Round.

The ward had an impressive seven day a week ward-based activities programme for a period of time but this became unsustainable when the responsible occupational therapy staff left. [REDACTED] cites an evidenced-based correlation between the time when there was a seven day per week ward based activities programme (when the number of incidents was lower) and the time when this programme collapsed (when the number of incidents was higher).

Before the arrival of [REDACTED], Norbury Ward had been without a substantive RC for some time (due to sickness absence). On her arrival, she found that nursing practice, in her opinion, operated from a low evidence base.

The Team Leader's role combines clinical leadership and general management duties; the latter of which appears to dominate the working week. The net effect of this is to reduce opportunities for clinical decision making, clinical supervision, risk management and monitoring of standards of care.

The clinical team has access to a facilitated reflective practice group (RPTD Project). The facilitator (a Consultant Psychotherapist) is accountable for this project to [REDACTED], but this has been delegated to [REDACTED]. For some considerable time this group took place on a day on when [REDACTED] was unable to attend. After protracted negotiation, the day was changed and [REDACTED] has been attending more regularly since January 2013. [REDACTED]'s attendance has been occasional.

The importance of RPTD, which operates on other wards in RH, as well as Norbury, is considerably diluted because it is not embedded within the process of management and its systemic gain is not fully realised.

In March 2011, Norbury Ward was the focus of an investigation commissioned by [REDACTED], following a series of incidents instigated by a patient who used his bodily waste to express his dissatisfaction with his care and treatment. These incidents resulted in a number of concerns including the maintenance of patient dignity, infection control, health and safety of the named patient, fellow patients and staff, and the action of clinical staff to effectively manage and resolve the situation.

At the time these incidents occurred 44% of Band 5 nursing posts were vacant. Following an internal investigation, disciplinary action was taken against a number of staff in the nursing team. In addition, there was a change of Team Leader.

The nursing culture of working long-days has recently been addressed, with a phased reduction away from this pattern.

Methodology

For the purposes of this Independent investigation, the Independent team reviewed the care and treatment of ten patients, five of whom were identified as perpetrators and five who were referred to during examination of events.

It should be noted that examination of care and treatment focused in the main on the month of September 2012, leading up to incident 1 and incident 2 on the night of 1st October 2012. This time frame was extended either side when it was considered to be relevant to do so.

The Independent assessment used Norbury Ward's operational policy as a marker, with particular reference to:

- **Section 2 - Philosophy of care:**
 - The staff of Norbury Ward believe in teamwork to achieve the assessment, treatment and early recovery of patients in a secure environment.
 - The team has adopted the 'Confidence in Caring' framework for best practice (DH, 2008), and therefore provide individualised care that has continuity and consistency. The aim is to promote each individual's optimum functioning, whilst being sensitive to personal preferences. Staff will involve patients and their families, with consent, in making decisions about their care and with regard to the running of the ward.

- **Section 11 - Care planning:**
 - Care planning is essentially about addressing an individual's full range of needs. This is done in collaboration with the patient and members of the multi-professional team. It is a holistic process with a strong focus on helping service users, together with their carers and family, achieve the outcomes they want for themselves. In Norbury Ward care planning will be documented and shared with patients and in some cases advance directives will be established with patients so that during management of serious incidents the patient's involvement is maintained.

- **Section 14 - Norbury daily routine:**
 - Activities, 10.30 – 12.00, 14.00 – 17.00.

- **Section 15 - Activities on Norbury Ward:**
 - It is recognised that meaningful occupation is an integral part of the therapeutic process on Norbury Ward and that activities should be as readily available as possible.

- **Section 20 - Intensive Care Area:**
 - The intensive care area (ICA) is to be used exclusively for the care of highly agitated and disturbed patients, who are at that time deemed to be a threat or danger to themselves and/or others or who require a less stimulating environment for a short period of time.

- **Section 22 - Service user involvement:**
 - Norbury Ward subscribes to the vision of "No decisions about me, without me" and at all stages in a person's recovery, will seek to involve them to the fullest extent in the assessment, planning, delivery and review of care.

[REDACTED]

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GENERAL FINDINGS FROM THE CARE & TREATMENT REVIEW

The Independent team was aware that [REDACTED] was absent due to annual leave for the period 13/08/12 to 05/09/12 inclusive.

Risk assessment:

The Independent team found that for all ten patients there was a completed ePJS risk assessment in place that ranged from satisfactory to excellent, completed by a range of disciplines. As at 1 October 2012, the average age of those ten patients' risk assessments was 40 days exactly.

In contrast, it is of note that no 'risk event' entry was made for the night of 1 October for any of the ten patients identified as being involved.

Of the ten patients, seven had HCR20 risk assessments. The three patients that did not have HCR20 risk assessments had been admitted to hospital for less than three months.

The Independent team was very impressed with the scope and depth of the HCR20s and with the risk scenarios. They went well beyond the standard and rather categorical approach.

There was quite a range of ages of HCR20s, with the oldest (on 1 October 2012) being 435 days old. The average age of the seven completed HCR20 risk assessments was 244 days, or eight months and one day.

The Forensic Inpatient Emergency Transfer protocol recommends the inclusion of a current and complete HCR20 at the time of patients transferring between wards. The Independent team found that transfers went ahead more often than not without transfer forms (i.e. clinical summaries) in place. It found also that HCR20s are not updated for this purpose and did not accompany transferring patients.

The Independent team was impressed with the good intention behind the running of the HCR group and the principle that lay behind it - the involvement of the patient in risk management.

Progress Notes:

Of the clinical notes examined, the Independent team was impressed with the quality of the OT entries in particular, by the thorough and regular CT-grade doctor entries for secluded patients, and by the contribution made to the record by gym instructors.

One of the features that really stood out, however, was the reduced amount of senior medical entries on ePJS and the reliance instead on Ward Round minutes to record clinical changes and decisions that had been made. The Independent team is clear in its finding that during the timeframe when care and treatment was reviewed there were fewer entries made by senior doctors setting out clinical information relevant to treatment than would be expected. The GMC's Good Medical Practice requires that doctors must keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment, and that they must make records at the same time as the events they are recording or as soon as possible afterwards. The Independent team found that the junior doctors were better at doing this than their more senior colleagues.

Of particular note (and here there is overlap with Mental Health Act Code of Practice compliance) was the insufficient number of senior medical entries on ePJS for secluded patients indicating regular review and assessment. Three periods of seclusion stand out: Patient B's seclusion between 28/08/12 and 07/09/12, Patient D's seclusion between 11/08/12 and 21/08/12, and Patient F's seclusion between 27/08/12 and 04/10/12.

This problem was particularly marked in [REDACTED]'s absence due to leave in August, but nevertheless it was when there ought to have been cross cover arrangements.

Taking patient D's case as an example, there were 35 entries by CT doctors, three reviews on three different occasions by three different SpRs, but no consultant entries. This is of some concern. There

are two entries, one by a nurse and one by a CT doctor, which highlight that concern. In fact, the patient's medicines were altered by a covering consultant who may have seen him in this period but made no entry. By implication, we were concerned about the senior medical cover arrangements for [REDACTED] in her absence.

The Independent team also raise this point inasmuch as they consider that senior doctors run the risk of damaging the relationship they have with their patients (and so negatively affecting their progression) by demonstrating to them an attitude to care when in seclusion which is less than satisfactory and which is less than the Code or Practice requires.

The Independent team also noted that not all management rounds and Ward Rounds were minuted reliably in terms of who attended them.

Care Plans:

Practice was variable. The Independent team was impressed by the OT care plans in particular but found that there was an inconsistent overall picture.

Medication:

The prescribing practice on Norbury Ward is up-to-date and is evidence-based. However, the Independent team did not find good evidence of medication changes always being discussed with patients and recorded and that is of note (see below).

Mental Health Act compliance:

The Independent team was impressed with the reliable pattern of consent always being obtained at the three-month point for newly admitted patients as Section 58 of the Mental Health Act requires it to be. However, the situation concerning valid Consent to Treatment procedures for patients who were already in River House but had moved on to Norbury Ward needs attention.

Three patients did not have valid T2 forms. This is not to raise a legalistic point but to stress a compliance and therapy point. One patient admitted to Norbury Ward from Chaffinch Ward (where there was a valid T2 form) stopped taking his risperidone one week later. Three days after he did that, the medicine card (but not the clinical notes) records that amisulpride was added. He never took it and voiced concerns about it to nursing staff. When he moved to another ward after the incident, on 02/10/12, the absence of a certificate of consent was picked up that day by a nurse and then by the consultant. He was seen by the consultant who found he was insightful and after some discussion he was agreeable to start taking the amisulpride if the risperidone could be stopped. He was back on the antipsychotics he needed.

The Mental Health Act Code of Practice states that If the patient is secluded for more than 8 hours consecutively or for 12 hours or over a period of 48 hours, then a multi-disciplinary review should be completed by a senior doctor or suitably qualified approved clinician, and nurses and other professionals who were not involved in the incident which led to the seclusion.

In a number of cases there was significant deviation from the Mental Health Act Code of Practice.

Other:

There were several positive findings as well. One hugely impressive feature of Norbury Ward is the Family Surgery which [REDACTED] operates (and which is a feature of a very busy Monday, alongside the Management Round). The Independent team was very impressed that the Management Round was used as an opportunity to ensure that invitations were made to others to attend this.

While substance misuse groups are available in the central therapies department in RH, in practice Norbury Ward patients have restricted access. However, [REDACTED] runs a substance misuse group. There is no dual diagnosis practitioner as part of the RH establishment. Given the prevalence of substance misuse, support to clinical teams with regard to dual diagnosis and access to substance misuse groups should be reviewed.

* * *

The Independent team heard just how hard it has been for [REDACTED] manage her responsibilities in this period when she had no SpR and when she worked with a CT doctor who - as she told us - found it difficult to function at a CT1 level. The burden on medical documentation was significant. This is a particular problem on a ward where there is much liaison work with the police (in assisting them with decisions to prosecute or not) and with the courts.

That the Independent team found deficiencies in the various procedural matters like doing the T2 forms and always recording events on ePJS as they happen, suggested how real a problem this was. On a ward like Norbury, which unusually has both PICU and Admissions Ward roles, a consistent medical presence needs to be assured. Although the Independent Team has been advised of the 'priority status' enjoyed by Norbury Ward in terms of SpR allocation, [REDACTED] for the ward gave a different account. [REDACTED] should ensure that an SpR (or SpRs) are always allocated to Norbury Ward. The training experience it offers is enormous and it should rightly be a popular ward to work on for aspiring consultant forensic psychiatrists.

12. Security Review

Background

Two months after River House construction works commenced, the Department of Health (DH) published Best Practice Guidance: Specification for Adult Medium Secure Units, July 2007. An invitation was extended to [REDACTED], who was asked to review security provision for River House against the DH guidance. This led to approximately one hundred and fifty recommendations being made, which added three months to the construction period, with a cost in excess of £1M.

BDP CAG. He reports to [REDACTED] although he is line managed by [REDACTED], who although has a responsibility for driving a programme of quality assurance across the CAG delivering in all aspects of CQC registration, Ministry of Justice standards, safeguarding principles and learning from serious incidents, is not accountable for security.

It is worth noting that since the incident on the night of 1st October 2012, there have been changes in managerial leadership [REDACTED] having secured another post left the Trust in early in October 2012. Her departure was unrelated to the incidents under examination. The post was held for a short period of time by [REDACTED] until January 2013, followed by [REDACTED]. [REDACTED] has recently been appointed and is due to take up her post 13th May 2013.

[REDACTED] returned to his substantive post at the end of March 2013.

On 7th January 2013, [REDACTED] with a forensic nursing background was based on Norbury Ward, which by all accounts has made a significant difference to care and treatment, and a higher success rate in the use of deescalation techniques.

This arrangement is a temporary one. The gain derived in a relatively short period of time suggests that there is an urgent need to invest in clinical leadership which directly improves nursing confidence and competence at ward level.

Shortly after the opening of RH, discussions with [REDACTED] at Bromley Metropolitan Police were held. At that point 'grab packs' were finalised and all calls from RH were rated as 'I-calls' (response within 12 minutes).

Over the years there have been numerous organisational and personnel changes in both police and SLaM but the work has continued.

The Trust has operated for some time a Trust-wide police liaison meeting. Above that the Chief Executive chairs a quarterly meeting with Borough Commanders and each hospital site has its own local police liaison group. [REDACTED] is the lead officer for BRH and all RH related police liaison work goes through [REDACTED], in conjunction with the BRH lead, The Trust's [REDACTED] and [REDACTED].

The Independent team has been told that nurses have an unrealistic expectation of police officers which results in some nurses discharging their authority to police when clinical leadership of situations should be retained. There have been a number of occasions when nursing staff fail to coordinate and brief police officers fully on their arrival.

Conversely, the Independent team understands that police officers complain that they get called to too many situations when patients have gone absent without leave (AWOL) from other wards on the BRH site, when they receive no handover on arrival. Consequently, many police officers have developed a bad impression of the BRH (based on previous experiences) and have unrealistic expectations of the BRH/RH response teams (equating it to their own response units).

Since late 2009 work has been undertaken on a GPS tracking project to manage AWOL situations.

Due to the level of police work generated across the BRH site, the police formed a Safeguarding Adults at Risk (SARs) team - working closely with [REDACTED], [REDACTED] and RH managers. This team deals with all crime reports at BRH. To support this, a Police lorry (the custody bus) came on-site to process this work and hold interviews with patients. The lorry was based in RH yard and patients from across the hospital came for their interviews. However, this work is now conducted within RH to support the prosecution process.

Around two years ago, [REDACTED] with PSTS Department arranged a number of days at BRH for police officers who walked the site, had PSTS demonstrations and aired their concerns. These were, according to what the Independent team have been told, very tough sessions, but went a long way to breaking down barriers.

Methodology

Trust and BDP CAG policies and guidelines were scrutinised, for clarity and organisational purpose. The following policies were used as markers for assessing relational and physical security:

- BDP CAG Operational Policy for River House – undated but specifies review date as July 2012.
- BDP CAG Norbury Ward Operational Policy undated, but specifies review date as December 2012.
- BDP CAG Alarm testing procedure, April 2012.
- BDP CAG Anti-barricade Doors, January 2012.
- BDP CAG Ascom Induction, May 2010, reviewed August 2012.
- BDP CAG (MSU) Daily perimeter checks, June 2012.
- BDP CAG Emergency response protocol, October 2011.
- BDP CAG Environmental checks procedure, August 2012.
- Trust Lock Down procedure (MSU Only), May 2012.
- BDP CAG Major Incident Protocol & Procedures, February 2012.
- BDP CAG Major Incident Protocol Appendix, February 2012.
- BDP CAG (MSU) Physical Security Document, October 2012.
- BDP CAG (MSU) Role of the Ward Based Security Nurse, October 2012.
- BDP CAG (MSU) Zoning Guidelines, June 2012.
- BDP CAG Summoning Police Support – Undated.
- Draft Metropolitan Police Protocols - SLaM & Metropolitan Police: Lambeth, Southwark, Lewisham, Croydon & Bromley – Undated.
- Police Liaison Protocol – Service Level Agreement between BRH and MPS - September 2000.
- Trust Supervised Confinement Policy and Procedure, June 2012 – effective from 30/07/12.
- BDP CAG Grab Pack & Grab Pack Procedure, April 2012.

Each policy was reviewed from two perspectives:

- I. The quality of the policy to contribute to the overall security envelope of River House.
- II. The translation of policy into practice.

See Think Act – Your guide to relational security, published by the Department of Health 2010, was used as marker, with specific reference to:

- Team functioning.
- Boundary setting.
- Therapy.
- Patient Mix.
- Patient Dynamic.
- Physical environment.

In addition, one planned and two impromptu daytime visits were made to Norbury Ward and two to Spring Ward. The Chair of the Independent team also spent a day with the RH Reception team using overt participant observation.

Findings:

The operational policies for both RH and Norbury Ward offer a clear vision and structure for the service. They are aspirational in nature, realistic and achievable. They are presented clearly and concisely, and provide a logical progression; setting out appropriate objectives for the care and management of patients within a Medium Secure Service.

Some policies, for example the operational policies for RH and Norbury Ward require updating to reflect recent changes.

The policies offer a baseline for service audit through which organisational assurance can be tested.

Some of the aforementioned policies are subjected to external scrutiny by the Department of Health's Annual Security Review and by the Royal College of Psychiatrists Forensic Network. Both the DH and the RCPsych reviews use the DH Best Practice Guidance: Specification for Adult Medium Secure Services, 2007, as the benchmark.

Comment: Despite the comments above, there is serious disconnection between excellence in policy and translation of policy into practice and serious concern on the part of the Independent team that assurance testing of agreed policies is not rigorously and consistently applied.

Relational security is poorly understood by some staff. The attitude and behaviour on the part of some of the nursing staff, observed during this Independent investigation is counterproductive to safe clinical practice.

Policies in practice during the night of the 1st October 2012:

I. Emergency response protocol

It is clear from interviews with staff, particularly [REDACTED] that a problem arose with following the Emergency Response Protocol.

The protocol states that the role of the UC is to lead in risk management within RH during the designated shift and the coordination of the response to emergencies over the course of a shift. The presence of the UC at a time of crisis is not intended to undermine the authority of the NIC. The UC should be there to support and enable the nurses on the ward on which the crisis is occurring. Only in the exceptional circumstances should the UC take charge.

Comment: The UC, along with other staff became trapped in the nursing station, with no means of egress. However, it should be noted that two HCAs managed to leave the ward during incident 1.

The Independent team found difficulty in delineating the duties and responsibilities between the NIC of the shift and that of the UC, once the latter had arrived on the ward, having responded to the emergency alarm.

The UC, by default, forfeited her delegated duties and responsibilities, when she retreated to the nursing station during incidents 1 and 2. This should not imply any negligence on her part. Much of what she did was commendable, for example she used anticipatory and forward planning skills when she arrived on duty and did her level best to manage a challenging situation under very difficult circumstances.

Her documentation of events on the night of the 1st October 2012 is commendable.

The Emergency Response Protocol states that the out-of-hours UC will be a single point of contact for:

- The BRH duty doctor.
- The police
- Senior Management on call.

Comment: As stated above, the UC became ward based. She had access to an Ascom unit, a radio and landline telephone which she used to good effect, but because she became trapped in the nursing station, this prevented her from locating herself in RH Reception to meet the police on their arrival and to work in partnership with them; particularly once the police declared incident 1 a Critical Incident and invoked the Bronze, Silver and Gold command structure.

████████████████████ offered help at an early point, once she was informed by the UC that incident 1 had occurred. However, this offer was declined until much later in the night.

Arguably, the UC, ██████████████████ from Waddon Ward (who was on night duty) or ██████████████████, should have located themselves in RH Reception to oversee the transfer of vital information to the police on their arrival to facilitate risk assessment.

II. Lock Down procedure

The Lock Down procedure was implemented on instruction of the first CAG on-call manager at some point after her arrival, having been advised to do so by the second CAG on-call manager. The Lock

Down policy stipulates that for a major incident the Bronze, Silver and Gold command structure should be established.

As previously mentioned, the police adopted this *modus operandus*, but despite the fact that several managers became involved throughout the night, four of whom came on-site at various times, there is no evidence that the Bronze, Silver or Gold command roles were assigned to Trust staff to work with the police accordingly.

In the first instance, this left [REDACTED], who was first on the scene at around 2247, to rely on communications between the Reception team and the staff in the nursing station, until the first CAG on-call manager arrived at approximately 2310, just shortly after the arrival of the [REDACTED] (Night Response Team), who arrived at 2305.

III. Major Incident Protocol

The staff directly involved in the incident, referred to the incident as a 'hostage taking' situation and used this terminology in their communications with the police, in their statements, and as part of incident reporting. This is incorrect terminology as there were no demands being made on the part of the perpetrators, conditional on release of staff.

Comment: The Major Incident Policy defines incident 1 and 2 as a 'riot', in that there was 'concentrated destruction by more than 2 residents'.

Arguably, It may have helped the team to focus better on the what was taking place, and the appropriate response, if correct terminology had been adopted, following the guidelines in the Lock Down procedure, and enabling UC to establish Bronze command when incident 1 occurred. This could have assisted the police in formulating an earlier plan of intervention.

Once the first on-call CAG manager arrived, clear information was provided to the nurses trapped on the ward.

IV. Use of Ascom – policy and practice

Staff entering clinical areas are expected to collect and return Ascoms from RH Reception, although in the case of the Rapid Response Ascoms, these are kept on the wards, for which charging units are available. Ascoms are tested by reception staff on every occasion prior to allocation.

Ascom is a global positioning system providing staff with a means of summoning help in an emergency from colleagues working in the same location or from the wider RH Rapid Response Team drawn from each of the wards, where there is a designated member of staff on each shift.

The manufacture and supplier (Ascom Wireless Solutions UK) of mission-critical communication systems has vast experience in working with the NHS and provides significant back-up, including diagnostic testing and training.

Some staff told the Independent team that they had little confidence in the Ascom system and that it was not uncommon for there to be systems failure, as opposed to incorrect usage by staff. However, when the Independent team met with [REDACTED], [REDACTED], [REDACTED],

and representatives from Ascom on 05/02/13, it became clear that the main problem lay with staff, as opposed to systems failure (soft or hardware).

Comment: At interview and during visits to Norbury Ward, there was a surprising number of staff who gave incorrect information, when asked to explain how the Ascom units worked, especially with regard to the means by which they could summon help in an emergency. This is something which has been identified previously in a number of internal investigations, but not addressed sufficiently to secure a high level of compliance and confidence in the system.

There were examples of user failure on the night of 1st October 2012. Some of this may have been the result of human error arising from ‘panic- scramble’ on the part of individuals. However, even allowing for this as a factor, the evidence presented to the Independent team indicates serious failings across RH as well as Norbury Ward as follows:

- Although staff are required to keep Ascom units attached to their person, it is not uncommon for the units to be left lying around. In such circumstances the system flags up a ‘man down’ message. (The clips which are used to attach Ascoms to the belts worn by staff are not adequate and recent steps have been taken to rectify this in March 2013).
- False alarms occur regularly as a result of incorrect usage and on each occasion Reception staff endeavour to make contact with the holder.
- Ascoms are sometimes turned off or placed on silent mode and if not returned to Reception at the end of duty, are picked up by another member of staff arriving on duty who may fail to check which mode the unit is in.
- When a point survey was done on 30/01/13 by [REDACTED], out of a total of 138 Ascom units, across six wards at RH, 20 were recorded as ‘missing’. The wards with the highest ‘missing’ scores were Thames Ward (6 missing out of 23) and Norbury Ward (6 missing out of 23).
- Ascom units have been returned to reception on occasions when key functions have been altered, such as replacing English with other languages.

There is evidence of very good and consistent training for staff on security and particularly the use of Ascoms.

The Independent team has considered different sources by which to triangulate a confident position that the Norbury Team (and other staff) are not effectively and consistently applying policy into practice with regard to the use of the Ascom System; the root cause of which appears to be a culture of no confidence in the Ascom system, ineffective controls assurance and a management culture which fails to engage staff in ways which addresses behaviours and attitudes.

V. Overt Participant Observation – RH Reception

On the 05/03/13, the Chair of the Independent Investigation spent most of the day in RH Reception, shadowing different members of the team in the execution of their duties and responsibilities. This demonstrated a high level of policy being delivered in practice.

There is commendable departmental leadership in RH reception, with a robust determination to ensure that the multiple security functions for which Reception staff are accountable, reach required standards.

During the placement the Chair of the Independent Investigation witnessed unacceptable and unprofessional behaviours on the part of some of the staff who came through RH Reception, who openly challenged security protocols.

There is considerable traffic in and out of RH, especially at certain times of the day. Between 1230 and 1330, approximately twenty staff from different wards (a mix of registered nurses and HCAs) arrived for duty, two thirds (approximately fifteen), of whom behaved in ways which indicated that their understanding of relational security was seriously flawed.

Some staff overtly expressed either verbally or non-verbally, their objection to being asked to present their identity badges; with escalating degrees of irritation when asked to wear their identity badges before leaving Reception.

Some of the staff had to be asked to place their keys on their person before leaving reception.

Comment: The Reception team used appropriately assertive intervention to secure required protocols, but in so doing became the recipients of unacceptable behaviour. This situation leaves Reception staff open to complaint, and undermines the integrity of security within RH. The attitude of some staff towards physical and procedural security is compromising the unit's aspirations to provide effective relational security within a therapeutic environment.

VI. Ward Visits

The Independent team visited Norbury Ward on three occasions and Spring Ward twice.

During the first visit to Norbury Ward (a planned visit), the SC rooms, in the opinion of the Independent team, were unfit for clinical purpose, for example:

The SC room nearest to the door leading from the main ward into the ICA:

- The CCTV was out of action and was reported to be regularly out of order by the Team Leader.
- The door leading from the ICA corridor directly into the en-suite bathroom could be moved forwards and backwards whilst in the locked position.
- During the inspection, a bolt approximately 5 cm in length in the lower part of the inside door leading from the en-suite bathroom to the ICA corridor (which appeared to be part of the lower lock) was loose and was removed by a member of the Independent team and handed over to [REDACTED].
- The lock on the door between the SC room and the en-suite bathroom had been tampered with to such an extent that it was almost unusable.
- The threshold section of the floor between the SC room and the en-suite was missing, presenting a safety hazard.

- There were screws missing from the panels above the toilet/sink and although subsequently assured that the screws were in situ but the heads were missing, the Independent team did not consider these panels to be tamper proof.

The SC room furthest away from the door leading from the main ward to the ICA:

- The door leading from the ICA corridor directly into the en-suite bathroom could be moved forwards and backwards whilst in the locked position.
- The door between the SC room and the en-suite bathroom had a lock assembly which had been badly damaged by it being partly prised from the door. It had extremely sharp and protruding edges.
- The lower section of the metal frame around the window was assembled such that it was possible to gain purchase behind it with one's fingers. Should part of the lock assembly (above) be removed, then an effective lever could be used to tamper with the frame.
- The panels above the toilet/sink were not tamper proof.

Before leaving RH on 3rd December 2012, the hazards listed above were discussed with [REDACTED], [REDACTED], [REDACTED] and [REDACTED] for RH. Later that same evening, the Chair of the Independent team brought the hazards to the attention of [REDACTED] and an Exception Report was discussed with [REDACTED] and submitted the following day.

The Trust took immediate steps to decommission the two SC room on Norbury Ward, whilst remedial works took place before the SC rooms were put back into clinical use. In addition, new measures with regard to monitoring the safety of SC rooms were immediately implemented. The incident, as reported above, was registered on Datix.

Comment: The poor design of the SC rooms on Norbury, their constant use and fabric present ongoing and costly problems for the Trust. The constant destruction of these rooms contributes to reduced confidence on the part of ward staff that patients with severely challenging behaviour cannot be safely nursed within them.

Comment: The lack of awareness of the risks outlined above and the ease with which these were quickly identified by the Independent team, suggests a less than optimal grip on environmental security in which safe clinical practice takes place.

In January 2011, [REDACTED] produced a briefing report outlining the problems with design and robustness of SC rooms at River House. In addition, a Trust –wide review of SC suites was commissioned by [REDACTED] in November 2012, undertaken by [REDACTED] and [REDACTED].

The Independent Team understand that the Trust is planning a further review and re-provision of supervised confinement facilities in RH.

At the same time as the first visit on 03/12/12 to Norbury Ward, the intensive care area garden was found to be very messy and unkempt, with a torn mattress on the floor, elastic from two pairs of boxer shorts adorning some shrubbery, and a lot of rubbish in corners of the garden and outside patient's rooms, which had been thrown out of their room windows.

In addition, the daily ward-based security checks were not up to date; in fact the last one available was from June 2012. Apparently some copies had been lost.

On the second visit to Norbury Ward on 10/12/12, the security checks were being done regularly, but the intensive care area garden was still messy, although the mattress had been removed. This is of note because the Independent team was told that mattresses often get destroyed and on one occasion, whilst a mattress was waiting to be disposed of, a patient had tried to use it as a trampoline to gain access on to the roof of the building from the ICA garden.

Despite repairs to the supervised confinement rooms on Norbury Ward, following the first planned visit on 03/12/12, more hazards were found during the first impromptu visit on 10/12/12, when another bolt was removed by a member of the Independent team.

During the third visit to Norbury Ward on 15/01/13, the loss of the two de-escalation rooms in the intensive care area, which occurred when bed numbers on Norbury Ward were increased from 13 to 15, led the Independent team to look more closely at the Norbury Ward Operational Policy which refers to de-escalation as part of the therapeutic approach, with intensive care as part of the response. In addition, the Independent team was notified that the ward had a snoozalum room, but that it was never used.

Two impromptu visits to Spring Ward were made on 10/12/12 and 28/01/13.

The first visit examined the exact location where the incidents on the night of the 1st October 2012 had taken place.

The second visit examined the lay-out of the ICA and access to the fire-road (the position the police adopted to monitor the ward before making a decision as to when to go in). The Independent team observed two nurses in this area providing observation for one patient in SC.

The internal door leading from the ICA into the airlock, through which access to the fire road is possible, was found to be unlocked, as was the outer door from the airlock to the fire road. This door can only be opened from the fire road and is controlled by RH Reception.

Comment: In the course of five visits, the Independent team found on three occasions, at best perfunctory attitudes and practice towards physical, procedural and relational security.

VII. The Team

The importance of shared understanding and mutual respect between patients and staff is vital in the maintenance of relational security, as advocated in See Think Act.

This Independent Investigation has identified that despite very laudable operational policies, there is not a shared and common understanding between members of the Norbury team. Central to this is

the lack of respect which some staff had for some members of the Nobury team and the lack of support from senior management perceived by some staff.

An earlier series of related incidents in March 2011, referred to at times as 'the dirty protest', resulted in a number of staff being suspended and disciplinary action being taken against them. This incident is cited by many of the staff who were interviewed as part of this Independent Investigation, to have adversely affected staff morale. Although there have been some staff changes since March 2011, there is a lasting and pervasive legacy which undermines team cohesion.

VIII. Boundary setting

Boundaries can be physical (such as room and ward design or the perimeter of the secure unit), procedural (such as operational policies) or relational (such as professional and personal rules). Relational boundaries underpin safe and effective therapeutic care with patients.

Having an agreed set of non-negotiable boundaries is paramount, although such boundaries need to be an integral part of the therapeutic approach. During visits to Norbury Ward and through the focused review of the care and treatment of ten patients, it was evident that boundary setting was not always fully understood and not always applied within the context of See Think Act.

Some of the evidence associated with this Independent Investigation demonstrates that there are times when control of the shift passes from the nursing team to some of the most challenging patients, rendering the clinical environment to a level of suboptimal safety.

IX. Therapy (therapeutic relationship)

It is important to recognise the impact of change in circumstances which effect how people feel. Although the Independent team found one example of a one-to-one session with one patient with reference to their move from Norbury to Spring Ward, this was not consistently the case across the cohort of patients considered as part of this investigation.

X. Patient Mix

Norbury Ward requires their patient mix to be fully appreciated at all levels in the service and subjected to continual impact and risk assessment.

The Independent team acknowledge that the very nature of Norbury ward means that patient mix is a continual challenge and something which requires robust clinical and managerial leadership to secure, as far as is possible, a clinical environment which is within the competency of staff allocated to work on this ward across all shifts, including nights and at weekends.

There is no documentary evidence to demonstrate that in the period leading up to Norbury patients moving to Spring Ward that patient mix was adequately assessed, either at ward level, Pathways or by the Senior Management Team.

Although there is a weekly Pathways meeting, usually chaired by [REDACTED], the record of such meetings is produced in such a way that concerns with regard to patient mix are not identifiable. For this reason, and from what some staff have said

about Pathways meetings, the Independent team is concerned that the clinical implications of decision making, both admissions and internal transfers, is not given a consistent level of priority.

XI. Patient Dynamic

See Think Act captures the very essence of why patient dynamics are a critical feature in safe and effective service provision: *'The mix of patients and the dynamic that exists between them has a fundamental effect on our ability to provide safe and effective services – the whole group can be affected by the arrival or departure of just one patient'.*

During September 2012, three patients arrived on Norbury Ward, two of whom played a part in the incidents on the night of 1st October 2012, namely: Patient C, who transferred from BDU on 07/09/12, and Patient A, who transferred from Thames Ward on 24/09/12; having perpetrated a serious assault on a member of staff. It is also worth noting that Norbury Ward received three other patients during late August 2012, whilst [REDACTED] was on annual leave.

There were known dynamics between named patients, for example, between patient B and patient D. However, there is no documentary evidence that patient dynamics were fully assessed in preparation for Norbury patients moving to Spring Ward on 29/09/12.

XII. Physical environment

The physical environment on Norbury Ward is such that there is no separation of the ward immediately between the main airlock and the main ward. This could be easily rectified.

There is no safe egress from the nursing station which has, on more than one occasion, led to nursing staff being trapped in this area, requiring police assistance. This requires urgent resolution.

The staff room and the staff toilet are not adjacent to each other which means that if staff go on break in the staff room, they have to re-enter the ward to go to the toilet.

The acoustic is such that the noise factor is significant. Noise is a well-known exacerbating trigger, adversely affecting people's mental wellbeing. This too is resolvable.

Internal investigations have raised concerns about ward design but to date a definitive course of action has not been agreed.

13. Liaison with Emergency Services

I. The Metropolitan Police

The Trust has a policy for working in partnership with the Metropolitan Police. When the police declared incident 1 to be a Critical Incident they put in place the Bronze, Silver and Gold command structure. The Trust's Lock Down procedure makes provision for this also. Although invoked, the policy was not fully adhered to. If it had been, then roles would have been assigned accordingly, thus providing a framework for working in partnership with the police on the night of 1st October 2012.

Arguably the UC was the Bronze command link, albeit she was trapped with her colleagues in the nursing station. Contact between the police and the UC did occur, but communication was limited to such a degree that staff in the nursing station felt abandoned at times.

As soon as it became clear that two or more patients were involved in destabilising the ward – defined as riot in the Major Incident Protocol - it would have been permissible for the Lock Down policy to have been invoked. If this had happened sooner rather than later, it would have aided liaison with the Police from the time of first arrival.

When the first on-call CAG manager arrived on the scene, arguably she was the Silver link but given the predicament of the UC, the role became a mix of Bronze and Silver. During the timeframe of the first incident (2200 to 0230), three other levels of Trust managers were involved on-site at varying times, namely: [REDACTED], [REDACTED] and [REDACTED]. In addition, [REDACTED] and [REDACTED] were informed of events; the latter came on-site.

The police expressed concern that despite numerous requests on their part to ascertain key information about the patients involved in the disturbance, there was no member of staff on duty who could provide a list of names or any sort of risk assessment, other than to inform them that the ward contained 14 patients, some of whom had the potential to be highly dangerous and that at least two patients had been convicted of murder.

There is evidence of liaison between Trust staff and the police, although the documentary evidence is variable. If the UC had not been trapped in the nursing station there is no doubt that she would have played a more central role with the police, before the arrival of the first on-call CAG Manager.

As has been mentioned earlier in this report, each ward in RH has ‘grab packs’ which contain vital key information and this material is available on the hard drive and could have been accessed from RH Reception.

There was a two hour period after the arrival of the TSG and their entering the main part of Spring Ward. During this period the police were engaged in risk assessments and tactical planning.

The following factors contributed to this delay to a greater or lesser extent:

- The absence of a designated on-site incident room, clear command structures between the police and the Trust during the incident 1.
- Hoax telephone calls made by patient C to the police from the patients’ telephone.
- A call made out of frustration by an HCA who was trapped with his colleagues in the nursing station to a discrete line direct to Scotland Yard.
- Delays in the police being able to access key information from RH.

The police also expressed concern that staff on the night of 1st October, were unaware of any contingency plan, other than to call the police in such a situation. The number of occasions on which police get called to assist staff is considerable.

It was not the remit of this investigation to examine the response of the Metropolitan Police to either of the two incidents, other than to say that very significant resources were deployed.

There are lessons for both the Trust and the police arising from these and other incidents at RH with regard to incident management protocols, command structures, accurate incident log recording and site management, in that police vehicles and those of other emergency services were parked haphazardly in the vicinity of RH, some of which blocked access.

II. The London Ambulance Service

The LAS arrived promptly and made appropriate interventions when staff were rescued from Norbury Ward and brought to the RH Reception. The absence of a single incident log makes it difficult to examine the degree to which the LAS played an integral part in the overall management of incident 1.

III. The London Fire Brigade

The LFB arrived promptly and made appropriate interventions to assure themselves that the situation was safe from their perspective. The absence of a single incident log makes it difficult to examine the degree to which the LFB played an integral part in the overall management of incident 1.

14. Management of the incidents on the night of 1st October 2012

This has already been commented on throughout the report. Very considerable resources were consumed both on the part of the Trust and the emergency services, especially the Metropolitan Police.

Whilst the management on-call arrangements were successfully and appropriately initiated, the on-call arrangements, with regard to the on-call RC were not due to the wrong rota being in place as the previous month's rota for September 2012 had not been printed off - albeit this was available on the hard drive.

When another Consultant was telephoned, he offered his assistance but was informed that he had only been contacted to inform him of the situation. Given the severity of the situation it would have been appropriate to telephone [REDACTED] who as it turns out was the designated on-call RC.

15. Actions taken following the incidents.

Several timely debriefing sessions were held (some with the night staff before they went off duty) for staff involved in the incidents during the night of 1st October 2012. Some of the staff, when interviewed, were unclear about what they had been offered.

Norbury staff and members of the Rapid Response team met with [REDACTED] before they went off duty.

The Trust provides access to an optional and confidential counselling service for staff exposed to traumatising situations. Staff who reported to being traumatised were advised to take time off from work to recover.

There was significant service disruption from 02/10/12. Norbury Ward, in particular, faced difficulty in covering shifts. This was exacerbated further by other bank staff cancelling shifts.

[REDACTED] met with Norbury patients to discuss what had taken place and to review patient mix. These contacts are not recorded on ePJS.

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

On the morning of the 02/10/12, [REDACTED] held an emergency crisis meeting at midday to take stock of the incidents, to recommend immediate actions to prevent recurrence, to support staff on duty and to consider measures to consolidate physical and relational security.

A diagnostic report was requested with regard to Ascom on the night of 1st October 2012.

A review of all emergency systems within RH was completed by the RH Maintenance Team and the findings reported to [REDACTED] on 02/10/12.

Comprehensive perimeter checks were undertaken by the security team on 02/10/12.

The medical on-call rota was re-established for the month of October 2012 for the BRH site and River House.

Although statements were requested from staff involved in the incidents on the night of 1st October 2012, the Independent team found that statements had not been secured from [REDACTED]. One statement made by [REDACTED] dated 01/11/12, was not forwarded to the Independent team when the statements were initially submitted on 19/10/12.

The importance of securing statements from staff as soon after the event as possible cannot be overstated, bearing in mind that some staff may have been too traumatised in the immediate aftermath to do so. Nevertheless, there is a requirement on relevant managers to obtain statements from all parties at the earliest opportunity.

A review of Ascom was initiated, following a facilitated meeting held on 05/02/13 by the Independent team.

16. Consideration of content and findings of parallel reviews commissioned by the Trust

The Independent Team requested the content and findings of any parallel reviews. The Independent team has faced considerable difficulties in gathering some of this information but the following has been reviewed:

- A Trust-wide review of SC Suites (Norbury inspection dates: 06/07/12 and 21/11/12) – document received.
- A CAG review of SC rooms at River House January 2011 – document received.
- A series of BDP CAG Medium Secure Service Action Plans (latest version 24th April 2013, version 7), which cover: Remodelling of Pathways, Leadership, Environmental changes, Workforce development, Policy review and development - document received.
- Review of Norbury Ward's function, whereby it has two core functions, namely: PICU and triage, with a reduction in beds from 15 to 12 – verbally reported but not underpinned by documentation.
- A review of Ascom policy and practice (March 2013) – document received.
- Draft (unpublished) report from Care Quality Commission (CQC) and the Trust Action Plan, following unannounced visits to River House on 07/02/13 and 14/02/13 – document received.
- Operation Metallah, a joint BRH/RH - Bromley Metropolitan Police protocol, with an operational implementation date of 20/04/13 – document received.

Findings:

The internal reviews of SC and subsequent, on-going evidence, demonstrates that SC provision in RH is untenable. It requires capital investment to underpin substantive redesign, reprovision and clinical evaluation of SC, along with other appropriate therapeutic options.

The action plans produced by BDP CAG to reduce risk and improve patient safety in the medium secure services are thoughtful, comprehensive and wide ranging. Benefit realisation requires robust managerial oversight, tight project management, clinical leadership and staff engagement.

The action plans cover:

- Remodelling of Pathways.
- Strengthening clinical leadership and safety audit.
- Environmental Changes.

- Workforce development.
- Policy review and developments.

What the actions plans do not address is leadership and management culture which supports clinical staff to do their best work, and high levels of engagement from medical and other professions in the process of management. The current management arrangements for the CAG, as examined through this Independent investigation, indicate that they require reappraisal in terms of management costs, processes, job-design and leadership style.

The recent review of Norbury Ward's function and its relationship to other wards within RH, whilst welcomed by the Independent team, needs to reconsider the tenability of running a forensic admissions function, alongside a forensic PICU, as opposed to running a forensic PICU alongside a forensic triage.

The action plan and the Ascom Protocol/Guidelines dated 31/03/13, which are to be considered by the BDP CAG Policy Committee in April 2013. It is noted that further focus groups with staff are to be held during 2013. Embedding the action plan to optimal effect requires cultural shift in the perceptions, attitudes and behaviour of staff, underpinned by relational competency testing of all staff, including NHSP staff.

The Action plan following the CQC visits makes provision for addressing some of the environmental issues on Norbury Ward. During the visit to Norbury Ward on 14/02/13, the CQC found:

- The communal areas were not kept in good order.
- There was an absence of posters and pictures and other attempts to make the ward environment welcoming and therapeutic.
- There were signs of broken furniture.
- Poor standard of cleanliness of the environment.
- Evidence of daily assessments of patient behaviours and presenting risks.
- Evidence that care planning arrangements were in place and that patient's needs were assessed and that care and treatment was planned and delivered in line with their individual care plans.
- Evidence that specific risk assessments and associated care plans relating to violence and aggression were in place, based on known risk to others, including interventions used to minimise risk of aggressive behaviour, such as staff support and changes to medication.

The CQC report concludes that the provider (The Trust) met the required standards for registration.

Operation Metallah, undertaken with the Bromley Metropolitan Police, in recognition that a new way of working was required to ensure optimal coordination and management of resources and sharing of information when police assistance is required, whilst not directly commissioned as a result of events on the night of 1st October 2012, has been influenced by it.

This joint work culminating in an agreed protocol is planned to go live Saturday 20th April 2013. It requires direct contact between Bromley Metropolitan Police and the BRH Emergency Team Leader or the River House Unit Coordinator.

Calls received by Metcall, who are the operators for all police 999 calls in London, relating to the Bethlem site will be cascaded down to Bromley police, via their 'grip and paste section', whose responsibility it is to prioritise all calls received via Metcall for the borough of Bromley.

Four defined categories listed below, namely:

- Danger to life,
- Use, Immediate threat of use of violence
- Serious injury to staff, patient or visitor,
- Whereby a patient poses, or is likely to pose, a serious risk to other people.

When calls are received and if they relate to one of the above four categories, they will be brought to the attention of the Bromley Metropolitan Police Duty Officer who will contact the BRH ETL or RH UC, depending on which ward the call relates to, so that staff concerned will be able to give an accurate description of the incident and whether police attendance/assistance is required.

There will be no delay in response from the police, as the duty officer will still deploy a vehicle to the hospital which will remain at the designated bays on site awaiting further instruction. This will allow the officers to have a named designated person to engage with and jointly plan any interventions.

It is envisaged that Operation Metallah will ultimately lead to improved planning, discussions, greater development of exit strategies for all concerned and positive joint working with the police. Operation Metallah is scheduled to go live on 20/04/13.

Exercise Hard Times (EHT). The Independent team was also made aware of a large scale table-top exercise which took place on 20/06/12, involving more than fifty people from the Trust and partner organisations, to test a number of specific aspects of the Trust's emergency and business continuity plans.

The Exercise followed a series of Command Post exercises on each of the Trust's four main sites during May and early June, and was to provide the final significant element of the Trust's assurances relating to the state of its emergency preparations in advance of the London 2012 Olympics.

The report emphasises the absolute reliance of RH on a secure and fully functional Reception, through which to manage the local response to a serious incident, should the communications Systems and equipment within RH fail.

There were a lot of recommendations and points to consider from the EHT report and it has taken some time to agree how they would all be taken forward.

Some of the more obviously 'pressing' planning issues are being addressed. Although nobody disputes the importance of a 'plan B' for RH Reception, formal consideration of options through which to achieve this have not as yet materialised.

17. Examples of Good and Commendable Practice

Throughout the investigation, examples of good and commendable practice have been identified, including:

- Documented nursing handovers on Norbury Ward, making it possible for staff unable to attend handovers to subsequently access such content and for others to use the content for auditing purposes.
- Seven day per week activity programme (albeit suspended on departure of occupational therapy staff).
- The weekly family clinic, run by the RC.
- The excellent contribution to the clinical record provided by gym instructors.
- Well-crafted policies.
- Evidence of some excellent HCR20s.
- Evidence of some care plans being translated into practice.
- The level of on-call and other managerial response given on the night of 1st October 2012 is commendable.
- The willingness of the service to listen and respond to feed-back given by the Independent team.
- The emergency services responded promptly and significant resources were deployed, particularly by the Metropolitan Police during the night of 1st October 2012.
- On-going Joint liaison work with Bromley Metropolitan Police.

In the BDP CAG response to the Independent Team's Draft Report the following areas (transcribed directly) were cited as additional example of good practice:

- *Leadership*; Establishment of 5 separate service lines with identified clinical leaders and managerial support. Our aim was to devolve leadership beyond the traditional roles of Service Director and Clinical Director. In this respect we have invested more in developing a cadre of multidisciplinary clinical leaders within the CAG.
- *Staff Development*; In 2011 the CAG embarked on an ambitious Leadership Development Programme for at least 110 Band 6 and Band 7 clinical staff.
- *Staff Engagement*; We have had an active programme of roadshows across all our service areas, with CAG directors directly engaging with staff on a range of issues from lessons

learnt from incidents, to quality priorities, service strategy and development to patient experience. The CAG scored highly in the most recent Picker Institute report (2013) on staff engagement and staff reporting they were listened to and felt able to influence decisions.

- *Staff and Patient Safety;* In the past year we have held a series of workshops with ward managers, consultants, clinical staff and members of the SMT and CAG Executive, to explore creative MDT solutions to managing and reducing the level of violence and incidents on our wards. These have included examining the evidence base from research, good practice and preventative strategies.
- *Improving Clinical Practice;* As a result of the incidents in Norbury in October, a clinical practice and patient safety group was established in January 2013. The group is jointly led by [REDACTED]. The purpose of this group is to analyse patient groups and evaluate current workforce capability and interventions to improve clinical safety, quality and productivity. It will also support the integration of cultures that drive values, positive attitudes, work ethics and relationship between and within teams. The CAG is expecting to receive recommendations and implement the findings of the group in September 2013.
- *Clinical Pathways Re-Modelling;* We have two current work streams that are reviewing the configuration of our service lines and the organisation of our wards (with a view to redistributing new admissions across more than one ward and review the PICU and admission roles of Norbury).
- *Unit Coordination;* All Band 6 staff are being retrained and inducted to provide the role of unit coordinator. Other experienced Band 5 nurses will be trained and inducted to provide back up cover in future. The two tier unit coordination cover will be implemented from June when our cohort of experienced nurses have been trained and inducted to take on the role.

Some of the above pre-date the incident under investigation and others post-date it. With reference to the items which pre-date the incident, the Independent Team could find little evidence of effective implementation in the Norbury ward environment or the other domains that the Team examined.

18. Summary of Findings

This Independent investigation raises a number of factors highlighted in the Francis Inquiry (Final Report February 2013) with specific reference to:

- A lack of impact assessment.
- Staff disengagement from the process of management.
- Leadership.

In addition, seven out of the twelve factors cited in the Contributory Factor Taxonomy (National Patient Safety Agency, Root cause analysis – 2004) feature generally in this investigation, namely:

patient factors, individual factors, task factors, communication factors, team and social factors, working condition factors and organisational and management factors.

Recurrent factors, previously identified as areas of concern by internal investigations carried out by the Trust and cited in an Organisation with a Memory (Department of Health, June 2000), are also relevant to this investigation, namely:

- Institutional context.
- Organisational and management factors.
- Work environment.
- Team factors.
- Individual (staff) factors.
- Task factors.
- Patient characteristics.

Institutional context

RH is the successor service of several medium secure services, all of which had their own discrete organisational and service cultures. The historical culture associated with working in secure settings, where financial incentive has played its part in attracting some staff, has meant that the commitment required to deliver therapeutic and safe services has made it important to employ additional care in the selection of staff.

Arguably, attitudes towards mental illness can differ considerably. Whilst this may be addressed during pre and post registration training, one's own cultural background and belief systems can remain a strong influence over attitudes and behaviour, whereby people with mental illness may not be considered to be amenable to treatment.

Junior staff challenged by complex situations, such as the one's which present on Norbury Ward, require strong clinical leadership and supervision, so that they can do their best work.

Women from some cultures struggle to assert themselves with men of the same culture and some men have difficulty taking instruction from women. This is highlighted only because it plays some part in relational security, team functioning and shift management, as was evident from interviews conducted by members of the Independent team.

A series of incidents on Norbury over the last few years has had a marked effect on how Norbury Ward is perceived, which at times has led to a significant reliance on NHSP staff filling gaps in the rota.

The Independent team has been told that NHSP staff are sometimes advised not to work on Norbury because it is too dangerous.

The option of nursing staff working long days on Norbury Ward is incrementally being withdrawn.

The reliance on Bromley Metropolitan Police over time has grown, insofar as there has been an increase in the number of incidents which require police assistance in terms of incident management, criminal investigation and the management of RH as a place of safety.

It is clear from this investigation that strong clinical leadership, supported by management processes, in addition to engagement of medical and other professions in the process of management, which keeps risk and impact assessment at the forefront of decision making, has a direct impact on nursing staff, especially during week-end and on night duty.

The Independent team has given careful consideration as to why a group of staff chose to retreat into the nursing office on two occasions on the night of the 1st October 2012. This was not an isolated behaviour insofar as it had occurred prior to, and since, October 2012 in RH. The factors are complex. Notwithstanding those factors already attributed to patient mix and management culture, the Independent team suggest that this could be a phenomenon relating to the degree to which some staff feel isolated and unsupported.

RH operates almost entirely in isolation from the remainder of the BRH site and the wider Trust. When attempts to engage with the services at RH have been made this has generally been met with resistance, according to some of the staff who have been interviewed as part of this investigation. It is essential that RH operates as an integral part of the BRH site and the wider Trust.

Organisational and management factors

Since RH opened in 2008, there has been an increase in management costs, as new posts have been established. This directly affected the unit cost per bed which was offset by an increase in bed numbers on Norbury Ward and other wards, placing additional demands on clinical staff.

The Independent team has been informed that when [REDACTED] have raised concerns about the risks posed by admissions, transfers or patient mix, that it is not fully acknowledged in a consistent and effective manner. The Independent team received documentary evidence of this but did so too late and in an uncorroborated way to be able to utilise it in this report.

Arguably, income generation took a great priority at this point in time. However, this could have been an unintended outcome and an issue which the CAG management team did not fully risk assess when implementing changes in service.

A weekly Pathways meeting, previously known as the Lambeth Pathways Group when it was first established in February 2008, changed its remit to become the Trust MSU Pathways Group in April 2009. Protocols were set out in an interface arrangement document, and in 2011, Referrals, Assessments and Admissions protocols were developed. The Terms of reference for the Lambeth Pathways Group was not reviewed when the protocol was reviewed in 2009.

In 2011, when [REDACTED] came into post, he was asked to review the ToR for the Pathways meeting. He reviewed this by changing titles of post holders in the original document. Another change to the document was that attendance at the pathways meeting was made compulsory for some key persons.

The Independent team examined the minutes of the Pathways Meetings for the month of September 2012 to determine the degree to which clinical risks, associated with ward moves, were considered. This revealed that, although attendance is stated to be compulsory for some members, attendance was significantly below the required standard.

Although there are two designated chairs for this group (The Clinical Service Leader – Service Line one and the Co-Clinical Director – Forensic Services), the meeting on the 12/09/12 was chaired by the Norbury Team Leader, at which twenty four apologies were noted and only one Consultant Psychiatrist present.

The Independent team understands that a CAG Executive summit was held on this date, the focus for which was finance, risk reduction and safeguarding, among other governance issues, to which Consultant Psychiatrists and Team Leaders were invited.

The meeting on 26/09/12 was chaired by Clinical Service Leader for Service Line One. This was the meeting before Norbury patients moved to Spring Ward on 29/09/12. Apologies from the Norbury Ward RC were recorded and there is no record of the Norbury Team Leader or a representative from the Norbury nursing team being present. At this meeting, the transfer of patient A from Thames Ward to Norbury Ward, having perpetrated a serious assault on staff on Thames Ward, was recorded. This transfer occurred 5 days before Norbury patients moved to Spring Ward. Patient A was one of the perpetrators of incident 1 on the night of 1st October 2012.

There were two other admissions and transfers to Norbury during September 2012: one on 04/09/12 and one on 07/09/12.

The Independent team consider the way in which Pathways currently functions to be a systemic problem, as opposed to individual failure. The Pathways Group consider all ward admissions and transfers and in so doing and by implication, has a duty of care with regard to risk.

The Pathways Group requires robust leadership skills so that its governance role in the context of patient safety can be effectively carried out.

Individual patient risk assessments, specifically in the context of ward moves, were a stated requirement in the project plan and referred to in 'Decant meetings'.

There is no documentary evidence that the move from Norbury Ward to Spring Ward was fully risk assessed, with specific reference to the availability of SC rooms or the known behaviours of named patients and their associated risk behaviours (with the exception of patient F), even though this was clearly stated within the Project Plan, which specified that 'all patients require decant care plans to manage risk'. Furthermore [REDACTED] had communicated this to be a requirement at a weekly 'Decant' meeting, and [REDACTED], circulated a pro forma to [REDACTED] which stipulated what was required.

Norbury Ward which had access to two SC rooms moved to Spring Ward which provided only one SC room. There is no documentary evidence that any contingency planning occurred with regard to the availability of SC rooms, despite the fact that patient F was transferring to the only SC room on Spring Ward and that patient A had recently been nursed in SC on his transfer to Norbury Ward, shortly before Norbury patients moved to Spring Ward.

[REDACTED] had also recognised and communicated that during the period of ward moves that there may be a requirement for special measures, including the use of the independent sector. However, there is no evidence that this was actively pursued at any level.

Some of the staff who gave evidence cited case-mix and acuity to be factors which challenged the nursing team beyond that which they felt equipped to manage. There was no contingency plan or interim arrangements in place to manage case-mix, prior to or during the transitional period when Norbury Ward moved to Spring Ward.

██████████ described the period prior to the move as being busy, in that there had been a lot of admissions, including prison transfers to the ward. She was aware that there had been much earlier meetings about scheduling of ward moves but due to clinical demands on her time, she did not feel that she was very involved in the process.

There was no senior member of the Norbury clinical team on-duty over the week-end when Norbury patients moved to Spring Ward.

A member of the security team was on duty on 29/09/12 (the day that Norbury patients moved to Spring Ward). He recalls escorting patients to find two rooms on Spring Ward very dirty. In addition, the SC room had congealed urine under the mattress and required a deep clean.

Drawing all of the above together, a picture emerges of a medium secure service that is not on top of its physical, procedural and relational security requirements.

When interviewing some staff on the ward they described a general disaffection and suspicion of the management structure, believing they only visit the ward when something bad happens, or to tell them bad things.

The Senior Management Team whilst referring to the use of incident trend analysis, learning from incidents, patient and staff survey feedback as a means to improve the service delivery and quality, seem unable to translate this into action.

Work Environment

The work environment on Norbury Ward suffers from poor design and ongoing remedial works are required to rectify this; including the frequent damage to SC rooms.

The level of industrial injuries caused by a small number of serial assailants results in significant staff absence. The Independent team enquired about PSTS statistics for RH and Norbury Ward, to ascertain the number of staff who were signed off as being unable to carry out PSTS. However, the training-log data does not make distinction between those staff who have 'not applicable' (N/A) marked against their name because it is not relevant to their job, and those staff who have N/A against their name due to industrial injury.

The ward design does not adequately make provision for its PICU function on Norbury Ward, in that once through the main entrance airlock, staff and visitors are directly into the main ward.

When the deescalation facilities were decommissioned, in order to increase bed numbers from 13 to 15, this removed an important clinical management option, without due consideration of an alternative. If Norbury Ward is to continue to function as a PICU then ICA facilities should be reprovided.

There is no means of safe egress from the nursing station when there is concerted indiscipline on the ward.

Staff rest room facilities are poor and the acoustic is such that the degree to which everything echoes adversely affects the therapeutic environment.

The moon shape structure in front of the nursing station serves no purpose and should be removed.

Team Factors

The multidisciplinary team on Norbury Ward has been adversely affected by the RC not having sufficient medical colleagues to meet the demands and complex challenges.

Decisions regarding admission and transfers at the time were not being consistently risk assessed, leaving nurses in particular to face the consequences. Departures of some members of the multidisciplinary team placed additional burden on the team and on the ability of nurses to cope, especially at weekends and during the night.

There is a culture of fear amongst some members of the Norbury nursing team which prevents them from partaking in specific security measures, such as room searches, for fear that this will lead to attack from the patients or accusations of overly-assertive practice with resultant disciplinary proceedings.

Patient acuity and case-mix are cited by staff as factors which challenge them and at times, undermine their confidence and competence. The attributed anxiety gives rise to defence mechanisms coming into play, whereby some staff distance themselves from patients to varying degrees.

The ward at the time was lacking in dynamism and was unable to provide a therapeutic environment that balanced physical, procedural and relational security hand-in-hand.

The decision to temporarily base one of the Modern Matrons with a forensic nursing background has seen a return on the investment, with notable improvements from her clinical leadership.

Individual (staff) factors

When English is not one's first language, difficulties in comprehension and interpretation can affect team communication and the therapeutic relationship with patients, as can be the case with differences in dialect. There are known concerns that if some staff are on duty that their personal impact can have a negative effect.

Patient Characteristics

The dynamic between Patient D's fixed paranoid delusional content and patient B's propensity to use this as an opportunity to challenge staff and to create disturbance, was well known. Patient B is known to be a dealer of cannabis, but this was not seen to be a significant risk factor in the context of Norbury patients moving to Spring Ward.

Although [REDACTED] had devised a behavioural response (clinical management plan) with regard to patient D's fixed delusional presentation, some of the nursing staff did not see it as being robust enough or clinically effective.

Patient consent to medication was not consistently adhered to. This, in addition to long periods of continuous SC, without being seen by a consultant psychiatrist, can adversely affect the therapeutic relationship and serve as antecedents to challenging behaviour.

19. Conclusions

There was a constellation of factors which, to a greater or lesser extent, played their part in some of the patients gaining control of the ward on two separate but linked occasions on the night of 1st October 2012, namely:

- Patient mix.
- Patient acuity.
- Disengaged staff from the process of management
- Sub-optimal senior clinical involvement in the planning process with reference to Norbury patients moving to Spring Ward, despite there being provision for this.
- Insufficient management oversight.
- Imperceptible clinical leadership.

Linked together, these factors represent systemic failure, which on the night of 1st October 2012, resulted in the destabilisation of the care environment which could have had catastrophic consequences.

Systems and safety culture are the root cause of the majority of incidents and no less so in relation to what took place on the night in question.

There was a departure from risk management protocols in fully assessing the risks of Norbury patients moving to Spring Ward and this too had a direct bearing on the night of the 1st October 2012.

Once the incidents took hold, there was impulsive and deliberate intention to harm on the part of the perpetrators, three of whom (Patients B, C and D), were very unwell. There is no evidence that either incident was premeditated.

The Independent team considered whether substance misuse, at least in the form of cannabis, may have played its part with some of the perpetrators. However, [REDACTED] is of the view that the patients did not require cannabis to be disinhibited. Patient B at the time, according to [REDACTED], had been very unwell, but was improving mentally. His significant mood disorder would account for his disinhibition. Moreover, when urine samples from the perpetrators were tested for cannabis they proved to be negative. Nevertheless, Patient B is known to be a dealer. His nursing management

plan written by patient B's Primary Nurse to manage his physical aggression and his drug taking/dealing activities dated 11/08/12, does not contain any specific therapeutic intervention, distraction techniques or focused work around drug issues. It does, however, insist that he must not have any access to private calls, other than his solicitor and benefit agency.

The RH management and service culture appears to place less than optimal emphasis on standards of professional practice, practice development, clinical leadership, risk management and impact assessment, which creates anxiety and stress amongst some staff. Some of the nursing staff have adopted 'distancing' as a means of coping.

The appointment of a new BDP CAG Service Director creates a fresh opportunity for transformational leadership of forensic services. The Independent team suggest there are three priorities:

- I. A review of management costs and arrangements, including medical and other professional engagement in the management process, and investment in supporting and developing clinical practice.
- II. A forensic service review which examines patient flow through RH, including: case-mix, triage, assessment and the management of patients who require forensic intensive care.
- III. Development of an agreed protocol which specifies the core competencies and behaviours necessary for effective clinical leadership and multidisciplinary working at ward level, for which the RC and Team Leader have accountability to deliver.

Arguably, if clinical leadership and managerial oversight at every level had been stronger in the preceding months, this would have reduced the likelihood of occurrence of the incidents which have been subjected to examination by the Independent Team.

The GMC published guidance for all doctors in January 2012 in leadership and management. In that guidance it is written (and the Independent Team cannot improve on this) that being a good doctor means more than simply being a good clinician. In their day-to-day role doctors can provide leadership to their colleagues and vision for the organisations in which they work and for the profession as a whole. However, unless doctors are willing to contribute to improving the quality of services and to speak up when things are wrong, patient care is likely to suffer.

The Medical Leadership Competency Framework sets out a description of the competences in shared leadership for all doctors – www.institute.nhs.uk/medicalleadership.

A new report (April 2013) from the Health Services Management Centre at the University of Birmingham and the King's Fund ("Are we there yet? Models of Medical leadership and their effectiveness: an Exploratory Study") provides a comprehensive and up-to-date picture of the state of medical leadership in NHS trusts today. It states that the NHS must fill the vacuum in medical leadership in the health service by creating more desirable and attractive leadership roles for doctors. They found that several factors put off doctors taking on leadership positions, including a preference for clinical work, a lack of adequate training and support, an absence of defined career paths, and a culture in the NHS that failed to value and regard doctors who took on leadership roles.

The NHS Leadership Academy provides a Leadership Framework for all staff in health and care irrespective of discipline, role, function, or seniority and represents the standard for leadership behaviours that all staff should aspire to.

It is evident that the BDP CAG commits itself to thoughtful initiatives, as can be evidenced in the examples provided by the BDP CAG in section 17 of this Independent report. Furthermore, comprehensive action plans are generated as and when required.

Successful implementation of action plans aimed at securing maximum impact with regard to relational security, pathways, risk reduction, improving patients and staff safety, the physical environment and service delivery in its broadest sense, is crucially dependent on transformational leadership which engages all staff in the process of leadership and management, and in particular a collective medical responsibility for the forensic service as a whole.

20. Recommendations

20.1 The appointment of a new BDP CAG Service Director creates a fresh opportunity for transformational leadership in forensic services. The Independent team suggests there are three priorities:

20.1.1 A review of management costs, culture, and arrangements and of the medical and other professional input into the management and leadership processes. Consideration should be given to the potential for an increased amount of clinical input. To be completed by September 2013.

20.1.2 A forensic service review which examines patient flow through RH, including: case-mix, triage, assessment, recovery, and the management of patients who require forensic intensive care. This should be underpinned by clear and consistent clinical leadership in the decision-making process. To be completed by October 2013.

20.1.3 Development of an agreed protocol which specifies the core competencies and behaviours necessary for effective clinical leadership and multidisciplinary working at ward level for which RCs and Team Leaders have clear leadership accountabilities. To be completed by October 2013 (The NHS Leadership Academy provides a Clinical Leadership Competency Framework).

20.2 Comprehensive relational security competency testing for all current and new employees (including NHSP staff). All employees to be tested by March 2014.

20.3 Redesign Norbury Ward to create safe egress from the nursing station, removal of the moon-shaped structure, provision of a managed and restricted environment between the main airlock and the ward, provision of improved staff rest room facilities which incorporate a staff toilet, and the installation of acoustic noise-reducing panels. Plans to be agreed by October 2013.

20.4 If Norbury Ward is to continue to function as a PICU then the ICA should be reprovided.

- 20.5** Designation of a critical incident room. Immediate action.
- 20.6** Restrict access to pornographic TV channels. Immediate action.
- 20.7** Careful consideration should be given to the installation of patients' ward telephones which have been manufactured or modified in such a way as to prevent emergency (999) calls being made.
- 20.8** The alarm buttons on the walls were compromised by the insertion of a matchstick leading to a continuous alarm sounding. If the alarm can be overridden (stopped) by staff, then a clear instruction package needs to be disseminated amongst staff to ensure that ward-based staff can cancel these alarms. If this is not possible then consideration should be given to the installation of new and tamper-proof alarm buttons.
- 20.9** Operation Metallah should be audited at quarterly intervals (from the date of implementation) with particular reference to communication flows and sharing of key clinical information so that risk assessment can be carried out promptly by the police.
- 20.10** The RC and Team Leader should be informed of riot or hostage taking situations which require police assistance, the on-site presence of an on-call manager and when the Bronze, Silver and Gold command structure is invoked, regardless of whether they are on-call or not. To be done with immediate effect.
- 20.11** The Ascom Protocol/Guidance dated 31/03/13, due for consideration by the BDP CAG Policy Committee, has the full support of the Independent team. Once approved, compliance should be reviewed within three months and subjected to further review at six monthly intervals.
- 20.12** Current access to substance misuse services at RH, regardless of which ward patients may be on, should be reviewed to ensure ease of access, when this is considered to be clinically appropriate by the RC. To be completed by October 2013.
- 20.13** Clinical teams at RH should have ease of access to a dual diagnosis practitioner, to ensure that they receive timely specialist advice, when patients with mental illness have present with substance misuse. To be completed by December 2013.
- 20.14** The Mental Health Act Office to develop a robust mechanism to ensure that RCs always and without fail maintain adequate Consent to Treatment practice. For immediate action and completion by October 2013.
- 20.15** There is a need to improve contemporaneous clinical record keeping by senior medical staff in particular. Consideration could be given to the design and implementation of an electronic system to monitor the frequency of multidisciplinary patient contact.
- 20.16** The practice of supervised confinement reviews by senior doctors requires attention. An audit designed to monitor compliance with the Supervised Confinement Policy should be commenced without delay and the results (and an appropriate action plan) shared with the Care Quality Commission.
- 20.17** The process for inpatient transfers to forensic services should be reviewed. A clearly agreed protocol for this purpose needs to be agreed and regularly monitored to assure:

20.17.1 Assessment of internally-referred patients by the intended receiving team takes place as a standard operating procedure

20.17.2 HCR20 risk assessments are conducted by the referring team as a standard operating procedure

20.17.3 A transfer form is completed as a standard operating procedure.

The current Forensic Inpatient Emergency Transfer protocol recommends the inclusion of a current and complete HCR20 at the time of patients transferring between wards. The Independent team found that transfers went ahead more often than not without transfer forms (i.e. clinical summaries) in place. It found also that HCR20s are not updated for this purpose and did not accompany transferring patients. For immediate action and completion by July 2013.

20.18 Although the Independent Team has been advised of the 'priority status' enjoyed by Norbury Ward in terms of SpR allocation, the RC for the ward gave a different account. If gaps in the allocation of an SpR (or SpRs) occur, when all reasonable steps have been taken to provide an SpR, an immediate impact assessment should be undertaken and documented by the Co-Clinical Director (Forensic Service), in conjunction with the Norbury Ward RC on each occasion. In addition suitable alternative medical cover arrangements should be put in place, and or reasonable adjustments to the clinical workload, to ameliorate the risks. For immediate action.

Appendix 1 - Independent Investigation - Terms of reference

An independent investigation has been commissioned because of the nature of the disturbances and their potential to result in more serious harm and disruption.

Chronology

The investigation team will begin their work by completing a chronology of the events to assist in the identification of strengths and good practice and care and service delivery problems.

Part one: Patient care and treatment

The investigation team will summarise and comment on the mental health history, care and treatment of the patients directly involved in the disturbance. This will be in the context of statutory obligations, relevant national guidance and local operational policies and make particular reference to:

- care planning;
- engagement and observation;
- assessment and management of risk; and
- Medication management.

Part two: Security management

The investigation team will:

- Summarise and comment on the systems in place to manage the procedural and relational security of River House. This will include internal communication and alarm systems and the security management of River House within the wider Bethlem Royal Hospital estate.
- Summarise and comment on the systems in place to manage the procedural and relational security of Norbury Ward. This will include reference to internal communication and alarm systems and the security management of Norbury Ward within the wider River House estate. Particular reference will be made to security management in the context of the:
 - Norbury Ward patient profile, patient flow and environmental indicators; and
 - Planning and contingency plans made in preparation for the recent temporary relocation of Norbury Ward.
- Review the extent to which the response and management of the disturbances adhered to the management systems outlined above. Particular reference will be made to the:
 - alerts and communication within River House; and

- Alerts and communication to CAG management and senior Trust management with particular attention to escalation through the on-call system.

Part three: Liaison with the emergency services

The investigation team will:

- Summarise and comment on the interface between SLaM staff and the police in particular:
 - the initial alerts by SLaM staff made to the police;
 - briefing by SLaM to the police upon their arrival;
 - communication pathways between command and control staff, the police and the SLaM staff involved in the incident; and
 - the timings of the interventions that followed.
- Summarise and comment on the interface between SLaM staff and the London Ambulance Service.
- Summarise and comment on the interface between SLaM staff and the London Fire Service.

Part four: Post incident actions

- Summarise and comment on the management of the patients immediately after the disturbances were contained.
- Summarise and comment on the support offered and provided to those staff and patients who were involved in the disturbances.
- Summarise and comment on any issues relating to crime scene preservation.

The investigation team will also consider the content and findings of any parallel reviews which have been commissioned.

The investigation team will complete and submit a written report. The report will fully assist further scrutiny of the events preceding and immediately following the disturbances.

The report will also:

- Identify strengths and good practice.
- Identify any care, security and service delivery problems and locate the underlying causes of these.
- Make SMART recommendations which can be used by the Behavioural and Developmental Psychiatry CAG to improve and develop services and reduce the risk of recurrence of similar incidents. Where appropriate the investigation team will also identify those recommendations which should be shared with other trust services to assist in service development.

Appendix 2 Trust-wide, Behavioural and developmental Clinical Academic Group and Forensic Medium Secure Services Policies and Procedures

Trust-wide

1. Incident Policy (September 2011)
2. Investigation of Incidents, Claims & Complaints (September 2011)
3. Promoting Safe & Therapeutic Services – Preventing and Managing Violence and Aggression (September 2011)
4. Safeguarding Adults (September 2008)
5. Secure environments Policy (September 2011)
6. Draft CPA Policy 2012 under review
7. Engagement & Observation policy (September 2011)
8. Clinical Risk Assessment & Management of Harm (October 2011)
9. Learning & Embedding Lessons arising from Incidents, Claims & Complaints (September 2011)
10. Supporting staff involved in Incidents, Complaints & Claims (September 2011)
11. Risk Management Assurance Framework (August 2011)
12. Safety Induction for Contractors working on Trust Premises (May 2012)
13. Staff Supervision Policy (October 2011)

Forensic Medium Secure Services

1. River House Operational Policy (undated)
2. Norbury Ward Operational Policy (undated, but review dated stated as December 2012)
3. Alarm Testing procedure (April 2012)
4. Anti-Barricade Doors (January 2012)
5. ASCOM Induction Package (undated)
6. Daily Perimeter Checks Protocol (June 2012)
7. Emergency Response (October 2011)
8. Environmental Checks Procedure (August 2012)
9. Lock Down Procedure (May 2012)
10. Major Incident Protocol and Appendix (February 2012)
11. Physical Security Document - River House (October 2011)
12. Role of the Ward Based Security Nurse (October 2011)
13. Zoning Guidelines (June 2012)
14. Draft Metropolitan Police Joint Protocol (final version not supplied)
15. Police Liaison Protocol BRH (September 2000)
16. Forensic Emergency Assessment Form (July 2011)- Late evidence
17. Norbury Brief operational outline & internal transfer protocol (Undated) – Late evidence

Appendix 3 – List of evidence considered

- 35 Transcripts of individual interviews
- Transcript of re-enactment event held on 22/02/13
- Transcript of meeting to discuss ASCOM (mission critical communication system) held on 05/03/13
- Nursing Engagement Survey results - Norbury Ward, 2011 & 2012
- Forensic inpatient satisfaction survey results – CAG PEDIC report financial year to January 2013 & February 2013 for Norbury Ward
- Complaints information – Norbury Ward
- Daily perimeter checks
- Various Risk and Datix logs
- BDP Medium Secure Services – action plans for risk reduction & improving patient safety (April 2013, version 7)
- Report from Consultant Psychotherapist - Reflective Practice & Team Development , Norbury Ward, November 2012
- Briefing notes for Operation Metallah (April 2013)
- Various email correspondence relating to further and better particulars
- Background documents relating to Pathways Meetings
- Pathway minutes for month of September 2012
- Trust-wide Review of Supervised Confinement Suites (November 2012)
- Review of Seclusion Rooms, River House (January 2011)
- CQC action plans relating to visits on 07/02/13 & 14/02/13
- ASCOM review – briefing note and action plan (March 2013)
- River House Defects Project Group –Terms of Reference (July 2011)
- Minutes relating to defects project group and decant meetings
- Frequency of staff supervision 2011/12 (Norbury Ward)

- NHSP staff induction
- Job Plan & leave record Norbury Ward RC
- 17 Statements
- Various Trust-wide policies and procedures
- Various CAG/RH policies and procedures
- Incident form number WEB5346 Fact finding report (two versions, both dated 03/10/12)
- Incident logs from emergency services
- Various on-call logs
- Medical records for 10 Norbury patients (ePJS)
- ASCOM diagnostic report
- Project management plan September 2012
- Datix Log River House incidents
- Various security protocols
- Staff training records of staff on duty on Spring Ward night of 01/10/12
- Exercise Hard Times June 2012
- SEE THINK ACT (DH January 2010)
- Various email correspondence (late evidence)
- Consultant on-call rotas for September and October 2012
- Protocol for transferring patients into Norbury Ward (Undated) –Late evidence
- Forensic Emergency Assessment Form (July 2011) – Late evidence

Appendix 4 – Acronyms, abbreviations and terms

ASCOM - Tailor made integrated mission critical wireless communication system

BDI - Beck Depression Inventory

BDP - Behavioural & Developmental Psychiatry

BRH - Bethlem Royal Hospital

CAD - Computer aided dispatch – designated incident number, allocated by emergency services

CAG - Clinical Academic Group

CCC - Central control room (Metropolitan Police)

CT - Post registration core trainee doctor

Datix - Incident & adverse events software reporting system

DHU - Denis Hill Unit

ECT - Electric convulsive therapy

ePJS - Electronic Patient Journey System

ETL - Emergency Team Leader

GMC – General Medical Council

Grab Packs – Packs held on each ward containing vital information in the event of incidents

HCA - Healthcare Assistant

HCR 20 – An assessment tool used by mental health professionals to estimate probability of violence

ICA - Intensive Care Area

NIC - Nurse in charge

NHSP - National Health Service Professionals

NMC - Nursing Midwifery Council

Operation Metallah - Joint Trust/Bromley Metropolitan Police protocol for responding to requests for police assistance at BRH, April 2013

Pathways - Weekly meeting to discuss admissions, internal transfers and waiting lists

PEDIC - Patient experience data information

PRN - *Pro re nata* – medication given as circumstances arise, when needed

PSTS - Promoting safe & therapeutic services

RC - Responsible Clinician

RPTD - Reflective practice & team development

RH - River House

RRT - Rapid response team

SC - Supervised confinement (seclusion)

SHO - Senior House Officer

SMART - Recommendations which are specific, measurable, achievable, realistic and time bound

SpR - Specialist registrar

ST - Post registration specialist trainee doctor

SVR 20 - A 20-item check list of risk factors for estimating probability of sexual violence

T2 - Mental Health Act consent to Treatment form – various numbers

Trojan - Metropolitan Police Firearms Unit

TSG - Tactical Support Group (Metropolitan Police)

UC - Unit Coordinator