SOUTH EAST THAMES REGIONAL HEALTH AUTHORITY

REPORT OF

COMMITTEE OF ENQUIRY

ST. AUGUSTINE'S HOSPITAL, CHARTHAM, CANTERBURY

MARCH, 1976

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Mr. J. Hampden Inskip Q.C.	Recorder of the Crown Courts, Chairman
Dr. Alex A. Baker C.B.E., M.D., M.R.C.P., F.R.C.Psych.	Consultant Psychiatrist, Coney Hill Hospital, Gloucester.
Mr. D.J. Downham	Assistant Director, King Edward's Hospital Fund for London.
Mr. John Greene O.B.E., S.R.N.,R.M.N.	Area Nursing Officer, Gloucester Area Health Authority.
Mrs. Betty K. Lowton J.P.	Member of Barking and Havering Area Health Authority.

Appointed by the South East Thames Regional Health Authority with the following Terms of Reference:

To enquire into the allegations concerning the care and treatment of patients at St. Augustine's Hospital, Chartham Down, Kent, contained in two documents entitled 'A Critique Regarding Policy' and 'A Critique Regarding Policy - Part II - The Evidence' by Dr. William Brian Ankers, Ph.D., and Mr. 011este Etsello, R.M.N., dated April 1974 and February 1975 respectively and to make recommendations

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LEGAL REPRESENTATION

MR. PETER SCOTT, instructed by Messrs. Bird & Bird, appeared as Counsel for the Committee.

MR. ANTHONY HIDDEN, instructed by Messrs. Furley Page Fielding & Pembrook, appeared as Counsel for the South East Thames Regional Authority, Kent Area Health Authority and Canterbury and Thanet Health Health District.

MR. ANDREW BROOKS, instructed by Messrs. Hempsons, appeared as Counsel for Members of the Medical Defence Union and Members of the Medical Protection Society.

MRS. M.E. NEWSTEAD (Consultant to the Labour Relations Department, Royal College of Nursing) appeared for the Members of the Royal College of Nursing.

MR. ANDREW HILLIER, instructed by Messrs. Gillhams, appeared as Counsel for the Members of the Confederation of Health Service Employees.

MR. PETER COOPER, instructed by Messrs. Robin Thompson & Partners, appeared as Counsel for the Members of the National Union of Public Employees.

MR. CHARLES GIBSON, instructed by Messrs. Bracher, Son & Miskin, appeared as Counsel for Other Members of Hospital Staff.

MISS A. WORRALL, instructed by Lawrence Grant, Esq., Law Clinic, University of Kent, appeared as Counsel for Dr. William Brian Ankers (8.9.75. - 26.9.75.)
MR. ADRIAN TAYLOR, of the Law Clinic, University of Kent, appeared for Dr. William Brian Ankers (17.11.75. - 28.11.75.)

Secretary to the Committee - Mr. G.A. Ferguson
Solicitors to the Commjttee - Messrs. Bird & Bird

"I would know my shadow and my light,
so shall I at last be whole. Then
courage brother, dare the grave passage."

From "A Child of Our Time" by Sir Michael Tippett

FOREWORD

This Report contains matters which, in our views should be known not only to all levels of the Health Service, but also to the public for whom the service is run.

We were told on several occasions, both in formal evidence, and in informal conversation, that the conditions and care at St. Augustine's at the time of the Critique were no worse than at many other mental hospitals. Those members of our Committee with experience of such hospitals in many parts of the country on the whole agree. In some respects, indeed, particularly in many of the acute admission wards, St. Augustine's is well above average.

If conditions in some of the long stay wards during 1974 and early 1975 approximated to those now existing in many other mental hospitals, it is right that every interested person should understand precisely what this means in human terms. We cannot see that it is healthy or useful to keep such information private.

If there had been true multidisciplinary team work between the professions at St. Augustine's, conditions in the long stay wards would have been much better, and this long, disrupting and expensive enquiry would have been unnecessary. Exhortation to a multidisciplinary approach is no good without ensuring that the medical profession fully participates, and this will not be achieved without giving clear guidance as to how this should be done, even if this does mean grasping some nettles.

Although we have used letters of the alphabet rather than people's names, many will be readily identifiable, particularly within the hospital. What we say will cause distress to some, but we are sure that it will be transient for it will be clear from the contents of this Report that although there were many unsatisfactory practices and unnecessary mistakes all members of the staff thought that they were doing their best, and many were. But they were working in difficult conditions with inadequate guidance. Similar mistakes will only be avoided elsewhere if people can read and understand and share in the ups and the downs and the frustrations and the low standards of these wards. Although much remains to be done to improve conditions and care in the long stay wards, we are confident that the staff have the skills and ability to solve these problems and that any patient can now enter St. Augustine's with confidence that he or she will be satisfactorily cared for and treated.

We hope that the Press will approach anything they say about or extract from this Report with caution and responsibility. It will be easy to seize upon extracts which without the context of the whole Report will present a cruelly distorted picture. We particularly commend to all those exercising this responsibility the last sentence in the preceding paragraph and paragraphs 1.9-10, 1.35-36, 2.144, 2.198 and 5.5.

Although we have endeavoured to produce a readable Report in which each Section grows out of those which precede it, we recognise that it is long and that there will be some readers who will not wish, or have the time, to get too deeply enmeshed in the affairs of St. Augustine's. We commend to them

Sections 1, 5 and 6 in their entirety

Section 2, paragraphs 154-156 and 238-239

Section 3, paragraphs 31-40, 41-55, 103 and 106-107

Section 4, paragraphs 15-17, 47-48, 51 and 112

With real pleasure we record our debt to our Secretary and our Solicitors and their respective staffs, and to our Counsel, for the friendly efficiency which characterised their work from beginning to end, and we recall with gratitude and admiration the warm and interested welcome we received from staff wherever we went in the hospital, even from those who knew that they would be criticised in this Report.

SECTION 1: GENERAL INTRODUCTION

The Buildings

1.1 The greater part of St. Augustine's Hospital was built 100 years ago as a mental hospital for South East Kent. It stands on a high and isolated ridge known as Chartham Down a few miles south of Canterbury. Various additions have been made since that time. It is constructed in red brick, and consists of a central administrative block around which are all the services required by the Hospital. On the outer perimeter lie 15 two storey buildings each of which contains two wards. The buildings are linked by long corridors. It was originally constructed for about 800 patients. Its peak number of 1,678 was reached in December, 1956. In November, 1975 it housed 929 patients.

The Authors of the Critique

1.2 Doctor William Brian Ankers, B.Sc(Hons), A.R.C.S., Ph.D. was born in 1946. He is not a Doctor of medicine. After taking his Bachelor of Science degree at the University of London he went to the University of Kent in 1968 to do research work and write a thesis on organic chemistry in the hope that he would be accepted as a Doctor of Philosophy. He fulfilled this ambition in September, 1973, but earlier, on 16th July, 1972, he had commenced work at St. Augustine's as a temporary Nursing Assistant in order to support himself while writing his thesis. He spent four weeks in Ash, a male epileptic ward with about 57 patients. Between August 15th, 1972, and July 7th, 1974, he worked in Heather, a Male long stay ward with 54, falling to 48 patients. Thereafter he served in Hawthorn, a male geriatric ward with 48 patients, until his resignation on December 7th, 1974.

1.3 Most people who worked with Dr. Ankers rightly regarded him as a hard-working Nursing Assistant, but he had a tendency to involve himself closely, sometimes too closely, with the patients. As a result of this involvement, he continued to work in the hospital after obtaining his Doctorate. He resigned at the end of 1974 through frustration and growing anger about the treatment of the Critique. Since that time he has devoted himself to the preparation of a further part to the Critique and to its annotation for the Enquiry.

1.4 We found him a reliable witness when he was describing what he had seen or heard. Sometimes, however, he deliberately presented a one-sided, distorting version of events.

1.5 Mr. Olleste Weston, R.M.N. was born in 1945. He left school aged 15 years and for the next four years worked in a factory, timber yards, bakeries, shops and labouring jobs. He then commenced training at a hospital for the mentally subnormal, but did not complete the course because "I was rather an idealist … I was not satisfied with the hospital and what was happening there. At the same time I had the opportunity to go and work in a sort of refugee camp in France. I felt that was the thing." After about four months in France he returned to work in various office jobs in this country, and in September, 1970, he commenced work as a Nursing Assistant at St. Augustine's in Maple, an acute male admission ward with 44 patients. After four weeks he became a student nurse, and during the next three years he worked on most of the male wards under the direction of the Principal Tutor at the Lawson School of Nursing. He qualified as a Registered Mental Nurse in November, 1973,

and thereafter worked on Heather Ward first doing relief work, and then as a Staff Nurse, until his resignation on April 3rd, 1974. About the time he came to St. Augustine's he took the name of Etsello in place of Weston: he has since reverted, to his original name.

1.6 He explained his return to nursing thus:- "At the time I intended to work overseas with the voluntary aid programme. I had applied many years ago and had not been accepted because I would have been no use to anybody with no full training. The only way I could do this work, without having to go back to school was to do a training course, such as nursing, which could give me a qualification which I could use to follow my at-that-time ambition."

1.7 Until the appearance of the Critique in April, 1974, he seems to have been regarded as a satisfactory nurse. One Charge Nurse told us that at the end of 1970 he was able "after a while" to get on very well with him. "He had some good ideas but he never carried them out. He proposed to me once about a therapy for a group of patients that could not go down to the industrial unit, and he suggested painting. I went to the trouble of getting paint and everything else, but he did it for two days and then he did not go on any further." Another Charge Nurse speaking of Mr. Weston on another ward in mid-1971 said that he had "some progressive ideas, but he did not appear to join in and become part of a ward team … I remember Mr. Etsello enjoyed talking with patients, but on occasions he would sit and talk with them and would fail to attend to their bodily needs." He appears to have been articulate in the company of his contemporaries, but to have lacked confidence in the presence of Consultants and the Senior Nursing staff. In our view he was more concerned with ideas than with the patients, and we did not think that he was a good psychiatric nurse. We are satisfied that on one occasion in Heather Ward he slapped a patient's face because "he gets on my bloody nerves".

1.8 Mr. Weston stated that he stayed on at St. Augustine's after qualifying because he had got involved in the life of Heather Ward, but mounting frustration led to his resignation in April, 1974. He has since nursed in this country and in Canada. He was not an entirely satisfactory witness and we have not acted on his evidence unless there is corroboration for it from other sources.

<u>The Background to the Critique</u>

1.9 The hospital into which the authors came had changed greatly since the early 1950's. Not only had many wards been modernised and furnished in contemporary style with attractive colours, but, also, in many wards care and treatment had moved with the times and were such that any patient could enter them with confidence. Credit is due to all those who helped to bring these improvements about.

1.10 Most progress, however, had taken place on the short stay wards at the expense of the long stay wards because it was on the short stay wards that the hard pressed Consultants and doctors had concentrated their efforts. It must be emphasised, however, that a significant number of long stay patients had been discharged into the community and that this represented a considerable effort by many staff without which conditions on the long stay wards would undoubtedly have been much worse than they were.

1.11 The Hospital Group Management Committee was served by a hard working team of executive officers in whom it had great confidence. Dr. A came to St. Augustine's as a Senior Registrar in 1948. From 10th August, 1955 until June, 1972, he was Medical Superintendent. Thereafter until August, 1975, he was Chairman of the Medical Executive Committee. Mr.B had been employed in health services since 1929. He first worked for the St. Augustine's Hospital Group in July, 1956, and from April, 1963, until his retirement on March 31st, 1974, he was its Secretary and Finance Officer. Until 1971 he held the appointment of Supplies Officer, and continued to use the title until he retired. Mr. C joined the staff of St. Augustine's in 1946 and spent the remainder of his working life there, apart from two years between 1950 and 1952 when he was seconded to the Kent and Canterbury Hospital in Canterbury. In 1959 he became Senior Assistant Chief Male Nurse, and in 1965 he was appointed deputy to the Matron on the female side. In 1968 he became deputy and in 1970 Acting Principal Nursing Officer pre Salmon. In December, 1971, he was appointed Chief Nursing Officer, In April, 1974, until his retirement on 31st July, 1975, he also took over the nursing administration in four other hospitals in the Psychiatric Nursing Division in the newly formed Health District 2 of the Canterbury and Thanet Health District,

1.12 This Triumvirate exercised great power within the hospital. Mr. C, however, inevitably saw himself in, and played, a subservient role to Dr. A and Mr. B. It was unfair to have called upon him to lead the nurses into their new post Salmon career structure. Likewise, Dr. A recognised that it was a mistake for him to have become Chairman of the Medical Executive Committee. Long established relationships are very difficult to change.

1.13 Many of the nursing and other staff in the hospital have long associations with it. For example one of Mr. C's sons and his wife work there. We came across a Senior Enrolled Nurse whose daughter and son-in-law also worked in the hospital. Three generations are all working in the laundry, and there are several husbands and wives working in the hospital. Promotion within the nursing structure has come almost exclusively from within the hospital and we noted that there are 56 members of the staff over 60 years of age, made up as follows:

age	60 - 64	31
	65 - 69	20
	70 plus	5

1.14 All these factors, added to the isolation of the site, have produced a relatively inward looking hospital community with a warm camaraderie and deeply felt loyalties. One Charge Nurse who had been a miner likened St. Augustine's to "the close knit mining community where relationships are very strong".

1.15 In November, 1971, the report of the Hospital Advisory Service was received at St. Augustine's. As will appear later in our Report it did not receive the examination it deserved, and many of its recommendations had not been adequately put into effect by April, 1974.

1.16 In August, 1972, amid much moving of patients from ward to ward, the hospital was divided into three clinical areas, each of which served a different part of the catchment area (see the map Appendix 1). Each area formed a psychiatric division. Heads of Department meetings commenced in 1972, as recommended by the Hospital Advisory Service, but examination of the minutes reveals that they did not deal with policy matters, and much of the administrative work continued to be done in unminuted, informal meetings between the Group Secretary, the Chairman of the Medical Executive Committee and the Chief Nursing Officer.

1.17 During the period December 31st, 1970, to December 31st, 1974, the number of patients fell from 1,293 to 938. The largest reduction was 101 in the last of those years. In 1972 there were 433 nursing staff in post (60% of the Review Establishment). In 1974 the figure had risen to 456 (64.5% of a reduced Review Establishment).

1.18 In 1971 there was the equivalent of 16.75 full time medical staff in post (90.5% of the establishment) and in 1972, 16 (82.05% of an increased establishment). By 1974 there was the equivalent of 19 full time medical staff in post (95% of a further increased establishment). There were included in these figures for each of the four years 1971- 74, the equivalents of 4.7, 5.7, 6.7 and 7.7 full time Consultants in post. This accorded with the establishment in each year apart from 1972 when there was one Consultant short.

The Writing and Circulation of the Critique

1.19 In April, 1974, Dr. Ankers and Mr. Weston sent copies of a pamphlet they had written and called "A Critique Regarding Policy" to the Secretary of State for Social Services, the Department of Health and Social Security, the Regional Health Authority, the Kent Area Health Authority, the Canterbury and Thanet Health District and the Hospital Advisory Service. They also distributed it widely within the Hospital. They did not send it to the Press.

1.20 The Critique is set out in Appendix 2. It is a well written, moderately expressed, but forceful criticism of the position of the long stay patients. We express our general conclusions on it at this stage. The authors were right when they said that the situation regarding policy was untenable, and one which should not be allowed to persist. They were right in their contention "that the management in this hospital exercise a policy by default with regard to the treatment of long stay patients in this hospital. They in fact acquiesce to a policy of laissez faire, which results in either the complete absence of policy in the lone-stay wards, or alternatively the formulation of policy by nursing staff without encouragement or guidance". The extent to which their conclusions were justified is best demonstrated in broad terms by reference to their following summary of their conclusions:

"1. There is lack of policy for treatment of long stay patients.

2. The majority of patients do not receive the benefits of individual treatment programmes.

3. There is an unacceptable standard of care for a great many patients.

4. On long-stay wards the care is primarily of a custodial nature.

5. Far too heavy a reliance is placed on chemotherapy, and medication is often not regularly reviewed.

6. It is our experience that often no guidelines are offered on the ward to nurses regarding a concerted psychotherapeutic approach to their work.

7. Nurses are not required to implement therapeutic activities on wards. If they take the initiative and do so, then it is up to them. But there is no obligation that they do so.

8. The therapeutic community does not exist for the majority of patients.

9. Totally unsuitable staff are permitted to occupy positions of responsibility on wards.

10. Mistreatment and malpractice occur in the hospital."

1.21 Conclusions 1, 2, 3, 4, 6, 7, 8 and 10 were, in our view, well founded. We are satisfied that medication was often not regularly reviewed, as alleged in conclusion 5, but we are not satisfied that the undoubted reliance on chemotherapy was far too heavy in other than isolated instances. Turning lastly to conclusion 9, we agree that nursing staff who were unsuitable without further training and counselling were permitted to occupy positions of responsibility on wards. With one exception, however, we do not consider that the word 'totally was justified.

1.22 Dr. Ankers and Mr. Weston stated in the Critique "The normal channels of criticism within the hospital have proved to be so ineffective and frustrating that we are obliged to try alternative pathways" We agree that their experience on the long stay wards justified them in coming to this conclusion. We trace in some detail at a later stage the steps that were taken by various authorities to deal with the Critique. Many were inept, and we can understand the authors' growing frustration which finally led to the production in February, 1975, of a further pamphlet "A Critique Regarding Policy, Part II - The Evidence", following which this Committee was set up to enquire into the allegations contained in both parts of the Critique and make recommendations. Part II is an angry, bitter, extravagantly written document containing 70 detailed allegations in support of the first part of the Critique. It is set out in Appendix 3. When they wrote the first part of the Critique Dr. Ankers and Mr. Weston had no intention of publishing a second part. They wished the authorities to concentrate on lack of policy, and not be diverted to the pursuit of people who had failed because of lack of policy and guidance. Even when they wrote the second part they gave no names. These were only provided when we said that. we would have great difficulty in conducting the enquiry without them.

1.23 As will be revealed, many of the allegations in Part II are fully proved, many others are proved in part. Few remain completely unproved.

The Form of the Enquiry

1.24 Statements were taken from 168 witnesses. These were given to all legal representatives, 78 witnesses were called to give oral evidence. As to the remainder, we said that we would call any witness who any legal representative particularly wished to be called, and that we would treat the statements of those who remained uncalled as less cogent evidence which we might accept or reject. This we have done.

1.25 The hearing of the oral evidence and speeches at the Hospital lasted 23 days in two periods of three and two weeks separated by a gap of seven weeks. Evidence was heard in private, apart from the presence of Dr. Ankers, Mr. Weston, legal, representatives and some members of the District and Area staff. We are all satisfied that a private hearing is to be preferred to one in public. It proved possible to achieve a very good working relationship with all those present, and there was a real desire, shared by all to arrive at the right answer in a constructive, helpful way. This is very much more difficult in public. 'We have no doubt, however, that the Regional Health Authority's decision to publish our findings is right.

1.26 The majority, of our time was spent in a formal setting listening to examination and cross-examination of witnesses by legal representatives. This situation is very unfamiliar to hospital staff and some of them were obviously unsettled by the experience. It is, however, necessary, when a Committee such as ours has to endeavour to arrive at the truth about past events, and a right to cross examine witnesses is an essential safeguard for those criticised. We also made a number of visits to a variety of wards and departments and, as far as possible, attempted to correlate the evidence given verbally with the personal impressions we formed on the wards and elsewhere.

1.27 During our second week of hearing evidence it became clear that there was a gap in the management system of the hospital and that staff were well aware of this. We decided that there would be many advantages if we consulted with staff at different stages of our enquiry to see if agreement could be reached on the key areas of organisational difficulty within the hospital. We therefore arranged to hold a series of informal meetings, the general purpose of which was:

(a) to check our personal observations made. during visits to wards;
(b) to increase our understanding of the many organisational problems within the hospital;
(c) to seek the views of the staff as how best to make changes in the organisation, and to sound out any reactions and resistance to such changes; and
(d) to obtain, if possible, a commitment from a majority of key personnel to undertake the changes.

1.28 As a first step in the process of consultation we circulated through the hospital three short questions designed to stimulate thought and produce ideas. They are set out in Appendix 4.

1.29 At the first meeting in September we talked with representatives of the Confederation of Health Service Employees, the National Union of Public Employees and the Royal College of Nursing. There appeared to be substantial agreement about the difficulties under which the hospital was functioning and on some of the basic steps which would have to be taken to remedy the situation.

1.30 At our second meeting with the Chairman of the Medical Executive Committee, the Divisional Nursing Officer, the District Administrator and the Sector Administrator, we pointed out some problem areas in respect of which remedial action could commence without waiting for our Report. At this meeting members of our Committee with specialist knowledge outlined the kind of developments they had in mind in their particular spheres, and their suggestions were followed by a general exchange of views.

1.31 On our return in November we again met the representatives Of the Confederation of Health Service Employees, the National Union of Public Employees and the Royal College of Nursing and they then put forward views on the need to develop a personnel function within the hospital and to increase the opportunity for in-service training, particularly for middle and senior grades of nursing staff. They emphasised that those grades received insufficient training related to the needs of the hospital, and we discussed various ways in which these needs might be identified.

1.32 The questions which we circulated in September produced helpful and interesting replies from groups and individuals, and in November at our final informal meeting with senior hospital staff and trade union and Royal College of Nursing representatives, we discussed and endeavoured to refine and develop some of those contributions. This was a most successful meeting during which the discussion centred not on problem areas, but on what machinery was needed to bring about improvements in the organisation of the hospital. The general views expressed were that this would best be achieved by setting up a hospital multi-disciplinary Team at St. Augustine's to monitor the level of service to patients and to initiate changes where necessary, instead of simply waiting for problems to be presented to it by the different disciplines or teams. It was agreed that the composition and terms of reference of such a Team would require further careful consideration.

1.33 This attempt to describe briefly the series of discussions held between the Committee and the staff does not cover the many informal discussions which took place between individual members of the Committee and members of staff and patients. Neither does it describe the many meetings held by staff themselves during the Enquiry to discuss the questions set out in Appendix 4.

1.34 In the remainder of this Report we propose to examine looking in turn at the wards which have been most criticised by the authors and other witnesses. Where possible we follow the order in which the authors and other witnesses served in them, but there is inevitably some overlapping. We then seek to extract from these findings some general conclusions and recommendations about the various services which should all contribute to the care and wellbeing of all patients, and we suggest some modifications in the management structure which we hope and believe will enable decisions to be more readily taken.

1.35 We wish to emphasise again at this stage that the Critique's attack was on the long stay wards. In many areas of the hospital there was admirable work being carried on. Even in the unsatisfactory areas, all those whose performance we criticise were, with very few exceptions, doing their best. Those working in the wards were struggling in the face of overcrowding, understaffing and inadequate guidance. Many of the nurses who were given important administrative roles received inadequate preparation and no counselling and the Consultants had very little time to devote to their long stay patients. A true partnership in care between the medical and other services was difficult to achieve because everybody believed, or acted on the basis, that there are some aspects of care which are solely the doctor's responsibility, but were without any clear understanding of where the boundary lay. It is not surprising that many of those working in the hospital were unable to give of their best.

1.36 St. Augustine's is rich in potential, particularly amongst the new generation of nurses some of whom are of outstanding ability. It is our aim to produce a framework of management that will release this potential. Our proposals require the expenditure of very little, if any, extra money, but they can, and we believe, will, make St. Augustine's a very stimulating place in which to work, and will improve still further the services to all patients.

SECTION 2: SOME LONG STAY WARDS', 1970– 1975

Box Ward

2.1 Mr. Weston worked in this ward as a Student Nurse for three Months at the end of 1970 and the beginning of 1971. It was then a locked refractory ward containing about 46 disturbed male patients. In August, 1972, it became a Male long stay Ward for the same number of patients.

2.2 We are satisfied that the attitudes and practices of many of the nurses on this ward between 1970 and 1974 were out of date and unacceptable. Although some patients Went out to Occupational and industrial therapy and a nurse came in to try and occupy the remaining patients on two afternoons a week, there were no multidisciplinary, or even nurses', meetings to discuss the progress or treatment of patients, and there was no real programme to keep the patients interested. In late 1972 a new Principal Nursing Officer found that the ward "was in a state of apathy and needed to be pushed". The ward had a strict unbending routine and patients Were herded around in groups rather than treated at individuals. Moreover, as we shall relate, patients were handled with unnecessary force and were subjected to uncouth indignities which denied them self respect. We do not think, however, that any of the staff who indulged in this behaviour intended to be cruel. They were doing their best in their own out of date ways, and, strangely as some will think, formed a rapport of some warmth' with the patients.

2.3 One young Charge Nurse who gave evidence before us contrasted Box Ward at that time with Holly, a long stay ward, in which he had found a team of nurses working together effectively in a relaxed, informal atmosphere to bring out the individual personality of each patient and combat institutionalisation. This contrast between Box and Holly is an excellent example of what the authors of the Critique Part I were attacking when they said "The management in this hospital exercise a policy by default with regard to the treatment of long stay patients ... If, as a nurse you offer patients custodial care, then that is acceptable. If, however, you wish to involve yourself in doing more for the patients in a therapeutic sense ... then it is up to you ... The sad part is that if you don't do it there is no policy implemented that says you should, and no-one Will tell you that you should".

2.4 Mr. D, S.E.N. spent the years from 1965 to 1974 on Box Ward. In many ways he personified the ward. Although he was unable to give evidence to us because of ill health, we were able to build up a good picture of him from several witnesses who spoke of both the good and the not so good. "He was firm, very firm" with the patients "and very physical, but, he was like this with all the patients and they knew where they stood With him". His firmness included regular and frequent slaps on the face, 'cuffing' and other indignities.

2.5 We have no doubt that Mr. D kept order very effectively by these methods and that they were known to his superiors. He and another nurse, who we find-used excessive force on another ward, were regularly used to restore order on wards other than their own where patients were causing trouble. His methods of maintaining order on Box were known and spoken of by staff on the ward and many off it. A Charge Nurse on the other shift made it plain by his conduct and demeanour that he did not endorse such behaviour, but apparently took his disapproval no further. There was evidence, which we accepted, of a nurse jocularly catching hold of a patient's throat and subjecting him to other physical indignities in the

presence of the Nursing Officer when the patient had failed to give his name to a prospective member of the staff. Everybody treated it as a great joke.

2.6 A young Charge Nurse put this behaviour firmly in perspective. "I would like to strongly say that people like D and E are essentially to my knowledge, kind people. They are not that malicious. D is a well known character in the hospital, he has a hard attitude, but the thing I question out of all this is that people knew about his attitude with work, just as people know about my attitude but at no time did anyone think to take him aside and offer him any guidance, and I do not think you can blame D and people like him for that. I would like to strongly reiterate that somewhere along the line there should have been some positive guidance available to these people. That was really the point I wanted to make." Another young nurse made the same point. We agree.

2.7 Inevitably in this setting and with inadequate guidance there were other staff who used similar methods. Mr. F a Nursing Assistant on Box Ward during 1972 and 1973, slapped and cuffed patients in much the same way as Mr. D but less predictably. Not all patients were treated by him in this way and sometimes there would be no apparent reason for his action. If patients were awkward when being shaved he would hold them roughly by the nose. His behaviour would on occasions produce angry retaliation from some patients, and other staff would then have to go to his assistance.

2.8 Mr. G a Student Nurse, also slapped patients on Box Ward. We will have to refer to him again later in this Report.

2.9 We now turn to consider Incidents 22, 37 and 63 of Part II of the Critique.

Incident 22

2.10 This is substantially accurate. The patient is a large, very powerful man six feet three inches tall and weighing about 16 stone. He is subject to sudden outbursts of great violence. Mr. 117 the Charge Nurse, could usually tell if an outburst was coming, and would then seek to send him to a side room and there give him a tranquillising injection. If he failed to do as he was told, or had already been violent, Mr. H would send to other wards for reinforcements and then overpower him with five or six helpers and inject him. He said that this reduced the harm to the patient and the danger to the nurses. This was a crude but effective way of dealing with repeated potentially dangerous situations. It is difficult to see what else could have been done in that ward at that time.

Incident 37

2.11 Paragraph 1: This again is substantially accurate. Part of the routine was that patients had to wash and shave each morning. Those who refused or were unable so to do had it done for them.

2.12 Paragraph 2: We find that the patient had been transferred to Box in a very agitated condition. After the meal he was walking up and down with a cigarette pestering the other patients, who were drinking tea, for a light. Fearing a disturbance Mr. H decided to take him to a side room to let him cool down. The patient was unwilling to go to the side room so Mr. H took him by the arm and used such force as was necessary. We do not find that he flung him to the ground. Immediately following this Mr. Weston complained to Mr. H that he bullied the patients. This upset Mr. H

who complained about his attitude to his Senior Nursing Officer and Dr. I. Dr. I saw Mr. Weston and tried to explain that he was misinterpreting events. Mr. H is in our view a kindly man although a firm disciplinarian, but there is evidence which we accept from another witness that on occasions round about this time he "clipped patients round the ear in a fairly jocular manner", and that they tended to treat him "much as a servile dog would react to a fairly strict master".

2.13 Paragraph 3: This again is substantially accurate. Mr. H did believe that a walk was good for the patients, but he was not resistant to all suggestions. It was he who at Mr. Weston's suggestion got paint and materials so that Mr. Weston could occupy the patients with painting. It was Mr. Weston who only persevered for two days.

Incident 63

2.14 We accept that patients were commonly slapped and treated with unnecessary roughness.

2.15 On an occasion early in 1972 a Student Nurse heard a sound consistent with a blow from a stick and a commotion in the bathroom area. He went in and found a small elderly patient lying on the floor in apparent pain with Mr. F standing beside him with a grin on his face and a broomstick in his hand. The Student Nurse subsequently examined the patient and found bruising on both shins. He concluded that Mr. F had struck this patient, and told us that he attempted to protest to Mr. F who ignored him and turned away. Mr. F in evidence denied any knowledge of either the incident or the protest by the student nurse. We accepted the student nurse's evidence, but bearing in mind that he did not see any blow and that the patient had in the past rolled on the floor crying as if in pain, we are unable to be sure as to what happened save that Mr. F applied undue force to the patient. The Student Nurse consulted his Royal College of Nursing steward who advised him that there was nothing he could do as he was the only witness. The steward, however, 'had a word in the right quarter' which did not appear to have any result. This same student nurse explained how difficult it was to complain because the nursing officer had previously been a Charge Nurse on the ward and was a great friend of one of the then Charge Nurses. It appears to have been widely believed throughout the hospital that it was no good making a complaint unless there was more than one witness,

2.16 The same witness told us of an occasion about the same time when a patient, who had been confined to the ward in dressing gown order, escaped and wandered round the hospital. When he was brought back Mr. D 'clipped' him about the ear and put him roughly in a side room where he remained for two days as punishment. We find that this occurred and that there were some other instances of side rooms being used for punishment at this time.

2.17 We heard from another Student Nurse, whose evidence we accepted, of unnecessary force by Mr. D in August, 1973. The Student Nurse brought back to the ward a patient who had been found wandering in the grounds in dressing gown order. Mr. D thanked the Student Nurse and then roughly handled the patient. The Student Nurse asked another to be a witness as to what had happened, but while agreeing that he had seen the assault, he expressed the strong wish to stay well out of it. The Student Nurse then consulted his Tutor who advised him to speak to Mr. D. When he did so Mr. D did not deny what had occurred and told him that he admired him for speaking to him about it. He assured him that he would not do any patient any harm, and we accept that he meant it.

Box Ward at the time of the Enquiry

2.18 During 1974 the position on Box steadily improved. The patients had fallen to 38 by the end of the year and to 33 by May of 1975. There were also changes in the Charge Nurses. We believe that with their guidance Mr. D until his absence through ill health, was using less vigorous and more acceptable ways to control violent patients. As we live already said, he could and should have been helped in this way far earlier. Instead it must have seemed to him that his methods were being endorsed.

2.19 In the Autumn of 1975 there were regular multidisciplinary meetings at which the patients were reviewed in turn. There were effective changeover meetings and the standard of student teaching was good. The patients were divided into three groups according to their ability, and each group received a different approach. Those patients with the greatest difficulties in normal activities were taught, for example, how to wash themselves and how to eat properly. There were regular trips out of the hospital to the seaside, public houses and so on. Some patients went to the Industrial Therapy Unit and others were taught painting. Unfortunately there was still no Occupational Therapist visiting the ward, and the nursing staff were doing their best to fill the gap.

2.20 In spite of all these improvements, real problems remained. The age range was between 24 and over 70. There were four patients who use violence with varying degrees Of frequency both against other patients and members of the staff, and, there were another ten patients who have been violent in the past. The patient who was discussed in Incident 22 was still on the ward. He was the most dangerous patient then in the hospital and at times behaved in a most aggressive manner to other patients and staff. This presented a constant problem in the ward.

2.21 In May, 1975, an episode occurred between one of the Charge Nurses and this patient which caused some of the Student Nurses considerable concern. The patient had been very disturbed for ten days previously and on the day in question had been refusing his medication. The Charge Nurse was sent for and decided to have a final attempt at persuasion before giving an injection under physical restraint. The patient attacked him as he knelt beside him, but the other staff who were waiting to help if forceable administration of the injection became necessary did not come to his aid sufficiently quickly, probably because his instructions to them had not been sufficiently clear. We are satisfied that he was with good reason a very frightened man and that he used all his strength to overcome the patient. We have no doubt some blows were struck. This reflex reaction in a moment of peril explains not only the rumours which the Charge Nurse told us subsequently circulated in the hospital about him, but also the fact that one of the Student Nurses felt that he must refer the matter to us. We are satisfied that the Charge Nurse used what would have appeared to onlookers to be excessive force in a moment of great peril to himself. We do not think that he can be criticised in reacting as he did.

2.22 It is difficult to see how this incident could have been avoided, and it demonstrates the problems caused by disturbed patients when there are insufficient experienced staff. If the Charge Nurse had instructed his inexperienced staff more fully as to what might occur and how they should react it is possible that the patient would have been brought under control earlier without the struggle which some of those present clearly found distasteful. We would add that there was only one member of staff on duty at night and that this did not seem sufficient, even though this patient was said to sleep very soundly.

2.23 Even with this patient, however, the Charge Nurse felt that they were making some progress. He took part in group therapy on the ward, and it had been found that a shampoo helped to calm him when he was disturbed. He spoke in a somewhat disjointed manner to a Member of this Committee of Enquiry at the end of November, 1975, and said that he had been home to his parents once a week in the recent past. The nursing staff confirmed that this was so, but felt that he remained unpredictable. It was inevitable that they had same fear of him.

2.24 The ward had been upgraded and had a bright, pleasant appearance. On the occasion of our visits the atmosphere was quiet and everything seemed orderly.

2.25 This ward has emerged from the doldrums. Staff need to continue to be selected with care and to be increased in number when possible. Patients should be reduced to 25. Instruction and regular counselling of staff on how to deal with disturbed and violent patients is essential.

Birch Ward

2.26 Mr. Weston worked on this ward as a Student Nurse for three months at the end of 1971. It was at that time a long stay ward for 26 patients run on rigid authoritarian lines, and presented an extreme case of the old type mental hospital regime very much alive in St. Augustine's without any attempt being made to deal with it. After the 1972 reorganisation it became a male psychogeriatric ward for 24 patients, but its way of life did not change until Mr. K, a Charge Nurse, whose attitude had dominated the ward for nearly 12 years, left the ward shortly before retiring.

2.27 The Charge Nurse who in 1971 worked the other shift suggested that there should be more flexibility, but Mr. K maintained that his method was the only practical one, and his view prevailed. There was strict rationing of cigarettes and sweets, which. were kept in locked cupboards, and they were often distributed on a reward system rather than by entitlement. The more handicapped patients were not given jam or marmalade because it was feared that little would have reached their mouths. Bovril and Horlicks at times did not reach. the patients. Stocks of new clothing and shoes were seldom used because the patients "would only wear them out". Although there was football and cricket in the courtyard on occasions, with walks at weekends, and although a few of the patients sometimes went to the social club, the life of the ward was regimented. Patients were shepherded about in groups. Windows were not opened or shut, and curtains were not drawn, unless the Charge Nurse gave the order. Books and games, such as draughts, were only available to certain patients for fear that the more disturbed ones would chew or tear them up. Some patients did simple jobs in the Industrial Therapy hut close to the ward and, at times, two patients did rug making while others painted shells and stuck them On flower pots and boxes There were two ward outings each year. There is, however, no doubt that the patients were chronically institutionalised and that far more could and should have been done to occupy them. Guidance was urgently needed to help staff to escape from the only method of nursing that they knew in this difficult ward. They undoubtedly achieved 'results' in giving the ward an orderly ward appearance, and a letter from the Group Secretary on behalf of the Management Committee complimenting them on this in 1971 must have confirmed the diehards and tended to silence the doubters.

Incident 30

2.28 Two students did ask their Tutor that they should not be sent to this ward for training and their wishes were met.

2.29 The second paragraph is expressed in over-emotive language. Factually however, it is a substantially accurate description of the ward when Mr. Weston worked there.

2.30 The third paragraph exaggerates the position.

Incident 33

2.31 This is substantially accurate.

Incident 34

2.32 Paragraph 1 is a substantially accurate account of the ward at the end of 1971. To another witness the Charge Nurse said that some of the undistributed provisions had been given to other wards that were short.

2.33 So far as the second paragraph is concerned, while it is true that money, cigarettes, sweets and the pay sheets were kept locked away, we have been unable to determine whether or not the other allegations are well founded. What is certain is that the method of dealing with provisions on this ward lent itself to abuses which it would be very hard to detect and prove.

2.34 It is correct, as alleged in the third paragraph, that Mr. Weston complained of some of these matters to a senior nurse. When she found that she was unable to satisfy him with her replies she referred them to his Nursing Officer and Senior Nursing Officer, who at that time was also Acting Principal Nursing Officer.

2.35 Mr. LI the Senior Nursing Officer, and Mr. M, the Nursing Officer, arranged a ward meeting at short notice at which Mr. Weston was to be asked to voice his criticisms. Neither of them spoke to him in advance and he only knew of the meeting shortly before it began. He raised all, or nearly all, of the matters set out in Incident 34. The remainder of those present seemed to have united in seeking to persuade him that he was misguided. No notes were taken of his serious allegations and no further investigation of any of them was made. Mr. Weston stated that as he left the meeting he knew that "the whole bunch were corrupt and that corruption started at the top". This unsubstantiated belief was an unfortunate outcome of an ill-prepared and ill-conducted meeting, This Senior Nursing Officer and Nursing Officer dealt with later complaints on Hazel and Elm wards in a similarly inept manner, but they undoubtedly meant well, and we will consider their reasoning when we report on those wards. Suffice it to say at this stage, that; we doubt whether open discussion is the best way of dealing with allegations of this kind. If, however, such an approach is to be used, the meetings require very much more preparation and greater skill in handling than they received. These meetings must have deterred other staff from putting forward complaints. Mr. M was anxious to assure us that he had, and still has, the utmost confidence in the way that Mr. K ran Birch Ward.

Incident 25

2.36 This is true. Mr. K had no intention of behaving unkindly, let alone with cruelty. Counselling and guidance should have been given.

Incident 24

2.37 Mr. O and Mr. P had been very close friends in Ash Ward for about seven years before the 1972 reorganisation. Mr. O had assisted the nursing staff in the care of several patients, but in particular he helped with Mr. P who was bedridden and hardly intelligible in his speech to those who did not know him well.

2.38 At the time of the reorganisation, Mr. O was sent to Heather Ward and Mr. P to Birch Ward, Mr. O, to begin with, visited Mr. P when he wished, but he liked things done in his own way, and we are sure that on occasions interfered with the routine of Birch Ward in a manner which was unacceptable to the Charge Nurse Who is now deceased. Moreover he sometimes upset Mr. P by saying such things as "You don't want me any more", and "You don't like me now". Dr. 17 Mr. P's Consultant, then issued instructions that Mr. O was not to be permitted to enter Birch because he upset Mr. P. Mr. O wrote to Dr. I asking permission to visit his old friend, but this was refused. Eventually Dr. Ankers suggested that

Mr. O should obtain the help of the Heather Ward Medical Officer. This he did and a compromise was reached under which Mr. O was permitted to visit Mr. P at times which did not interfere with the running of Birch Ward,

2.39 The relationship of these two close friends was handled unsympathetically. We were given no explanation as to why they had to be sent to different wards save that they were under different Consultants, The system should not have been so inflexible. If, however, it was necessary to split them the difficulties which developed should have been foreseen and prepared for. A ward meeting should have produced a satisfactory solution instead of the cold instruction from Dr. I. Common sense did not return until the intervention of the Heather Ward Medical Officer. We can understand that the separation of Mr. O and Mr. P and the events that followed must have appeared inhuman to Dr. Ankers.

Magnolia Ward

2.40 The ward's condition before the 1972 reorganisation was described to us by a witness whose evidence we accepted. "This ward", he said "contained approximately 60 elderly, demented and confused patients. It was locked, and I was shocked at the standard of care given to the patients. In my opinion there was a good nursing team on this ward, but the team were battling against impossible odds, e.g. Often you were left to give these patients total care with sometimes as few as three nurses. This situation affected the morale of the nursing staff such as it was." He added that there were no multidisciplinary or ward meetings at that time.

Incident 35

2.41 We accept that the first paragraph is substantially correct, although extravagantly written. As to the second paragraph, see Incident 64.

Incident 61

2.42 We were satisfied that some of the nurses were in the habit of teasing a blind patient, and that this annoyed and upset him. Another member of the staff on one occasion reproved an S.E.N. he had seen behaving this way. The S.E.N. apologised to the patient and did not behave in this way again. To this extent only we accept the allegations in this incident.

Incident 64

2.43 The regular night nurse on this ward had the reputation of treating patients rather roughly. There was an occasion when the same member of the staff, referred to in our Report on Incident 61, saw the night nurse push an old patient off his bed because he had urinated on it. The member of the staff protested vigorously to the night nurse and reported the behaviour to the day Charge Nurse On the next shift. The Charge Nurse spoke to the night nurse who subsequently modified his behaviour.

2.44 To this extent only we accept the allegations in this incident.

Magnolia at the time of the Enquiry

2.45 In 1972 Magnolia became a long stay male psychogeriatric ward of 54 patients. By the Autumn Of 1975 the numbers had been reduced to 38.

2.46 At that time the physical condition of the ward was poor and redecoration was necessary. There were no curtains between beds, but there were four portable screens. If these were used for the routine tasks of getting patients up and putting them to bed the staff felt that with their limited numbers too much time was taken up dragging the screens round. More than four portable screens were necessary on occasions but the Charge Nurses had been told that there was no chance of getting them. There were two baths side by side with no division or curtaining and the lavatories had stable type doors. The dark plastic flooring material was very difficult to keep clean with incontinent patients.

2.47 This ward provides good examples of the frustrations of the

requisitioning system which we will consider in some detail later in this report. The kitchen had a dirty old cupboard which, although quite unsuitable, was used for storing bread and jam and some other provisions. Repeated efforts were made by the Charge Nurses, Nursing Officer and Ward Medical Officer to get two Formica cupboards in its place. After 18 months of being told that not even one cupboard could. be supplied, two were provided.

2.48 Another example is provided by the attempts to get new commodes. When a new Charge Nurse arrived on the ward in February, 1975, he found that they were having to use three old and rusty commodes which had been condemned for over a year. He joined in the attempts to get replacements, but was told that the Unit Administrator had marked the requisition 'noted and deferred'. The help of the Ward Medical Officer was again enlisted and after a great deal of persistent nagging the commodes were eventually replaced more than 18 months after they had been condemned. The requisitioning system had no effective means of identifying priorities, and far too often those who sent in requisitions received no explanation for the failure to supply the items except that the requisition had been 'noted and deferred'. These words came to be treated with derision throughout the hospital.

2.49 On our visits to the ward we saw that the television area was carpeted and separated from the rest of the ward by some dividing units, This had been achieved in spite, and not because, of the system. When requisitions for the carpeting and dividing units had been 'noted and deferred' one of the Charge Nurses had then successfully asked the W.R.V.S. for help. He was, however, reproved by his Senior Nursing Officer for this display of initiative.

2.50 We found a warm, friendly and lively atmosphere. The patients appeared to have pride in themselves and were well dressed. On one unannounced visit a patient was busy preparing: food in the kitchen and another very old and unsteady man was carefully laying the tables. Another patient came up and told us that the Charge Nurse had gone to get the minibus key as a number of them were going out to a pub that evening. The staff assist patients in ordering new clothes (many have two good suits), and wash many of the clothes themselves in a ward washing machine because the laundry spoils many articles of personal clothing.

2.51 This ward in the autumn of 1975 was an example of what can be achieved by enterprising nursing staff, for there were no multidisciplinary meetings to assist them. The Charge Nurse who joined the ward in February 1975, told us that by the end of September he had never seen a Consultant on the ward, although he had heard from the other Charge Nurse that a locum Consultant had recently been in and said that he would do his best to visit Magnolia on the fourth Friday in every month to discuss problems. The Charge Nurse told us that he had spoken to the Ward Medical Officer, for whom he has considerable respect, about his attendance and that of Consultants at ward meetings, and had been told by the Ward Medical Officer that the Consultants had too little time and that he felt it was sufficient if the Charge Nurse cted as his link with the other ward staff. There were no individual treatment programmes for any of the patients in the sense of a multidisciplinary team getting together and discussing a patient and then deciding what his total needs are and how far they can be provided in the hospital. The nursing staff, however, were doing their best to fill this gap assisted by an unqualified occupational therapy helper who started work on this ward in the Spring of 1975 for 15

hours a week, and whose contribution to the life of the ward was felt to be considerable.

2.52 The Charge Nurse had also attempted to enlist the help of his Senior Nursing Officer in obtaining more medical participation, but had received the same answer – lack of time. The Charge Nurse told us that he did not feel that the Consultant's presence Was essential at all multidisciplinary meetings on that ward, but that if the Ward Medical Officer could devote more time "things would be better. To be frank? I probably have not pushed it because I did not want to mar my own professional relationships with him". The Ward Consultants were Dr. Q (until his retirement on 31st July 1975) and Dr. R.

2.53 Much more could be achieved on this ward if true multidisciplinary team work could commence. The staff feel, with some justification, that the contrast between the decoration, furnishing and facilities on the acute admission wards and the long stay wards is too great. The allocation of the admittedly very limited resources should in our view be adjusted in order to reduce this disparity.

Ash Ward

2.54 This was the first ward on, which Dr. Ankers worked between his arrival at the hospital on July 16th, 1972, and the reorganisation on August 15th. It was a long stay ward for about 57 long stay epileptic males whose ages ranged between 20 and 80 years and many of whom were incontinent. Very often there were only three nursing staff and on domestic worker on duty, and there were no proper ward meetings. A few patients went to the Industrial Therapy Unit or worked on the farm. In the past an occupational therapist had spent part of two days a week on the ward helping some patients in rug making, basket weaving and tray and lamp making, but this had almost wholly, if not completely, lapsed during the run-down period when Dr. Ankers worked in the ward. During that period there were no ward outings, although patients were occasionally taken out into the sunshine, and two dug in the garden. Those who were able to occupy themselves did so both in the ward and on outings to Canterbury, but the remainder watched television or just existed.

2.55 Many of the patients were Chronically institutionalised. Of such patients, Dr. Ankers said, and we agree, "I feel that those people need some encouragement as part of their care and treatment in the hospital to participate in activities. If a patient is of a mind and well enough to participate of his own accord, that is a good thing, but a lot of these patients were not. They sat around in chairs on Ash Ward all day long. I felt that the nurses should be doing something more for the patients, and, indeed, that they should have been instructed to do so. There should have been a policy. There was not this policy. It was lacking," He described how he and another Nursing Assistant on their own initiative helped an elderly patient, who could only walk with a' walking frame, to get some exercise round the ward as an alternative to just sitting.

2.56 It must be remembered, however, that Dr. Ankers was seeing with fresh eyes and mind a ward in which staff had been battling with appalling conditions for a long time, and in which much of the Staff's time was concentrated on the impending reorganisation. He probably saw it at its worst period for some time, and what he saw was put in perspective by a Charge Nurse who had worked there as a Student Nurse shortly before.

2.57 "Ash Ward really looked like a Victorian poor law institution. There were filthy floor boards, the furniture was dreadful, there were far too many patients, the ward had not seen even a lick of paint in donkeys' years. The dormitory was shocking. The ward was just unbelievable. You had got to see it to believe it. There was Mr. E and Mr. N, a tiny nursing staff, on this ward and Dr. S was there as the ward doctor. They had this dreadful situation to work in, nobody did anything about it and the way things were in that ward, the situation was stagnant". The same witness emphasised that Mr. E had worked hard in Ash for seven years with far too few staff, and had formed a good rapport With the patients. He said of him, "He is a good nurse. He is a nice chap who tries his best. He had been a bit of a rebel in his younger days. He had knocked his head against a brick wall for Ash Ward and got virtually nowhere over many years. I think it affected his overall performance. He had the spirit knocked out of him over the years by getting nowhere."

2.58 The demoralised condition of the staff is well illustrated by the state in which they left the ward on changeover day. The chamber pots under the beds were unemptied. Two mattresses in side rooms were soaked in urine and covered in green mould on their underside, and the whole ward had to be disinfected.

Incident 7

2.59 This accurately records the circumstances in which Mr. T lived during the month Dr. Ankers worked on the ward. The ward report books show that between July 1st, 19721 and changeover day (August 15th) Mr, T was nursed in bed in a side room every day, other than July 10th when he was allowed up for exercise in the afternoon, and August 8th when he was allowed up in a dressing gown.

2.60 Why was this considered necessary? One nurse told us that when he had worked in Ash in 1970 Mr. T had spent most of his time on the ward, but that when he returned in 1971 he was spending Most of his time in the side room. We have no doubt that Mr. T presented a management problem: he was unpredictable and violent at times: he set his clothing alight on several occasions, and his side room mattress on another. Mr. E tried, but failed, to get him transferred to Box Ward. The Nursing staff received little help from the Consultant, and we find that they understandably took the line of least resistance and confined him for longer and longer periods to prevent the Ward from being unnecessarily disturbed. The side room door Could only be opened from the outside. Mr. T slept on a mattress On the floor and the shutter was often over the window during the day to prevent him emptying his chamber pot onto the grass outside. He frequently urinated on the floor and, although the room was cleaned out at least once a day, it inevitably stank. There was no proper heating although some hot water pipes ran through the room., One of the Charge Nurses of that period said that his treatment "involved fairly heavy sedation, and he probably preferred to sit quietly or lie and sleep in his room".

2.61 Dr. Q, who was Mr. T's Consultant at that time, said that he would be "put in seclusion in a side room for a limited period only. The nurses were permitted to do this and he would be secluded for about two hours until his medication took effect". Dr. Q's recollection does not accord with facts. Dr. Q was one of the two Consultants responsible for patients in Magnolia ward throughout 1975 until his retirement on July 31st 1975. We have already reported that a Charge Nurse who started work in February in that ward never saw him there at any time. We shall have to refer to him in further passages of this report.

2.62 Mr. T's subsequent treatment in the hospital is worthy of note. After spending periods in Magnolia and Holly wards he was transferred to Cedar. Dr. R, his present Consultant, described what then happened thus:-"He has had a horrifying - perhaps I should qualify that word - a disquieting number of sedating injections over the years coupled with an amount of medication which, unhappily, one has had qualms about. But, again, in this situation of an overcrowded, disturbed ward with less than adequate staff, it is Hobson's choice. One has to increase medication if what one has prescribed does not achieve results. You get to the point where you defeat your own object. In retrospect, I can see that this happened in my own management of (Mr. T). He got to the point where he was becoming somewhat confused through the effect of the medication. Therefore we transferred him to Cedar Ward. This has happened more than once. In Cedar Ward it was found possible to nurse him without medication, simply because

of the environment of that ward which is in part a sick ward. There are general hospital patients there as well as ill mental patients. The staffing ratio is also a little higher. It is generally a very pleasant ward... There is an air of tranquillity and peace in there which is quite remarkable. This patient settled down in this environment - it took time - on no medication. Indeed, it was possible to train his habits to a certain extent, though not as much as we would hope, because the nursing staff there have other duties to a time he was able to attend industrial therapy. This is a clear example of the undesirability of excessive medication. Again, I do not want to give a wrong impression. This is one case. There are other individual cases. I think that by and large, overall, I would not subscribe to the view that in this hospital, or any part that I know, there has been consistently an over-prescribing policy in general. I do not believe that to be true in general, but there are individual cases. Mr. T is the best example I can give of an extremely intractable, disturbed patient."

2.63 The initiative to reduce Mr. T's medication came from the nursing staff and Dr. R responded. This is an excellent example of both disciplines sharing in a true partnership of care. As we will emphasise later in our Report, there is, in our opinion, no aspect of a patient's treatment or care which is solely the responsibility of any one discipline.

Incident 10

2.64 We do not agree that nurses did the bare minimum. There may well have been rather more tea drinking by staff on this ward than on some others, but this was understandable where staff were working with difficult patients in very depressing surroundings.

2.65 We do not find that any patients went hungry as a result of staff eating food sent up for them. It was, however, the practice for staff, on occasions, to eat food that was surplus to requirements rather than put it in the dustbin. This can, of course, be abused, particularly when staff work the shift from 7.00 a.m. to 2.00 p.m. and bring sandwiches to eat in their meal break. Nine bottles of beer were sent up each day for those patients who had been authorised to have it by the Ward Medical Officer. The Charge Nurse had to take action over one nurse who consumed a bottle of patient's beer at Christmas, and there was evidence which suggested that this was not an isolated instance. We do not find, however, that nurses were in the habit of drinking patients' beer.

2.66 With these exceptions the description of Ash Ward given in Incident 10 is substantially correct.

Ash Ward since August 15th, 1972

2.67 On reorganisation Ash became a female geriatric ward in Clinical Area 1 with Dr. A as the Consultant. Within a few months the ward had been completely redecorated and there were new curtains and floorboards. Since 1972 new bathrooms and toilets have been added, and in February, 1974, the ward, became a mixed admission ward.

2.68 When the ward first opened as a female geriatric ward there were about 57 patients who constituted a very heavy workload for the staff who normally numbered three or four. By August, 1973, the numbers had been reduced to 36. An occupational therapist came on several mornings a week and helped some of the old ladies to knit, but a large number of the patients did not appear to wish to be disturbed and were left in their chairs to watch

television or listen to the radio or just sit. Voluntary workers sometimes came from the Social Centre and took patients out in the grounds.

2.69 The patients do not seem to have been regularly reviewed, and none had individual treatment programmes in the sense that that word has already been described. There were irregular ward meetings attended by all available ward staff, the Ward Medical Officer and the Nursing Officer. These consisted of fairly informal discussions about ward problems and the progress of some patients. Ward changeover meetings took place each day.

2.70 In the Autumn of 1975 Ash seemed to function effectively, and Dr. A. was holding regular multidisciplinary meetings.

Heather Ward

2.71 Since August, 1972, Heather, has been a long and medium stay ambulant male ward. During the intervening years its numbers have only fallen very slightly from 54 to 48. Ages ranged from the early 20's to over 0. Dr. Ankers worked on the ward as a Nursing Assistant from August 15th, 1972 until he was moved to Hawthorn Ward on July 7th, 1974. Mr. Weston worked there from August 5th, 1973, until his resignation from the hospital on April 30th, 1974. During the first three to four months he was awaiting the outcome of his examination. From December, or thereabouts, onwards he was a Staff Nurse.

2.72 The difficulties immediately following the reorganisation were great. Mr. U, one of the two Charge Nurses at that time, said that many of the patients "had become very institutionalised. When they first came up to Heather Ward half of them would not speak, and half of them would do nothing for themselves. They were totally dependent on nurses to do everything for them."

2.73 We shall subsequently point out that the programming of the August, 1972, reorganisation seems to have had far too little thought. The same Charge Nurse told us what happened in Heather. "Before reorganisation it was a long stay female ward. When Heather ward patients inherited it they took over an ill-equipped ward. There were not enough knives, forks, spoons, plates, cups and saucers. The bathroom was full of brick rubble. There were no facilities for bathing the patients. No provision had been made for patients clothes or other basic requirements. For a whole month 54 Heather Ward patients had only the clothes in which they stood. There was no change of underwear, shirts, jackets, nothing. When you tried to do something about it, you were told that you were grumbling." He explained that female wards are equipped with female requirements. "On reorganisation the majority of the females were taken over to Areas 1 and 3 and they took their own basic requirements with them." The male wards which remained male wards "retained all their basic requirements like underwear, shirts, vests, pants etc. The female wards which were handed over to the males had nothing. They were just blocks with nothing in them."

2.74 At all times since August, 1972, Heather has presented problems of management because of the mix of patients, many of whom were transferred from Box, the locked refractory ward, on reorganisation. Some were informal patients, some were admitted under the Mental Health Act 1959. Dr. Ankers in our view described it accurately when he said:- "It was regarded as a disturbed ward, and at times it was very disturbed. Patients on that ward had an extreme range of diagnoses. They were regarded as chronic schizophrenic, catatonic, suicidal, manic depressive and suffering from anxiety states. There were sub-normal people and old people who had suffered mental illness in the past."

2.75 The position had not changed by the end of 1973. A Charge Nurse, Mr. V, who commenced work on the ward at that time said that "When other wards, in Area 2 had a difficult problem they always sent them to Heather Ward, so we had more problems... It was known to be a disturbed ward in the hospital." Dr. W confirmed Mr. V's description of Heather as a disturbed ward. "It is", he said "the only long term disturbed ward for 'male patients in Area 2."

2.76 The numbers of Staff on duty varied. Between 7.00 a.m. and 6.30 p.m. they usually numbered three or four, but occasionally they would rise to

five or sink to two. Between 6.30 p.m. and 9.00 p.m. there were usually two, and during the night there was only one.

2.77 Throughout the period since reorganisation there has been very little help given by trained occupational therapists or aides. Even in the summer of 1975 there was only attendance by an occupational therapy aide on one afternoon each week. In the Summer of 1973 Mr. U and Dr. Ankers started to organise minibus outings for patients in their free time. Until then such outings had been few and far between. Both Dr. Ankers and Mr. U had been aware since August, 1972, of the need to do more for the patients, but they had made very little progress because Mr. U felt that innovations, although desirable, were potentially dangerous unless recommended by doctors, and the Consultants failed to devote sufficient time to the ward to initiate such changes. Moreover, the other shift was unsympathetic to change, and Dr. Ankers during his first year on Heather was still only finding his feet. Elementary ward meetings of staff and patients began in late 1972 after encouragement from Mr. U and Dr. Ankers, and formal staff meetings attended by the Senior Nursing Officer and the Nursing Officer began in February, 1973, but there were no multidisciplinary meetings until Dr. X began to hold them very irregularly at the end of December, 1973. Such meetings became regular following the publication of the first part of the Critique. Dr. W held no multidisciplinary meetings until July, 1974. Dr. Y had held no such meetings by the Autumn of 1975.

2.78 Although changeover meetings for all staff were started, they were not properly used and were mainly the occasion for a cup of tea. During the first half of 1973 Dr. Ankers raised at meetings the need for more outings and greater participation by residents in the life of the ward. He also raised the question of the differing approach by the two shifts and the suitability of Mrs. Z (see below). Dr. Ankers, however, was only a Nursing Assistant and his protests were of noavail, although he felt that Mr. AZ, the other Charge Nurse, became less opposed to change.

2.79 The arrival of Mr. Weston after he had completed his training added strength to the reform movement, and Mr. V, who took over from Mr. U in December, 1973, was more ready to adopt the suggestions of the younger staff than the more cautious though sympathetic Mr. U. had been.

2.80 During the next nine months, Mr. Weston, Dr. Ankers and other junior members of the staff endeavoured to plan and put in effect improvements in the ward. Many of them were only attempted after the arrival of Mr. V. We list them briefly, not chronologically nor in order of importance.

(i) Patients were encouraged to make their own beds and do other odd jobs on the ward. Although the older school of thought disapproved, they did not seek to prevent this experiment. Within two or three weeks 95% of the patients were regularly making their own beds.

(ii) Monthly ward 'socials' were started.

(iii) The number of outings was increased both for groups and individuals. The ward staff negotiated a special reduced rate of 5p per Patient at a Canterbury cinema. Because efforts to get an allocation of hospital funds for outings failed, staff helped to pay for them with their own money and assisted the patients to save some of their pocket money which was used both for the outings and for the purchase of clothes. As a necessary part

of this scheme the pocket money paid to many of the patients was increased.

(iv) Chairs in the ward, instead of being lined against the walls, were put in groups of three or four to create a more informal atmosphere.

(v) Much old clothing was thrown away and replaced, in part by the hospital, and in part by what the patients were able to afford. Because ties were in short supply in the hospital, Dr. Ankers bought 30 at a jumble sale in Chartham.

(vi) Pressure was put on the Consultants and other doctors to come and speak to the nurses about problem patients (see for example lower down under Incidents 27 and 41) and to review medication more frequently. As a result of this pressure Dr. X began his irregular multidisciplinary meetings at the end of 1973, but these had not resulted in any individual treatment programmes for patients before the circulation of the first part of the Critique.

(vii) A ward notice board was acquired on which was exhibited information about outings, each patient's pocket money entitlement, and what that amounted to in terms of cigarettes or sweets per day.

(viii) A ward routine was written down and posted on the board together with a staff duties delegation system. This delegation system set out six different groups of tasks. Three of the groups covered, all the routine work. The other groups were intended to cover therapeutic activities which had been so notably absent in the past. In addition there was a teaching programme and list of suggested projects.

2.81 In spite of these initiatives by this group of nurses the shift which was headed by Mr. AZ and Mrs. Z followed its old method of working, and as a result the life of the patients was strangely variable. These 'old school' nurses undoubtedly felt threatened by these new ideas, but, so far as we could ascertain, received no counselling or worthwhile advice from their superiors on how they should react or could adapt to them. In this situation confusion and unhappiness were inevitable. Their opposition was manifested not so much by open disagreement as by indifference. There were comments about "These young nurses who are only interested in going out" and difficulties were placed in the way of arranging outings. The systems on the notice board were not followed when they were on duty, and after Mr. Weston left most were removed. On the few occasions when Mrs. Z was required to work under Mr. Weston after he had become a Staff Nurse she declined to carry out any work under the delegation system if it was not her normal work.

2.82 Progress, however, was made and we accept Mr. Weston's description of this. "The patients were starting to open their eyes, to see what they hadn't seen for years, and they started to enjoy these outings and to ask if anything was arranged for that day. Patients who never spoke or responded started to smile and answer questions. Other patients we encouraged to go out on their own and they became more confident of themselves. If we arrived back from an outing late and missed the last meal we would encourage everyone to muck in and prepare their own meal; a couple buttering bread, someone' setting tables, someone frying up eggs or making omelettes. The atmosphere on the ward changed dramatically during such events. Patients were happier, more relaxed, showed initiative and enthusiasm, and talked of future possibilities." As will be seen, however, some mistakes were also made, but this is not surprising when the

initiative was coming from the most junior nurses, with no effective guidance or support from their superiors, and very little from the medical staff. We will try to set out shortly why this was so.

2.83 With one exception there seems to have been no understanding of the duty that lies on nursing staff to formulate and implement ward policies. Although this should be carried out jointly with the other disciplines, failure by the other disciplines to participate does not relieve the nursing staff of their duty to do their best. Although the Senior Nursing Officer and Nursing Officer expressed approval of the staff initiatives they did nothing to see that the 'old school nurses' followed this lead. We believe that all, including the reformers, believed that the duty to initiate such changes really lay with the Consultants. The reformers, however, were not prepared to wait, and the Senior Nursing Officer and Nursing Officer, while not prepared to condemn the initiative, exerted no pressure on the others to follow. It was truly a laissez faire management without any real leadership. Miss BY, the Senior Nursing Officer, while recognising that she had a leadership role, found it very difficult to explain her understanding of it. "I feel very strongly", she said, "that the Charge Nurse is responsible for the ward. He is in control of the ward. The Nursing Officer supports him. If there were problems and the Nursing Officer could not cope he would come to me and I would do my best to cope with them." She continued "I see myself as the co-ordinator of my Area... I see leadership as delegation and communication and cooperation."

2.84 This interpretation of leadership has too often resulted in a failure to grasp occasions that should have been grasped, a failure to see that decisions that required taking were taken, and in a failure to lead forward those below for fear of impinging on their responsibility and so stifling their initiative. It is very difficult to get the balance right and We are satisfied that most of the middle management nurses at St. Augustine's need further help and continuing guidance in this field.

2.85 The one exception we have already mentioned was Mr. CX, a new Principal Nursing Officer from outside the hospital. He firmly believed in initiatives coming from ward level. He attended a meeting on Heather Ward in January, 1974, and was asked by Mr. Weston what the ward policy was. He replied, by a question "Don't you know?" and proceeded to explain that if Patients were stagnating the responsibility for this lay on the nursing staff. This was resented by some, largely We believe, because the staff were still imbued With the concept that the Consultants were responsible for giving a lead to the formulation of ward policies. Mr. CX felt that the clashes between young and old were part of the inevitable growing pains of hospitals like St. Augustine's. He had a high regard for Miss BY and his description of the leadership role of a Senior Nursing Officer and the manner in which she fulfilled it goes a long way to explain her failure in Heather Ward at this time, The Senior Nursing Officer leads "by setting an example, by being able to be humble, by being able to be wrong. This is one aspect. There are many aspects to leadership. I think: Miss BY led by gentle persuasion, guidance and counselling. She is this sort of lady, and I think she achieved quite a bit." He went on to say "I think she got remarkable results in many areas of the hospital." In our view Miss BY's difficulty was that she lacked experience and guidance in leading her staff to fill the gap left unfilled by the medical staff: indeed she and others had grown up, and still, deep within, believed in a system under which it was the prerogative of the doctors to order all matters concerning the life of patients in the ward.

2.86 We believe that the Consultants, perpetuated this belief. Dr. A was asked to comment on the criticism that the decision as to the kind of care to be given to patients was left to the staff on the ward. He replied "I will accept that in a way in some areas it must have been so, but I have no doubt at all in my own mind that the responsibility for altering that state of affairs rests with the individual Consultant. That is how I see my job and I regard it as my responsibility for my patients." Dr. A had no patients in Heather, but he had been Medical Superintendent and was Chairman of the Medical Executive Committee from 1972 until 1975. We are satisfied that that view was supported by the other medical staff as well as the nursing and administrative staff. If the Consultants were too busy to carry out this function in the long stay wards, no-one else apart from Mr. CX, considered that anybody else had a duty to fill the gap.

2.87 We consider the Incidents in the order that in our view will throw the most light on the difficulties of the ward.

Incident 36

2.88 Mrs. Z worked at St. Augustine's for 15 years, first as Nursing Assistant and then, having qualified by length of service, as a State Enrolled Nurse. When she Was first employed the Hospital was divided into male and female sides, and she worked on the male side. When that division was abolished she preferred to continue working with male patients. For the three-and-a-half years before the 1972 reorganisation she worked on Ash Ward and then after on Heather until June, 1975. She then worked for a short time on Myrtle, a female long stay ward, and finally, after a spell of night duty, she resigned in the Autumn of 1975 because of poor health.

2.89 We are satisfied that Mrs. Z was totally unsuitable to work as a nurse, in the context of modern psychiatric medicine. Her knowledge of basic nursing skills was poor and she was incompetent in handling medication. We are not satisfied that she deliberately gave the patient referred to in this incident more than the prescribed dose. The prescription left it the nurse's discretion as to whether to give 100mg or 200mg of Largactil three times a day, but she interpreted this discretion too liberally, and her dispensing methods were primitive. She was intolerant of junior staff: and treated the patients as children. Although she formed a rapport with a few patients, particularly those who had moved with her from Ash, she treated the majority with a harshness that caused real concern to almost every young nurse who worked on the ward. She did not distribute all the patients supplies such as jam and butter, but kept back a percentage "against a rainy day". Where the undistributed supplies went we were unable to discover. It is not suggested that Mrs. Z removed them from the ward. When serving the lunch or supper she gave small helpings, and frequently refused second helpings, although this meant that food was put in the dustbin. She did administrative work rather than help with getting the patients up or putting them to bed or washing or shaving them because she felt that such work was unsuitable for a woman in a male ward: yet she insisted for as Long as she could in working on a male ward. She had an undue influence on her Charge Nurse and obstructed progress.

2.90 It is unnecessary for us to go further into the other allegations contained in this Incident. Although what we have said amounts to formidable criticism, it must always be remembered that Mrs. Z had no help in bringing her ideas up to date, and that she was left on the ward long after She should have been moved, not only for the good of the patients and of other staff, but also of herself. Her superiors, we are satisfied, knew of her defects. They realised that she represented the

older generation and out, of date systems, and they knew that she was failing to cope with change, but they themselves seemed incapable of dealing with the situation, and so failed to provide the kind of support which she so desperately needed.

2.91 A young nurse of considerable insight, who qualified in 1974, saw her predicament as follows: "I think Mrs. Z was a frightened person on a very difficult Ward which was potentially quite dangerous at times. I think it was wrong – it crossed my mind while I was working there, not just in retrospect – that such a person should be left in control of a ward with approaching 50 long stay patients. The general impression was that she was unable to deal with any difficulties, and difficulties arose daily. That is my general impression." When asked about her manner he gave a reply which was repeated in different terms by others: "I think her manner Was highly critical and very institutionalised. I can remember one conversation that I had with her when I tried to tackle her On a matter. She seemed to have formed the impression that the main problem with the long stay patients was laziness rather than the specific mental conditions which kept them in this hospital."

2.92 As we have already said, Mr. AZ, the Charge Nurse on Mrs. Z's shift, was unduly influenced by her. He comes from overseas and has some speech difficulty which prevents fluent and lucid communication. Mr. CX fairly said of him "He had years Of knowledge and wisdom in looking after patients. This has to be assessed against his lack of professional knowledge. He May not have been highly professional or always had a crisp white coat… but he was not afraid to throw his arms round a patient's shoulder, give him a hug and say "Do not worry, Tommy, Mother will come tomorrow" or something like that, depending on the psychological need of the patient." In our view he was unable to come to terms with the new ideas coming into the ward and was content that the ward should remain as it was. Although he personally became more sympathetic with the aims and methods of the other shift after discussions at ward meetings, he did not try to influence Mrs. Z and left her to lead in many matters, such as the allocation of staff duties.

2.93 We now turn to consider how much of this information reached the Nursing Officer and Senior Nursing Officer. Mr. DW, the Nursing Officer, agreed that he had complaints about Mrs. Z from both the Charge Nurses who had served on the other shift. That from Mr. U had been rather vague, but it had been followed by complaints by Dr. Ankers and Mr. Weston to Miss BY, which we deal with under Incident 70. Their complaints, which covered most of the allegations in Incident 36, were followed by complaints from Mr. V who had succeeded Mr. U as a Charge Nurse. Mr. V's main allegation was that Mrs. Z controlled her Charge Nurse, but it was also clear that Mr. V and Mrs. Z did not get on together and that there were differences of approach between the two shifts. Mr. DW was also repeatedly approached by a Student Nurse, now a Charge Nurse, who told-him of Mrs. Z's incompetence and harshness.

2.94 Mr. DW told us that he found himself out of his depth in the problems of Heather Ward. He was subsequently relieved of any responsibility for any ward in July, 1974, and after a short spell as a Duty Nursing Officer he was transferred to night duty. He told us, and we accept, that he suggested to Miss BY that Mrs. Z should be moved to another ward, but that Miss BY had told him that whatever ward Mrs. Z had worked on in the past the same kind of difficulty had arisen. He formed the view that Miss BY "felt that there was not much point in moving her to another spot where there might be some other trouble."

2.95 Mr. DW also raised this matter with Mr. CX, the Principal Nursing Officer, who after discussion with Miss BY, accepted her judgment that Mrs. Z, although a difficult woman, was a good nurse and should be left on Heather Ward.

Incident 70

2.96 This relates to a complaint made by Dr. Ankers and Mr. Weston to Miss BY about Mrs. Z, almost certainly in October, 1973. We find that the conversation was substantially as set out in the Incident. Not long afterwards another student nurse told Miss BY that Mrs. Z was 'wrong for the ward', and was told that it was very difficult to move staff within the hospital.

2.97 Following the complaint from Dr. Ankers and Mr. Weston Miss BY consulted with Mr. DW and decided to ask both Charge Nurses for written reports on Mrs. Z. That from Mr. AZ was, predictably, good. The report from Mr. U was equivocal. Miss BY told us that she thought that Mrs. Z would have benefitted from a change to a female ward, but when she offered her the change it was refused and she pushed this suggestion no further as she wrongly understood that Mrs. Z's contract specified that she should work on male wards. Her recollection is that she sought to find a male ward for her, but that there was none that wanted her services. In her evidence to us Miss BY was very reluctant to accept that Mrs. Z's departure would have benefitted the ward.

2.98 Miss BY told us that she thought at this time that Dr. Ankers was disrupting the ward and undermining the authority of the Charge Nurses by a hostile attitude towards the administration, and that although some of his ideas may have been good the trouble they caused was greater. Holding these beliefs it is unfortunate that Miss BY did not seek to talk to Dr. Ankers or Mr. Weston about the problems she felt they were causing by their criticism, or seek to help them or Mrs. Z to work through the problems inherent in the challenge of youth. We accept Dr. Ankers' evidence that when visiting the ward Miss BY expressed approval of what the young nurses were doing.

2.99 Mrs.Z should have been sent on a training course, and then sent to work on another ward. If she refused her contract should have been terminated, Instead the position was allowed to drift. As in so many parts of the hospital, people talked together about the problems but shrank from taking decisions. Some were even unable to tell us how or by whom a decision on a matter ought to be taken if the imagined panacea of 'talking together' failed. In our view an approach to Mrs. Z's Union steward for assistance in solving this intractable problem might have led to an acceptable solution.

2.100 Decisions were eventually taken and staff moved in the summer of 1974 following complaints by a patient, Mr. EV. These events will be related in due course.

Incident 51

2.101 This Incident concerns Dr. W who came to St. Augustine's as a Consultant for Thanet (Area 2) in November, 1972. Until that time the hospital had four Consultants responsible for a population of 600,000. The size of this burden of work will be appreciated in the light of the Department's guideline of one Consultant to each 60,000 people.

2.102 On arrival Dr. W was responsible for a population of 1277000. He had patients in 14 wards at St. Augustine's and in eight, wards at St. Martins. He also had duties at a Day Hospital in Margate with 80 patients, For many months he had no Registrar and only half a share in a Senior House Officer. At Margate the Clinical Assistant resigned shortly after Dr. W's arrival, and for the next six months he was without assistance there.

2.103 Dr. W's workload was grossly excessive and as a result he felt that he must concentrate his efforts on the acute admissions wards. This meant that he was unable to give as much time as was necessary, or he would have liked, to the long stay wards until the arrival of Dr. FU as a Consultant for Ramsgate (population 45,000) in July, 1974.

2.104 Dr. W said that in the 18 months before Dr. BTU's arrival he visited Heather once every two to three weeks. He would stay an average of 15 minutes and go through the list of his 24 patients with the Charge Nurse and see any patient who was disturbed. Mr. AZ recalled that Dr. W was mainly concerned during this period with a patient, Mr. GT, and then Mr. EV, a patient who took Mr. GT's place. We do not think he was able to see many of his patients during these brief visits to the ward office, and this accounts for the evidence of many junior nurses who at this time either never saw him, or only saw him once in three or four months. Dr. W agreed that because of the little time he was able to spend on the ward "the patients might not receive the attention that they were due", and that for some patients "it could have been harmful".

2.105 Mr. CX,-the Principal Nursing Officer, described how he and his Nursing Officers were very perturbed by Dr. W's attendance. "I talked with the man. Miss BY pleaded with the man." Mr. CX told us "It was being taken up repeatedly because we were very aware of the lack of medical cover especially on Heather Ward, but there were other wards. Dr. W felt that he had very genuine reasons, and he was a very difficult man: I think that is the honest term. He is a man of very few words, he would make his case very plain that he was overworked, that he did not have the time etc. and he made a categoric statement that until such time as he got help he could do nothing about it. At the same time we got an old friend, Dr. X, to bend over backwards and stretch his workload yet a bit more, to go into Heather Ward, to give his cover to this ward and see patients there. Nevertheless, We got this difficulty with Dr. W which we never really resolved satisfactorily, because he always had these pressures and he had other reasons for not wanting to involve himself in certain wards of the hospital."

2.106 It is easy to understand in these circumstances how Dr. Ankers and Mr. Weston felt that Dr. W neglected his patients. Although a Ward Medical Officer visited the ward each day, some of the patients were deprived of appropriate treatment. Dr. X already had over 20 patients in Heather and could not hope to give to this additional workload the attention it required. Dr. Y only had three patients and rarely visited the ward. In July, 1974 they were joined by Dr. FU who took over about ten of Dr. W's patients.

2.107 The Consultants Were cast by the rest of the hospital in the role of leaders in the wards. They were content to be so cast, but they were failing to lead the long stay wards away from custodial care. They attributed this failure, with considerable justification, to shortage of time, but they never informed the Management Committee that they were in default or invited the nursing staff into a joint partnership of care to

help fill the gap they left unfilled. It was left to individual nurses or groups of nurses to try to fill the gap if they so desired. It was management by default.

2.108 Since July, 1974, Dr. W has visited the ward once a month for multidisciplinary meetings, and once a week for 20-30 Minutes at a time to discuss his patients which are now down to 14. As we will report in due course there are still problems in Heather Ward. If Dr. W had more time he would not give it to his long stay patients. He expresses his dilemma clearly and we sympathise With him in it. "As a Consultant I have to make the best use Of my time, to provide a psychiatric service for a community of 80,000 people. This includes a day patient service, an outpatient service, visits to the general hospital to see overdoses and consultations." If he had more time he "would devote it to the people in the community who are crying out for psychiatric treatment and are not getting it because there is no time at the outpatient clinics for them to get it," He continued "I think prevention of chronic illness it the most important function I have to perform. My aim is to prevent admissions, to prevent chronosity in patients, so I feel one should concentrate one's efforts in one's acute admission wards to prevent chronosity, and also on one's outpatients and day patients to prevent their admission to the hospital in the first place."

2.109 Heather Ward like many other wards, has suffered from sharing too many Consultants. It must be obvious-that when a Consultant has a few patients in several wards he can waste a considerable amount Of time in going' from ward to ward taking meetings. Equally if all the Consultants with patients in a ward held regular meetings On the wards, a good deal of nursing staff time would also be taken up attending meetings and the problems of differing attitudes and expectations between Consultants would become more marked, particularly as no one Consultant had overall responsibility for policy making. The Consultants seemed to have a limited awareness of the problems caused by this multiple sharing of wards.

Incident 1

2.110 All these incidents are alleged to have occurred during 1973 and to have involved Mr. HS, a State Enrolled Nurse who did night duty in Heather.

2.111 Paragraph i: We find this proved. Mr. HS said it was just a figure of speech to try to entice the patient back to bed. We are not satisfied that he would have carried out the threat.

2.112 Paragraph ii: We find that this is proved. We are not satisfied that Mr. HS intended that the patient should be permanently deprived of food that night.

2.113 Paragraph iii: We find this proved. The patient involved is powerful and unpredictable. Mr. HS said that he could remember giving him the "odd playful slap or tap to make him calm down or to demonstrate to him that he had done something wrong". When asked how the giving of a playful slap would achieve that end, he replied "I do not know. I would not like to try to answer that question." He later sought, unsuccessfully, to persuade us that he would "tap them on the bottom with the palm of his hand or something like that". Although he did not see other nurses behave in the same way, he understood from conversation that they did so. He said he could not recall, any guidance as to where the Line should be drawn in the application of physical force, and continued "I found that I was left to

my judgment on this matter and it was never criticised by any of the senior nurses in the wards that I Worked on."

2.114 We are not satisfied that Mr. HS ever intended to be cruel. He was doing his best to control difficult patients in his own way which he believed was widely accepted. Staff received insufficient guidance as to how to deal with disturbed patients. In our view no patient should be slapped. It is not children that the nurses are trying to discipline, but full grown powerful and often irrational men.

2.115 Paragraph iv: We are satisfied that this same patient was injured as described while Mr. HS was trying to restrain him in a lavatory. There was no eyewitness. We are not satisfied that Mr. HS deliberately struck him. Mr HS left the hospital in 1974 and is no longer working as a nurse.

Incident 3

2.116 We accepted Dr. Ankers' account of this incident as substantially correct. It occurred during 1973 in the following circumstances.

2.117 One morning when Mr. AZ was away the ward became very disturbed, with the patient referred to in paragraphs iii and iv of Incident 1 at the centre of the disturbance. Mrs. Z telephoned the nursing office for help as a result of which Mr. IN, a Charge Nurse who was on duty in his own ward, was asked to go over and assist for a couple of hours. Mr. IN explained "it was because the ward was so disturbed that morning. I was asked to go up there and try to get some form of order." He said "this happens so often. When there is trouble in this hospital or in a ward, it is usually 'Mr. IN, will you go and help them out there?' This is what has happened to me for some time. It is pretty obvious why they picked on me when there is trouble. I am twice the size of an average person, and I have probably twice the strength, plus a good deal of experience in dealing with disturbed patients."

2.118 When he reached the ward he found it in a state of Confusion and uproar. He called for some quiet and got some response.Then this patient appeared with his fly buttons undone and his penis exposed. When Mr. IN told him "put it away and do your buttons up" he just grinned. It was then, as we find, that Mr. IN hit him several times quite hard with the back of his hand "above the testicles but below the belly button", saying each time "Do them up." He then removed the patient in the manner described in Incident 3.

2.119 We do not consider that Mr. IN had intended to be cruel. He had be sent to restore order, and when confronted by disobedience he dealt with it in his own way. Indeed, it may be said that the role in which he was repeatedly and, in our view, unfairly cast almost demanded this response from him. We agree with his comment, which applies with equal force to the similar use of Mr. DI "It is not very nice to get an unearned reputation of being the heavy gang. I do not like it."

2.120 Mr. IN should have persevered with peaceful persuasion, but the atmosphere in the ward, and the purpose for which he had been sent, were not conducive to these more peaceable remedies.

Incident 14

2.121 We accept this incident as described. It occurred during the night January 3rd-4th, 1973. The patient concerned was Mr. GT. He was a well

known and longstanding source of trouble in the hospital, and was transferred to Broadmoor in January, 1974. He had been disturbed for some days prior to the night in question. On the morning of January 3rd he struck another patient several times and attacked yet another patient in evening. It was unfortunate that the Charge Nurse's judgment was rejected and doubly so that it was treated with such insensitivity.

Incident 27

2.122 Mr. KR was admitted to St. Augustine's in 1955 aged 17. He is suffering from schizophrenia, with epilepsy and mental handicap. His behaviour has been aggressive, threatening and childish and this led to his attendance at the Occupational Therapy Unit being brought to an end. In August, 1972 he was transferred to Heather. His home was in the area for which Dr. Y was responsible, but he was apparently unable to give him sufficient attention until 1975, and therefore Dr. X agreed to look after him until his Consultant colleagues had more time. There came a time when he was unwilling to leave the ward or be on his own. This was probably caused by delusions and the lack of volition which is often found in long term schizophrenia.

2.123 During 1973 Mr. U and Dr. Ankers wearied of What seemed to them to lack of any treatment programme for this patient. Dr. Ankers described how be began to take him to the public house outside the hospital gates, and, later, further afield, and how as the patient's confidence returned, he encouraged him to go Out with other patients. In January, 1974, a multidisciplinary meeting chaired by Dr. X confirmed this programme. Unfortunately Mr. KR's confidence and liking for alcohol both grew and although for a time his progress was such that he was working on another Ward, he presented a serious alcoholic problem in the Autumn of 1975.

2.124 This is an example of an initiative by nursing staff that at first achieved its object and then went wrong, probably because of lack of co-ordination with the doctors, combined with lack of experience by the nurses who were implementing the programme.

Incident 29

2.125 This is true.

Incident 41

2.126 Mr. LQ was born on 31st March, 1945. He entered St. Augustine's in 1961, suffering from hebephrenic schizophrenia, which had started in early adolescence. His IQ was assessed at 85. It is of some significance that in 1959 a doctor reported from an Adolescent ward, where he was then being treated, that "when Largactil was discontinued increased excitement and sexual activity became noticeable". The drug was therefore recommended at 50 mg t.d.s.

2.127 Since he entered St. Augustine's the case notes have been of variable quality. They show that at times Mr. LQ has responded to a variety of treatment including medication and E.C.T. On occasions he has been well enough to go home, but these Visits have not always been satisfactory, and on one of them he punched his mother. There are references to sexual behaviour since his arrival at the hospital. In 1962 the notes point out that he was on considerable medication, but that without it "he tended to

develop gross restlessness with absconding from the ward, overt masturbation, tongue sucking etc."

2.128 LQ was transferred to Heather in August, 1972. The staff found that he frequently left the ward and followed females about the hospital causing them annoyance. Sometimes he tried to look up their skirts and sometimes to touch them. When the nursing staff asked for guidance messages were received from the Chief Nursing Officer that they should keep him in dressing gown order, and from Dr. X, his Consultant, that he should be confined to the ward and suitably medicated.

2.129 Several of the ward staff became increasingly unhappy at this apparently negative attitude to Mr. LQ's problems. At ward meetings they asked that the Consultant should come and discuss the case with them. They shared, we believe, the concern that was well expressed to us by Dr. Ankers, "I would like to have discussed with Dr. X the situation in regard to Mr. LQ. I felt concerned about Mr. LQ. I felt that if I was involved in his treatment I should treat him as best I could. If I was to be a party to confining Mr. LQ to Heather Ward I wanted Some reassurance from the doctor that this was justified." Mr. U told us that Dr. Ankers asked him to arrange for Dr. X to attend a ward meeting to review the case. Mr. U approached Dr. X Who replied that he was too busy. Mr. DW was also approached with the same request and received the same response from Dr. X. Mr. DW continued "I think at the end of the day it was indeed left to the initiative of the individual nurses to think out and implement Other methods of helping Mr. LQ.

2.130 At the beginning of December, 1973, after about 12 months of effort by Dr. Ankers, he and Mr. Weston persuaded a comparatively new Ward Medical Officer to review the case of Mr. LQ and it was then decided to encourage more contacts with his parents and home and to seek to stimulate his interest in films and socials. In view of his abnormal behaviour with women it was agreed that he should have some supervised contact with them. His medication was also to be reduced slowly and his progress reviewed after one month.

2.131 The efforts to carry this programme out were probably misguided in some ways. For example, showing Mr. LQ pornographic books probably excited his curiosity more than satisfied it. The nurses required more supervision than they received; and without supervision errors of judgement of this kind were inevitable, Dr. Ankers, at one time in his evidence sought to persuade us that the programme instituted by the review resulted in improvement in Mr. LQ's behaviour. This was an example of his slanted advocacy, for any improvement which occurred was very ephemeral. In February, 1974, Dr. X had to confine him to the ward and increase his medication in order to prevent him pursuing women and causing them annoyance and he was still continuing to behave in this manner during our Enquiry.

2.132 The problem of helping concerned young staff to understand the difficulties remained in 1974. On March 3rd, a Student Nurse wrote the nursing notes "<u>WHY SHOULD THIS PATIENT BE ISOLATED ON THE WARD WHEN THE TREATMENT HE REQUIRES IS COMPLETELY IN THE OPPOSITE DIRECTION?</u>" He said he hoped to some acknowledgement from the medical staff, but that none was forthcoming. From his nursing superiors he received "sympathy, I think, and apathy as well. I think that several of them felt the way I did about the situation. Again I felt that some thought 'What is the use of trying if you are not going to get anything done in the long run about it'"

2.133 Incident 41 stated that Mr. LQ "just stared at the girls". As Dr Ankers knew, he did more than that. Apart from this, however, the complaint is well founded. Nothing positive was being done. No initiative was shown by those off the ward. The nurses needed guidance which was not given. They were left to do their best for a patient who posed many problems in an overcrowded and understaffed ward, and whose treatment seemed to lack any consistent pattern.

Mr. EV

2.134 The second part of the Critique was dedicated to the memory of this patient who was admitted to St. Augustine's from Broadmoor in January 1974, and who died in strange circumstances on February 14th, 1975 on the eve being returned to prison.

2.135 We deal with the circumstances of his admission and his time in St. Augustine's in Appendix 5 in order to avoid devoting a disproportionate amount of the body of the main Report to one patient. The events set there drive home yet again the importance of proper multidisciplinary at all levels.

2.136 Heather at the time of the Enquiry
The ward consisted of a large square day room without any subdivision and the dormitory presented a typical picture of an overcrowded sleeping area with four rows of beds separated only by a narrow locker space. No partitions or curtains were provided. Quiet and privacy were not available to any patients, other than those who were occupying the few side rooms. Heather could properly be described as the male disturbed ward for Clinical Area 2. It contained some extremely disturbed patients who together, or in rotation, frequently disrupted the life of other patients and added to the work of the staff for days on end. Indeed our first impression of Heather in August, 1975 was reminiscent of the male refractory wards seen in most mental hospitals 20 years ago. There was an atmosphere of disturbed noisy behaviour. The 47 patients varied from fit young men to frail, elderly patients. Some wore dressing gowns and pyjamas, which further visits confirmed as a frequent mode of dress. The lack of divisions in the day room made it impossible for the quiet, anxious and easily upset patients to escape from the noise and interference of those with disturbed psychotic behaviour.

2.137 This ward should be reduced to 25-30 beds and given a good concentration of well trained nurses. In the Autumn of 1975 numbers seemed low by day and night, and there was a marked shortage of trained, experienced nurses. In a reorganised ward, providing some privacy and opportunity of grouping patients of a like nature together, the level of disturbed behaviour could well be lowered quite considerably. Occupation must be provided for the patients who remain in the ward throughout the day.

2.138 In conclusion we emphasise that the tensions between the shifts, and the absence of any consistent medical policy which preceded the circulation of the first part of the Critique led directly to the kind of unstable atmosphere and disturbing incidents which we have described.

Hawthorn Ward

2.139 Dr. Ankers was transferred from Heather Ward to Hawthorn Ward on July 7th, 1974. He served there until his resignation on December 9th, 1974. Some people believed that the purpose of his transfer was to secure his immediate resignation.

2.140 Hawthorn is on the ground floor underneath Heather, and its layout is very similar. Since August, 1972, it has been a male psychogeriatric ward in Area 2, and between that time and May, 1975, the numbers had fallen from 49 to 45.

2.141 Dr. Ankers summarises his experiences and views in Incidents 13 and 43. We accept them as accurate, although we emphasise that patients were only put to bed naked or given urine soaked slippers or radiator dried urine soaked pillows when supplies of replacements ran out. These shortages, however, occurred far too frequently. In addition to the deficiencies spoken of by Dr. Ankers, there was a shortage of flannels which was common to the whole hospital. This shortage resulted in one flannel being used to wash several patients, who were often doubly-incontinent. The supply of pyjama jackets began to improve during the last half of 1974 and flannels have been more readily available since early 1975. Slippers and pillows also became more readily available during 1975.

2.142 There was no occupational or industrial therapy available on the wart while Dr. Ankers was there, but the position had improved slightly by the Autumn of 1975. Five or six patients were then going to the solarium, which we have already described adjoining the ward, and three patients were going to the Industrial Therapy Unit. The need for stimulation and activities for the many left in the ward was great.

2.143 During Dr. Ankers' time in Hawthorn there were no proper changeover meetings, but these have been in operation since the Spring of 1975. On her arrival in July, 1974, Dr. FU started monthly multidisciplinary meetings. Some other Consultants have gradually followed her example, but in the Autumn of 1975 Dr. X had still not found time to hold such a meeting in this ward.

2.144 In Spite of all the difficulties, the totally insufficient nursing staff have worked hard, Dr. Ankers had great admiration for them.

2.145 We were told by a Charge Nurse that the position in the Ward had changed during 1975 to such an extent that one would hardly know it was the same ward. Things must indeed have been bad before. At the time of our first visits in August, 1975, the number of staff (usually four or five) was insufficient to give the patients more than the most elementary care. The picture we retain is of restless and confused old men wandering aimlessly about and in need of attention to their dress and general appearance. A ward sister who had recently moved to the ward expressed feelings of frustration and hopelessness about her work there. The combination of both overcrowding and shortage of nursing and domestic staff meant that remedial, social and occupational activities were very limited. The position of the nursing office and the ward kitchen removed nursing activity from the centre of the ward. The toilets were considerably further from both living and sleeping areas than the 30 feet now generally regarded as desirable, and this may have contributed to the high proportion of incontinent patients. At the time of our visits the lavatories had unlockable and unboltable stable doors which prevented privacy. This can lead to bewilderment, confusion and embarrassment for

even the most demented patients. Although the bathroom and washroom had dividing curtains, space was very limited. This meant that undressing, washing, bathing and dressing lacked the privacy which is so desirable for all hospital patients.

2.146 The beds were in four rows and all were the high type, although some the patients might have preferred, or have been accustomed to, low beds. There were no carpets in the dormitory, and scarcely any sign of personal possessions On the lockers.

2.147 Although it was claimed that Hawthorn was an unlocked ward, the main doors were locked on almost every occasion any of us visited it. No record was made on the ward of the occasions when the main door was locked, as it was asserted that the ward retained its unlocked status because entry could be obtained through an unlocked door into the kitchen. We are satisfied that wards have been locked very much more frequently than have been entered in the ward books kept for that purpose. Between April 22nd 1975 and November 5th, 1975, the Catering Officer, during his routine visits to the wards, recorded in his notebook that a total of seven wards were locked on a total of 21 occasions. Only four of those occasions had been reported in the proper manner.

2.148 Subsequent visits to Hawthorn did not reassure us. At 6.00 p.m. one evening several patients were already in bed, others were wandering round the dormitory half undressed, and many remained in the day room. The limited number of nurses were doing what' they could. One old man lay dying in his bed in full view of the other patients. There were three portable screens available, but these were not in use; indeed the shortage of space round the beds made their use inconvenient. The nurses were distressed at the low standard of care they, could provide. One said "It's not right that these old men should die in a slum like this." On that same day, however, there were a number of empty beds in the sick ward being kept for surgical patients who, at the most, only occupy half the beds retained for them on two days a week, and there were about 130 other unoccupied beds in the hospital. We shall have to consider in due course how this state of affairs was allowed to continue.

2.149 The basic problems of the ward were described by one of the Consultants, Dr. X: "There are far too many patients in a ward of: this nature, being patients of the type they are, senile dements, terminal cases that have come to the end of their life and really have very little to do but sit, and so demented that the nurses cannot really communicate with them, and involving very heavy nursing indeed. A large proportion of these people are incontinent." The problem and the work load have long been recognised, but we emphasize that modern psychiatric services do not accept that such patients have "very little to do but sit", and good nurses are able to form a relationship and communicate with the most severely demented. Lack of a progressive medical policy inhibits the development of nursing treatment for such patients. We need now to consider why nothing was done to reduce the numbers to a level at which the staff workload was tolerable, and a little more than basic care could be provided.

2.150 On June 13th, 1974, the nurses on the ward sent a memorandum to the three ward Consultants and Miss BY, their Senior Nursing Officer, and to their Nursing Officer. It said "Due to the large numbers of High Dependency Geriatric Patients on Hawthorn Ward and the acute shortage of staff, at times only two or three for 43 patients, the staff on this ward would like it known that they would not like to be held responsible for any neglect which might occur while this critical situation continues. Difficulty is experienced in giving minimal care" A similar memorandum was sent to the same persons from Laurel Ward a few days later. Although there followed a plight improvement in staffing, it was minimal.

2.151 On September 3rd, 1974, Miss BY sent the following memorandum to Mr. C, the Chief Nursing Officer: "At the Area 2 Ward Charges meeting yesterday concern was expressed in the strongest possible terms about the staff shortages. The Ward Charges feel that they can no longer provide adequate patient care and they are neglecting the training of learners and the ward administration. They have become another pair of hands, in the struggle to maintain even minimal care. They would appreciate an early meeting with you to discuss the problems and attempt to find a solution. A suspension of informal admissions has been suggested; followed, if necessary by ward closures." Mr. C felt unable to meet the Charge Nurses of Area 2 because of pressure of work, but he said that he would put it on the agenda for his next meeting with the Charge Nurses from all areas. However, the minutes of the Ward Sisters and Charge Nurses' meeting with Mr. C on September 5th contain no reference to this memorandum or the issues' raised therein. This is another example of management failure.

2.152 On July 30th, 1975, Miss BY sent a memorandum to all Consultants in Clinical Area 2 with copies to the Divisional Nursing Officer and the Hawthorn Nursing Officer. She said "A crisis situation has blown up in Hawthorn Ward, staff morale is abysmally low resulting in general dissatisfaction, poor time keeping and the taking of odd days off... Among themselves the staff have discussed the possibility of taking strike action, resigning or requesting a ward move en bloc. Fortunately their concern for their patients has influenced them against taking such drastic action. The main complaints are the extremely heavy workload at the present time, combined with the staff situation. With 45 patients only basic care can be given, resulting in lack of job satisfaction and general frustration. The present bed allocations are Dr. FU 7, Dr. X 12, Dr. W 18, Dr. Y 8." Miss BY went on to suggest that each Consultant should give up a bed as it became vacant and she concluded "The present staff are conscientious and hard working and have a sincere regard for their patients well being. In my opinion they are worthy of our support."

2.153 This memorandum does not appear to have been discussed at the next Divisional meeting for Area 2, although the hope was expressed that when the Elder complex opened after upgrading early in 1976 it would be possible to reduce the beds on Hawthorn by five. Dr. X kept a bed empty in order to help, and Dr. FU promised Miss BY to take a bed down at some uncertain time in the future, but Dr. W said he could not agree to her suggestion because of the pressure of people awaiting admission. The Divisional Nursing Officer raised the matter at the next Medical Executive meeting, but no decision on the number of beds was taken. At the end of September, 1975 there were 40 patients in the ward with five empty beds. Dr. X, the Chairman of the Medical Executive Committee, felt that they should not be taken down because of the pressure for admission that would probably develop during the Winter. When we left, there were 42 beds, with the Consultants and nursing staff all in disarray as to what had been agreed between them at a recent meeting at which all thought that they had agreed on a reduction of beds.

2.154 There is clearly a conflict of interest between the patients and nurses in overcrowded wards, on the one hand, and the doctors who seek to find beds for people outside requiring admission, on the other. How is this conflict to be resolved? Whose decision should it be as to whether a bed is taken down? Dr. W was asked about this conflict of interest and stated unequivocally "I cannot see how one can reconcile the two. We have got to provide a psychiatric service for the community." He said he could not take down any bed, and the only answer he could see was new wards "because our catchment area is expanding and the age group of our population is getting older. This inevitably brings about admissions to the hospital. The community services in Thanet, which is the area I represent, are appalling. There is no support in the community for patients." He felt that the position in Hawthorn with the pressures on staff described by Miss BY's memorandum of July 30th, 1975, was better than a patient not being cared for at all, "which is the case With geriatric home-patients sitting alone in squalor, where the patient's life is in danger and they require admission to hospital". Because of the pressures for admission Dr. W is sure that the opening of the Elder complex will not produce the hoped for reduction of beds in Hawthorn.

2.155 One Of the barriers in the way of resolving this dilemma has been the widespread, but erroneous, belief throughout the hospital that no bed can be taken down unless the Consultant agrees. For example, the Nursing Officer for Hawthorn during 1974 told us "Until the Consultants agree to take a bed down we cannot do anything about it". He was asked how far the nurses were prepared to go in pushing the Consultants and replied "We have discussed this With the Consultants, and they say we have a duty to the Consultants." Dr. W also considered that the Consultant has the final decision, and explained "I represent the community: I represent my Catchment area: I do not only represent My hospital. I have to provide a service for my catchment area."

2.156 There must be an end to this Wrong thinking. The Consultant does not own the bed and has no more authority over it than the nurse. It should be an essential part of ward policy that there is an agreement between medical and nursing staff on the number of patients on any one ward, the function of the ward, and the rate of admission, if it it an admission Ward. Where it is not possible to reach agreement at ward level the problem should be referred to the Clinical Area Multidisciplinary Team and from there, if necessary, to the Hospital Management Team (See Section 6.). Failing agreement within the hospital the problem must be taken to the District Management Team, and from there to the Area Health Authority and ultimately, if need be, to the Region. As noted elsewhere in this Report, it is unfortunate that the District Management Team responsible, for St. Augustines has disproportionate representation on behalf of the medical profession, so that it is difficult for the nursing point of view to be adequately and forcibly represented. There are many hospitals with wards containing too many patients. Where no immediate reduction is possible it should at least be possible to agree forward plans, including the rate at which beds will be taken down and the eventual totals. Monitoring of the progress is an essential part' of the job of both the Hospital Management Team and the District Management Team.

2.157 During the Enquiry an improvement in staffing ratios was achieved, mainly as a result of improved recruitment generally. The reduction of beds to 42 is regarded by staff as a step in the right direction. There are hopeful signs of a patient assignment programme for nurses but this will require a guaranteed minimum number of staff and some prospect of continuity.

Incident 47

2.158 The first sentence is intended to refer to a patient in Hawthorn. The person who gave this information is now overseas and we have not been able to identify the patient. A random selection of case notes in each long stay ward, however, revealed periods of a year or more during which patients do not appear to have been seen by their Consultant. We checked a random 30 medication records of patients in Hawthorn and found that 12 of those patients had not had any medication change for 12 months.

Hazel Ward

2.159 Although neither Dr. Ankers nor Mr. Weston worked on this ward, there are 11 incidents in the second part of the Critique which relate to it. Ten of those were based on information supplied to Dr. Ankers by a Miss OA who, after obtaining a degree in History and English at the University of Kent, worked as a Nursing Assistant in the hospital from November 18th 1973, until July 13th, 1974. She worked in Hazel Ward until January 14th and thereafter in Elm Ward. During her eight months at St. Augustine's she was absent from work on 50 days, usually as a result of ill health, and was frequently late. She was aloof from the majority of the staff and more interested in attitudes than basic physical care. At times her attitude towards those requesting her to carry out routine tasks approached dumb insolence. The more unreceptive the senior staff were to her ideas, the more she withdrew from them and from the rest of the staff, and she was fairly regarded as setting herself apart from the team. She proved herself an intelligent and an astute, if selective, observer, but she was not in our view a good nurse, and it is surprising that the hospital continued to employ her as long as it did, even on the basis that she was a pair of hands.

2.160 Hazel has been a female psychogeriatric ward in Clinical Area 3 since August, 1972. The number of patients was reduced from 65 to 45 in the first 12 months. In November, 1973, when Miss OA joined the staff of Hazel, there were 42 patients, of whom 19 needed feeding and 30 needed dressing, and of whom more than 20 were doubly incontinent. There were normally three, sometimes four, staff on duty. There was only an occasional visit by an Occupational Therapist, who helped some patients with knitting and painting, and about six patients went on very occasional outings. There were virtually no ward activities for patients: they were, in the words of one nurse, "dressed, placed in their. chairs, fed at meal times and put back to bed. As I recall, in between there was absolutely nothing."

2.161 The problems of the staff were enormous. They had no guidance and no effective support. Within their own limitations, and the environment in which they had to work they all probably did their best. We think that there was force in Miss OA's answer to the question "Are you suggesting that the nursing staff on Hazel Ward were not making a proper effort to look after the patients adequately?" She replied "I do not think that it is as simple as that. I know that they had been with these patients and each other for a number of years. They were still working with set procedures and attitudes which they had learned quite a while ago. There did not seem to be any kind of training or educational opportunities offered to bring them up to date. Therefore, in their own eyes they might have been doing the best that they thought possible ... I felt that they themselves, just as much as the patients, had been worn down by routine to accepting anything which went on, doing it mechanically, not seeing these patients as people but as objects to be potted, fed, put to bed and so on."

2.162 This insidious dampening down of the sensibilities by the environment was spoken of by Miss QB, another young nurse of high calibre, who worked on the ward a year later. After she had told how, because of shortages, she had used one flannel for several patients on all parts of their bodies, she was asked if she knew that it was wrong. She replied "Of course. One of the criteria that I have always used is: 'would I like it to be done to me or my mother?' obviously to be washed with the same flannel as a complete stranger, and especially a geriatric patient who is incontinent, is not very pleasant, and I was aware of this, but after a day or two when you are a new nursing assistant, and you are not in a position to introduce any new procedures, after going along with the others for a day or two it just became an insignificant issue. That is all I can say. I was aware that it was wrong."

2.163 We now turn to consider the incidents relating to Hazel in the order most helpful for understanding the ward's way of life and problems.

Incident 26

2.164 There is much truth in this allegation. The staff's knowledge and understanding was out of date. We accept Miss QB's description of the ward at the end of 1974, and find that it applied with equal force to the time when Miss OA was there. "Compared to other wards in the hospital, many of the procedures were disgraceful... I did find that all grades of nursing staff expressed attitudes which were insensitive and degrading to the patients on Hazel Ward. I frequently heard such statements, said from one nurse to another as they were washing the patients, as 'this ward is the end of the road', 'you can see this one is on the way out'... It was assumed that the patients were so demented that they would not understand, but in my opinion sometimes they definitely did. I did hear nurses on my ward describe patients on other wards as being 'a bunch of psychopaths', In some ways the physical care of the patients was excellent e.g. they were washed regularly, this being a priority, although the baths were few. Also I never saw any bed sores throughout my (six month) stay on the ward... When I first went on the ward it was common practice to spend at least an hour over the tea break for the shift. I feel that the morale of the staff and the conditions of work were so bad that the only way they could tolerate the work was by getting it over quickly in time for their tea break. If Mr. RC was on duty this did not happen. With him the breaks were much shorter and sometimes less often."

2.165 Mr. RC was a Charge Nurse who was described by Miss QB as, a capable man who worked very hard to alleviate the load on the nurses. He was kind and had the patients welfare at heart but "when I worked on the ward he did not seem interested in altering the day to day routine which I found surprising:. .I got the impression that he had tried to make changes in the past, but had received insufficient support."

2.166 We find that at this time the staff were providing only the bare minimum in care, and that for the reasons explained by Miss QB there were frequent and long tea breaks.

Incident 8

2.167 We accept that patients were not bathed sufficiently-often. At this time they did not receive more than one bath a month, and sometimes the gap was much longer. Miss QB, speaking of October, 1974, to April, 1975, said. "As far as I remember, the bathing tended to happen in spates. When someone would get enthusiastic one morning quite a few baths mould be done. Otherwise they were only done when a patient was exceptionally dirty, and there was absolutely no routine whatsoever about the bathing. Some patients went for several months, two or three months, without a bath. I know that for certain."

2.168 The frequency of bathing was totally inadequate. Although every patient had a daily 'strip wash' this did not include the feet, and it is a crude and Undignified procedure.

Incidents 18 and 28

2.169 We find these incidents proved

Incident 39

2.170 We find this proved. Miss QB said that the Ward doctor visited the ward daily and would spend a few minutes in the office talking to the Charge Nurse "If a patient became physically ill the doctor would then, examine the patient, but I never saw a doctor go round the ward aid look at each patient. I was never made aware of the medical policy, if any, in treating patients on the ward, as I was to be involved in their nursing I thought I should have been. I never saw a Consultant on the ward, and I do not know who the Consultants were for that ward. A Consultant could, of course, have come onto the ward when I was not on duty." Dr. Q, one of the Consultants for the ward, said he never held a multidisciplinary meeting in Hazel between August 1972, and his retirement in July, 1975, and he never heard of any other Consultant holding one there. The problem, he claimed was getting sufficient people to attend.

Incident 23

2.171 We are satisfied that it was an unwritten ward practice that the dozen or so most helpless patients who were unable, or did not like, to ask for more received unduly restricted liquid. This resulted partly from forgetfulness, and partly from a desire to limit the output of urine onto the floor or chairs by incontinent patients. Miss QB noticed that the urine of these patients was strong and concentrated. A student nurse of that time told us, and we accept that when he started to brew up mid-afternoon tea for" the helpless patients he got strange looks from the permanent staff and that one of the enrolled nurses said that they did not usually do that.

2.172 Food at this time was sometimes unappetising and unimaginative and often cold. There wasp and still is, too great a-reliance on mince for patients who are alleged to be unable to manage ordinary food. We accept that helpings were often small. This was probably a consequence of the need of so many patients to be fed.

Incident 19

2.173 Save that we substitute 'several' for 'ten to twenty', we find this incident proved.

Incident 16

2.174 All patients who needed spectacles were not deprived of them, but there was a practice to keep spectacles belonging to a number of the patients in a cupboard in the office in order to prevent them getting lost or broken. The effect of this practice was that a patient's spectacles were kept in the office unless she proved that she had some use for them and would be able to look after them properly.

2.175 With this qualification we accept the matters alleged in this incident as substantially accurate.

Incident 12

2.176 This refers to Mrs. NE who qualified as a Registered Mental Nurse at the end of 1969. She has worked in Hazel Ward since August, 1972, first as Acting Ward Sister then, from January, 19731 as Ward Sister. She had an arrangement with Mr. RC that she would be responsible for the administrative work, and this meant that she spent most of her time in the office. In our opinion she has limited insight into psychiatric nursing and the needs of the elderly. She is a bit of a martinet who lacks tolerance for the young and tends to display too much deference to those in authority. For example, she endeavoured to explain to Miss OA that she should 'stand up' in a proper manner for higher nursing staff. She contrasted what she regarded as that "established courtesy" with Miss OA's practice of standing with her arms folded.

2.177 We accept that Mrs. NE discouraged criticism and suggestions and that she dealt with Miss OA's suggestion about flannels in the manner alleged.

2.178 We reject the suggestion that patients' gifts were not distributed. Gifts of the kind described were kept in the office and gradually distributed. We do not accept that fresh fruit, cheese and cake were never distributed. They normally were.

Incident 4

2.179 This refers to Mrs. SF. She has worked at St. Augustine's for about 30 years. For the first ten she worked in the housemaid section; thereafter she has nursed mainly on geriatric wards. About ten years ago she qualified as a State Enrolled Nurse by virtue of long service and has worked in Hazel since August, 1972. We found Miss QBs description of Mrs. SF to be fair and accurate "I worked closely with her for long periods. Mrs. SF is a very kind, good hearted woman, and often worked very hard indeed on the ward. She is, however, a moody woman, and tended to be impatient. Her handling of the patients was very rough, but she had no conception, in my opinion, that she was being insensitive to the patients' feelings. As an example, when getting patients up in the morning she would roughly strip the bed clothing from a sleeping patient and lift them on her own out of bed, she being a very strong, well built woman, and then slam them onto a commode. Although the patient cried out I can honestly say I do not think she realised that she was being unkind to them." We would add that she had no real insight into the patients' needs and that she never learnt to nurse the whole patient. Moreover, some measure of deafness causes her difficulty in hearing the patients. She and Mrs. NE desperately needed in service training. At present they are good examples of well meaning nurses who are unsuited to carry out their tasks.

2.180 We are not satisfied that the particular incidents alleged in sub paragraphs (a) and (b) of Incident 4 have been proved.

Incident 62

2.181 We do not find this proved. It was based information given to Mr. Weston by a patient.

The Circumstances in which Miss OA left Hazel Ward

2.182 After she had been on the ward for a few weeks Miss OA saw Mr. L, her Senior Nursing Officer, and asked for a transfer away from the ward and geriatric nursing. In the course of the interview she mentioned most of her complaints regarding Hazel which are set out in the 'incidents' already considered We accept her evidence that Mr. L did not ask her for details and conveyed the impression of wanting to get through the interview as quickly as possible.

2.183 Mr. L told us that he decided that the best way to deal with the situation was to have an open discussion on the ward without revealing the source of the complaint. He and Mr. M, the Nursing Officer, held a ward meeting a week or two later. The first Miss OA knew of the meeting was when she arrived on duty at 1.30 p.m. and found it about to begin. There was very little dispute between Miss OA and Mr. L as to what followed. Mr. L told the meeting that a member of the staff, who would remain anonymous, had made allegations that the ward was badly run and that a patient had been stuck by a member of the staff he did not name. He invited discussion, but there followed a generally embarrassed silence. Mr. L said Mrs. NE "was quite exercised to find out the source of, my information, but I put it to them that these points had been raised and that they should examine their role in the ward to see if there had been justification for the allegations, and, if so, could they come back and say what they would do to remedy it, or, if it was untrue, to let me know that it was untrue, and then I could take it back to the source." We are not surprised that Miss OA felt confused. "I felt in a very difficult position", she told us, "because he had described me as being anonymous. I was not sure what the procedure was. I did not know whether I should remain silent or wait for other people to voice any disquiet. So feeling confused, and in a way

embarrassed, I just kept quiet... I felt that the meeting had been neutralised, because I did not know what to do. I did not know whether to declare myself or not."

2.184 The whole Of Miss OA's complaint was handled ineptly. Mr. L and Mr. M ought to have done more investigation before the meeting and Mr. M should have ensured that Miss OA had ample warning of the date and time it was to be held. We do not understand how the meeting could have been expected to achieve anything under the cloak of anonymity. Mr. L and Mr. M really had no idea of how such a meeting should be conducted. Mr. L spoke to us of "group dynamics". We feel that he had been given a smattering of information about 'open discussion', without any real assistance as to what this really meant.

2.185 Following the meeting Mrs. NE and Mr. RC went to see the Chief Nursing Officer and asked for the complainant's identify. This was given to them. Mr. L concluded that Miss OA's position had become untenable and moved her to Elm Ward.

2.186 It is sobering to reflect that Miss OA's complaints really achieved nothing except her removal from the ward, whereas we are satisfied that the great majority of those complaints were well founded.

Hazel Ward between Miss OA's departure and the beginning of the Enquiry

2.187 It will have been clear from what we have already said that no improvement had occurred by the time Miss QB started work on the ward in October 974. If anything, the position had deteriorated, although the number of patients had been reduced to 39. Staff on duty fluctuated between two and five. Often staff who had reported for work were redeployed by the Nursing Office to meet cries for assistance from other wards. Miss QB often spoke about the situation to Mr. M during his daily visits to the ward. He is a man of charm and goodwill, but we accept Miss QB's account of his response. "If one asked him about any situation, either on the 'phone or person to person, he was an absolute master of the art of putting off, of calming you down in a situation with promises, and not doing anything. I always felt this about him."

2.188 There was no improvement, and no effective support from Mr. L and Mr. M, until all the staff joined in sending Mr. L a letter dated February 22nd, 1975. It was written at the end of a period of 10-14 days during which there had been an outbreak of diarrhoea. Every day, for at least part of every shift on which Miss QB worked, there had only been two nurses. The letter included these passages: "This ward is nearly always under staffed and so we have found it impossible to put into practice any policy regarding such basics as bathing, regular toileting nail cutting and hair washing: so the patients are becoming neglected at this very fundamental level. When the ward is properly staffed a nurse is almost always taken out, and the ward situation is becoming so depressing that the morale of the staff is being seriously undermined.

2.189 "There is a lot to do here besides the basic nursing care: the staff also have to make 39 beds, make sandwiches for two-thirds of the patients for tea and breakfast, and at night after the domestic staff have gone home it has become essential to wash over half the day room floor and wipe down about 15 of the chairs.

2.190 "We must mention that we have pleaded for a heated trolley for years

without success and consequently nearly half the patients always have cold food.

2.191 "Because of the staff situation the patients when they arrive here quickly become difficult (lack of attention), chair-bound, (insufficient time to walk them) and incontinent (lack of toileting). Also, if we had the staff, the patients could go out on the minibus once a week as on other wards, whereas at present most never leave the ward.

2.192 "The minimum of staff required we feel is four nurses plus one Charge and often now we are left with two."

2.193 This letter was followed by a meeting with Mr. L and Mr. M who promised that the staffing situation would improve. Staff who had been detailed for duty on Hazel were no longer diverted elsewhere, and the numbers detailed for duty increased.

2.194 Why did Mr. L and Mr. M fail to do anything before? Miss QB said "I personally feel very strongly indeed that the Nursing Officers were to blame, and that they knew the situation and that they simply did not care." By 'Nursing Officers' she meant Mr. L and Mr. M. At the end of her evidence she was asked what she hoped the Enquiry would do to bring about change. She replied "Above all, I hope that the people who are effectively running the hospital, the Nursing Officers, will never let a situation like that on Hazel arise again. I feel that it was a neglected backwater, and that basically nobody cared. If that happens with the people who are administering the place the whole feeling will run right through the staff."

2.195 It is impossible to quarrel with this apportionment of blame. Mr. L and Mr. M failed in the course of their visits to discover the situation, or, alternatively, failed to take appropriate action. In particular, they did nothing until after the letter to lift the morale of the nurses. This is an essential element in leadership. What can, and must, be said, however, is that Mr. L and Mr. M needed more training for, and counselling in, their important roles than they received. Mr. M had attended a Middle Line Management Course, but this is not adequate for the role required of him. Mr. M told us that he believed patients were bathed once a week. If he had asked the staff or patients he would have found out that this was not so. He never checked whether there were bed sores. He indulged in the form of leadership which claims to give support when problems are raised. Unfortunately the support was too often not forthcoming when problems were brought to him.

2.196 Mr. L agreed that patients in Hazel Ward had failed 'for a limited period of time' to receive an acceptable standard of care. When asked why he had not taken action before the letter he replied "I have not got a crystal ball. When complaints are brought to my attention I take action as I can". In our view Miss OA's complaints following the circulation of the first part of the Critique should have led Mr. L to make searching enquires and satisfy himself about conditions in Hazel.

2.197 Mr. L and Mr. M agreed that the heated food trolley referred to in

the letter had been on order for years. Mr. M said he had been told it would cost £2,000 and that money was not available. Mr. L told us the cost of such a trolley "runs into thousands of pounds". Such an estimate of cost was nonsense. It is probable that the confusion crept in because the hospital required four heated trolleys costing in all £2,000. It is sad, however, that for two years Mr. L and Mr. M had never doubted or queried the information they believed that they had been given to explain the delay. This inactivity and lack of questioning throws light on why Hazel had continued for so long in its quite unacceptable state. The four heated trolleys, including that for Hazel, arrived between our two spells of hearing evidence.

2.198 We have quoted at length from Miss QB's evidence as we found her an impressive witness. Let us put what she told us, and the sorry state of affairs in Hazel, into perspective by one last extract from her evidence. She was asked her experience of other parts of the hospital, and replied "I have never worked on a long stay young people's ward. On the young admissions ward on which I am now working I have nothing but admiration for the staff and what goes on there. It is superb. I only hope that I shall be as good as they are. Generally I do not feel in any way at odds with the way the patients are spoken to and the way things are done. Occasionally you come across a nurse whom you think is rough or someone with whom you do not get on. Most wards go through periods when their administration goes kaput because the Charge Nurse is away or something like that. But I have never felt anything like I felt when I was on Hazel Ward in the way of criticism. Before T worked on Hazel Ward I really loved every ward on which I worked. In fact when people asked me 'Is it a depressing job?' I did not know what they Meant. But when I was on Hazel Ward I understood for the first time what it meant, or could mean."

Hazel Ward at the time of the Enquiry

2.199 On our visits we found that the layout was similar to that already described. The decoration was unimaginative, and the curtains drab. It contained 38 patients, 30 of whom were incontinent (12-14 doubly). There were normally four nurses on duty, but this might rise to five or fall to three. Incontinence was inevitably taking up a great deal of the nursing time by day and night.

2.200 The most noticeable feature of the ward was the high proportion of severely demented old ladies who required a great deal of attention with feeding and dressing. The patients got up early: some of them on Saturdays between 6 and 7.00 a.m. They were put to bed between 6.30 and 8.15 p.m. having had their last meal at 4.00 p.m.

2.201 Bathing remained a problem. A Nursing Assistant came to help with the bathing on the morning shift. If she made a fifth member of the staff she was able to bath five or six patients. If, however, the total staff was less than five this was not possible. Although the aim was that each patient should have a weekly bath, this was frequently not achieved.

2.202 At the end of August, 1975, an occupational therapy aide started attending the ward for four hours on three or four mornings each week. She worked

with six or seven patients. In the four weeks prior to November 18th only four patients had been out of the ward. In the three months before that same date no patient had been out in a hospital coach or minibus. It is not surprising that, apart from the basic tasks of feeding the patients and keeping them warm and comfortably seated by day, the ward presented to us an atmosphere of inactivity.

2.203 The arrival of the heated food trolley has ended the serving of cold food, but there seemed to be lack of imagination in the planning and presentation of meals for the 20 or so patients who require assistance with feeding, in that there remained an excessive use of mince. The Catering Officer was willing to meet requests for alternative diets from nursing staff, but the trouble was that this needed initiative from the nurses and would make more work for them at meal times. It is clear that they will need advice and encouragement if they are to look beyond mince for other alternative diets.

2.204 There is no doubt that Hazel Ward has suffered from staffing problems, both in the numbers of staff allocated to the ward and the quality of the nurses in Charge. It was evident that they had worked hard in their own differing Ways, but there seemed to be a lack of organisation and due sensitivity to the physical and emotional needs of these long stay patients. The Senior Nursing Officer and Nursing Officer for this ward in the Autumn of 1975 were unlikely, without further training and support, to provide the stimulus and sense of direction that the ward requires.

Elm Ward

2.205 This is the ward to which Miss OA was moved in January, 1974. Prior to August, 1972, it was a large ward with patients sleeping on the floor above. It was then attractively upgraded to accommodate 30 patients on the ground floor and has since served as a mixed psychogeriatric admission ward for Clinical Area 3. There are now 20% men and 80% women and it has three Consultants. To some extent it serves as an assessment and treatment ward from which patients may be discharged or transferred to long stay wards like Hazel.

2.206 Mr. Weston worked in the ward for four months early in 1973. Two of them were spent on night duty. He was responsible for giving the information contained, in Incident 45, but the information contained in Incidents 5, 20, 32, and 38 came from Miss OA. Care on this ward was for a time of the same basic nature as we have discussed elsewhere. Several witnesses told us that when there were shortages of male or female nightwear and underwear garments there were occasions when patients had to wear clothing belonging to the opposite sex. Although supplies of new clothing were received from time to time, this was often withheld from incontinent patients who Were given older garments. This may seem logical at first sight, but the long term result is that deteriorating patients were made to feel even more deprived, and their deterioration was thereby accelerated.

Incident 45

2.207 We accept this as substantially accurate. Mr. TM was in charge of one shift and Mrs. UG of the other. There were differences in approach between the two shifts. Mrs. UG agreed that she did not regularly carry out the aseptic technique for dressing, but she maintained that there was not time for this and that the patients did not suffer as a result. Other examples of the differing approaches were that Mr. PM's shift encouraged patients to use knives and forks and sit where they liked, whereas Mrs. UG's preferred them to use spoons and sit in fixed places. Mr. TM's shift dressed the patients when they got them up: the other shift got them up in dressing gowns and dressed them after breakfast. Mr. TM's shift favoured outings and tea parties: the other did not, as Mrs. UG felt that the escorts and those preparing the tea were needed for basic care. No effective steps were taken to end this thoroughly confusing and unsettling position for both patients and students until March, 1975. Since August, 1972, the Senior Nursing Officer and Nursing Officer had been the same as for Hazel.

Incident 32

2.208 We agree that there was virtually no discussion of policy regarding patients treatment. Junior staff did not attend ward meetings and were discouraged from discussing treatment directly with doctors. We find that there was a patient who it was very difficult to persuade to leave her bed, and that Mrs. UG tried to encourage her to get up by the temporary withholding of food. We do not accept that she used the words attributed to her, or that the patient became more intractable. Neither do we accept she lapsed into a worse state than before after receiving E.C.T. We find no grounds for criticising this experiment. We find the allegations in the last half of this incident to be proved.

Incident 38

2.209 We find this incident proved. The nurse concerned is Mrs. UG, who agreed that she referred to some patients as ‘Dumbos', but explained that she did so in a jocular, friendly manner. Nevertheless we are satisfied that what she said, could, and probably Would, be interpreted by at least some of the staff as derogatory and unkind.

2.210 We must at this point say more about Mrs. UG. She has been nursing since about 1957, and has spent all her time at St. Augustine's. She qualified as a Registered Mental Nurse in about 1964, when she won a prize for practical nursing. She was also a member of the team that won Agnes Pavey Award, a competition in practical nursing open to staff from all hospitals. She became a ward sister in 1967 and commenced Work in Elm Ward in August, 1972. She has always been conscientious and hard working: nevertheless we are satisfied that there came a time when she found herself out of sympathy with, and unable to show compassion for, the more disabled and demented patients. Mrs. VH, a reliable witness, and a good State Enrolled Nurse, Who had worked with Mrs. UG for five years, always received consideration from her, told us that Mrs. UG regarded that category of patient as deliberately awkward, and that she Was unable to hide her feelings and appeared not to understand them. We are satisfied that on occasions this attitude led to roughness of handling and inconsiderate speech by Mrs. UG to the more demented patients. She got on well, however, with the less disabled patients, and this inconsistency Was the subject of some puzzled discussion by ward staff. We are satisfied that at no time did Mrs. UG intend to be unkind to any patients, but that with some she was unable to help herself.

Incident 5

2.211 Mrs. UG agreed that she instructed staff to use the method described in this incident to make this patient release her urine. When this patient was moved to a different ward, under a different regime with different medication her incontinence was cured. We find that on occasions Mrs. UG handled patients roughly as alleged in this incident.

Incident 20

2.212 The complaints set out in this incident were made against a Student Nurse, Mr. GI who we have already referred to in connection with Box Ward. The police decided not to prosecute him, and he was subsequently disciplined in the hospital for failing to make out an accident report in respect of the cut which he claimed he had discovered on the patient's head. He was then moved to another ward where there were further allegations against him. He refused to give evidence to us. In spite of this record he was permitted to qualify as a Registered Mental Nurse and received his certificate at St. Augustine's in 1975. We do not understand how this came about. From an early time in his training there were signs that he was unsuitable for this form of nursing and his training should have been terminated. Pairs of hands alone do not give adequate care or maintain morale.

The manner in which complaints about Mrs. UG were dealt with

2.213 In about February, 1974, Mrs. VH and a Nursing Assistant, Miss WI, spoke to Mr. TM and said that they could no longer tolerate Mrs. UG's attitude to some of the patients. As they were reluctant to report the matter to the Nursing Officer Mr. TM did so. Be also mentioned it to Dr. XK, the Ward Medical Officer.

2.214 Mr. M decided to convene a ward meeting and invited Mr. L to attend, but it could not be held for about a week as Mrs. UG was on holiday. In the intervening period he made none of the enquiries which he claimed he would normally have made to prepare for the meeting, because he attributed the unrest to the arrival of Miss OA in Elm Ward. As in Hazel Ward, the time of the meeting seems to have been fixed at very short notice, for Mrs. VH first heard of it 20 minutes before it was due to commence. After an introduction from Mr. 1119 which did not make the purpose of the meeting clear, the staff were invited to put forward their points of view. Miss WI started and was followed by Miss OA who made most of the allegations about Mrs. UG which we have already considered. Mrs. UG denied them. When Miss WI supported Miss OA on one matter Mr. L asked why she had not raised it at the time it occurred. This did not encourage further contributions from Miss WI. After accusation and counter accusation between Miss OA and Mrs. UG, Mr. M intervened. He explained "In an attempt to break this personality difficulty between them I think I suggested really that we should try to leave personalities out of it and look at attitudes, which I think Miss OA was driving at." The muddled thinking behind Mr. M's intervention is demonstrated by the following questions and answers by him.

Q. What did you mean by 'attitudes'?
A. This business of Miss OA thinking (Mrs. UG) was unnecessarily harsh, or, if you like, rough with the patients.I thought that discussion of the question of attitudes was essential, because my opinion of (Mrs. UG) is that she was firm on occasions, but that she was basically a kind person.

Q. Forgive me, but how on earth is it possible to discuss attitudes in that kind of situation and leave personalities out of it, when there really are only two personalities involved, (Mrs. UG) and (Miss OA)?
A. I am not saying that what I did was necessarily right, but I was purely attempting to break up this verbal battle between them.

2.215 Mr. L supported Mr. M's request to concentrate on attitudes. The effect this had on Mrs. UG and Miss OA is illuminating.

2.216 Mrs. UG said "The nurses were asked to say what their complaints were about me. (Miss WI) spoke, (Miss OA) spoke, and I suppose I misunderstood, but I thought that it was a meeting where we would each discuss our opinions of each other, but When I expressed my opinion of (Miss OA) I gathered that I should not have done it. I got the impression that I was not supposed to do that and I was told that it became a personality clash. I did ask for a further meeting so that everyone could say what they had to say and tell me what their complaints were about me, but Mr. L thought that there might be another personality clash and that it would be better to forget it.". Miss OA on being asked if anything useful came out of the meeting replied "I thought it was a complete whitewash of Mrs. UG because it felt as if the meeting was being directed to generalities, not to discuss her behaviour, which was of great concern to most nursing staff. Suggestions were made that she took too much responsibility on herself, did too much physical work, and so on, which I did not feel was the. case at all, so I felt very much more it was a question of protecting her."

2.217 We have set this out in some detail as we wish to demonstrate as clearly as possible that it is no good talking to middle management nurses about "open discussion" and "concentrating on attitudes rather than personalities" and then leaving them to get on with it. The conduct of an open discussion, if it is to be useful, needs considerable skill and much practice. This is an area in which all middle management need continuing instruction, counselling and practice.

2.218 Following that meeting Mrs. VH was away from work for some weeks because of ill health. When she returned She saw Mr. M and said that although she had not spoken up at the meeting she did not wish to go on working on Elm Ward because of the harsh way Mrs. UG behaved to the patients. In the weeks that had elapsed since the meeting Mr. M had not given any advice to Mrs. UG, although he felt that there was some substance in the criticism. Neither had he spoken to Miss OA about the meeting or her attitudes which he believed had precipitated the discontent. He sought to explain "I see my job as not, if you like, to stir up trouble".

2.219 Following his discussion With Mrs. VH Mr. M spoke to Mrs. UG and told her that some of her actions could have been misinterpreted, and warned her to refrain from attitudes which could be considered harsh. He advised her to examine her attitudes and be rather more flexible towards staff and patients. He felt that she subsequently modified her behaviour.

2.220 Round about this time Mrs. UG found Miss OA becoming increasingly resentful every time she asked her to do anything. She spoke to Mr. M and Mr. L and explained that she did not think that Miss OA would ever make an acceptable nursing assistant, and that she really should not be on the wards. They told her "that there was a shortage of staff, that she was another pair of hands, and that there Was no one to replace her". So Miss OA remained on Elm for two or three months longer until she resigned in July, 1974, on obtaining a job that suited her better. Neither Mr. M nor Mr. L attempted to speak to her about her attitude or to seek to understand her resentment. This really was management by default.

2.221 Following the circulation of the second part of the Critique in February, 1975, Dr. XK asked some of the nurses on Elm Ward whether there were any matters causing concern on the ward. He set out what he was told in a memorandum which he sent to the Chief Nursing Officer. After referring to the earlier complaints about Mrs. UG's "attitude to and handling of geriatric patients", he continued, "On 1.3.75. a Staff Nurse complained to me on lines similar to above. She felt unnecessary force was being used in toileting and "force feeding" and that incontinent patients were told that they were being dirty intentionally and such was not the case especially one patient who has Paget's Disease with an associated pathological fracture who is unable to leave her chair. On Mr. TM's shift apparently this patient was potted regularly and there was no problem."

2.222 The Staff Nurse concerned confirmed that this memorandum accurately summarised her complaints, save that she wished to amplify the reference to force feeding. "I was", she said "referring to an occasion when I saw Mrs. UG giving medication to a particular patient. I have not seen her force feeding as a general rule". No one sought to obtain further information from her, although about the same time Mr. M had a similar complajnt about Mrs. UG's roughness from another nurse.

2.223 At the suggestion of the Chief Nursing Officer Mir. L and Mr. M saw Mrs. UG and suggested that she should move to another ward. Mr. M was "beginning to feel" that she was not a satisfactory Ward Sister for that ward, and that it was getting her down a bit after two or three years. Mr. L also thought that Mrs. UG should move "in the best interests of the ward". Mrs. UG after some hesitation declined to be moved. We were anxious to discover why a move was not then insisted on. Mr. L sought to explain "I would not move anyone against their will, and particularly in a situation like this where a lot of the logic of management of wardships would bear scrutiny from either direction".

2.224 At Mrs. UG's request a ward meeting was held. During the meeting Mr. L announced that Mr. TM would be responsible for ward policy. This had not been discussed with either Mr. TM or Mrs. UG before the announcement was made.

2.225 There followed an uneasy compromise. Mrs. UG told us that she had received no advice or counselling from Mr. L or Mr. M between that meeting and giving evidence to us. Neither does she seem to have sought it. She said that the atmosphere was strained, and that she had the feeling that she was being watched and everything she said or did noted. She appeared to us to be under very great strain. She expressed a willingness to move to another ward, and this has since taken place. She ought to have been moved in March for her own good and for the good of the ward.

2.226 Mr. L and Mr. M attributed the discontent on the ward to the arrival of Miss OA. When Mrs. UG asked for her removal they declined to take any action. When they felt that Mrs. UG should move and she declined, they gave in. No investigation was made as to whether the complaints made in March were well founded or ill founded. This sorry story indeed exposes some of the weaknesses of middle management.

2.227 On our visits we found the atmosphere was bright and pleasant, and the patients lively and responsive. The number of nursing staff allocated to the ward seethed reasonable, although additional help would have been an advantage in assisting with occupational, social and recreational activities.

Maple Ward

2.228 The incidents concerning this ward are 6, 91 11 31 and the second part of 47. We will consider Incidents 6 and 11 under a separate section dealing with electro-convulsive therapy.

2.229 Mr. Weston worked in this ward for one month in 1970 and three months in 1971. It was then a male admission ward for the whole hospital. The senior Consultant for the ward was Dr. Q. Since 1972 it has been a male admission ward for Clinical Area 3. The Consultants have been Dr. Q, until his retirement in July, 1975, and Dr. R. Dr FU joined them in 1974. Patients have numbered between about 40 and 36.

Incident 9

2.230 We do not find this proved.

Incident 31

2.231 The information in, and wording of, this incident came from Mr. Weston. The State Enrolled Nurse referred to is a Mrs. YL. She has worked in St. Augustine's since 1953, and qualified as an S.E.N. by length of service in 1965. She has worked in Maple Ward since about 1966, and has normally been the only woman on duty.

2.232 We accept as substantially accurate a description of Mrs. YL which was given by Mr. ZO a Registered Mental Nurse who worked in Maple Ward as a student nurse shortly after Mr. Weston. He described her as tempered, arrogant, impatient and bad mannered with patients. When she wanted patients or staff to do anything she commanded rather than asked. She used to spend much of the day sitting on a chair by the door watching people come in and go out. This behaviour did not help newly admitted patients to settle down, and there was a lot of muttering and cringing by them when she came on duty, although she had some favourites. When she was on duty the door into the ward was locked more often than when she was not on duty. Dr. Q made no mention of this when she let him into and out of the ward.

2.233 Mrs. YL agreed that the ward was locked on occasions, but claimed that this was never done without the authority of -the Charge Nurse, and that it was always duly reported. However, examination of the ward reports during the time that Mr. ZO worked on the ward revealed no occasion when the ward was reported as locked. We are satisfied that the ward was frequently locked, often on Mrs. YL's own initiative, and that no proper records of locking were kept at this time. To this extent only do we find Incident 31 established, and we regret the lurid language in which it was expressed.

Incident 47 (second part)

2.234 In April, 1971, a patient, Mr. ABC, then aged about 41, was admitted to Maple Ward from Broadmoor Hospital under Section 60 of the Mental Health Act, 1959. From that time until Dr. Q's retirement in July, 1975, he was kept in pyjamas and dressing gown, apart from one period of four months from January to April, 1974. Dr. Q described him as very psychotic with very disordered thinking. The purpose of keeping him in dressing gown order was according to Dr. Q, to let him adjust to mental hospital conditions. The period of four months to which we have referred was when Maple Ward was closed for redecoration and the patients had to go elsewhere. While they were away from Maple they went to the patients cafeteria for meals, and Mr. ABC and other patients who were in dressing gown order had to dress for this. Dr. Q told us that when the patients returned to Maple he told the staff that as Mr. ABC had returned to familiar surroundings he should be put back into dressing gown order. When one of the Charge Nurses protested Dr. Q agreed that Mr. ABC should be allowed to dress, but told him that time would prove that this was wrong. Some time later he absconded, but neither threatened nor did anyone any harm. He was returned to the ward after about six hours.

2.235 Dr. Q agrees that the decision to keep Mr. ABC in dressing gown order was his. The time for which he was kept in this attire cannot be justified, particularly in the light of Dr. Q's evidence that after the first 12 months he only reviewed this patient about once a year. The case notes suggest that the intervals had been rather greater than that. Dr. Q told us that he tried in vain to get Mr. ABC readmitted to Broadmoor, and agreed that he had formed the view that this patient was incapable of any rehabilitation. Since Dr. Q's retirement there have been frequent reviews of this patient's treatment, and some improvement in his condition.

2.236 Dr. Q was well known for his practice of keeping patients in dressing gown order following admission. He said "I was the only Consultant in this hospital who used this system fairly regularly. Other patients from Broadmoor have been kept thus for over a year." Even informal patients often spent three or four weeks in pyjamas and dressing gowns. Mr. CX the Principal Nursing Officer, told us that he had recorded and reported his displeasure at, and disapproval of, Dr. Q's insistence on dressing gown order, and that the Chief Nursing Officer told him "I am very sorry this is the Responsible Medical Officer's decision, and it must be abided by". The Chief Nursing Officer in his evidence agreed that some of the nurses found it a shocking situation but he never raised the issue with Dr. Q.

2.237 Dr. Q said, in effect, "What else could I do? The only alternative was over medication to prevent the patients absconding." When asked if he was suggesting that other Consultants over medicated patients he said "No". He emphasised that the ward had a full size billiard table on which the patients could' play, and that in sunny weather they could go outside. It was the spectacle of numerous patients outside the ward in pyjamas and dressing gowns that Mr. CX found so distasteful.

2.238 Dr. Q agreed that the nurses might be in a better position to judge whether a patient should be in dressing gown order than he, but maintained that where there is a conflict it is the Consultant who must decide as he is the person who will carry the responsibility if the patient escapes and causes injury or damage. This seems to have been the widely held view, and is part of the mystique of the clinical autonomy of the Consultant. We are satisfied that this view is wrong. The decision as to whether a patient needs to be in dressing gown order must be a multidisciplinary one, and if it turns out to be wrong the Consultant will carry no greater responsibility than any other member of the team. There are various factors, and conflicting interests to be balanced, and each member of the Team has an important contribution to make in striking the right balance.

2.239 The manner in which Dr. Q was permitted to adhere to his quite unreasonable insistence on prolonged"dressing gown order" illustrates yet again the extent to which doctors were allowed to hug to themselves decisions which were essentially multidisciplinary. For example, Dr. Q knew that the Occupational Therapy staff protested that his insistence prevented patients attending the department for occupational therapy, but he remained quite undeterred.

SECTION 3: OTHER MATTERS COMPLAINED OF IN THE CRITIQUE

3.1 Living Conditions (Incidents 2, 15, 17, 40, 46, 48, 49, 55, 58, 59 and 69)

3.2 Incidents 2 and 15 we do not find proved.

Incident 17

3.3 This criticism was well founded so far as Heather Ward was concerned. See paragraph 3.104.

Incident 40

3.4 There was overwhelming evidence that the long stay patients received old fashioned, short-back-and-sides haircuts unless they asked for anything different. Many were unable to make such requests. Ward staff can help to solve this problem by encouraging patients to tell the barber how they would like their hair cut, and where a patient is unable to do this, by friendly discussion with the barber when they take him for his haircut. If patients paid for their haircuts this would assist in introducing, or restoring, some dignity and normality.

Incident 46

3.5 No catering service will be perfect. In the past food was on occasions substandard and not hot enough. It may have been delivered late on occasions, although it was not proved that this was ever due to the luncheon requirements of the Management Committee. The distance of many wards from the main kitchens, the absence of lifts, the difficulty in obtaining heated trolleys, shortages of staff and large numbers of patients have all created substantial difficulties which have gradually been overcome.

3.6 We have already mentioned that in our view there is excessive use of mince for some patients. If it arrives or is served cold it is particularly unattractive. The catering staff will provide alternatives to mince, and the nursing staff need help in selecting alternatives, and encouragement to order them in time.

3.7 We are satisfied that the food is now good in quality and adequate in quantity. The menus provide a choice, and there are attractive restaurants for patients and staff. For one week we selected food from the patients' menu and for the remainder we chose from the staff menu. Although the menus were different so that staff do not have to eat the same food as they had just been serving and feeding to patients, there was no difference in the standard. The Catering Officer or his Assistant pay regular visits to wards to ensure, so far as they can, that they are providing an adequate service. There have been occasions in the past when wards have had insufficient food, and although more could always be obtained from the kitchen, it must have been very irritating to have to send a nurse to collect it when the ward staff were fully occupied feeding the patients, particularly on the geriatric wards, or helping them to feed themselves.

3.8 The Hospital Advisory Service recommended that last meals should be later than 4 or 4.30 p.m., and as a result about six wards began to have their last meal at 6.00 p.m. Not all of those continued. We were told that meals at 6.00 p.m. interfered with the patients' social life and evening activities. Staff also had less time to put patients to bed before going off duty. However, 4.00 p.m. or thereabouts is in our view too early for the last meal of the day, and we have no doubt that by a concerted effort the life of the hospital can be adjusted so that the last meals can be served at a more acceptable hour.

3.9 We have no evidence that the patients' Utility rand has been misused. Money was requested for ward outings and refused as it was considered that money for these outings should come from the patients' earnings or pocket money. Some staff provided their own money to help finance these outings, and took part in them during their off duty hours. The expenditure of a large sum of money on a rear entrance to the hospital which is rarely, if ever used has seemed to many staff a questionable use of money.

Incident 48

3.10 From what we have already said it is clear that life for the patients on some of the long stay wards would have given this impression.

3.11 Some of the long stay wards are rather dull and shabby but this is gradually being corrected. There are several wards in need of central observation offices: they have been asking for them for years. Privacy is not obtainable in some bathrooms, washrooms, lavatories and dormitories. We know that money is very short, but there must be multidisciplinary systems starting at Nursing Officer level by which priorities can be put forward and agreed for Clinical Areas. The Management Team for the hospital (see Section 6) will then have to balance the needs of the Clinical Areas. What the National Health Service Funds are unable to provide, the Friends of St. Augustine's and other voluntary bodies may be able to produce.

3.12 In April, 1974, many of the patients' clothes were shoddy and institutional. There were difficulties in obtaining adequate supplies, and the laundry had the reputation, with some justification, of being able to shred a piece of steel. There was a tendency in some wards to keep new clothes for special occasions. All this is gradually being put right. Many Charge Nurses have shown real initiative in bringing outfitters into the wards, and in helping patients to choose and save for suitable clothes. However, there is a continuing and urgent need to achieve a situation where all patients have personal clothing. We observed many shabbily dressed patients wandering about the hospital and sitting in wards, but we are confident that as the quality of living for the long stay patients improves they will take increasing pride in their appearance.

3.13 The shortages of clothing were particularly degrading to patients. As far back as November, 1971 the Hospital Advisory Service had reported that on occasions there were no night clothes for patients, and yet these shortages continued. A staff nurse Spoke of occasions when patients were put to bed wearing only vests and of males in female nightgowns. An Occupational Therapist told us of an occasion when she had to search for some clothes that would fit patients as it was impossible for them to take part in occupational therapy holding up their trousers and without socks or shoes. Other witnesses spoke of missing buttons and of having to put dirty clothes on to patients after a bath instead of the clean clothes that they were supposed to have. The supply of clothes improved greatly

during 1973 and early 1974. Some shortages, however, continued because of deficiencies in the laundry which were exacerbated by a longstanding and notorious personality conflict between the Group Secretary and the laundry Manager.

3.14 We have already referred to the shortage of flannels and slippers in some Wards. There are many references to the shortage of flannels in the minutes of Senior Nursing Staff meetings and staff in several wards tore up old towels in order to avoid having to use one or two flannels on up to ten patients. The Supply of flannels was controlled by the Group Secretary Who took the view that patients could normally afford to buy their own. Ward staff were, however, unaware of the reason for the shortage. All that they did know was that it was not within their power to remedy the position. During his last five years at the hospital the Group Secretary authorised the issue of an average of 400 flannels each year for the whole hospital, He sought unsuccessfully to persuade us that there was an adequate supply in circulation at all times and that "this matter was never presented to me as one of Very great moment".

3.15 There was some criticism of the failure to provide fire-proofed, non-inflammable night clothes, but we did not feel that this was entirely justified. The Group Secretary took advice from the British Laundry Research Association and decided that there was insufficient justification for obtaining fire-proofed night clothes when they would have to be reproofed after every ten washes.

3.16 For several years there have been many staff without pass keys. The situation has been known to everyone, but until the time of this Enquiry the management system had failed to remedy it. During September, 1975, there were 30 or more night staff without pass keys. It would be pointless to catalogue the three years of talking which achieved nothing. We give one example of the kind of thing that has held up progress.

3.17 In March, 1975, the Chief Nursing Officer sent a memorandum to the Group Senior Nursing Officer of the Night Division reminding him that he had authority to withdraw pass keys from staff and issue them on a nightly basis. The Group Senior Nursing Officer took the legalistic view that as neither he or the Chief Nursing Officer were the 'issuing body' for keys they had no authority to withdraw them. Each allowed the impasse to remain. This is a classic example of people in authority refusing to shoulder it. At long last in the Autumn of 1975 the District Management Team was taking effective steps to see that there were sufficient keys.

Incident 55

3.18 This was true of the great majority, of the long stay wards at the time of the Critique.

Incident 58

3.19 There Was very little effective training on the majority of the long stay wards because of the heavy workload and inadequate facilities. On some wards there was a great discrepancy, which was still present in the Autumn of 1975, between what was taught in the school of nursing and what is found on the ward.

Incident 59

3.20 There was overcrowding which had the results set out in this Incident and created very difficult working conditions for staff. Overcrowding was still present in the Autumn of 1975.

Incident 69

3.21 There was an occasion in April, 1974, when a Sister was summoned to the Occupational Therapy Department in the circumstances alleged. On arrival she expressed annoyance when she found that the injection was no longer necessary. We do not find that she Used the words attributed to her, or that her annoyance was as great as the wording of this Incident, implies.

Medical Matters (Incidents 50,53,54,56)

Incidents 50 and 53

3.22 Although there was nothing to suggest that the practices described in Incident 50 were generally followed, there was evidence that until' recently on Maple Ward the procedure was. to take away a new patient's possessions and clothes and put him in dressing gown order until he could be seen by the Consultant. Such a procedure was unnecessary and removed self respect. We hope that it no longer goes on anywhere, and we are sure that it would not have occurred if there had been a proper multidisciplinary approach to admission procedures, instead of leaving the Consultant with too much authority in matters which are not solely his concern. Drugs were sometimes prescribed by a doctor on the word of the Charge Nurse alone, but this was normally only done in an emergency or under great pressure of work. It is not a good practice.

Alleged excessive Medication

3.23 This will be a convenient point at which to consider the allegation made in Part I Of the critique that far too heavy a reliance was placed on chemotherapy. This is not easy to assess. Examination of random medication records does not reveal above average medication. Indeed, in some cases it is rather less than might have been expected. However, if this allegation is interpreted as meaning there was more chemotherapy on the long stay wards than would have been necessary if there had been a proper multidisciplinary approach to patient care, the charge has some substance, and is supported by the following matters:

(i) The evidence of Dr. R about the over-medication of Mr. T. He states that there were other instances of over-medication. (see paragraph 2.62).

(ii) One reliable witness spoke of a readiness to increase medication after an outburst by a violent patient, but a reluctance to reduce it again after a period of orderly behaviour. Two or three witnesses spoke of doctors renewing prescriptions without seeing the patient.

(iii) The treatment of Mr. LQ and Mr. GT in Heather had an emphasis on medication in place of a treatment programme. Indeed, where there are overcrowded and understaffed wards, particularly those containing disturbed patients, there may often be greater reliance on medication than if the same patients were cared for in smaller groups with a higher staff ratio. Shortage of occupational and

industrial therapy on the wards will tend to increase the need for medication still further.

(iv) Examination of medicine cards on long stay wards suggested that many patients went for long periods without medication review. For example, out of 30 cards selected at random on Hawthorn ward in September, 1975, half showed no review within ten months, and of these 12 had not been reviewed for 12 months. It could be argued that all these patients were stabilised on medication and that no change was necessary, but since many of them were old and frail it seemed unlikely that no change could have occurred from one year to the next. It could also be argued that every time a doctor visits a ward and has a discussion with nurses an automatic review of the medication takes place, since problems should be drawn to his attention, and he can reasonably assume that there is no need for change if no problem is presented. This in our view overlooks the fact that many patients, particularly the elderly, are notorious for failing to complain of symptoms, and that those living with them from day to day, whether relatives or hospital staff, may not notice the insidious and subtle changes which herald serious, and sometimes treatable, disease.

Incident 54

3.24 Examination of random case notes revealed that this was very often true on long stay wards. An improvement was noticeable during 1974.

Incident 56

3.25 The first sentence is substantially true of the long stay wards.

Incident 60

3.26 The ward referred to is Ebony, and the allegation, which we find proved, relates to an examination of the case notes by a social worker in mid-1974. Random examination of other case notes in other long/stay wards revealed that until the first part of the Critique was circulated it was common for no entries to be made for periods of 12-18 months, and on occasions there would be gaps of over two years.

We recommend that:

3.27 1. The medical, nursing and pharmacy staff should review the concentration and content of all syrups where more than one strength is available to see if simplification would reduce the risk of accidents and overdosage. They should also review the use of various beakers and measures.

2. The Nursing Officers should agree with ward charge nurses and sisters a regular programme of monitoring and supervision of all less trained nursing staff (including those with long service) who are involved in giving medication of any kind.

3. The medical staff should agree a minimum frequency With which patients' progress and medication is reviewed.

4. The medical staff should agree a system of monitoring to see that the policy for patient review is implemented and any failing reported back to the Medical Staff Committee.

Occupational and Industrial Therapy and Physiotherapy (Incidents 44, 52)

Incidents 44 and 52

3.28 This was substantially true of the Industrial Therapy Unit at the time both parts of the Critique were circulated, although we are not satisfied that the Charge Nurse adjusted the rates of pay with the intention of securing power over the patients. He was in charge of the Unit for 15 years until his retirement in February, 1975. There have been problems over staff and shortage of storage space, and the selection of patients to attend the Unit could have been better.

3.29 We heard no criticism of the carpentry shop, Which was started in 1967, or thereabouts: it has at all times been a first class unit.

3.30 When we visited the Industrial Therapy Unit in September and November, 1975, the quality of the staff appeared to be good, but the Unit is limited by the size of the building and the range of stimulating jobs available for the patients.

3.31 There has been very little occupational therapy carried on in the long stay wards, and too few of the long stay patients have been able to go to the Occupational Therapy Department. There has been, and still was in the Autumn of 1975, chronic Understaffing as demonstrated by the following table.

Establishment for St. Augustine's, St. Martins, Highland Court and the Day Hospital

Grade	Establishment	In post September, 1975
Head Occupational Therapist	1	3
Senior Occupational Therapists	4	2 part-time totally 37 hours per week
Basic Occupational Therapists	11	-
Technical Instructor	1	-

3.32 The prospect Of any appreciable increase in trained Occupational Therapists in post is very poor owing to the national shortage. Miss DEF, the Head Occupational Therapist has recruited the equivalent of seven-and-a-half full-time unqualified helpers. These include four helpers who commenced work in the Spring of 1975 and give each of the geriatric wards about five Sessions a week.

3.33 Miss DEF has in the past suggested to the Chief Nursing Officer that the nursing services might be, able to help her, but was told that nurses could not be spared from the wards. No consideration seemed to have been given to training interested nurses, if necessary paying them for any overtime spent in such training, so that they can put their knowledge to use during their normal working hours on the wards. It might be very partial knowledge, acquired very slowly, but it would help to cope with the present chronic shortage and, we believe add to the interest of the nurses job.

3.34 Miss DEF has also tried to recruit more untrained helpers, but there were difficulties in arranging transport for them, and the proposal got lost in the administrative corridors of the hospital.

3.35 With this very restricted staff Miss DEF said that the O.T. Department was "catering in the main for the short stay and medium stay patients". She feels that there is a great need to do more for the geriatric patients, even though the activities may have to be social rather than productive. She said “So many of the geriatrics here we have found are past being productive, they are very demented, but we must do something to lighten their days. They are in the slough of despondency, and I think we must do something for them." She disagreed with the doctor who had recently told her that all that can be done with the senile dements is let them sit. So do we.

3.36 At our request Miss DEF looked again at the whole problem between our departure in September and our return in November. She produced an imaginative plan involving the use of more paid helpers, nurses, students and voluntary workers on the Wards. This would result in considerable improvements, and we hope that it will have begun to be put into operation immediately as it had the support of the District Administrator. We shall have to consider in due course why Miss DEF was not asked to produce a scheme of this kind before.

3.37 The Physiotherapy Department is equally understaffed. In November, 1975, it had one full time senior physiotherapist, one part-time senior physiotherapist (20 hours each week) and one part-time physiotherapy aide (15 hours each week). The service provided is totally inadequate, and steps should be taken to increase the staff and find some accommodation that can be used as a geriatric gymnasium. Discussion should also take place with the nursing administration to see how nurses can be helped to increase their skills and so begin to fill this gap in the wards, particularly for geriatric patients.

3.38 We are sure that it has been recognised for some time at St. Augustines that occupational, social, recreational, remedial and, indeed, educational activities are essential adjuncts to medical and psychological therapies in a psychiatric hospital. What has not been sufficiently realised is that to be effective these activities must be well co-ordinated and organised, and their purpose and relationship clearly understood by those who run them and those who make use of them. Unless there are clear policies and reasonable facilities good staff will not be attracted, and those who are available will not be used to the best advantage.

3.39 At St. Augustine's these various activities tend to be carried on in isolation from each other. There is a Consultant responsible for keeping in touch with the Industrial Therapy Unit, but he does not do the same with the Occupational Therapy Department. Social activities are largely left to the initiative of ward staff. For example, there is no central organisation to co-ordinate the use of minibus outings. The poor posture of many patients seen walking in the corridors suggests a lack of physiotherapy and remedial activities.

3.40 We recommend the establishment of a Patients Activities Team or Committee consisting of the main people involved in these activities, with medical, nursing and administrative representatives. The purposes of the Committee will include the co-ordination of the therapeutic activities, the estimation of needs, and the control of an agreed budget for occupational, social and recreational therapy.

Electro-Convulsive Therapy (E.C.T.)

3.41 The problems involved in the use of E.C.T. were mentioned several times in evidence before us. Later in this section we shall refer to particular instances of its use which have caused us, and others, concern. The doctors at the Hospital and, on a national basis, the Royal College of Psychiatrists, should give urgent consideration to these problems and issue clear guidance.

3.42 E.C.T.- consists of passing electric current through the brain while the patient is under anaesthesia, and is a widely used form of treatment in all mental hospitals in this and other countries. It is probably the most effective treatment for moderate or severe depressive illness, and is still one of the most effective methods of treating many forms of schizophrenia. But there are also risks, and those using it must, as in all forms of treatment, consider whether the expected benefits from it outweigh the risks and disadvantages.

3.43 The giving of the anaesthetic and the passing of the electric current both constitute the criminal offence of assault unless the patient has consented to the treatment or is detained under Section 26 or 60 of the Mental Health Act, 1959, or there is some other justification in law for those acts. Many psychiatrists believe they are entitled to order E.C.T. for a patient who has refused his consent, if he is detained under Section 25 of the Act. It is probable that there is no criminal assault if those administering the treatment honestly believe on reasonable grounds that the patient has consented.

Consent

3.44 It is self-evident that those whose illness is such that E.C.T. is considered necessary are likely to have some impairment of judgment: this may vary from the slight to the severe. It is most improbable that a fully informed consent is ever obtained. If a person whose consent to E.C.T. is sought is to be given the full information upon which to give or withhold us consent he would need to be told the details of the treatment, the choice and advantages and disadvantages in his particular case between E.C.T. given with and without relaxant drugs and with and without anaesthetic, the comparable risks of drugs that might be used instead, the probable duration of his illness if E.C.T. is not given, and any additional risk in the treatment due to physical disability or old age. No sensible doctor will go into all these matters with a patient who is already depressed or anxious, or has difficulty in thinking clearly. This is a dilemma which faces doctors in all branches of medicine.

3.45 In each case, therefore, the information given to the patient in order that he may decide whether to give or withhold his consent has to be modified, and often severely modified, in the light of the severity of his illness and his likely degree of understanding.

3.46 Written consent is rightly regarded as preferable in all cases as it is the most readily available Check on whether and, if so, when and to whom, the patient gave his consent. It must be emphasised, however, that a written consent does not mean that it is a fully informed consent: neither is a written consent a continuing consent. It means no more than at the time the patient signed the consent he was willing, on the information given him, to receive E.C.T. As will be seen, in many cases the patient must rely heavily on the judgment, clinical competence and integrity of the therapeutic team treating him. This situation can be seen

in other fields. For example, an elderly person whose ability to order his own affairs is beginning to fail, and who wants to give his solicitor a power of attorney, must rely heavily on the solicitor's integrity in deciding whether to accept it and how to execute the powers given him.

Refusal to give consent

3.47 Clearly a criminal assault is committed if E.C.T. is given to an informal patient who makes it clear that he is unwilling to give his consent. It is in our view irrelevant on that issue that the refusal. may only be a manifestation, of the illness from which he is Suffering, or that those wishing to give him such treatment are convinced, that it is in his best interests and know that his family wish him to have it.

3.48 It is, however, the duty of the therapeutic team, when satisfied that E.C.T. is in a patient's best interest, to try to overcome his refusal or reluctance by persuasion and firm encouragement. The team would be neglecting its duty towards that patient if it allowed a temporary whim, a bout of indecision, or some renewed fear or anxiety about the process to prevent the patient receiving the treatment he needs. There is a great difference between the situation where a nurse takes a patient by the arm or hand and leads him to the treatment room, and then, perhaps, holds his hand while the anaesthetic is given, and that in which a patient is dragged, protesting, by two or three nurses, and then held firmly down on the bed while the anaesthetic takes effect. It is the duty of staff to try to overcome a patient's anxiety of or reluctance to have treatment by peaceful, if firm, persuasion. It most certainly is not their duty to force a patient, even though he has given his consent to a course of treatment, to have any treatment when he is flatly unprepared to have it, and it would have to be given against his will.

3.49 If an informal patient cannot be persuaded to consent to E.C.T., and in the view of the therapeutic team E.C.T. is essential for his health, the only way in which it can be lawfully given is to obtain an order under Section 30 of the Mental Health Act 1959 which authorises the detention of the patient for three days while the formalities are completed for admission for treatment under Section 26. Even with a detained patient, however, it will be prudent to make every effort to persuade him, to give his consent to E.C.T., for treatment voluntarily accepted is from every point of view preferable to that applied against a patient's wishes. If this is not forthcoming the position Should be explained to his next of kin or other interested person, for, although they cannot give a valid consent on the patient's behalf, their approval is clearly desirable. Written approval is the best evidence that it has been obtained. If neither the patient nor his next of kin agree to E.C.T., the therapeutic team concerned will be wise to obtain a second opinion in writing from colleagues. The important thing is that the detained patient should receive the treatment that is necessary for his good, preferably with his consent.

Inability to give a valid Consent

3.50 We have in mind here the position where a patient is so impaired, that he is either unable even to to-through the gestures of consent or, if he is able to get thus far, the therapeutic team are satisfied that no reliance should be put upon it.

3.51 If a patient's life is in immediate danger the therapeutic team should go ahead and administer E.C.T. if satisfied that this is appropriate treatment, but they will have to justify their action if objections are subsequently raised.

3.52 In all other cases, however, the same procedures should be followed as set out above under "Refusal to give Consent".

Unwillingness to receive E.C.T. after consent given

3.53 Nobody suggested that a written consent for E.C.T. is valid consent to a course of E.C.T. other than the course for which it is given. If, for example, it was given before the commencement of a course of treatment it does not apply to a fresh course begun, say, six months later. In such circumstances a further written consent should be obtained.

3.54 A patient who has given his consent to a course of E.C.T. is entitled to withdraw that consent at any time, and if the therapeutic team is satisfied that he intended to withdraw his consent they must go through the procedure under "Refusal to give consent" before completing the treatment. It is, however, often difficult to judge whether a patient has really Withdrawn his consent. If a patient who has given his consent to a course of E.C.T. behaves in a way which would certainly indicate to any lay person that he is objecting to, and trying to avoid, any particular treatment, can and should the therapeutic team give him that treatment on the basis that his consent is still operative? Indecision and frequent changes of mind are sometimes significant symptoms in mental illness. S omehow a sensible and, of necessity, bold path must be found between, on the one side, an overcautious response to signs of reluctance by a patient to receive treatment for which he has already given his consent, and, on the other side, refusal to accept that a patient has clearly withdrawn his consent to a treatment, even where the withdrawal is a result of his illness. We consider later in this Report two examples of this dilemma at St. Augustine's, and how it was met. If a patient withdraws his consent to E.C.T., either before a course has begun or in the middle, no further E.C.T. must be given. If he Cannot be persuaded to renew his consent and such treatment is essential to his health, an order must be obtained under Section 30 and then under Section 26.

3.55 Throughout this section we have referred to decisions and action by the therapeutic team. There may be one team concerned with the decision whether E.C.T. is the right treatment for a patient, and another with its administration. We develop the concept of these teams later in this Report. We emphasise at this stage, however, that each patient and situation is unique. New situations may develop quite rapidly, and, if misunderstandings are to be avoided and the right decisions made, it is essential that the members of each team discuss and agree their policies and attitudes well in advance. If two teams are involved there should be close co-operation.

3.56 We proceed now to the consideration of Incidents 6, 11, 5 and 67.

Incident 6

3.57 The information in this incident was given by Mr. Weston. We find that it is accurate, and that the incident described occurred in about 1972. The patient concerned was a Mr. GHI, an informal patient in his late 60's who suffered from chronic depression and had received E.C.T. on many occasions. The Charge Nurse told us that he frequently had to be carried to the treatment, sometimes pleading not to have it, and was then held down on the bed. We do not doubt that all concerned in the administration of the E.C.T. were satisfied that it was the right treatment for him. His attitude was described as negative towards all aspects of his care. That may well be so, but it did not justify the action taken on the occasion described in the incident or on the other occasions.

3.58 Examination of Mr. GHI's case notes revealed a disturbing state of affairs. There was an entry of February 7th, 1972 "E.C.T. was to be given but patient protested so violently that it was impossible to administer the anaesthetic. As patient injured attempt discontinued. Possibly he could be sedated prior to the next attempt".

3.59 These notes also disclose, as Dr. Q agreed, that on August 25th, 1971, he directed that Mr. GHI should have a course of six treatments at the rate of two per week. They started on August 26th and without any further written instructions he received 13 treatments. On November 22nd, 1971, Dr. Q directed that they were "to continue once weekly until clinically recovered". His treatments continued at the rate of one or two a week until he had received 20. In January, 1972, Dr. Q interviewed Mr. GHI's relatives and wrote 'No further E.C.T.' Without any further written directions E.C.T. started again in February and continued until Mr. GHI had had 30 treatments since August 26th. Later in 1972 Dr. R found that Mr. GHI was showing signs of organic cerebral deficit or dementia. Excessive use of E.C.T. can be a cause of, or contribute to, this condition. Dr. Q agreed that it was unusual to give 30 E.C.Ts. He was then asked whether he thought there was any connection between those treatments and the development of the organic deficit. He replied "I should not have thought we should have pressed the E.C.T. to that extent. I think the original six would have been adequate. I think it should have ended at that time". Any comment by us is superfluous.

3.60 Another occurrence took place in Ash Ward in May 1975 when a female patient was brought to the ward for E.C.T. She was an informal patient who was known to resist E.C.T. on occasions. She was brought forcibly into the room by the Nursing Officer and held on the bed. The Charge Nurse in charge of the E.C.T. team declined to participate further and there were protests from some of the student nurses. The Nursing Officer afterwards explained to the nurses that the patient had been in a "deeply negativistic state" and they thereupon signed statements that they were content. In some cases, however, their concern remained. The Nursing Officer agreed that this patient was physically resisting E.C.T., but because she resisted everything else as well, and usually gave in at the end, he "did not consider that (the patient) was being forcibly compelled to have E.C.T."

3.61 These incidents show how unreal a patient's supposed consent often is, and how tortuous are some of the arguments resorted to in order to avoid facing reality. It is no wonder that there have been unhappiness and misunderstandings in some staff, particularly the younger ones. We are satisfied that a degree of force that exceeds any legitimate persuasion has been used to administer E.C.T. to unwilling informal patients on many occasions. Indeed, it has attracted a jargon of its own. Dr. Q informed us "We do not refer to 'force' but 'support' when assisting a patient to a ward where he is to receive E.C.T." Some doctors boldly take the stand that in their patients interests they have to take professional risks. The team of nurses that forcibly applies the E.C.T. may, however, be less able to assess the situation and may unknowingly become involved in a criminal assault. There must be clear multidisciplinary discussions, leading to agreed multidisciplinary policies and procedures. When these have been a agreed the 'nursing procedure.' leaflet on E.C.T. will need redrafting.

Incident 11

3.62 We accept this as accurate.

Incident 57

3.63 We are not satisfied that E.C.T. has been used as a punitive measure The forcible application of E.C.T. in circumstances such as we have been considering can, however, too easily lead to a belief that it is used for that purpose, and intimations that a patient will require E.C.T. if his disturbed behaviour continues can be interpreted as threats.

Incident 67

3.64 Mrs. JKL had been both inpatient and outpatient at St. Augustine's for about 20 years. She was a chronic schizophrenic and had required E.C.T. on several occasions. Her Consultant was Dr. Q.

3.65 In October, 1973, Mrs. JKL, who was then in her mid 50's, complained to her General Practitioner of pain in her back following an accident two months earlier. She was X-rayed at the Royal Victoria Hospital, Folkestone, and the X-ray report sent to her General Practitioner referred to 'moderate degenerative changes at all levels in the dorsal and lumbar spine'. No other lesions were seen. In November, 1973 while an inpatient at St. Augustine's, Mrs. JKL had a left mastectomy for carcinoma. In May, 1974, Mrs. JKL was still complaining of central lumbar back pain so her General Practitioner arranged for further X-rays at the Royal Victoria Hospital. He received the X-ray report on May 29th. It said that there was some compression of the body of L3 and that the appearance could be due to metastatic deposits. This indicated that there might well be a cancerous tumour present in that area.

3.66 Subsequently Mrs. JKL was readmitted to St. Augustine's as an inpatient because of her mental illness. On about July 24th she was examined by the Surgical Registrar who found that she had local secondary tumours at the site of the operation, Otherwise her physical condition was satisfactory. Dr. Q saw her on July 28th and found her mental condition 'pretty fair', but he did not examine her physically. She was discharged on that day.

3.67 On July 29th Mrs. JKL's General Practitioner found her in a state of depression and feeling very shaky. He does not recall that she said she had fallen. The following day he telephoned the hospital and spoke to Dr. Q whose recollection of the conversation was that the General Practitioner

had told him that Mrs. JKL had fallen down the stairs and was suffering from depression., He told us that he had agreed with her doctor to readmit her as an inpatient for E.C.T. but that he had told him that as far as the fall downstairs was concerned, St. Augustine's was not the hospital for admission for physical injuries and asked him to arrange that she should be sent to the Royal Victoria Hospital for a full examination to exclude bony injury. He explained to us that he had in mind that she would be X-rayed there. The General Practitioner did not recall any reference to the physical examination, and arranged for an ambulance to take Mrs. JKL straight to St. Augustine's on the same day. On the way she complained of abdominal pain and was taken to the Royal Victoria where she was given an abdominal examination in the Accident Department and sent on to St. Augustine's with a diagnosis of "? constipation".

3.68 On arrival at St. Augustine's Mrs. JKL was examined by a Medical Assistant who was the Duty Admission Officer for the day. She had no information as to why the patient was being readmitted. She gave her a physical examination and noted a history of her having fallen and injured her elbow. She found no abnormalities. If she had known Mrs. JKL's recent history she might have looked for evidence of further secondaries.

3.69 Mrs. JKL walked to her ward and was observed in the ward walking satisfactorily to and from the toilet. Later that evening the Duty Admission Officer was told that the patient had slipped on the floor in the toilet but there were no bruises or signs of injury. The doctor a sked the nurses to keep the patient under observation.

3.70 The following morning Dr. Q walked through the ward. As he passed Mrs. JKL she said "good morning" to him. On his own evidence that was the only contact he had with her before authorising a course of five E.C.Ts.

3.71 There was evidence that Mrs. JKL, after signing the form of consent referred to in the next paragraph, fell or slipped to the ground as she was getting out of bed prior to going for E.C.T., and that thereafter she said that she was unable or unwilling to walk. There was also evidence that Dr. Q was told of this and said that E.C.T. shou1d proceed as arranged, Dr. Q denies that he was told of any such incident by the bed or that Mrs. JKL was, or might be, unable to walk. Dr. Q's version was that he was told that Mrs. JKL was not prepared to get out of bed to walk upstairs to ECT, and that he thereupon gave instructions that she should be carried upstairs. This required four people as she weighed 15 to 16 stone.

3.72 When Dr. Q gave the form for consent to E.C.T.to the Sister so that she could obtain Mrs. JKL's signature he had already signed the declaration "I confirm that I have explained to the patient the nature and effect of this treatment" and had given written instructions for "5 E.C.Ts at 2 per week from Wednesday 31.7.74." Moreover, the form required a signature by Mrs. JKL to the effect “I (Mrs. JKL) hereby consent to undergo the administration of electroplexy the nature and effect of which have been explained to me by Dr./M '. When the form was brought back with Mrs. JKL's signature no name had been inserted. Dr. Q says that he was told at that time by the Sister that Mrs. JKL was complaining of a pain in the leg.

3.73 Dr. Q told us that although he would normally have seen the patient and explained the position, he did not do do on this occasion because he was afraid that his presence might cause her to say 'yes' to E.C.T. when she really wanted to say 'no'. "I deliberately avoided seeing her. I felt that if I went to see this woman I might influence her into having it. I wanted her to have a free choice." He told us that he felt she could more readily say 'no' to a nurse. Very shortly after this he gave some answers which were totally irreconcilable with that explanation for falling to carry out his normal practice. He referred to Mrs. JKL's complaint of pain in her leg and said that he had decided before ordering her to be carried upstairs for E.C.T. that she had invented the pain to avoid E.C.T. He then had to agree that he had ordered her to be carried upstairs to be given E.C.T. at a time when he believed that she did not want to have it. She was an informal patient.

3.74 After she had received E.C.T. Mrs. JKL complained of pain in her back. The Duty Doctor was summoned and she was immediately sent to the Kent and Canterbury Hospital, from which she was transferred to Brook Hospital, woolwich, where she died on August 5th. It Was not disputed that the information given by Dr. Q to a Sister in St. Augustin was accurate, namely that Mrs. JKL died from a combination of a tumour of the corda equinal metastases and two collapsed vertebrae.

3.75 What was the state of Dr. Q'S knowledge when he authorised E.C.T., why did he fail to examine her?'

3.76 Dr. Q told us that he had no knowledge of the X-ray taken in May, 1974 or the findings based on it. We proceed on that basis. However, he admitted that he knew:

(i) that Mrs. JKL had local secondaries where the left breast had, been removed, and that secondary tumours in the bones from cancers in the breast are Common;

(ii) that contrary to his advice no physical examination had been made at the Royal Victoria ,Hospital and no X-rays taken;

(iii) that on the morning he authorised E.C.T. she was complaining of pain in her leg and was unwilling to walk, and that she was a woman who had not previously behaved in this way.

3.77 We have no doubt that the exercise of reasonable care by Dr. Q demanded that he should satisfy himself (i) that Mrs. JKL required E.C.T and (ii) that she was physically fit for such treatment.

3.78 On the question of whether she needed E.C.T. he agreed that he had discharged her four or five days earlier as fit to go home on medication, and that her General Practitioner's' view that she required more E.C.T. might be wrong. He further agreed that he was the Consultant Psychiatrist whose duty it was to decide whether or not to administer E.C.T. Dr. Q sought at that point in his evidence to justify his failure to see her to decide whether E.C.T. was required by telling us that he had shortly before this read an article that E.C.T. can help in the treatment of cancer and he thought that Mrs'. JKL would be a suitable patient on whom to experiment. That in. our view made it even more necessary to examine her before commencing such an experiment and explain the treatment fully to her. He told no-one, and made no note, that one of the reasons for giving E.C.T. was to see whether it would help treat her cancer. Later in his evidence he said the real need for E.C.T. was fear that she might

commit suicide in the future. None of these explanations begin to excuse Dr. Q's failure to examine Mrs. JKL to make up his mind about her mental state before authorising the further course of E.C.T.

3.79 Dr. Q tried to excuse his failure to check Mrs. JKL's physical condition by relying on the physical examination carried out by the Medical Assistant the day before, but he had clearly had in mind something very much more thorough than that when he requested her General Practitioner to have her examined at the Royal Victoria Hospital, otherwise there would have been no point in sending her there. He had also had in mind that she would be X-rayed at the Royal Victoria, but he knew that had not been done. If there were local secondaries from breast cancer he knew that bones could be affected and that X-ray and/or blood tests were advisable to reveal this. Any weakening of bones could lead to serious damage from E.C.T. Moreover he knew that Mrs. JKL was that morning complaining of a pain in the leg, but he says that he concluded that it was an invention without even seeing her and enquiring from her and the nurses when it had first been felt and whether she had had any accident which might account for it. Dr. Q knew that Mrs. JKL had local secondaries. He also knew of complaints from Mrs. JKL within the past 24 hours of pains in the abdomen, elbow and leg, and that she had fallen at home. This history of pain in the limbs and abdomen, and of falling, should have alerted him to the possibility of further widespread secondaries, and we are satisfied that he should have undertaken far more extensive investigation of Mrs. JKL's physical state by examination, X-ray and blood tests before prescribing the course of E.C.T. Secondary metastatic disease in tile bones does not necessarily mean that E.C.T. should not be given, but it calls for large doses of muscle relaxant to reduce the risk of fracture of bones.

3.80 As we have said, he not only failed to make any examination of her mental condition, without which he was in no position to justify E.C.T., but he also failed to explain to her the experimental nature of the E.C.T. and what he hoped it would achieve. He should also have warned her of the increased risk if there was any metastatic disease of the bones.

3.81 When the second part of the Critique was received the Medical Staff Committee met and went through the incidents, seeking to identify them. The following note was taken of the explanation that Dr. Q then gave of Incident 67. "Patient with long chronic history (1955). E.C.T. ordered as usually giving good results on patients having had Mastectomy. The patient was very depressed as well as suffering from carcinoma with metastases. After a fall she had been X-rayed - with a negative result at the RVH Folkestone. Dr. Q would have no hesitation in prescribing the same treatment again."

3.82 Our criticisms of Dr. Q have been based on his own evidence. His casual approach to E.C.T. on this occasion, and the large number of treatments given to Mr. GHI disturb us deeply. Neither are we at all happy about his use of E.C.T. as a diagnostic measure to distinguish between depression and dementia. Dr. Q estimated that he used E.C.T. for this purpose about once a month, although accepting that in some forms of dementia it would involve increased risk to the patient. We understand that Dr. Q, although retired, has facilities to treat patients at St. Augustine's Hospital. The Regional Health Authority should consider this Report before extending these facilities.

Laundry and Linen Services

3.83 The National Health Service Hospital Advisory Service in November, 1971, referred to the substantial criticism it received of the shortage in the amount of linen supplied to the wards, particularly on geriatric wards where the demand is greatest. In March, 1973, the Regional Advisory Team of the South East Metropolitan Regional Hospital Board received similar complaints from all grades of staff, and many wards which were visited by that Team at varying times of the day and night had bare shelves in the linen stores.

3.84 We also received many criticisms about the inadequate supply of linen, especially at weekends, and it seemed that many of the nurses and, indeed, the laundry manager believed the problem would only be overcome if the hospital implemented the recommendation of the Hospital Advisory Service to introduce a 'topping-up' system backed up by an additional supply of linen. Under a 'topping-up' system each ward is supplied on weekdays with enough linen (i.e. sheets, pillow-cases, towels etc.) to bring ward stocks up to a pre-determined level calculated to provide the ward with sufficient linen to last until the next delivery

3.85 The Group Secretary disagreed with the advice of the Advisory Service. He alleged there was sufficient linen in circulation and that shortages were caused by hoarding on wards. He further claimed that the Regional Board's work study officers had supported his view that a 'topping-up' system could not be used successfully on all wards because of the problems of access, and that the 'standard-pack' system was, therefore, the best one for St. Augustine' s Hospital. With a 'standard-pack', system each ward receives a fixed quantity of linen each weekday, the actual amount supplied being based on the average consumption of the individual wards. Mr. CX, the former Principal Nursing Officer, and the Group Laundry Manager in fact commenced to carry out a successful trial of the 'topping-up' system on selected wards but this experiment was stopped by Mr. B who told us that this was because he had not been consulted in advance. A study of the documents submitted to us, however, showed that Mr. B had attended a meeting at which approval had been given to this trial being carried out and it was difficult for us not to conclude that the experiment had been stopped because it seemed likely to succeed.

3.86 There were serious personality clashes between the Group Secretary and the Group Laundry Manager, and the Hospital Management Committee set up a sub-committee to investigate the problem, but it failed to find a solution acceptable to these officers. The Laundry Manager resented having to report to the Hospital Management Committee through the Group Secretary and asked for direct access to the Committee in the same way as some of the other group officers. This request had not been accepted, and at one stage the difficulties became so acute that members of that Committee were called into the hospital to carry out on-the-spot enquiries into complaints about the laundry service.

3.87 The members of the Management Committee were undoubtedly aware of the views of nurses about the general shortage of linen in the hospital and of the statements made by the Group Secretary that the shortage had been the result of stockpiling on wards or linen being held up in the laundry. However, a comparison of actual costs per in-patient week between St. Augustine's Hospital and two other psychiatric hospitals in the same region would have shown that during this period (1970/73) substantially less had been spent on bedding and linen at St. Augustine's than at the

other hospitals and it is surprising that this basic information does not appear to have been made available or to have been called for by members of the Committee.

3.88 Whatever the explanation, the indisputable fact remains that wards had been deprived of an adequate supply of linen and that nurses were, therefore, unable to provide a satisfactory service to their patients because of the inability of management to solve a basic laundry supply problem. If the test of an organisation is a test of performance and results, then the Group Secretary as the Chief Administrative Officer and the Hospital Management Committee failed to deal with this long-standing problem of laundry. Laundry problems are endemic in the hospital service, but it is rare to find a state of affairs as bad as we found at St. Augustine's during the periods covered by both parts of the Critique.

3.89 The District Management Team has made great efforts to improve the position and there was general agreement among nursing staff in the Autumn of 1975 that, although not ideal, the situation had improved, and that emergency issues of linen could then be obtained if shortages occurred during the weekends and public holidays. In the last few years some wards have been supplied with their own automatic washing machines, and this has also made a major contribution to solving the laundry problems, although it has meant that in some cases quite senior nursing staff have been involved in operating the washing machines or carrying out other duties inappropriate to their training and experience. The hospital also experienced considerable difficulties with the marking of patients' clothing, but again a great deal of progress had been made in the 12 months preceding our arrival at the hospital, and the washing machines on the wards are often used for personal clothing which might otherwise get mislaid in the laundry.

3.90 We are pleased to report that towards the end of the Enquiry a working committee composed of all those principally concerned with the laundry and linen services was set up to make a start on solving the outstanding problems, and that as a result a topping up system has already been introduced in some wards. The District Management Team will have to watch the laundry situation carefully and take resolute action if this further attempt to provide an acceptable service founders on personality problems.

Requisitioning System

3.91 Both the Hospital Advisory Service and the Regional Advisory Team in their reports of November 1971 and March 1973 respectively, referred to the dissatisfaction and irritation expressed by the nursing staff at St. Augustine's Hospital about the requisitioning system. This system, in most essentials, was still in operation at the time of the opening of our Enquiry.

3.92 Briefly, the requirements of the system were as follows:

3.93 The ward nurses put requests for normal replacements and for additional items to their area Senior Nursing Officer, and he, if he agreed with the request, would enter it in a standard requisitions book. This was passed, usually weekly, to the Sector Administrator (formerly the Group Secretary). There was normally no difficulty with the majority of requests, and the goods concerned were delivered to the wards without unreasonable delay. Additional or high cost items would be discussed by the Sector Administrator with the Divisional Nursing Officer or Senior Nursing Officer, and frequently would be marked "Noted and Deferred" by the Sector Administrator. The requisitions book showing the action taken on each item would then be returned to the Senior Nursing Officer. The Sector Administrator also maintained a list of all outstanding requisitions which were kept in reserve, until money became available, when the Senior Nursing Officers and the Senior Medical Staff in each of the clinical areas would be asked to Place the outstanding items in order of priority.

3.94 In practice, however, unless the goods were actually delivered, the ward staff were frequently left unaware of the outcome of their requests as there appears to have been no instruction that they should be told if and why a request could not be granted, or had to be deferred. It was not uncommon for a ward nurse who had submitted a requisition to hear nothing more, even after numerous enquiries.

3.95 Whilst recognising the need for strict controls on the sanctioning of new equipment due to the amount of money involved, it seemed to us that the existing procedure had been designed to impede rather than facilitate effective communication between the nurses and the supplies department. We thought that basic supplies and routine replacements, at least, should have been more freely accessible and that the paperwork should have been streamlined with, for instance, more responsibility for economy and the allocation of resources vested in Senior and Unit Nursing Officers and, indeed, the ward staff. The system for fixing the priorities between various requisitions did not function satisfactorily because insufficient use was made of the practical experience and knowledge available in the wards.

3.96 The System as outlined has been the subject of criticism for a number of years and Mr. CX, the former Principal Nursing Officer, tried consistently to persuade the Group Secretary to consider simplifications; but this approach proved unacceptable to a man who, to quote the words of the Hospital Advisory Service, "gave too much time to details usually delegated to other staff". It was widely believed within the hospital that the control of the supplies system, and any decisions about priorities, rested with the Group Secretary.

3.97 In consequence of Mr. CX's representations, the Group Secretary eventually agreed to allocate £2,000 a quarter for specific types of expenditure to the nursing staff, who would be left to agree their own priorities within this limit. The Group Secretary took this decision shortly before his retirement in March, 1974, hut at the time of our Enquiry, eighteen months later, it had never been implemented, partly, no doubt, because it had never been recorded in writing. However, we were informed that a new requisitioning system had been put into operation and in the Autumn of 1975 there was no restriction of any kind placed on normal replacements. Additionally, the sector which includes St. Augustine's had been given a block allocation for additional furniture and furnishing textiles. The new system was not perfect but we are satisfied that the District Management Team Will make necessary improvements.

3.98 Examples of the old system in operation are to be found in paragraphs 2.47-49.

Patients' Moneys

3.99 In November, 1971, the National Health Service Hospital Advisory Service recommended that nursing staff should not be involved in the distribution of patients' cash and that urgent consideration should be given to a new memorandum from the Department of Health and Social Security which was at that time about to be published. This memorandum was published in November, 1971, and recommended that a patients' bank should be set up, that nurses should not be used as agents for paying patients, and that, except for patients who were severely handicapped or confused, all goods paid for by a patient or from his account should be delivered to him personally and not form part of a bulk issue to the ward.

3.100 On September 1st, 1975, a patients' bank was opened at the hospital. Initially it operated for three wards and is to be extended progressively throughout the hospital. The position at that time for most of the hospital was that nearly four years after the first recommendation a senior member of the nursing staff from each ward was still required to go to the Finance Office each week to collect cash in bulk, which the nursing staff then paid out to each patient after obtaining individual receipts.

3.101 The reason we were given for the delayed implementation of this recommendation was that it had not been possible either to find a suitable room for the bank until 1975, or to release a clerk from the finance department to take the cash each week to the patients in their wards. It was said that the South East Metropolitan Regional Hospital Board had not provided the money to the Hospital Management Committee for an additional clerk to handle patients money, but we doubted whether during the years 1972 to 1974 a strong enough case had been made to the Regional Hospital Board for the necessary additional revenue. Certainly in one of those three years this post ranked next to last in the submissions made to the Regional Hospital Board for extra money. In any event, we consider that had the Management Committee really wished to implement the scheme, the Regional Hospital Board should have been asked for funds to be switched from the nursing head of expenditure, which was invariably under spent at the and of each year because of staff shortages. In our view this would, at least initially, have been a legitimate transfer of funds for it would have relieved the nurses of a very time consuming task.

3.102 We found it difficult to escape the conclusion that the Hospital Management Committee had not given a high enough priority to the need for relieving the nurses of the responsibility for handling of patients' money, and that it had missed an opportunity to demonstrate in a practical way that it was concerned about the pressures and difficulties under which its nursing staff was working. To the nurses, it must have seemed that the Management Committee and the top administrators were oblivious of the time which they had to devote to handling patients' money and the accompanying risk to them of accusations of mishandling.

3.103 We endorse the view taken in some psychiatric hospitals, that except for severely confused patients, details of patients' personal accounts should be treated as confidential and not released to ward nurses except with the approval of the patient concerned. It may be necessary at times for a senior nurse to be given some indication of an individual's overall credit worthiness, but in general we consider that patients' financial affairs should be treated in the same way as any hank would treat those of its customers.

3.104 It was stated in Incident 17 that the allowances of pocket money paid to patients were ungenerous and we were told of delays in passing on increases in standard allowances to the patients. We are satisfied that both these criticisms had some foundation. Senior ward nurses were always notified of increases in the standard allowances, and, in accordance with the regulations, it was left to them and the medical staff to decide to what extent the increases should be passed on to individual patients. When we checked the position in Heather Ward the records showed that there were two patients who only received 30p and 25p respectively per week in 1973, this being payment for their work in the Industrial Therapy Unit. At this period they had no other source of income and were not receiving pocket money from the Management Committee. We noted, however, that from the first week in January, 1974, shortly after a change of Charge Nurse, both these patients were allocated the maximum pocket money allowance of E1.55 per week. Heather Ward records also revealed that the increase of the pocket money from £1.35 to £1.55 authorised by the D.H.S.S. in October, 1973, was not reflected in increased payments to the patients until the arrival of the new Charge Nurse in January, 1974. As the former Charge Nurse himself commented at the time on the low rates of pay we assume that he was unaware of the patients' entitlements rather than that he had deliberately withheld money from them. Nevertheless, we would have expected the Nursing Officer responsible for Heather Ward to have discovered these lapses.

3.105 It should be added that, if money was withheld from individual patients, it was certainly not because of a shortage of funds since the Regional Hospital Board always funded the Hospital Management Committee with the amount requested by the Group Treasurer, and this allowed for increases authorised by the D.H.S.S.

3.106 We have given a considerable proportion of space in this Report to this subject of patients' moneys, not just to draw attention to the irregularities uncovered and the delayed implementation of an alternative arrangement, which we particularly regret, but also to illustrate the importance of the correct handling of patients' moneys or goods purchased on their behalf. It is essential that doctors nurses at all levels Occupational Therapists, industrial therapy officers and administrators, as well as the finance department, should be involved and encouraged to work together be produce a solution satisfactory for the patients and those responsible for them.

3.107 A policy document should be prepared for the guidance of everyone involved in the lives of long-stay patients. This should be available to, and clearly understood by, every member of the staff. In particular, it should incorporate an approved method for handling purchases made by nursing staff on behalf of those patients who are unable to manage their own affairs; and there should be proper safeguards to protect both the property and privacy of the patients as well as the nursing staff.

SECTION 4: REACTION TO AND IMPEDIMENTS IN THE WAY OF CRITICISM

4.1 At the end of the second part of the Critique, Dr. Ankers and Mr. Weston indicted the 'Medical and Administrative Bodies' for 'creating a climate in this hospital which discourages open, free discussion, and discourages patients and staff from publicly making criticisms and complaints'. It was because they had found the 'normal channels' of criticism so frustrating that they produced the first part of the Critique.

4.2 In this section we look at various incidents and procedures which throw light upon attitudes at various times and levels in the hierarchy, and which have led us to the conclusion that there were good grounds for their frustration.

1. The 'J' Enquiry

4.3 In August, 1971, Miss J, a student nurse, made written complaints about events in Bay Ward. They can be summarised thus:–

(i) Two patients were on occasions locked in the clinical room, toilets and linen room.

(ii) Another patient was not given sufficient fluid as a punishment for scratching her legs.

(iii) Another patient was left unnecessarily long in a urine saturated bed.

(iv) Another patient was shaken and had her hair pulled by a Sister.

(v) A Sister came on duty at 5.00 a.m., and started getting up patients requiring more intensive care.

4.4 This was a ward containing 35 female patients, many of whom were disturbed. Sometimes there would only be one or two members of staff on duty. One of the Sisters concerned was in her late 60's with years of hard work and many kindnesses to patients behind her. We can understand the wishes of all to support staff working long hours in difficult circumstances: nevertheless, the following respects in which the complaints were handled suggest that criticism was resented, and that hospital loyalties were too heavily on the side of its long-serving members.

4.5 (a) When the matter came to the attention of the Group Secretary his actions are best described in his letter of August 23rd, 1971, to the Department of Health. "I arranged for Miss J to be interviewed by two members of the Hospital Management Committee immediately in the presence of the Physician Superintendent and Principal Nursing Officer. She withdrew the allegation concerning a nurse coming on duty at 5.00 a.m. as this was outside the scope of her personal experience, but she persists with her other allegations and the Hospital Management Committee decided to enquire into this officially."

4.6 At the commencement of the enquiry that followed Miss J withdrew the allegation about the withholding of fluid because she had been told by the two Management Committee members that the drink withheld was not one of the standard meal time drinks and the patient was, therefore, not officially entitled to it. Although the members of that Committee of Enquiry had before them written information that the patient had told Dr. A that drink was temporarily withheld if she scratched her ankle, and that in the Ward Medical Officer's opinion there was no medical reason for withholding fluid from her, they did not investigate this allegation any further.

4.7 In our view both these matters should have been investigated. The preliminary meeting with the two Management Committee members could well have given Miss J and others the impression that the authorities did not wish to investigate a complaint unless there was no other escape.

4.8 (b) It was accepted before the hospital Enquiry that the two patients had on occasions been locked in the lavatory and clinical room in order to prevent them disturbing other patients, or other, patients disturbing them. The clinical room door could not be opened from the inside when it was shut, and these rooms were used because the side room doors could not be locked. There was a written statement from the Ward Medical Officer saying that she had not given permission for this and knew nothing about it. The nurses against whom the allegation was made agreed that they had not informed any doctors. Miss J said one of the things that concerned her was that she believed a patient could only be locked in a room with 'a doctor's approval.

4.9 In a note prepared by Dr. A for that Committee of Enquiry, he pointed out that prior to 1959 the power to lock a person in a single room could only be authorised by a doctor and that there had then been a statutory obligation to record the time for which he was secluded in a book. He continued "there is no similar provision made in the Mental Health Act, and there is now not, so far as I am aware, any medico-legal reason why a patient should not be confined in a room. At the same time the doctors would prefer to know of and authorise in advance any such occasions and should also be given the opportunity to instigate alternative procedures such as appropriate medication or a temporary transfer of ward". His oral evidence or advice given to that Committee was more positive. The proceedings were recorded and we had a transcription of the tapes. At one point he said that since 1959 a patient could be locked up 'at the discretion of the Nurse in Charge', and later he added "I was just going to mention again this question of seclusion, if we can use that word. There is no reason why a Sister or Charge Nurse should not confine a patient to a single room if she feels that it is in the interest of the patient, or in the interests of other patients to do so. She might like to discuss this with the doctor - I do not know. You see, no other patient was concerned."

4.10 Unfortunately, however, Dr. A's evidence to that committee differed materially from what he said to us. He told us that since 1959 "the policy has been that you do not lock patients up without reporting the fact". He amplified that later, saying "There was no change when the 1959 Act came in. I sent a short summary of that Act to the Nursing Administration and pointed out that there would be no change in our procedure with regard to seclusion. It was no longer a legal necessity to through this. This as far as I know, and I hope, is still on the nurses procedure file. Certainly a reminder was sent to all nurses not so long ago by the Chief Nursing Officer about it - that you cannot shut a patient up without a doctor's permission. You can if it is an emergency but no more. It has to be recorded both in the nurses summary, setting out the times and who authorised it and it has to be recorded in the patients case sheet." He said that had always been the position and his understanding of it.

4.11 The summary of the Act to which Dr. A referred stated "While the keeping of a Register of Seclusion ... will no longer be a statutory obligation, there will not, at present, be any alteration in the present procedure". No instructions to alter this were ever issued.

4.12 The Chief Nursing Officer confirmed.mhat Dr. A had told us. He amplified it slightly, saying that if nurses "secluded in an emergency, then they would inform the ward doctor immediately. That was my understanding and that was based on advice given by Dr. A." He, like Dr. A, attended the Miss J enquiry. He heard what Dr. A said there, but never suggested that it was wrong, although taking part in the deliberations of that Committee which were also recorded and transcribed.

4.13 The Hospital Committee found none of the complaints they investigated proved. The nurses who had locked the patients in the clinical room and toilet were not criticised in any way. We have no doubt that the evidence of Dr. A played its part in bringing about that outcome on that particular complaint. No-one had suggested that the patients had been confined for cruel or vindictive reasons.

4.14 This is a good example of how ranks close in the face of criticism. We are satisfied that the procedure for shutting patients into rooms so that they cannot get out has always required that the doctor must be told afterwards if there has not been time to get his authority beforehand, and that the period of seclusion must be recorded in writing. The information given by Dr. A to the Committee enquiring into Miss J's allegations did less than justice to her complaint on that matter and was unduly favourable to those she criticised.

2. Absence of clear complaints procedure for staff

4.15 There has been confusion about whether there is a written complaints form for staff and whether there is any definite procedure.

4.16 On December 18th, 1973, an Assistant Secretary at the South East Metropolitan Regional Hospital Board wrote to Mr. B sending at his request an extract from a report of a recent Committee of Enquiry set up by the Board, relating to recommendations on complaints procedure". The extract included the following recommendation. "There should be one clearly defined written procedure for dealing with staff complaints verbal or written. This procedure should be made known to all staff who should be told at which level their complaint was being dealt with and they should be made aware of the action taken". Confusion crept in because those in authority at St. Augustine's and subsequently at District level, did not distinguish between 'complaints by or on behalf of patients', for which there was a written form, and complaints by staff for which there was none unless the complaint was made by or on behalf of a patient. When we commenced to hear evidence we asked for the staff complaints procedure and were given that appropriate for complaints by or on behalf of patients. There was a covering note from the Sector Administrator stating that that procedure "is applicable to complaints by staff as well as patients. This is generally accepted and understood". There is however, no written instruction to that effect and we were told that the choice as to whether or not to follow that procedure would probably be governed by the gravity of the complaint. This absence of one clearly defined written procedure for staff is not conducive to making complaints 'respectable', or facilitating their presentation. This matter must be dealt with.

4.17 It became apparent during the course of the Enquiry that there is no recognised national procedure for dealing with complaints by staff about other staff, although, as referred to in the last paragraph, the Region had issued advice to their own hospitals, including St, Augustine's. We consider that the Department of Health and Social Security should have produced guidelines on a procedure which could be nationally adopted, and we recommend that immediate consideration be given to this.

3. The complaint against Mr. IN

4.18 During 1973 three students made complaints against Mr. IN, who has already been referred to in this Report in connection with Incident 3. The complaints included allegations which, if true, were criminal assaults, and allegations involving bad nursing. They were promptly referred to the police who decided to take no action on the alleged criminal assaults. The Hospital should without doubt have then proceeded to investigate the other matters, but failed to do so. It will not be profitable to set out in detail why this was not done. It is sufficient to say that the decision by the police not to prosecute was received within a very short time of the take over by the new administration in April, 1974, and those who should have taken the decision were not informed of what had gone before and were too busy to go into the matter as fully as they should. Such failure, however, does not encourage others to complain about bad nursing procedures. Too easily the apathetic or cynical 'what's the point?' defeats the sense of duty.

4. Other impediments to criticism

4.19 (i) The widespread belief that no action will be taken on a complaint unless there are two witnesses.

(ii) The inept procedures too often followed when complaints were made, for example' in Ash, Hazel, Elm and Heather.

(iii) The failure of too many of such complaints as were made to produce any change. Examples are the failure to investigate properly, or take adequate action on, the complaints about Mrs. Z, Mrs. UG, and Miss OA, and the failure to get sufficient reduction of beds on Hawthorn.

5. Reaction to the report of the Hospital Advisory Service on St. Augustine' and St. Martin's Hospitals and the visit of the Regional Advisory Team

4.20 The Report was received at the Hospital in November, 1971. The Group Secretary circulated it widely and asked individuals for comments. The way in which the Group Management Committee were invited to consider it, and the form their consideration took, is instructive and explains why no action was subsequently taken on important parts of the Report.

4.21 The Group Secretary, the Medical Superintendent, the Chief Nursing Officer and Principal Psychiatric Social Worker each prepared written comments on those portions of the Report which were stated to refer to their particular areas of work. As will appear, on some important matters in the Report they made no comments at all. These were then presented to the Management Committee without any attempt at multi-disciplinary consideration. It is of some significance that although the Medical Superintendent asked his medical colleagues. to provide comments, none were received from any other nursing staff or heads of departments.

4.22 The minute of the Management Committee meeting which discussed the Report reads "The Chairman stated copies of the above Report had previously been circulated to members with comments thereon by the Group Secretary the Medical Superintendent, the Chief Nursing Officer and the Principal Psychiatric Social Worker. The Group Secretary stated that comments made by (a Consultant), Dr. R and Dr. I since then had been laid on the table for the members information. The Chairman went on to say that broadly speaking a large number of the items reported on were already included in our Capital and Extra Ordinary Maintenance programmes and were awaiting finance to carry out the work involved. The Committee considered the Report in depth and following a very lengthy discussion on the recommendations made by the Team agreed that the Group Secretary would collate the Committee's comments for submission to the Regional Hospital Board". As we have already said, the recommendations were by individuals not a Team. The Management Committee selected what they considered an appropriate comment sometimes adding one of their own. Where there was no comment they occasionally provided one. Moreover, this took place during a normal Management Committee Meeting and is, so far as we could discover, the only consideration the Management Committee gave to the Report's observations and advice on policy matters.

4.23 There is no doubt that the Report was on the whole tolerated rather than welcomed, and that some parts were resented. Dr. A, the Medical Superintendent in his comments to the Management Committee, although 'quite prepared to accept the report with some reservations... as being in the main valid and reasonably constructive", went on to describe it as "a bit of a non event", and Mr. B in contemporaneous documents was no more enthusiastic.

4.24 Paragraphs 10 and 11 contained some very important observations and recommendations which were as follows:

"10. The triple role of the Chief Administrative Officer has enabled a highly centralised administrative pattern to be developed with effective financial control over all aspects of the Group's activity, inevitably however this officer has to give too much time to details usually delegated to other staff, and cannot give as much time as is usual to overall planning and policy. It is clear that the hospital is in the process of developing new patterns of medical and nursing management and it is essential to achieve effective interdisciplinary coordination."

11. ADVICE

1. The functions of Group Secretary and Treasurer should be vested in separate individuals.

2. Special attention should be given to the development of personnel services including clarification of roles and preparation of job descriptions, as well as coordinating the work of the various departments involved in the introduction of Salmon."

4.25 Those paragraphs received no comment from the Medical Superintendent, the Chief Nursing Officer or the Principal Psychiatric Social Work Officer. One Consultant, Dr. R, approved of the advice in paragraph 11.1, but his contribution had not been circulated and only 'lay on the table'. The Group Secretary wrote of paragraph 11.1 "In view of the changes in the whole administrative structure in 1974 it would seem-that the reorganisation advised must in any case take place then." The Management Committee endorsed that, and added "the administration has always been effective despite the dual role". No consideration seems to have been given as to whether there was a need for a change, and, if so, whether it could wait over two years before taking effect.

4.26 It is remarkable that no comments whatever were made on paragraph 11.2. We would have expected very positive comments from the Group Secretary and the Chief Nursing Officer.

4.27 Paragraphs 17 and 18 were as follows:

"17. No general meetings of heads of departments are held, although a number of meetings of certain heads of departments take place, for instance the Group Secretary, Physician Superintendent, Principal Nursing Officer, Group Engineer and Building Supervisor meet regularly to discuss building works. There is a need for more general and positive discussions on policy matters. The Chief Officers consider that consultation is adequately achieved by informal means but some areas feel themselves to be excluded; for example the adolescent unit clearly feels itself cut off and remote. The team is convinced that there is an immediate need for the fullest possible discussion between all senior staff on policy and planning.

18. ADVICE

Active steps should be taken to implement regular full interdisciplinary meetings for comprehensive discussion, i.e. Heads of <u>all</u> Departments within the ambit of the hospital. The use of, and inter-relationship of each department in turn should be a first item on the agenda."

4.28 The Chief Nursing Officer commented "a degree of informal meetings do take place. I am sure the advice given will be useful". However, the contribution endorsed by the Management Committee was that of the Group Secretary:- "The administrative arrangements in psychiatric hospitals generally achieve by other means the results which would accrue from the advice. There would appear to be an implication that departmental heads are unaware of the use of an inter-relationship of each department. That does less than justice to those at St. Augustine's." The Management Committee added "In matters affecting everyone all Departmental Heads are invited to discuss and are consulted in detail." The Report's emphasis on policy and planning was again missed. The Heads of Departments meetings that followed were not concerned with policy and planning in the broad sense.

4.29 Paragraphs 21 and 22 concerned laundry and linen services which have caused real discontent for years. After referring to substantial criticism of services at ward level, and evidence of unmet requisitions leading to shortages or stockpiling, the Report advised that the requisitioning system for linen should be replaced by a topping up system which would initially require a more generous provision of supplies, The Chief Nursing Officer supported that advice. He pointed out that shortages occurred at weekends and holidays, in part because it was a four-and-a-half day service for a seven day week. He wrote with justification "We query whether topping up system is proper answer without further supplies". The Management Committee, however, accepted the Group Secretary's recommendations that the Report's advice should be rejected, even though he failed to comment on the deficiencies referred to. He told them "It is difficult to see how a topping up system would, offer a better service than the present system with the same or less effort", and that it would require "a quite disproportionate amount of linen", and additional staff. He explained the difficulties of providing a topping up service in, St. Augustine,'s because there Were no lifts to first floor wards, and the topping up trolley therefore could not always reach the topping up point. In our view the topping up system should have been tried when recommended by the Hospital Advisory Service.

4.30 Out of the many further examples we could give of observations and advice in the Report being ignored or rejected, we have chosen the following:

4.31 Paragraphs 75 and 76 observed that *"although there is goodwill and informal discussion, there is little evidence that effective Tripartite administration of a multidisciplinary Team Management exists, and this is reflected in bad communications, delay and frustrations*",, and recommended "*There should be regular meetings (weekly until many of the existing problems are solved) of the Chairman of the Medical Committee, Group Secretary and Principal Nursing Officer with a formal agenda*" The Chief Nursing Officer's comment was that this seemed to be quoting history and was not "really true of the existing situation regarding co-operation between the disciplines", and that "regular formal meetings would he welcomed" although they already took place informally. Most surprisingly no comments were received from the Medical Superintendent or Group Secretary, presumably because these paragraphs were included in a section head "Nursing Administration". The Management Committee adopted the Chief Nursing Officer's observations after deleting his support of formal meetings. Thereafter the informal Tripartite meetings continued as before.

4.32 Paragraphs 85 and 86 concerned the operating-theatre and read:

"85. In the period 21 July 1970 to the 21 July 1971, 143 operations on male patients were performed, but in the period the 22 July 1971 to the 31 September 71 only 16 operations were performed. In the whole of the period referred to above only 15 operations on female patients were done because of the shortage of beds on Cherry Ward. The operating theatre has to be prepared and fully staffed for, a list of one or two patients. I was told that all realise it is an uneconomic project no longer required as a means of reducing the Kent and Canterbury waiting list, but is regarded as having prestige value in furthering good relationships with the public. St. Augustine's Hospital's reputation is dependent upon the quality of the psychiatric service it provides, not the surgical amenities.

86. ADVICE

No patients, should be admitted for the sole purpose of surgical operation and the operating theatre team should be deployed elsewhere and the theatre closed."

4.33 Neither the Medical Superintendent nor the Group Secretary commented. The Management Committee simply endorsed the note of the Chief Nursing Officer "Views expressed referred to S.E.M.R.H.B." The operating theatre continued in use, and eight beds, only about half of which are used for not more than two days each week are kept for minor surgery in a relatively well up-graded Ward, whilst psychiatric patients in many wards live continually in far less satisfactory conditions.

4.34 Paragraphs 95.2 and 97.2 stated that access by student nurses to patients case notes was severely restricted and that students had to apply in writing to the Medical Officer in charge of a patient before they can see them. The Report recommended that patients case notes should be available to student nurses after consultation with the nurse in charge of the ward. The Report also observed that there were too few ward conferences in which there can be an exchange of information between doctors and nursing staff.

4.35 The Chief Nursing Officer commented to the Management Committee that it was not accepted that access to case notes was severely restricted and that student nurses could obtain access to them when required "in accordance with the recommendations of the Medical Defence Union." He did not, however, say that that recommendation did not accord with that in the Report. He went on 'We feel that there should be more ward conferences dependent on availability of doctors (who are at present in short supply)". No comments were received from the Medical Superintendent or the Group Secretary. Mr. C's observations ‘on the table' sad "The more access to records' the less informative they will have to become. There should be more ward conferences and with more medical staff this could happen." The Management Committee endorsed the Chief Nursing Officer's comments after deleting the sentence about the need for more ward conferences.

4.36 There has been a Continuing argument at St. Augustine's about access to patients case notes · The Consultants have in our view adopted an unduly restrictive attitude (see paragraphs. 6.36– 41).

4.37 Paragraph 96 included the important statement "Many nurses felt that they would like to extend their nursing roles realising that nursing care at St. Augustine's is too frequently custodial, the exceptions between Redwood House and Oak House where nurses are encouraged to accept more therapeutic roles". Once again the Medical Superintendent and Group Secretary made no comment. Dr. R recorded "Really!" The Chief Nursing Officer stated "To some extent this is true.” The Management Committee endorsed that comment but no investigations seem to have followed as to why care was "too frequently custodial" Or what could be done about it. That kind of questioning regrettably had to wait for the arrival Of Dr. Ankers and Mr. Weston.

4.38 Paragraphs 98 and 99 reported "Regular ward meetings exist on some wards where multidisciplinary team work is more evident such as Oak House and Acacia. These meetings are an essential art of patient care. The absence of ward meetings on other wards makes it difficult for nurses to contribute to policies directly relating to patient care." There followed the advice Multidisciplinary ward meetings should be established on all wards, weekly where possible and otherwise monthly". There were no comments from the Medical Superintendent or Group Secretary. Dr. R stated "We have been over this topic many times and have been unable to implement". The Management Committee adopted the Chief Nursing Officer's contribution:, "Multidisciplinary meetings are taking place on some wards and some areas and this will be developed further in the future." There the matter rested with no further investigation.

4.39 Paragraphs 116 and 117 dealt with 'Disturbed wards' and stated that these were provided separately for males and females and were locked. “The regime is essentially custodial rather than therapeutic.” The advice was "A multidisciplinary team should consider the policy for disturbed patients and review the need for any disturbed wards. If still considered necessary such a ward should provide intensive treatment, a high Staff/patient ratio, and preferably be open, mixed and of fewer than 30 beds," Neither the Medical Superintendent nor the Chief Nursing Officer nor the Group Secretary commented. Dr. R said "Abolition already agreed under team system." The Management Committee reported "The use of closed wards will be discontinued." Its members had apparently equate a disturbed ward with a closed ward, and had overlooked the advice that if a disturbed ward was found necessary it should be open. The advice that a multidisciplinary team should consider the policy for disturbed patients was not followed.

4.40 We have already described the situation in Heather Ward and the problems caused by its high proportion of disturbed patients. No policy had been discussed or formulated. It provided neither intensive treatment nor a high staff/patient ratio. Dr. W described Heather Ward to us as a disturbed ward, yet when the District Management Team later reported to the Area Health Authority on Dr. Ankers' assertion that these and other paragraphs in the Report had not been fully implemented, they said "It is reported that there are no disturbed wards at St. Augustine's now that the scheme for 'clinical areas' has been implemented." Denial of a problem does not mean that it will go away.

4.41 The Report also recommended that nursing staff should visit the wards at Fulbourn Hospital and see the management of 'disturbed patients'. The Management Committee endorsed the Chief Nursing Officer's. comment that this would be done. A team of nurses visited Fulbourn in May, 1972, and the Nursing Officer who led the party wrote a report on what they had seen. Unfortunately, however, it contained no suggestions as to whether anything they had seen or heard could helpfully be applied in St. Augustine's, and the report was filed until the first part of the Critique pointed out that this paragraph of the Hospital Advisory Service Report, amongst others, had not been implemented. The District Management Team then commented "A party visited Fulbourn Hospital and it is reported they received the impression that conditions were worse than at St. Augustine's." The Hospital's response to this and much of the Hospital Advisory Service Report, including these paragraphs, was negative and defensive.

4.42 Paragraphs 124 and 125.2 pointed out that many of the patients in the psychogeriatric wards had no psychiatric involvement and were primarily geriatric patients, yet the wards were not equipped to nurse geriatric patients. It recommended that they should be properly equipped after advice from a geriatrician. Nobody commented on this, and it was only in late 1974 and 1975 that any appreciable progress was made in carrying out this recommendation.

4.43 Paragraph 125.1 repeated the advice given in paragraphs 71 and 72 that all patients over 65 should be assessed and treated in the first place at St. Martins Hospital. The Chief Nursing Officer had commented "A mixed psychogeriatric assessment/screening unit at St. Martins would be a good thing and welcomed by nursing staff". The Medical Superintendent, however, differed and said it would be a very retrograde step, and suggested an alternative. The Management Committee in their comment to the Regional Hospital Board endorsed the Medical Superintendent's view but failed to indicate that the Chief Nursing Officer had supported the HAS advice. In September, 1974, after Part I of the Critique had pointed out that this and other paragraphs of the Report remained unimplemented, the District Management Team supported the Hospital Advisory Service advice, stating "It is agreed that action is still required to assess and treat all patients over 65 at St. Martins Hospital but lack of resources have so far prevented this." In the Autumn of 1975, St. Martins still presented a picture of a neglected backwater for geriatrics, When visited at 6.00 p.m. one evening patients were being put to bed for lack of any evening activity.

4.44 In its conclusions the Report referred again to the many areas in which custodial care could be found and the "urgent need for a multidisciplinary review of many activities, particularly the formation of teams, the admission policy, mixed sex wards, and the reduction in numbers of the large wards." It added "Nevertheless, there is a considerable fund of goodwill and latent energy waiting to be released." It is significant that many of the items which were not commented on in the notes submitted to the Management Committee related to this need for a multidisciplinary approach. It must have been clear to the Hospital Advisory Service Team that the development of the concept of multidisciplinary teams and the division of the catchment area into sections related to teams working within the hospital would require a great deal of work, and that the Group Secretary would have to provide a major back-up service by collating information, working out areas of the hospital and ensuring that the changeover went as smoothly as possible by getting the right equipment to the right wards. For example, supplies of the correct clothing had to reach wards which changed from female to male and vice versa. This must have been one of the reasons for the advice that he should give up his multiple role, delegate his responsibilities and develop the personnel services. We heard of many problems which arose at the time of, or as a result of, 'areaization', and in our view some, at least, would have been avoided if the Group Secretary had given more time to policy and overall direction instead of continuing to concentrate on the detail which should have been delegated to others.

4.45 We have dealt in some detail with the ways in which the recommendation of the Hospital Advisory Service were treated because a comparison between what we found in the wards and those recommendations makes it clear that if they had been fully discussed and implemented there would have been no Critique. Instead the Report was treated with something approaching a patronising disdain.

4.46 The first part of the Critique was correct in asserting that the paragraphs there referred to had not been fully implemented. The authors could have added many more.

4.47 There should have been full multidisciplinary discussions on the Hospital Advisory Service Report at ward, clinical area and Management Committee level. Only when this had been done could the Management Committee make its report to the Regional Hospital Board. Instead, part of a Management Committee meeting was devoted to the consideration of the individual comments of four individuals, several of whom had failed to comment on matters profoundly affecting or affected by their disciplines.

4.48 Early in 1973 St. Augustine's was visited by the Regional Advisory Team which had been formed by the Regional Hospital Board to follow up visits by the Hospital Advisory Service and to monitor standards generally, The Team's visit was lengthy and involved discussions with a great many people of all disciplines. It was most Unfortunate that its Report nowhere sets out the progress made in implementing the advice contained in the Hospital Advisory Service Report. Moreover, the Team's report was concerned in the main with the long term and did not tackle or refer to the most urgent problems in the long-stay wards: it appeared to concentrate on material needs rather than attitudes and the standard of care provided. We can well understand anybody reading that report coming to the conclusion that there was nothing to cause serious concern at St. Augustine's.

4.49 It is of great significance that, having signed a report in those terms, the doctor who led the Team should have reported to the Regional Administrator following the publication of the first part of the Critique that "most of the comments are basically true", and that the nursing member should have telephoned and written to the Regional Nursing Officer in the terms set out in paragraphs 4.83-88 of our Report.

4.50 We have no doubt that the explanation for the discrepancy between the terms of the Regional Advisory Team's report and the reaction of those two members to the Critique is that that team was over anxious to avoid its Report being received with the same resentment occasioned by the Hospital Advisory Service Report. This exposes the difficulty of having an Advisory Team which is too close to those whom it is advising. The realisation that they all have to work together in the future may, as here, lead to their Report omitting important matters of concern that have come to their attention and of which the Regional Hospital Board should undoubtedly have been informed.

4.51 We recommend that all future follow up visits to Hospital Advisory Service Reports should result in reports which detail ·the progress made on each recommendation. Where it is not intended to implement a recommendation, or where implementation has been postponed or delayed, full reasons should be given. If a Hospital Advisory Service Report comments, for example, that care in certain wards is largely custodial and that there is an absence of multidisciplinary working, the follow up report, no matter who it is produced by, should state whether that is still the position and, if so, what is being done about it.

6. Reaction to the Report on the "Survey of Teaching at Ward Level"

4.52 During 1973 two young nurses who were members of the Nurse Education Committee conducted a survey amongst learners in St. Augustine's in order to find out whether there were improvements that should or could be made in ward teaching. It was prompted in part by their appreciation of a certain degree of apathy among some learners which had led to complaints by the doctors of poor attendance at their teaching Sessions, and in part by the discovery of the following entry in minutes of a Nurse Education Committee meeting in December, 1971:- "Regular clinical teaching and ward conferences are now, an accepted feature of modern psychiatry and the trend is towards more relaxed, informal multidisciplinary meetings. These are a feature of hospitals which have the therapeutic community approach... Dr. A stated he was under the impression these meetings were taking place regularly in all wards." That impression was ill founded and appeared to these nurses to show little knowledge of the true state of affairs.

4.53 In the survey 96 questionnaires were sent out and 38 returned. The authors analysis of the returns was well written and balanced. They stated that learners were dissatisfied about the following matters:-

(i) Although handover Meetings took place on most wards, it was felt that they were 'too skimpy' and "that they could be used to discuss more in depth patient care".

(ii) Nursing Officers visited the wards infrequently "and their interest in the training of learners was negligible."

(iii) "Nursing procedures were not adhered to, e.g. ward administrator on one ward had little introduction to CSSD and was obviously unable to teach its correct use. Wards have a lack of proper equipment for carrying out work. On one ward the dressing trolley was stored in the bathroom to hold socks etc. because the ward was without a general purpose trolley."

(iv) The ward changeover books could be used to better effect.

(v) "The storage of nurses notes separately from the main case notes discouraged learners from writing them."

(vi) The wards lack quick reference books.

(vii) Nurses in training had little to do with ward doctors. Although many doctors were giving some time to specialised lectures which were favourably received "the point of contact in the modern psychiatric hospital should be at team meetings where free discussion on patient care should take place. It is clear from this survey that most wards in this hospital have no such meetings... Team discussion has two major benefits – patient care is likely to be improved with clear policies to refer to which all staff fully understand, and the educational value of such meetings cannot be over-emphasized."

4.54 There followed a list of sensible recommendations culled from the survey returns.

4.55 The survey was sent with a covering letter to Dr. A (the Chairman of the Medical Executive Committee) and the Chief Nursing Officer, amongst others, Neither of them acknowledged the receipt of the survey or ever sought to discuss it With either of the authors who had spent about six months in its preparation, and yet both Dr. A and the Chief Nursing Officer subsequently maintained that they welcomed helpful constructive criticism. Further comment by us is unnecessary.

7. <u>The Reaction to and the investigation of the Critique</u>

4.56 The opinion is widely held in St. Augustine's that if the investigation into the first part of the Critique had been better handled there would have been no Second part, and no long, disrupting and expensive Enquiry. Before we look at the main steps that were taken it will be helpful to indicate in broad terms the circumstances and attitudes which did much to shape the pattern of events.

4.57 (i) Both within and without the hospital many people, while doing their best to adopt a responsible attitude to criticism much of which they must have known was well founded, nevertheless felt distaste for the authors. The basis for this distaste is not easy to distil. It had much to do with 'bad form' and 'disloyalty'. They were seen as two young and inexperienced men who did not know their 'station'. The hierarchy had been treated with disdain. Didn't they appreciate that the matters of which they were complaining were inherent in an under financed and understaffed National Health Service? Why pillory St. Augustine's when it was better than many other hospitals?

4.58 We have no doubt that Dr. Ankers sensed the resentment and criticism close beneath the surface of the formal invitations to talk, and that this contributed to his over-reaction.

4.59 (ii) The first part of the Critique was received in April, 1974. within about two weeks of the take over by the new National Health Service administration. Members of the Regional Team of Officers and their supporting staff had worked for the Regional Hospital Board and, with their knowledge and previous contacts, were probably the team most suited and qualified to investigate the allegations in the Critique. However, on 1st April two administrative tiers had appeared between them and St. Augustine's and the investigation had to be left to them, although it was realised that they were hopelessly overstretched in manpower and resources and that the District Management Team contained no member with any psychiatric knowledge or experience. In those circumstances the Area Health Authority would have been wise to accept the Region's offer of help.

4.60 (iii) The Regional Administrator, who had been Secretary to the Regional Hospital Board since 1968, told us that St. Augustine's had not been regarded as a problem hospital in the Region: the Management Committee had been regarded as good and was known to have a high regard for its officers: moreover the performance indicators of press cuttings and complaints indicated no serious trouble, and there had been no complaints from any voluntary organisation. In his opinion the Reports of the Hospital Advisory Service and the Regional Advisory Team, although critical, were far less so than of other hospitals in the Region. A member of the Regional Hospital Board, who he regarded as the best informed in the mental health field, and who had served at the same time on the Group Management Committee, believed St. Augustine's and St. Martins to be the best hospitals in the Region. We are confident that this assessment of St. Augustine's permeated down from the Region to both Area and District.

4.61 We now pass to look at the manner in which the Critique was investigated at various levels and the attitudes of some of the people involved. Where possible we keep to the chronological order of events.

(a) <u>Investigation by the Nursing Administration within the Hospital</u>

4.62 Within a very few days of receiving the Critique, Mr. C the Chief Nursing Officer, on April 24th wrote short but polite letters to the two authors thanking them for sending him a copy, assuring them that the points they made would be considered in detail by the senior nursing staff, and concluding that he would then "like to convene a meeting which I hope you will be able to attend, when the Critique can be discussed and you could then elaborate the points raised."

4.63 Dr. Ankers had a long friendly talk with Mr. C lasting one and three quarter hours on May 2nd. Mr. C asked why he had not brought the grievances to him. Dr. Ankers replied that he had taken them to the Nursing Officer, the Senior Nursing Officer and the Principal Nursing Officer without result and had then decided to adopt other means. Mr. C tried to impress on him the progress already made in the hospital and described the Critique as a "lump of half truths". When Dr. Ankers gave a few examples of Mrs. Z's behaviour in order to illustrate what he meant by mistreatment and malpractice, Mr. C said he thought that they were rather extreme examples and explained that it was difficult to do anything about unsuitable staff because of the power of the Unions.'

4.64 Following this interview, and having heard views expressed within the hospital that they were just two young inexperienced voices crying in the wilderness, the authors began to approach members of the staff to sign a document stating "We, the undersigned, being members of the staff of St. Augustine's Hospital, Chartham Down, Canterbury, endorse in general terms the substance of the Critique Regarding Policy by W.B. Ankers and O. Etsello of April 1974 relating to St. Augustine's Hospital". It is significant that 33 out of the 34 signatories were nurses. 13 were trained nurses, including four Ward Sisters or Charge Nurses, 16 were either student of pupil nurses, and 4 were untrained Nursing Assistants. In addition to the nurses there was one occupational therapist.

4.65 On May 15th Dr. Ankers had another long talk with Mr. C who asked him not to precipitate a split between young and old attitudes by asking student nurses to sign the document. He added that any Charge Nurse who signed it would be indicting himself. At the end of this meeting Dr. Ankers explained that if there were to be any meetings to discuss the contents of the Critique Mr. Weston must be present. (It will be recalled that he had left the hospital on April 30th.)

4.66 On May 16th Mr. C again saw Dr. Ankers for two and a half hours in the course of which he tried to persuade him to meet the District Nursing Officer and others on May 20th to discuss the Critique. Dr. Ankers said he would do so if Mr. Weston's expenses could be paid so that he could also attend, Mr. C replied that he could not authorise payment of those expenses and asked him to give, particulars of the mistreatment and malpractice. Dr. Ankers declined to give these details as he did not wish for a witch hunt after individuals when he and Mr. Weston were concerned with lack of policy.

4.67 On May 20th Dr. Ankers met the District Nursing Officer in private and she tried to persuade him to attend the meeting that had been arranged, but he repeated his objection to attending without Mr. Weston. She accepted that this was reasonable, but said that she could not authorise reimbursement of Mr. Weston's fares as this was a matter for the District Treasurer.

4.68 There the matter rested and no further invitation to meet the health authorities was extended to Dr. Ankers and Mr. Weston until the end of September. The District Nursing Officer told us that she did not ask the District Treasurer to authorise this expenditure.

4.69 On May 20th Mr. C handed the District Nursing Officer a memorandum of 19th May prepared by Mr. L and in which he sought to set out the views on the Critique expressed by Senior Nursing, Officers and Nursing Officers at a meeting held on the instructions of the Principal Nursing Officer. This paper is full of the two way look we have already described. It included these two sentences:- "It was generally agreed that the Critique had fulfilled a function in reviving the stimulus to overcome shortcomings. The hospital was actively defended against these criticisms." It pointed out that the policy of the hospital was "to get patients back into the community as far as the limitations in terms of finance and manpower allow and that it was probably wise to concentrate on the return of the short term patients. After stating that there was an obligation on staff to use their initiative the memorandum continued "A paper written by a Staff Nurse of many years experience concerning the Critique <u>was unanimously accepted as being the answer to the situation</u>." (our underlining). That paper ridiculed the Critique. Two passages convey its flavour. "My next reaction was that this was sour grapes. A case of the modern trend of student bodies 'doing their thing'. Sit-ins - kick the Admin - Up the Fuzz etc. etc. I felt I wanted to reply in a humourous ridiculous type of vein 'with apologies to Abbott and Costello', but then I felt that ridicule would be out of place - this Critique was ridiculous enough." Then later on:- "Only constructive criticism is any good, any bloody fool can read various pamphlets and pick out passages that do not ring true to the existing regime. You may think that that is what I am doing now but I offer the authors constructive criticism - if you don't wish people to know you are foolish then don't open your mouth and prove it."

4.70 That this kind of document should have been universally accepted by the Senior Nursing Officers and Nursing Officers as the "answer to the situation" is deeply disturbing. It reveals an attitude of derision beneath the surface of respectability and responsibility in the upper nursing echelons. The District Nursing Officer sent the document to the Area Nursing Officer. It is in our view significant that neither of these officers, nor indeed the Chief nor Principal Nursing Officers, thought it right to meet Senior Nursing Officers and Nursing Officers in an endeavour to lead them to a more constructive response.

4.71 The Principal Nursing Officer's written comments of May 14th were restrained but gave no indication as to whether he regarded the contents of the Critique as well founded. He wrote "I know Dr. Ankers to be a well intentioned and caring young man who I am sure has taken this line of action for best intentions. Mr. Etsello, however, I feel I would have to question his motives. The document is well written - it is bound to have a good effect on the hospital in the long run - my one concern however is that Dr. Ankers is only referring to Heather Ward when, in fact, he quotes the hospital." He then supports what his officers have said.

4.72 On June 5th, Mr. C wrote to the District Nursing Officer expressing his views on the Critique "in relation to the areas where it affects nursing". It is a classic non-answer. First he says that criticism has always been welcomed and encouraged by nursing staff "providing it is constructive and informed and well intentioned", but he continues that he finds the Critique very hard to answer. "Whilst I accept that the criticism is basically well-intentioned it has been developed without a thorough knowledge of many situations here which has resulted in a number of what I can only call half truths being expressed and these are always difficult to answer without going into a great deal of detail". He went on that there were areas needing improvement, but the "nursing administration are very aware of this and are doing their best within the resources, manpower and financial, that are allotted to us".

4.73 Nobody in authority, however, made any enquiries among the student nurses and pupils. It was important to find out whether they agreed with the Critique. If they did, it would surely mean, at least, that such policy as was claimed by authority to exist was not understood by an important part of the caring staff. The fact that they were not consulted confirms our firm view that, whatever the outward veneer, the views of, junior staff were not really welcome, particularly if critical.

(b) Investigation by the Medical Staff within the Hospital

4.74 Dr. R said of the first part of the Critique "No doubt its overall purpose was intended to be constructive, but the general tone is exclusively destructive". Dr. W felt that it "made one or two constructive suggestions which could only be carried out if we had an increase in medical and nursing staff and additional money was spent. I find a lot of the things said in the Critique were destructive and detrimental to the morale of nursing and medical staff". He explained "I meant mainly by that it created a paranoid atmosphere in the hospital, an attitude of paranoid anxiety which is very difficult to work in... T think it has destroyed the morale of this hospital for many, many years to come". We are convinced that he is wrong in this. The hospital will never be the same again, but it was necessary that in the long stay wards it should change. The great majority of the young staff, who were not consulted about the Critique, were wanting change, and, to use the words of one as we walked round, are looking toward the recommendations in our Report as a lifebelt.

4.75 Dr. I described the first part of the Critique as "more a linguistic exercise than informed comment. It struck me that the points which the authors were making would probably apply to any organisation employing a large number of human beings. It seems to me that it was designed to arouse emotional response rather than to convey information. It is also written, in my opinion, from a certain social and political standpoint which may not have general agreement in this country". He explained that he meant by that last sentence that it was written from a perfectly respectable body of social and political opinion which may not be shared throughout this country, but which "holds that institutions, using the term as applicable to this hospital, are inherently bad things, and overall that the abuses contained within them are greater than any benefits which they offer". We do not understand how any sensible person approaching the first part of the Critique with an open mind could come to such a conclusion.

4.76 Dr. X, who is now Chairman of the Medical Executive Committee, demonstrated his disapproval in what he now generously acknowledges to have been a most unfortunate manner. He had begun to give teach-ins to nurses shortly before the Critique was circulated. In his own words "I said to myself 'If this is what they think of us I am going to stop it'," He did not recommence those teach-ins until August 1975 and he agreed that that gap of 16 months was a measure of his disapproval.

4.77 All these doctors accepted that there were some good points in the Critique and that some improvements were necessary, but that two junior staff should have sought to hasten them in this way seems to have stirred deep resentment.

4.78 The Medical Staff Committee met on May 9th. The minute of their informal discussion of the Critique, after indulging in what was almost a ritual 'knocking' of the authors, accepted by inference that much of it was well founded and, in effect, asked for help. "The general view was that while the document was the product of two people who were not really qualified to criticise the management of the hospital and the care of patients in particular, it nevertheless reflected disquiet felt by some members of the nursing staff. Everyone was aware that there was room for improvement particularly in the care of long stay patients… There was discussion whether Consultants could give more time to the care of long stay patients, either directly or indirectly through their colleagues, but all present felt that demands on their time for the care of acute cases must be given priority and therefore it was not possible to see how any better arrangements could be made."

4.79 This was amplified on the same day by a letter from the Chairman of the Medical Staff Committee to the Chairman of the Medical Executive Committee. After saying that the Critique "as it stands shows an immature and naive approach and unrealistic expectations", the letter concluded forcefully, that it "should not be ignored. It shows disquiet and dissatisfaction among nursing staff and an apparent breakdown in communication. At the very least more efforts should be made to channel the desire of these nurses to do more for their patients and to give them an opportunity to take part and speak at ward meetings. Consultants should look again at their work programme and perhaps review more closely what is happening in long stay wards: their own junior staff need more help."

4.80 On May 22nd Dr. A, then the Chairman of the Medical Executive Committee, wrote a long letter to the District Administrator giving the views of the Medical Executive Committee and the Medical Staff Committee. It is full of conflicting views. After stating that constructive, informed and well intentioned criticism is always welcome it continues "In the case of the Critique, however, although the medical staff as a whole felt that they must accept it at its face value as an honest attempt by two members of the nursing staff – though one of them no longer works here – to improve what they considered to be a state of affairs very much in need of improvement, at the same time some reservations were expressed that this was in fact so". He went on to allege that Mr. Weston by a previous written communication had gone a fair way to wrecking "relationships between the hospital and an after care hostel by alleging lack of co-operation which was 'totally untrue'. He was also the author of a somewhat questionable article in the Nursing Times." He then refers to a psychological test carried out on Mr. Weston before he was accepted as a student nurse, and continues "he should not in my opinion have been engaged as a psychiatric nurse in the first place. Of the other author, a

Nursing Assistant, I am afraid I know next to nothing. However, I am only writing about the Critique as it seems to affect medical staff and medical policy and it is certainly not my purpose to denigrate its authors." After stating that the policy of the Medical Executive Committee is to reduce the number of patients by 400 before 1981 he accepts that the Consultants spend too little time on the long stay wards and explains the problems caused by to few Consultants. He concludes "On the whole I think the publication of the Critique will do nothing but good, though whether this was the intention of its authors I am afraid I am less convinced. By a reorganisation of our working days some of us have been able to cut out what we had felt to be essential in favour of other things which our nurses obviously felt were more essential. But as it stands, the Critique is really little more than theory, some of it preconceived I think, little that is original and much that is very familiar. It contains few facts, some distortions of fact and many half truths. There is however some good in it and as such it is welcomed, and I have no doubt that its publication will have a beneficial effect on psychiatric performance at St Augustine's."

(c) Investigation by the District Management Team and above

4.81 To the initiated a nod is as good as a wink. Dr. A's ambiguous letter, together with that from Mr. C and a short report from the Unit Administrator, were considered by the District Management Team on July 1 2th, following which the District Administrator wrote to the Area Administrator giving his team's conclusions. He reported that the Medical Executive Committee had 'received' those documents at its meeting on July 5th and 'felt that it had no further observations to make in this connection as the reports were fulsome replies to the Critique'. He continued "The District Management Team... received the views of the Medical Executive committee and agreed that whilst they did not appreciate the wide circulation of this particular document, they did not object to staff giving their views on the standard Of care of patients. The Team accordingly endorsed the comments made in the letter from the Chairman of the Medical Executive Committee commenting on the Critique and also the further comments of the Chief Nursing Officer and Unit Administrator. It concluded by Stating that it had every confidence in the staff at St. Augustine's Hospital."

4.82 There the matter would have rested if the District Management Team had not been encouraged from above to further action.

4.83 What had been happening elsewhere? It is convenient to start with the Regional Team of Officers. On May 14th, Miss MNO, the Regional Nursing Officer, had a telephone call from Miss POW, the Nursing member of the Regional Advisory Team which had visited the hospital in 1973. She told Miss MNO that the Critique did not surprise her and that she felt some of the allegations had Substance: that the allegation that totally unsuitable nursing staff were in positions of responsibility had some substance due to the implementation of Salmon and the assimilation procedure: that the former Group Secretary had been remote and that there had been a suppression of nursing: that the Consultant Medical Staff had a poor relationship with nursing administration: and that there was a general feeling Of simmering under the surface.

4.84 Miss PQR augmented this by a letter of the sate date. It included the following important passages:-

4.85 "There is no doubt that the 'long stay' Patient is not getting the therapeutic approach of a multidisciplinary team in many of the wards, and, while not wishing to make excuses under any circumstances, the fact remains that too few people (medical, nursing and remedial staff) are trying to cope with far too many patients. In these circumstances, apathy and frustration are the result. The initial enthusiasm With which staff approach their role is replaced by a laissez faire attitude when no-one in particular appears interested in their efforts.

4.86 "The impetus for change and encouragement in development of the therapeutic environment MUST, in the first instance, come from the Consultants. In my opinion, this does not happen at St. Augustine's - the concentration of efforts are limited, in the main, to acute admission wards.

4.87 "The H.A.S. Report was considered, in the main, unfair and biased by former management. Many of the recommendations said to have been put into effect by top management were not apparent. The recommendations in our Report (RAT) on the follow up visit were said to have been implemented. I was not present at this meeting and in fact was not convinced that the recommendations had been implemented with any enthusiasm...

4.88 "I am sure this Report is in essence what appears to the authors valid observations. In my opinion, the points raised should be investigated by an outside body. I would not think it wise to leave too long a gap before an investigation takes place. Does the D.H.S.S. ever ask the Health Commissioner to look into Reports of this nature?"

4.89 Miss MNO told the Regional Administrator about Miss PQR's communication on May 20th. They agreed that "the first step would be to discuss at the earliest opportunity with the Area Team of Officers their proposed action concerning the contents of the Critique" and the need to check on certain matters including the complaints procedure, the incident recording procedure in use, progress in case conferences and the establishment of therapeutic programmes, the extent of custodial care, the introduction of a retirement policy for staff and nurses in particular, and the meeting p where staff participation was allowed.

4.90 Everybody was so busy that no meeting could be arranged until July 22nd. In the meantime the Regional Administrator had obtained the comments of the doctor who had been head of the Regional Advisory Team. He reported of the Critique that "most of the comments are basically true".

4.91 It was the meeting on July 22nd which set the District Management Team off on a further investigation. Although Miss MNO told those present of Miss PQR's views, a copy of her letter was not handed over, and we do not think that the Area or District Administrators were fully informed of or, at least comprehended, the strength of the confirmation for the Critique coming from these two former members of the Regional Advisory Team. It is a great pity that their Report in 1973 did not convey their feelings with sufficient clarity.

4.92 On September 11th the Area Team of Officers considered 'a summary of comments' on the Critique by the District Management Team which was presented to them by the District Nursing Officer. At the request of the Area Team a more detailed report on the Critique was produced by the District Team for a further meeting on 16th September. Both documents formed part of the Agenda for the public part of the Area Health Authority meeting on September 17th.

4.93 The first summary included the following passage:- "The following suggestions are being considered as items on which positive action can be taken at the present time", and there then follows: (i) Development of In Service Training aimed specifically at long serving senior nursing staff, and the establishment of guidelines for implementation of therapeutic activities at ward level: (ii) the establishment of a patients bank and the relief of nurses from the distribution of patients cash, (iii) a report by the Unit Administrator to the Medical Executive Committee on the progress of multidisciplinary ward meetings, and (iv) the establishment of participative Management groups "which could involve such grades as Nursing Assistants".

4.94 However overworked the District Management Team was, it was regrettable that these steps were still in the 'consideration' stage four-and-a-half months after the circulation of the Critique. The Area Team recommended "that a multidisciplinary executive team comprising for example, the Medical Executive Committee Chairman, the Sector Administrator and the Principal Nursing Officer, should be formed to consider the day to day running of the hospital, and "that there should be a policy of staff retraining in modern psychiatric care for staff with long service at" the hospital.

4.95 The more detailed report on the Critique from the District Management Team left very many unanswered questions. In order to give its flavour and illustrate the questions which should have been asked about it we set out the first two sections.

"1 THERE IS LACK OF POLICY FOR TREATMENT OF LONG STAY PATIENTS

Medical staff and nursing staff comment that the declared policy is to get patients back into the community and to reduce the number of patients at the hospital, as far as the limitations in terms of finance and manpower allow. The reduction from 1,314 in August 1972 to 1,032 in July 1974 is an indication of the progress made so far', and represents an extraordinary effort on the part of all concerned with the intensive rehabilitation and discharge of these patients. Nevertheless, much remains to be done for those still regarded as long stay patients.

2 THE MAJORITY OF THE PATIENTS DO NOT RECEIVE THE BENEFIT OF INDIVIDUAL TREATMENT PROGRAMMES

Consultant medical staff are prepared to accept that they do not spend enough time with their long-stay patients and are concerned about this, but it is pointed out that each Consultant has responsibility for Populations averaging over 120,000 whereas an acceptable figure would be 60,000 The appointment of additional Consultants has improved the situation to some extent and future appointments are planned in 1975. Nursing staff comments are that although there are facilities for Industrial and Occupational Therapy these need to be greatly extended. Proposals for this development are in the Development Programme."

4.96 The first comment confused policy with objective, and in any event left totally unanswered the question "What is the policy for the long stay patients Who cannot be discharged because of their condition or the lack of hostel accommodation?"

4.97 The second comment left unanswered the question "Do any, and, if so, how many, long stay patients have individual treatment programmes?"

4.98 It does not seem to have occurred to the District Management Team which prepared those comments, or the Area Team or Health Authority members who received them, to ask those elementary questions. Why not? The Area Administrator told us that his team were 'very dissatisfied' with the District Team's comments and asked them to be °a little bit more specific'. The Area Medical Officer, on the other hand, said "My impression was at the time of the Area Health Authority meeting in September that the District Management Team had done as reasonable a job as I would have expected them to do… On the medical side my honest opinion was that there was nothing particularly untoward which I could say, or I could identify, as worthy of further enquiry. I was happy." If the Consultants had been asked at that time how many long stay patients had individual treatment programmes they would have answered, as they answered us, 'none'. The Area Medical Officer said such an answer would not have satisfied him that all was well. He was unable to tell us why that question had not been asked, although he explained that he, too, like the Regional Administrator had to some extent assessed the Critique in the light of the known reputation of the hospital.

4.99 The Area Health Authority had, and still has, serving on it, two of the most active members of the former Management Committee responsible for the Hospital. One of them gave evidence to us and told us that their views on the Critique were 'broadly the same' and that they made them known to the Area Health Authority members. They were 'very surprised' at the contents of the Critique: "I thought it was related to the period when I first knew the hospital ten years before', when there might have been more justification, but it did occur to me that a great number of the things which the authors were imputing had already been dealt with". The following question and answer followed. "Q. Did you think then that what was said in the Critique Part I was unjustified so far as this hospital was concerned in 1974?" - A. "A good deal of it. There were a few things which I felt were justified and which probably would have been dealt with previously if there had been enough money."

4.100 She added that, although she visited the hospital and toured the wards asking questions, she had not been aware of shortage of flannels or clothing or of infrequency of bathing on any ward. When asked about a minute of a meeting between the Regional and Area Officers in which the Area Officers were reported to have said that the Area Health Authority regarded the Critique as immature, she confirmed that this was so.

4.101 The minutes of the Area Health Authority meeting on September 17th record that three members of the District Management Team "were present at the meeting to answer Members questions on this matter. A copy of the Critique, which it was reported had had wide circulation, and comments on this document by the Canterbury and Thanet District Management Team were received. RESOLVED (i) that the authors of the Critique be asked to meet the Area Team of Officers to substantiate their allegations of mistreatment and malpractice in St. Augustine's Hospital, or to withdraw them". Further resolutions endorsed the steps which we have already said were being considered by the District Management Team.

4.102 On September 25th an Administrative Assistant from the Area Health Authority met Dr. Ankers at the hospital and extended an invitation to him and Mr. Weston to meet the Area Team of Officers and the Chairman of the Area Health Authority "to discuss the allegations of mistreatment and malpractice that had been made in the Critique". All their expenses would be paid. Dr. Ankers said that he would pass the invitation on to Mr.

Weston and that they would send a joint reply. In the course of a friendly conversation he pointed out:

(i) that they wished to discuss the allegations of lack of policy and that too much was being made of allegations of mistreatment and malpractice, and
(ii) that judging from the documents circulated to the Press by the Area Health Authority and the Comments of. its members reported in the Press, the Authority seemed to have prejudged the tatter, and that it appeared that they Were "being hauled before the authorities almost as criminals".

4.103 The local newspapers had, indeed been full of reports and comments. Among the documents reported in considerable detail was that containing the comments of the District Management Team on the Critique. In the Kentish Observer of September 19th it was referred to under a headline 'Document suspect says the Hospital'. Members of the Area Health Authority were reported as having said "The contents are immature" and "the authors were confusing idealism with realism".

4.104 In the light of the following two extracts from the Press, which are typical of other reports, it is not surprising that Dr. Ankers and Mr. Weston interpreted the invitation as a "disciplining exercise': "Authority Chairman Mrs. Jean Cockerill suggested the men being told to appear before officials of the District Management Team, but Area Administrator Mr. Peter le Fleming felt this might inhibit them. 'If they have already refused to talk to the District Management Team they must talk to the Area Authority and confirm or withdraw their comments and afterwards make a press statement'." Another Area Health Authority member was reported as saying "If the authors are not prepared to substantiate the allegations of mistreatment and malpractice they can withdraw the critique as publicly as they put it forward." From the time these press reports appeared we are satisfied that Dr. Ankers and Mr. Weston abandoned any desire they may still have had to discuss the Critique with the Health Authority or its officers, and determined to press for a full scale independent enquiry. If the Area Team of Officers had really wished to discuss the contents of the Critique with its authors they should, and would, have issued an invitation before the public meeting of the Area Health Authority.

4.105 On the day following this visit there were further press reports of an interview with the Unit Administrator in the course of which he said 'a lot of trouble here has been caused by the lack of experience of these two young men', and that in his view, 'the Critique was outdated'.

4.106 On October 5th Dr. Ankers wrote on behalf of himself and Mr. Weston declining the invitation on the grounds explained in the interview on September 25th, and enclosing copies of a Press statement they had issued in answer to what had appeared in the press. Further efforts to get them to change their mind failed. These included a telephone call from the Area Administrator.

4.107 Although the Area Administrator told us that the District Management Team had been asked in September to be more specific in their answers to the Critique, the Area Team of Officers was still ignorant in February, 1975 a s to whether long stay patients had individual treatment programmes. Indeed they were still ignorant when our Enquiry opened in September. But in February there burst upon the scene the angry, bitterly expressed, second part Of the Critique.

4.108 At its meeting on February 26th the Area Health Authority was informed that the Regional Health Authority had decided that there must be an independent enquiry into the allegations. The Medical Staff Committee went through the incidents in the second part of the Critique with some care and were able to identify some of them. We have already referred to the note purporting to record Dr. Q's explanation of Incident 67. Dr. X's summary, as recorded, seems balanced. "There must be bad instances to write this sort of thing. Many sweeping allegations – some of which are definitely wrongly, reported… probably deliberately. There are patients in Heather Ward who refuse to leave. Hospital has received many letters of thanks. Although there are – obviously – deficiencies, [I] feel that the hospital is not all that bad."

4.109 This contrasts with the attitude of the Medical Executive Committee as a whole when it met on April 4th, 1975. The minutes record that a doctor "said the medical members of the District Management Team were worried about seeming complacency at St. Augustine's concerning the Critique. The Chairman replied that the Critique had been thoroughly discussed and some items identified. The members generally felt that this was a malicious document containing inaccuracies and falsehoods which was disparaging to the hospital staff both nursing and medical. Dr. R said in view of the points raised... the Committee should reassure the District Management Team that (a) we have considered the Critique and (b) having considered it feel, on the whole, it should be treated with the contempt it deserves. The Consultants had considered writing to the local press, but the Medical Defence Union felt this could be misconstrued and recommended their members to leave it to the Enquiry."

4.110 As a final commentary on attitudes we set out the last paragraph of a statement sent to us at the suggestion of the Regional Administrator by the former member of the Regional Hospital Board and of the Hospital Management Committee to whom we have already referred. "Finally I doubt if this campaign of witch hunting, digging up drains, opening cess pools is in the best interest of patients or recruitment of staff. I believe it may be part of a coordinated movement throughout the world to attack psychiatric methods and mental health care." But we have found substantially the whole of the first part of the Critique and a large proportion of the second part of the Critique to be well founded.

4.111 We do not forget that the first part of the Critique arrived at a very bad moment for the reorganised Health Service-and that the problems were very considerable at all levels. This to an appreciable extent mitigates the failure to take effective steps and the over-readiness Of Area and District Teams to rely heavily on the arguments and explanations of those who were themselves criticised, but we are not convinced things would have been very different had the first part of the Critique arrived a year later. The underlying attitudes would have been the same.

4.112 Full scale, outside enquiries should be avoided where possible. We suggest the following guidelines for the future.

(i) Every complaint, whatever it is and whatever form it takes, should go at once to the Management Team above the level which is criticised. The steps that are set out below should then be taken unless there are circumstances, which will be very rare indeed, making it clear that the complaint merits no serious consideration.

(ii) Unless the complaint can be answered at once from knowledge already possessed it should be acknowledged in writing and the complainant assured that it will be investigated. A time limit within which a further communication can be expected should be put in the response and, at the same time, any further information felt desirable should be requested, but this must not hold up the investigation unless progress is absolutely impossible.

(iii) At the same time the written comments of any individuals or groups who have been criticised should be invited. They should be told the nature of the allegation against them and asked to state specifically in relation to each allegation (a) whether and to what extent it is justified, (b) where they feel that the criticism is not justified they should give full reasons why it is not justified, and (c) where the criticism is justified but no immediate action is being taken, they should give full reasons for the absence of action.

(iv) When the replies are received the Management Team concerned must consider whether they meet all the criticisms which have been made and whether it can accept the response of those criticised. It should not so do, except in rare cases, merely on the face of what is said in the reply. It should go and see for itself whether the reply is accurate and whether excuses are justified. The Management Team concerned is responsible for the accuracy of the reply to the complainant: it is not just a redirecting house for the answers of those criticised.

(v) When satisfied as to the truth, the Management Team concerned should write to the complainant explaining the position and inviting him to indicate if the response is not clear. Where appropriate he should be thanked for raising the matter.

(vi) Only if necessary should the investigation be held up by referring the matter to a still higher level for guidance. This does not preclude ordinary reports which enable the next level up to monitor performance.

(vii) Finally the Management Team concerned should check that any promised action has been taken by the time when it can reasonably be expected to have been completed.

SECTION 5: WHY?

5.1 The main theme of the Critique is that without clearly understood Policies, both for the hospital and wards, the care of patients will not be as good as it could be with policies, and that on occasions it will fall below an acceptable standard. This is undoubtedly right, and the evidence presented to us clearly demonstrated that in the long stay wards of St. August's there was no policy, and that as a result there was no agreed standard of care for the long stay patients. On the contrary, there was confusion of ideas and practice, and, too often, a minimum, or below minimum, standard of care when judged against the standards of today. (We use the word care as embracing treatment as in our view they are incapable of separation).

5.2 In this Section we seek to isolate some of the strands from this confused pattern in order that we may see more clearly how and why the matters complained of in the two parts of the Critique came about. It will help us in this task if first we summarise the proposals which we make for the future in the next Section and which we believe will help to keep standards as high as possible within the limits imposed by the available resources, and will also release and channel to the best use the potential that exists at all levels. They fall conveniently under five overlapping headings.

1. There must be a policy for the hospital and for each area and ward. The setting of both minimum and desirable standards is an integral part of the formulation of policies.

2. Since all disciplines are involved in the care there must be
(a) a clear understanding of how the disciplines can and should use their particular skills to complement and strengthen the skills of others in true multidisciplinary team work, and
(b) a clearly understood multidisciplinary framework for the hospital which complements and strengthens the organisational structure of individual disciplines and co ordinates their services.

3. Those who have a managerial role must understand what such a role requires of them.

4. Those who have a monitoring role must understand much more clearly than at present the duty of positive action encompassed by it.

5. There must be increased and improved in service training at all levels.

A. The Wards

5.3 At the time of the Critique many of the long stay wards provided, and to a lesser extent still did in the Autumn of 1975, out of date custodial care. It often amounted to no more than the bare minimum of physical care and, on occasions, fell below even that. At times nurses were guilty of uncouth and rough handling and speech. On at least two wards shifts set about their Work in very different ways, and some members of staff who should have been immediately sent for further training and then, if suitable, moved to other wards, were permitted to remain in post. The Consultants attended infrequently, no patient had an individual treatment programme, and a year or more would often pass without a case being reviewed. What all this meant in human terms can only be understood by reading Sections 2 and 3 of this Report.

1. The Nurses (including Nursing Officers)

5.4 We take the nurses first because not only are they the people around whom all other activities must be centred, but they are also in the unenviable position of frequently being left 'to carry the can' if they fail in some way because of insufficient guidance and help in overcrowded, understaffed wards.

5.5 The nurses who gave evidence, and others whom we met on the wards, presented the variety of ability and insight to be found in any profession. Some who had worked for many years in the hospital without adequate assistance to keep up to date still regarded themselves as under the control of the Doctors. This meant that they waited for the Doctors to initiate changes in wards and when this lead was not forthcoming they were often acting as little more than bare custodians of the patients. Even within this limited concept, however, the great majority of nurses cared deeply for the patients, showing and doing for them many kindnesses, both on and off duty. With further in service training of the right kind and imaginative leadership they have much to contribute to St. Augustine's, and its long stay wards in particular.

5.6 Suitable in service training would have assisted in giving nurses a continuing insight into the patients needs, without which there is an increased risk of staleness and dulled sensibilities leading to the kinds of roughness and coarseness of which we heard. It would also have helped the nurses with long experience to work more closely and easily with those who lacked experience but were brimful of ideas.

5.7 The Lack of any policy or treatment programmes meant that nurses tended to work in the idiom in which they had been trained, and whether old or new ideas prevailed depended very much on the personalities involved instead of the pursuit of clearly formulated and understood ward policies.

5.8 The nurses working in the wards should have been supported and led by their Nursing Officers, who occupy positions of considerable responsibility, but with a few exceptions they failed to measure up to their responsibilities. The evidence revealed failure to check by detailed inspection that nursing standards were being maintained and that such rules as existed were being obeyed. Requests for assistance from the ward staff often met with inadequate response. Counselling was often primitive, if not totally absent. As a result the majority of the Nursing Officers, although liked as people, did not carry the confidence of the ward staff who felt that they were insufficiently aware of problems and ineffective in remedying them.

5.9 The Nursing Officers, however, were in a difficult position and had to overcome the following difficulties:

(i) In the main they belonged to the old school of psychiatric nursing and were promoted from within the hospital.

(ii) Although they attended middle line management courses, these were largely theoretical and, by definition, concentrated on the manageria1 side of the role. A man or woman is not transformed into an adequate manager by a course of this kind, and much continuing support and advice will be necessary. This was not often forthcoming because some of the Senior Nursing Officers were suffering from the same deprivation. Training for the clinical side of the Nursing Officers job seems to have been ignored.

(iii) They were not in practice given authority to match their theoretical responsibility. For example, they did not appear to have had a proper voice in the selection, appointment and allocation of staff, or to have been fully consulted on matters affecting their units. More positive steps should have been taken to see that they met officers and members of the employing authority on official visits.

(iv) They work from a central nursing office instead of having offices of their own within their units. This inevitably increases the sense of remoteness. Moreover there is no significant secretarial help.

(v) Any desire that was present to formulate new ward policies was thwarted by the absence of true multidisciplinary working and the difficulty of having up to four consultants with patients in one ward.

5.10 As a result of all these matters new ideas were not being generated at the Nursing Officer level, and the necessary correctives for slipping standards were not being applied. Without further training and continuing support some of the Nursing Officers have been over promoted in the sense that they are at present unsuited to the task. This is not their fault. They are the victims of the national policy of absorbing staff in post into the middle Salmon structure, and of the failure to prepare or support them sufficiently

5.11 If there had been clear policies with minimum and desirable standards there would have been no Critique. Ward staff would all have known what they were seeking to achieve, and both old and new, young and not so young could have formed a cohesive whole. Moreover Nursing Officers would have had standards below which they knew the wards must not fall, and reasonably attainable targets towards which they could help the ward staff to work.

5.12 Time and again in this report we have referred to wards being short of staff. The agreed nursing establishment for St. Augustine's based on the Regional Hospital Board review of 1973 was 706 nursing staff for 1,143 beds – a ratio of 1 nurse to 1.6 beds. The position on July 31st 1975 was that there was a funded establishment of 504 for 1,068 beds. This gives a ratio of 1 nurse to 2.32 beds which is only just above the minimum standards recommended by the Department of Health and Social Security. In numerical terms this does not seem unusually low for a large Mental hospital, but when it is remembered that some of the many wards are designed for a small number of beds, that there is a shifting student and pupil population and that there are very few Occupational Therapists and

Domestic Staff, it is clear that nursing resources have been reduced to a low level. The continued use of the hospital for general surgery has meant not only that beds are taken up which could be Used to reduce the general crowding elsewhere, but also that nurses are diverted from psychiatric nursing.

5.13 The large discrepancy between the agreed and the funded establishments was attributed to both shortage of funds and difficulty in recruitment. We very much hope that with the improved prospects for recruitment the Regional and Area Health Authorities will make it possible to reduce this gap, for there is no doubt that the low number of nurses on shifts was a significant cause of much that we had to report in Sections 2 and 3.

2. The Doctors

5.14 The Consultants failed to give sufficient attention to the long stay wards. They admitted that they knew that they had insufficient time and that reviews of patients took place at unacceptably infrequent intervals, but they preserved their old image of having total ultimate responsibility for patient care and failed to ensure that nurses were encouraged to develop their own initiative in ward activities and policies generally.

5.15 In this setting ward policies and standards, to which all disciplines subscribe, are essential to maintain an acceptable standard of care and make the best use of the resources. For example, if there had been policies requiring individual treatment programmes, whether largely determined by nurses or not, the District Management Team and Area Team of Officers would not have remained in ignorance from April, 1974, until September, 1975, that there should have been such programmes and that there were none. Neither would they have said in answer to the Critique's, charge that there was an unacceptable
standard of care for many patients, "the problem here is to define a standard of care".

5.16 Sections 2 and 3 of this Report establish the need for some form of assessment and review of doctors' workloads. This only confirms the lesson that has emerged from other hospital enquiries in recent years. We deal with this later in paragraphs 6.41-49 of our report. Suffice it to say at this stage that, in our view, if hospital and ward policies and standards are agreed by all disciplines, any doctor, including consultants, who declines to follow the policy or whose performance falls below an agreed minimum standard should be required by the District Management Team to explain his failure so to do and failing a satisfactory explanation his employers, the Regional Health Authority should be asked to intervene.

5.17 As we have already indicated, without such a common policy and standards there are liable to be confusingly different approaches in wards, especially where there are up to four consultants.

3. Patients Activities

5.18 As related earlier, there were serious inadequacies which were very largely caused by shortage of staff. If there had been true multidisciplinary team work and agreed policies and standards we are satisfied that the improvements which have now been suggested would have been put forward much earlier. The Patients Activities Team which we have recommended in paragraph 3.39 will help to co-ordinate all these activities. The aim must be to fill the present gap by helping nursing staff to extend their role in the wards with suitable guidance from the trained specialists.

4. Supplies of clothes, sheets, flannels, etc.

5.19 These were very inadequate. The ward staff's frustration and difficulties were increased as they battled with or gave up under the systems which have already been described. (See paragraphs 3.83-08)

5. Mentally Handicapped and Disturbed Patients

5.20 Mentally handicapped patients cause difficulties in St. Augustine's as many of them do not fit into the way of life of a hospital for the mentally ill. The policy for the admission of such patients should be reviewed and advice should be sought from a. consultant and nurse experienced in mental handicap as how best to care for those who are already present.

5.21 We have many times referred to the problems created by violent and disturbed patients in over-crowded and under-staffed wards. The question of how best to care for such patients should be reviewed. We do not advocate the use of special "disturbed wards", and we deplore the restoration of order by "heavy squad" reinforcements. Care must be taken, however, to see that suitable staff are employed on wards where such patients are to be found, and that they are all prepared in advance for such eventualities as may occur.

B. Above Ward Level

1. Nurses

5.22 The performance of Senior Nursing Officers was of variable quality. Most have been promoted from within the Hospital, One, at least, was failing for much the same reasons that some of the Nursing Officers were failing. Another needed help and continuing guidance in some spheres. All are hampered by lack of secretarial help. Agreed policies and standards and suitable in-service training will help them all.

5.23 The Chief Nursing Officer emerged from his evidence to us, and from what we heard about him, as a pleasant quiet man who did not like difficult decisions and failed to give the nursing staff the professional identity and leadership his job required. As we said earlier in this report, and will refer to again later, this is not surprising in view of his personality and long standing position of subservience to Dr. A. and Mr. B. If the Management Committee wished for new ideas and for the nursing staff to be led to a greater independence and responsibility, they should not have appointed him as Chief Nursing Officer. We wondered whether a desire to retain the long standing balance of power in the hospital may not in part have been responsible for his appointment. He was inadequately prepared for his new role, and had been in an acting position

for a humiliatingly long period before he was finally appointed Chief Nursing Officer in December 1971. He retired in July 1975.

5.24 This balance of power with the nurses in a subservient position Was not easily disturbed. Mr. CX took up his post as Principal Nursing Officer in September, 1972. He came from St. Wulstan's Hospital, Malvern, and brought with him new ideas and a far from subservient attitude which were badly needed at St. Augustine's. In a short time he made some progress, but he found that he was unable to use his initiative and left in May, 1974. His departure was a. great loss to the hospital.

5.25 Mr. CX told us something of the position of the nurses. "First and foremost the status and accommodation for Nursing Officers was appalling. The SNOs and Nursing Officers all shared one little room with three desks between 15 and 20 people. I thought this was intolerable." He described how a position was achieved where each senior Nursing Officer has a small office and each Nursing Officer has a desk and chair in the central office.

5.26 Another problem was the lack of initiative by Senior Nursing Officers and Nursing Officers. "I came into a position where they did they were told, but never as they felt their right to do". In this They were reflecting the behaviour of their Chief Nursing Officer. In Mr. CX's opinion the Group Secretary ran all but the medical side of the hospital, which was effectively in the control of Dr. A. although he was no longer formally the Medical Superintendent, Mr. C. "saw it not necessarily as his duty, but his need to report to these gentlemen, one every morning and the other quite regularly. This, again, was a source of annoyance to me because I did not see it as absolutely necessary with the nursing administration being a profession on its own and wanting to stand on its own two feet."

5.27 Mr. CX tried to increase the status of the nursing profession in the hospital, asking that he and the Principal Nursing Officer, Education, should attend the Heads of Department meetings, but Mr. B did not agree and the request was turned down. He also suggested that they should attend the Medical Executive Committee meetings to facilitate a free exchange of views between the two professions. This again was turned down, although during his last few months he and the Principal Nursing Officer, Education, were invited into the meetings for 15 minute periods to explain the Salmon structure.

5.28 We were left with the impression that there had been a deliberate closing of the higher ranks in the hospital to prevent this intruder from disturbing the accepted balance of power. We do not doubt that he was regarded as abrasive and 'too big for his boots'.

2. <u>The Doctors</u>

5.29 When the hospital was split into clinical areas in August, 1972, each area formed a psychiatric division. There were three adult psychiatric divisions and one child psychiatric division. Although all disciplines were represented at divisional meetings they were outnumbered by the doctors.

5.30 All the doctors of the hospital belong to the Medical Staff Committee which was formed in 1972 and meets once a week. It is concerned with routine medical matters and reports to the Medical Executive Committee which normally meets monthly and is attended by all the Consultants, the Divisional Nursing Officer, the Senior Psychologist and the Community Physician. Until his retirement the Chief Nursing Officer attended.

5.31 We have already mentioned that staff working in the hospital did not seem to know who was responsible for taking decisions if there was disagreement. Some of the lack of clarity is well demonstrated by the following extracts, from the evidence given by Dr. A and Dr. X, the past and present chairmen of the Medical Executive Committee,

5.32 Dr. A. was asked about his understanding of his role as Chairman of Area 1 Psychiatric Division,

"Q. To whom do you regard yourself as being responsible as Chairman of Division 1? - A. To whom do I regard myself as being responsible? In what sphere? Professionally?

Q. For the running of the Division. You are the person who is primarily responsible for Area 1, are you not? - A. Yes.

Q. To whom are you responsible? - A. I am responsible to myself.

Q. Is there any other area of responsibility than the clinical one? - A. I do not think that T regard myself as responsible medically. I would not use the word 'responsible?. I am obviously responsible to other groups and bodies - the DMT, the Area Health Authority and the Regional Health Authority."

5.33 Dr. X. on the other hand considers that the psychiatric divisions are "accountable to the Medical Executive Committee. They are in a sense sub committees of the Medical Executive Committee as I see it". He explained that the Psychiatric Divisional (Area) meetings and the Medical Executive Committee are concerned with "medical matters basically".

5.34 Of the Medical Executive Committee Dr. A said that "it is concerned with major policy decisions mostly medically based". Efforts were made to clarify the role further:

Q. Does it have responsibility for coordinating the medical and nursing services within the hospital? - A. Very much less the nursing services, but certainly the medical services. It always receives reports from the different divisions and from its own medical staff committee and other sources. It has a coordinating function, yes.

Q. Is it in any way concerned with the standard of nursing at ward level. A. No, I do not think that it would be concerned with the standard of nursing at ward level. It might be concerned with the deployment of nurses or with the functions of nurses; for example, an increase in the number of psychiatric community nurses or a matter of general policy affecting us all, but not necessarily the standard of nursing at ward level.

Q. If it were felt by the members of the medical staff that the standard of nursing was unsuitable or inadequate or that the standard of teaching of nurses was inadequate, how would they pursue that point of view? - A. By individual members of the medical staff regarding individual instances?

Q. No; in general terms? - A. I suppose that if it was felt on the whole that the nursing of patients was inadequate, it would clearly have to be brought up at the Medical Executive Committee, but I cannot envisage such a thing happening."

5.35 Later on Dr. A. appeared to be indicating that if a. Division (Clinical Area) reported unhappiness about some matter, action might be taken by the Medical Executive Committee, and he was asked "do you regard the medical Executive Committee as having a monitoring function?" Answer: "No."

"Q. You do not? - A. It is very limited I think.

Q. You do not regard it as having a monitoring function? A. I am sorry, I do regard it as having a, monitoring function of essentially medical performance.

Q. Did the Medical Executive Committee have a monitoring function for the care of patients on Heather Ward? - A. No, apart from any information that might have been given about Heather Ward in an area or divisional report to them."

When it was suggested that his answers were hedging and amounted to both 'Yes" and 'No" he disclaimed any such intention.

5.36 When we endeavoured to find out how far the Medical Executive Committee is concerned in divisional (Clinical Area) affairs, Dr. A. said "the Medical Executive Committee was not very much involved in divisional affairs, unless it was being asked to formulate some major hospital policy which might have affected everybody in the hospital. T think divisions very much, perhaps too much, took care of their own affairs."

5.37 Towards the end of his evidence we tried to find out to what extent the Medical Executive Committee regarded itself as responsible for patient care.

“Q. Did the Medical Executive Committee collectively, in your view have an overall responsibility for the care of patients in the hospital? - A. More individually than collectively. As far as policy decisions are concerned, collectively their major decisions influence the care of patients.

Q. I do not understand the answer. Is it not capable of a clear answer? Did the Medical Executive Committee have an overall responsibility for the care of patients in the hospital? -A. I am sorry, but I cannot answer that any more clearly. The consultant has responsibility for the care of his patients.

Q. I am trying to find out where the buck stops, to use a colloquialism. In your view, who did have responsibility for the overall care of patients in the hospital? - A. If you have got to accept that any body or person has overall responsibility for other consultants' work, then clearly you can say the chairman or the medical secretary of the Medical Executive Committee or the management teams if you like. I do not understand this concept.

Q. You do not understand the concept of an overall responsibility for the care of patients in the hospital? - A. Not for clinical cares no.

Q. You feed into the phrase "clinical care". Would you define to me where clinical care ends and other care begins? - A. In the overall circumstances which contribute to the patients’ well being and care, obviously the Medical Executive has a large responsibility. What I am trying to get over is that it is not responsible for an individual consultant's treatment of his patients Perhaps I am misunderstanding or being very obtuse, in which case I am sorry.

Q. I am sorry if I have not been making myself clear. Suppose a visitor comes to the hospital and asks you, "who or what is responsible for the overall care of patients in the hospital?" Is that capable of an answer which will be meaningful to him? - A. I think it is a difficult question to answer meaningfully, quite honestly.

5.38 When Dr. A. was asked whether as Chairman Of the Medical Executive Committee he could be described as the leader of all the doctors in the hospital, he replied "Not in any clinical sense".

5.39 Dr. X said that the Medical Executive Committee "should and does receive communications from the divisions and it should consider them and itself make recommendations. These, in the present bureaucratic system, should be passed on to the District Management Team, which should then pass them to the District Medical Committee, and eventually one would hope that some action would be taken. Apart from this the Medical Executive Committee Considers matters of wider medical importance within the hospital and the relationship of medical matters to the nursing, Psychological and administrative areas..." As Chairman of such an important committee, Dr. X seemed strangely ignorant of the nursing hierarchy. Having explained the relationship of the Divisional and Medical Executive Committees to the District Management Team he added that the nurses "have an independent organisation with which I am not familiar". He did not know if there was any comparable structure in the nursing side. This lack of information Must hamper his function as a co ordinator.

5.40 It would have been convenient to have been able to summarise the above answers, but the difficulty in so doing will be clear, and in this lack of definition and clear understanding of function lie many of St. Augustine's past problems. Dr. W. said "The big problem is that the Medical Executive Committee has got no teeth. It makes recommendations, they are minuted and that is that, nothing happens".

5.41 An example of the lack of, or failure to use, teeth occurred when the Medical Executive Committee recommended that subject to the views of Division 1 there should be a swap of two wards as between Clinical Areas 1 and 2. Clinical Area I rejected the recommendation but the Medical Executive did not consider it any further or report the disagreement to the District Management Team, although satisfied that the swap was in the best interest of the Hospital as a whole.

5.42 Other problems on which the Medical Executive Committee had failed to make any real impact by the time we left were the number of beds in Hawthorn ward, how the number of empty beds in the hospital could be utilised to reduce the numbers in overcrowded wards and the correction of the apparent imbalance between the Clinical Areas which we refer to later.

3. The Group Management Committee

5.43 At the time of Critique No. 1 St. Augustine's Hospital was managed by the St. Augustine's Hospital Group Management Committee, which consisted of 15 members and a chairman appointed by the South East Metropolitan Regional Hospital Board. This Committee was also responsible for St. Martin's Hospital (186 beds) situated near the centre of Canterbury. The two hospitals comprised a group which was devoted entirely to the care of the mentally ill. The Hospital Management Committee was responsible to the South East Metropolitan Regional Hospital Board both for the management of these hospitals and for the maintaining of an adequate standard of patient care, subject to the regulations, and directions made by the Secretary of State and the Regional Hospital Board.

5.44 To carry out this commitment the Hospital Management Committee set up the following sub-committees:

Finance sub-committee
Nurse Education sub-committee
Estate and Equipment sub-committee
Medical Services and Patient Care sub-committee
Group Medical sub-committee

5.45 In putting forward their recommendations to the full meetings of the Management Committee, these sub-committees relied upon the Group Secretary, the Chief Nursing Officer and the Chairman of the Group Medical Executive Committee for their information and advice, for it was they who would eventually have to implement any decisions reached by the Hospital Management Committee. These three principal advisers met weekly to co-ordinate the various activities of the Group, to deal with day to day matters on which immediate action was required and to identify other matters on which joint agreement would be necessary before making a recommendation to the Hospital Management Committee. Contrary to the advice of the Hospital Advisory Service they continued to meet informally and without any agenda or minutes.

5.46 Ideally, and in most hospitals, these three would have equal status, but for reasons we have already explained this was not so at St. Augustine's, and the main consequence of the imbalance was that the nursing staff, who carry the brunt of the day to day pressures, were not always as adequately represented as they should have been. Furthermore, this triumvirate had put themselves in a position of considerable insularity and were, in consequence, out of touch With the needs of middle administration and the views of the junior nursing staff. This concentration of power in the hands of a small group of men also tended to destroy initiative from below, and it is not surprising that Mr. C, the former Principal Nursing Officer, who displayed considerable willingness to initiate change, left in the circumstances we have described.

5.47 Mr. B. the Group Secretary, also held the post of Treasurer and Hospital Secretary with St. Augustine's (but not St. Martin's). In addition he was Group Supplies Officer until 1971 when the responsibilities of this post were taken over by an Area Supplies Officer and a subordinate officer based at St. Augustine's Hospital. Notwithstanding this transfer of responsibility, Mr. B maintained that since his appointment had not been officially terminated by the Management Committee he was still the Group Supplies Officer.

5.48 By virtue of his appointment and his undoubted ability and energy, Mr. B exerted considerable influence in the Group, and his authority and power tended to grow as Dr. A's diminished. He was a very able administrator, respected by the Hospital Management Committee and, we understand, by other group secretaries in the Region, as well as the Chief Officers of the Regional Hospital Board. His achievements were considerable, especially in the relatively stable period prior to the major reorganisation which took place between 1971 and 1974. This reorganisation involved fundamental changes in the organisation of the medical and nursing services, and Mr. B's considerable administrative skills should have been used in planning and coordinating the division of the hospital into its three virtually autonomous clinical areas. It is regrettable that Mr. B underestimated the importance of his role in this respect and continued to pay too Much attention to routine matters which he should have delegated to others. It must be remembered, however, that this period coincided with the years immediately prior to his retirement during which he was also Secretary to the Local Joint Liaison Committee set up to deal with the preparatory work for the reorganised health service in Kent which would come into operation on April 1st, 1974. It was noticeable, however, that even before this period Mr. B tended to rationalise and ignore any advice unless it fitted in with his own pattern of thinking. This was exemplified by his unwillingness to support much of the advice of the Regional Advisory Team and the National Health Service Hospital Advisory Service, particularly those sections which stressed the necessity for delegation and the need for him to become more involved in achieving effective interdisciplinary co-ordination. Mr. B also failed to devise new, and revise old, systems for such essential services to the wards as supplies, laundry, and patients' moneys.

5.49 The Management Committee seem to have been unaware of the extent of the deficiencies in the long stay wards and did nothing to see that there were policies and standards for them. In our view they regarded patient cape as being primarily a matter for the doctors, and did not want to impinge on the Consultants clinical autonomy. Unfortunately the boundary of clinical autonomy was entirely fluid and varied from individual to individual.

5.50 The minutes of the Management Committee reveal very little consideration of policy and standards of care, and we consider it probable that the following views of Mr. B were shared by many members. In his written statement he said "Regarding the programmes, or policy for each patient, I think the Committee were satisfied that the medical staff reviewed each patient's requirements on admission and subsequently at intervals, but I think they would have admitted that more medical time was required in some of the longer, stay wards. These matters were not discussed formally by members of the H.M.C. I think it is inconsistent with the responsibility of a doctor for a layman to assume that he is not doing his job and it is seen as part of the Consultant Psychiatrist's responsibility to programme a patient's course of treatment as a matter of routine. A layman cannot go to a doctor and enquire what he is doing for a particular patient. The H.M.C. have never had any occasion to doubt the integrity of the medical staff here". Honest and hard-working doctors may, nevertheless, fail to co-ordinate their activities with other professions, and thus provide an inefficient service.

5.51 Mr. B was asked to amplify his written statement. "You say in your statement that a layman cannot go to a doctor and enquire what he is doing for a particular patient?" He replied "On clinical grounds. Are we talking about clinical grounds or general care?" In answer to the next question "Where do you say clinical grounds end?" He replied "Where the doctor says that they end." The difficulties created by such views is demonstrated by a report from the District Management Team to the Area Team of Officers in January 1975 that "The Medical staff say holding multidisciplinary ward meetings is a matter for clinical judgment although it is generally agreed it is part of the therapeutic programme".

5.52 The former member of the Management Committee who is now a member of the Area Health Authority gave evidence about the functioning of the Medical and Patients Care Committee. She told. us that it discussed "matters concerned with patients, matters concerned with complaints by relatives, matters concerned with things like the amenity fund which the hospital had for the benefit of patients, for instance how many visits had been paid to various places, and also things to do with the voluntary services organisation which we had at the hospital."

5.53 Her evidence included these two questions and answers:

"Q. Where did you as a lay member of this body draw the line on subjects you could reasonably discuss at H.M.C. meetings? Was there a line first, and if there was where did you draw it? - A. I would have thought there was a line, the sort of thing which doctors would expect to be their professional preserve.

Q. Was that a line that the doctors drew, Mr. B drew, or Mr. C drew or anybody drew? A. I think it was just acceptable procedure."

5.54 Of the complaints that came from relatives Mr. B informed. Us "I think in the main I found the complaints were without foundation. I do not remember having to take any action with regard to a complaint by a relative."

5.55 The minutes reveal that the Management Committee and the Medical and Patients Care sub-committee showed frequent concern about the lack of occupational therapy, but there was no attempt to fill the gap in the way now being worked out by the occupational and nursing services.

5.56 We have already commented that the resources of the hospital seem to have been concentrated on the admission wards at the expense of the long stay wards. This accorded we believe with Mr. B's understanding of priorities. In his written statement he said "Regarding the point in the Critique that the long stay and elderly patients' treatment is of a custodial nature, you have got to remember that the Department itself laid down the doctrine that where a patient has came to regard the psychiatric hospital as his home, nothing should be done to disturb him. Some old people do not react favourably to an abrupt change in their routine. HM Circular (72)71 specifically says that those patients who have come to regard the hospital as home shall be allowed to remain undisturbed. By that definition those patients are bound to become institutionalised. They have become established to a pattern of life which suits them. What is wrong with institutionalisation if you are happy?"

5.57 In fact that Circular had a very different emphasis. It said of patients who had grown old in mental hospitals and became institutionalised, "Every effort should be made to provide as full a life as possible for all such patients and to prevent them from being cut off from regular contact with people outside the hospital".

4. The District Management Team

5.58 The Canterbury and Thanet Health District covers an area of 288 square miles and includes 21 hospitals containing 3,500 beds which were previously managed by three Hospital Management Committees and two local authorities. After considerable argument it was finally decided that the team should include an elected Consultant and General Practitioner from both Thanet and Canterbury District Medical Committees. When the Community Physician is added this results in a District Management Team comprising the Administrator, the Finance Officer, the Nursing Officer and five doctors. No member of the Team has any psychiatric experience and the doctors have insufficient time to familiarise themselves with the hospitals they try to manage. The Consultant member of the Team who gave evidence to us had attended meetings at St. Augustine's but had not had time to visit any part of it.

5.59 The District Management Team's task is enormous, and it is totally unrealistic to imagine that it will ever be able to fill the gap left by the Management Committees. Indeed, everyone seemed to be agreed that it could only function if most of the management is carried out by the hospitals under authority delegated by the Team.

5.60 We set out below some of the ways in which the District Management Team failed to get to grips with the problems of St. Augustine's, and then try to identify some of the causes for this failure in addition to the obvious one of shortage of time.

(a) Empty beds

5.61 On October 31st, 1975, after allowing for patients on leave, there were 160 empty beds in the hospital. This was not unusually high and the numbers had been running at about 130 for a considerable time. The District Management Team was unaware of this although it had authorised considerable expenditure for upgrading the Elder complex to provide more beds. It had not apparently contemplated reorganising the allocation of beds to reduce the overcrowding and pressure on the staff in some wards. Nor had it collected any statistics to enable it to assess bed usage on admission wards, beds available throughout the hospital and other relevant factors.

(b) Uneven work load for Areas (Divisions)

5.62 It is impossible to walk round St. Augustine's using one's eyes and talking to the staff without becoming rapidly aware that Clinical Area 1 seems, and is considered, to be much better off in all respects than the other two areas, particularly Clinical Area 2 which is regarded as the Cinderella. A careful check should have been kept to see whether any adjustments were needed to the geographical areas or the resources allocated to them. The following table provides statistics which demand careful consideration by the hospital and the District Management Team:

Clinical Area	Staff Numbers	Beds	Resident Patients	Patients on Leave	Vacant Beds	% of patients over 65 who are non-ambulant
Area 1	109	348	222	39	87	27
Area 2	108	384	298	42	44	60
Area 3	84	344	287	35	30	43

5.63 It may be that examination of the problem will reveal that no adjustments are needed. The point we make is that the District Management Team were not aware that there was anything requiring examination.

(c) Shortage of Occupational Therapy

5.64 This is a problem which was known to the District Management Team, and at the request of the Head Occupational Therapist it authorised the employment of four additional untrained Aides. This, however, was not really dealing with the problem. It should have appreciated that there is no reasonable prospect of recruiting the qualified staff required and asked the hospital to produce alternative plans, based upon a realistic assessment of the numbers and categories of staff which it could reasonably expect to recruit.

(d) The Critique

5.65 It failed to ask the right questions and too easily accepted the answers of those criticised. (See paragraphs 4.81-2, 4.91-8, 4.110,111).

(e) The balance between the medical and other professions

5.66 In asking the Chairman of the Medical Executive Committee, but not the Divisional Nursing Officer, to attend its meetings it has overemphasized the role of the Doctors. Indeed it has sought to use the Medical Executive Committee as the management team for the hospital without sufficiently appreciating that that Committee's concern is with medical matters and that it feels unable, for reasons already set out, to do much managing. On the question of the continued use of the operating theatre, the District Management Team sought advice from doctors, but not, so far as we are aware, from the nurses in the hospital.

5.67 The District Administrator has been diligent in his visiting: for example he paid the hospital 69 visits between April and December, 1974; but on the whole he has not had the time or the knowledge to identify problems which are not presented to him, and his efforts to solve individual problems have sometimes obscured the wider picture.

5.68 A further factor limiting the District Management Teams effectiveness has been that it has not regarded itself as having any role, on the clinical side, even in policy making. We asked the District Administrator "Where do you draw the line on a long stay ward, which is what the Critique has been concerned with, between a clinical matter and a non, clinical matter?" He replied "It is very difficult to do so. You can only go on the view of your medical colleagues." We asked a Consultant member of the Team where he would draw the line in a long stay ward in St. Augustine's. He replied "That is a very difficult question for a radiologist to answer." We pressed him further, pointing out that on the answer might depend the power of the District Management Team to act, and he then said "With a long stay patient I presume that the Consultant would be responsible for the patient's general well being and that he would be responsible for matters that would impinge on the patient's continuing treatment." If, in fact, a District Management Committee is unable, as this one believes, to act in matters within the clinical autonomy of the Consultant, the wide limits placed by this Consultant on its boundaries would mean that the team was largely powerless in the long stay wards. If members of the District Management Team held differing views as to the limits of clinical autonomy, consensus decision taking would require that the matter be referred to the Area Team of Officers and the Area Health Authority for decision. While this procedure was being followed urgent matters within the Hospital requiring decision and action would have to wait. Such a system is certainly not conducive to effective management.

SECTION 6: A PLAN FOR THE FUTURE

6.1 We have already reported that there is at present no formal body between the clinical area level in the hospital and the District Management Team. The need to create Some kind of body to fill this gap is recognised not only by the District Management Team but also by all the disciplines working in the hospital. All accept that the Medical Executive Committee, Which by definition is medically orientated and dominated, is unsuitable to fulfil, this role and that the answer is not provided by the Heads of Department meetings or the informal meetings of the Sector (or Unit) Administrator, the Chairman of the Medical Executive Committee and the Divisional Nursing Officer.

6.2 Later we suggest a multidisciplinary framework for the hospital with multidisciplinary teams at hospital, clinical area7and ward levels. Apart from the Hospital Team we suggest that the teams should have a coordinating and persuasive, but not a managerial, role. Their task, in broad terms, will be to complement and strengthen the managerial structure and function of the individual disciplines.

6.3 Before we develop these proposals further we wish to make some suggestions which, in our opinion, will lead to better functioning of the individual disciplines, including all levels of administration, and to a greater ability to use their skills and resources as members of teams for the common good.

1. Those with a managerial role must manage

6.4 A manager is defined by 'The Grey Book' as "a person who is responsible not only for his own performance but also for that of his subordinates. They are accountable to him, just as he is accountable to a superior authority (either a manager or a statutory authority). The manager participates in the selection of his subordinates and is responsible for the training and development of his subordinates, for delegating to them work which is within their competence and for assessing their performance."

6.5 All managers should ask themselves not only "who am I responsible to?", but also the much more important and challenging question "who am I accountable for?"

6.6 Let us look at the managerial role of the Nursing Officer as an example of how this definition should work:

(i) Unless he knows the policy of each ward and has in mind minimum and desirable standards, he will be unable

(a) to participate usefully in the selection of ward staff;

(b) to Understand the varying fields in which those for whom he is accountable need further training and/or counselling;

(c) to know whether those for whom he is accountable are carrying out their work satisfactorily;

(d) to know what enquiries and investigations and checks should be made by him to ensure that those for whom he is accountable are providing the best service possible within the resources available,

(e) to decide priorities for expenditure.

(ii) He is therefore responsible for seeing that there are clearly understood policies and standards in each of his wards. If they do not already exist he must formulate them with the help of all disciplines. If they do exist he must ensure that they do not require revision in the light of fresh ideas and knowledge or changed circumstances.

(iii) He must ensure that he is consulted about the appointment and moving of staff.

(iv) He must check that those for whom he is accountable are performing satisfactorily. Simply to ask his subordinates whether they are doing all they should is an unreliable form of checking. He must be able to say of all people and matters for Which he is accountable "I know", not "I have been told".

(v) If things have gone, or are going, wrong, he must take immediate corrective action. This will not necessarily entail an order. Counselling or persuasion may be all that is necessary, but if these fail there must be an order.

(vi) If a member of staff is unsuitable for the ward he, must consider whether further training will make him suitable. If it may, he must ensure that it is obtained. If it will not, he must recommend and press for the removal of that member of staff. His duty, first and foremost is to the patients and other members of the staff-whose work will be hampered by having to carry and endure unsuitable members.

(vii) If it is necessary to obtain a certain item of equipment or extra staff for the ward he must see that his request is made in clear terms on paper, and if it is not granted he must ensure that he understands the reasons and that he passes them on to his subordinates.

(viii) Through the exercise of the above functions he will know just how far he can delegate and will be able to delegate to the maximum extent compatible with his accountability. Delegation without the exercise of those functions is abdication.

(ix) He should keep written notes on important matters concerning individual members of staff. Not only are they important as an aide mémoire in carrying out his duties, but they will assist when he takes part in a formal appraisal or assessment of his subordinates, and will help a new nursing officer or senior nursing officer to know the strengths and weaknesses of the ward staff in his unit.

6.7 This list is, of course, not exhaustive. It can be applied at any level where there is a managerial function.

2. <u>Those with a monitoring role must monitor</u>

6.8 The 'Grey Book' tells us "The person who monitors has the authority to require to be kept informed about the, activities of the persons monitored and has authority to persuade them to change but in the final analysis, he cannot order them to do anything and, if not satisfied, must refer the matter to higher authority. Monitoring does not call for any particular managerial relationship in the ranks of the persons concerned."

6.9 In our view the phrases 'has the authority to require to be kept informed' and 'has authority to persuade' are thoroughly unsatisfactory. They are permissive and connote no duty. Far too much monitoring consists of waiting to be told and then of taking no effective action when information does come. The monitoring function requires penetration downwards. We suggest the following definition. "The person who monitors must keep himself informed by personal enquiry and inspection about the activities of the persons monitored and, where necessary, must try to persuade them to change, but in the final analysis, he cannot order them to do anything etc."

6.10 This clarifies the role. A person charged with monitoring does not keep himself informed by waiting for information or simply by receiving reports from those whom he is charged with monitoring. He is responsible for devising a system which provides him with reliable information, and personal visiting and inspection of the services provided by those whom he is under a duty to monitor, is an integral part of the monitoring role.

3. Training

6.11 Because of the recommendations of the General Nursing Council there is a division of responsibility between those charged with student and pupil nurse training and those charged with in-service training of qualified staff and nursing assistants. This at St. Augustine's has meant that the' Nursing Officer responsible for in-service training has been largely deprived of the facilities and expertise of the Lawson School of Nursing. Every effort must be made to secure the fullest co-operation and use of all educational resources and personnel in the hospital.

6.12 Training of Senior Nursing Officers and Nursing Officers is at present based on the policies of the National Nursing Staff Committee and takes place in training centres and colleges of further education. One of the weaknesses of the present system is that the courses are largely theoretical and take place away from the hospital setting in which those attending will have to work. The clinical side of the work is largely ignored. We recommend that there' should be continuing training and counselling for those holding these important posts. Course Tutors should familiarise themselves with St. Augustine's Hospital and make a skilled assessment of the particular needs of those attending management courses so that the training can really help.

6.13 Visits to, and periods of working in other hospitals will be of great assistance in broadening perspectives and identifying training needs in St. Augustine's. Much help could also be gained from inviting staff of other hospitals to come and work for short periods at St. Augustine's. These exchange visits would complement the formal management training and on-the-spot courses.

6.14 It should also be possible with the training facilities and clinical experience available to interest the Joint Board of Clinical Nursing Studies in providing an advanced nursing course of some kind at St. Augustine's. In addition, the resources of local colleges of further education and the University of Kent should be fully exploited. In the short term the possibility of a Diploma of Nursing course should be considered, and in the longer term the opportunity of participating in a Nursing Degree course should be kept in mind by the Nursing Education Committee for the District. The hospital will benefit from these suggestions in two ways:

6.15 Firstly, many of the highly intelligent and well educated members of staff in post are capable of an expanded nursing role from which the patients would ultimately benefit. Secondly, more staff of the right calibre will wish to come and work at St. Augustine's.

4. Staff Appraisal

6.16 This is closely allied with in-service training. Without an adequate appraisal system unsuitable staff are more likely to be promoted or left too long in positions for which they are unsuitable. Adequate staff appraisal will assist to identify the areas, if any, in which further training is necessary before a person is promoted or moves to a new post.

6.17 We suggest that staff appraisal should be carried out in two parts. Firstly it should consist of regular, close and constructive supervision and contact by superiors, and the noting of any important discussions or problems or strengths in personal files. Secondly it should consist of periodic formal appraisals using a common form of appraisal.

5. Patients Activities Team

6.18 We have already explained our proposals in paragraphs 3.38-40.

6. The Voice of the Patients - Patients Committees

6.19 Within the hospital a large number of meetings take place in which the staff are mainly involved. The voice of the patients we were told was mainly heard at ward meetings which are run by the staff. We believe that since the patient is at the centre of all activities there should be opportunities for patients to meet together to discuss their role in the hospital, to represent their own views, and to accept a participative role in the therapeutic community. This could be achieved by the establishment of formal patients committees for the three clinical areas of the hospital, or for the whole-hospital if preferred. Such committees should meet formally under their own chairmen, and facilities should be provided for the preparation of agendas and the taking and distribution of minutes.

7. Information Systems

6.20 We have already remarked on the District Management Team's unawareness of the significance of empty beds in relation to the known overcrowding and the apparent imbalance between the areas. Other examples of ignorance of available and relevant information could be given at various levels.

6.21 One of the most important functions of an administrator in a psychiatric hospital, and indeed at every level in the Health Service, is to assemble and convey to people or teams charged with managing or monitoring, the information which is necessary for them not only to arrive at the right decisions, but also to recognise matters requiring their attention.

6.22 Within a psychiatric hospital we suggest that disciplines and teams will require statistical information about the rate of admissions and discharges, the use of beds and their relationship to the catchment area population. Without such information it will not be possible to judge whether, or to what extent, the catchment area requires more resources than are currently available and whether admissions and discharges are in balance.

6.23 By producing a simple document at regular intervals the administrator can help all sections of the hospital in their work. The information which we suggest below and which should be regarded as a basic minimum, should be given in relation to each clinical area and could usefully be circulated to all wards so that those interested can see the position of their ward in the perspective of the whole hospital and bring any apparent imbalance to the attention of their multidisciplinary team.

(i) Available beds
- (a) by type (e.g. acute, psychogeriatric)
- (b) by Consultant

(ii) Beds required according to Government guidelines - by type.

(iii) Average daily occupancy.

(iv) Number of first admissions by Consultant.

(v) Number of readmissions
- (a) by type
- (b) by Consultant
- (c) by length of stay in the Community

(vi) Number of
- 1. discharges) (a) type
- 2. deaths) (b) Consultant

(vii) Number of patients admitted from outside the Team's catchment area.

(viii) Number of patients transferred from acute to non-acute wards.

(ix) Number of patients whose stay in hospital is approaching
- (a) two months
- (b) twelve Months

(x) Number of outpatients seen by each Consultant
- (a) new
- (b) follow up.

(xi) Total outpatients seen by each Consultant and other medical staff.

(xii) Number of domiciliary visits by
- (a) Consultant
- (b) Nurses
- (c) Social workers

8. <u>The relationship between the professions</u>

6.24 The relationship between the professions in any multi-professional organisation must be crucial for the success of the organisation. This is particularly true in hospitals where there have been very significant changes in the relationship between the professions in recent years. Ten years ago, in a psychiatric hospital which had a medical superintendent, this doctor was indeed, the 'Head of the Hospital' with responsibility over all other staff within it. Not only was he in charge of the nurses but he was also in charge of any social workers who might be at the hospital, and was responsible for the administration. The senior nurse, the senior social worker and the Group Secretary would all report to him. This situation had been gradually changing and in the more progressive hospitals, irrespective of the presence of a Physician Superintendent, there had been a recognition that the senior doctor, senior nurse and senior administrator were each responsible in their own sphere for the staff under them.

6.25 These changing attitudes and practices received formal recognition when the post of Physician Superintendent was abandoned in many mental hospitals, and the old system was of necessity swept away when the "Salmon" organisation was implemented for the nursing staff, and the Seebohm recommendations were implemented for social workers. From that time onwards, whether there was a Physician Superintendent in post or not, he had no authority over the nursing staff or over social work staff, each of which were responsible to their organisation. The significance of this has not percolated to all corners of the system even now, and there is no doubt that some doctors have resented this reduction in their power.

6.26 It will be clear, therefore, that a multidisciplinary approach to patient care by all these professions is essential if their separate and overlapping skills are to be used to the best advantage of the patient, and, indeed, each other.

6.27 For obvious reasons, it is likely to be to the detriment of the patient if the professional staff caring for him disagree over any significant matter. Equally, it is obvious that treatment policies must be agreed between the professions by a consensus, and not because any one profession has authority over the others.

6.28 The most effective organisations are likely to be those where there is parity of esteem between the professions. This means that each profession recognises that in some fields the other professions have a greater expertise and additional skills to offer. Each profession should recognise that the development and encouragement of other professions will be to the benefit of all, and of the patient in particular, and that any attempt by one to dominate the others will inhibit the professional growth of those concerned.

6.29 Unfortunately not all doctors have been able to accept this and some have felt compelled to keep what they consider the clinical side of care outside the multidisciplinary ambit. Moreover, <u>their</u> definition of clinical responsibility is sometimes very wide indeed. The Report on the Committee of Enquiry into South Ockenden Hospital which was submitted to the Secretary of State for Social Services in March, 1973, stressed the need and called for central guidance in this matter, but it has not yet been forthcoming, although the Third Cogwheel Report tiptoed round the perimeter of the problem.

6.30 In our view true multidisciplinary team work requires that each member recognises and accepts that no one profession can be totally responsible for any aspect of the patients clinical care, even though the initiative and main responsibility at any given moment may lie almost entirely with one or other. For example, the making of a diagnosis or prescription of medication is largely the responsibility of the doctor. However, even he in many cases is unlikely to make a sound diagnosis without the additional information which may be provided for him by nursing observation, or the psychologist's report. In the final event, however, having heard the opinions of others, it will be for the psychiatrist to write the diagnosis in the case notes. Again, in the case of medication, the prime responsibility lies with the doctor, but he will be wise to consult the nurses and Others involved, and agree a policy. An obvious example lies in the realm of night medication The doctor may well prescribe a particular sedative, but whether or not it is given lies very much in the hands of the nurse. The patient may be asleep at the time, and the nurse will have to decide in the light of the patients agreed treatment programme and agreed ward policy whether, or not it is reasonable to wake the patient.

The nurse will also have to decide whether or not to give a sedative to a patient who has been on leave and has returned under the influence of alcohol. Even the type of medication needs to be discussed and agreed with others.

6.31 Equally, the nurses have a prime responsibility for many parts of the patients' care in hospital, for example bathing, dressing and feeding. For example, where a patient with diabetes needs to have a special diet, the exact form of the diet may well be a matter largely for the doctor to decide, but whether or not the patient could or should be persuaded to take it, in the light of difficulties present at any given moment, is very much a nursing matter and, in a final analysis, the nurse will probably have the day to day decision as to how far a patient should be persuaded to eat any particular meal.

6.32 Similarly with dress; the time of dressing, whether the patient dresses himself or has assistance, and the kind of dress likely to be available, are very much in the hands of the nurses. Whether or not a patient's dress is restricted, for example by keeping him in night attire in order to reduce the likelihood that he will run away, is very much a nursing matter, as only the nurse is likely to know from minute to minute the number of nurses available on the ward for observation and the attitude of the patient to absconding at any particular moment in time. There must, however, be added to the knowledge and skill of the nurses that of the other professions. The doctor, from the information he has obtained in the clinical interview, may have much of value to say on the on the risks of absconding or attacks on other people. The remedial professions may also have valuable suggestions to make on the sort of activity which will or could be available, either to the individual patient or to the ward as a whole, and which might reduce, or sometimes increase, the likelihood of a patient absconding. The nurse, therefore, may well have the final decision on the patient's clothing, but will need to consult with her clinical colleagues and justify her actions if there are problems.

6.33 These are but examples by which we seek to demonstrate that the bringing of all patient care within a multidisciplinary team does not deny or denigrate the individual skills. In a matter of medication the team will normally be happy to defer to views of the doctor, just as in other matters the team will be happy to defer to the views of the nurse. This will be consensus agreement, as opposed to placing either the clinical skills of the doctor or the expertise of the nurses outside the team. In between these extremes there will be many decisions in which all discipline will have a substantial contribution to make to the final decision. Any member of the team can, and should, be called to account by the others if they are unhappy with his performance.

6.34 When a decision has been reached each member of the team should feel personally committed to putting it into practice. We were' most encouraged to hear while we were at St. Augustine's that the medical profession there are happy to work in such multidisciplinary teams. This opens up a most exciting prospect and we wish them well.

6.35 It will be convenient under this heading to refer to the vexed question at St. Augustine's of the confidentiality of medical records.

6.36 The medical profession has been rightly proud of its ethical standards in the matter of confidentiality of medical records over many years. It is expected that a doctor will keep confidential all matters which come to his notice as a result of the professional relationship with his patients.

At the time when the psychiatric hospital had a Physician Superintendent, he was able to insist on this confidentiality at any level he wished, including the access to case notes by nurses, social workers and others. Since the nursing and social work professions achieved independent status, however, the problem of confidentiality has caused concern at St. Augustine's and many other hospitals.

6.37 There is no problem where the relationship is entirely between the doctor and the patient and no other profession is involved. With all in-patients and many patients in the community, however, more than one profession is involved. It is obviously essential that other staff working on the ward should have access to case notes, not only as part of their training, but also to ensure that they are up-to-date with information about the patient and can adopt the right attitudes and follow through an agreed line of treatment. Most doctors have assumed that the confidential information acquired by nurses from patients, will automatically be passed on to them, but the fact is they no longer have the right to insist on this. It must be quite obvious that if a doctor insists that information coming to him is confidential, and nurses and social workers take similar attitudes about information coming to them, the patient will suffer.

6.38 Neither should it be thought that the doctor always has the most reliable or the most confidential information. Many psychiatric patients will deceive their doctor, or fail to confide fully in him. It is common to find that when information is pooled from nursing, medical and social work sources, that all three have had a somewhat different account of essential matters in the patient's life history or current problems. A typical example will make the matter clear. A young girl may have had a difficult relationship with her parents, neither of whom she trusts. On the ward she gives a very limited history to the ward sister and the ward doctor, but forms a good relationship with a junior nurse on the ward and confides freely to the latter her conflicts, difficulties and problems. There is no doubt that a sharing of information between members of the therapeutic team treating the patient will benefit the patient. This sharing must take place on a basis of mutual trust and the patient should know from the beginning that, whatever member of the therapeutic team is involved, the team as a whole will receive all relevant information.

6.39 It would appear that some years ago the Medical Defence Union gave the St. Augustine's medical staff a very limited definition of the extent to which case notes should be made available to nursing staff. However, it was noticeable that even when this definition was amended to show that it was reasonable to allow access to case notes by nurses in training, the medical staff were reluctant to agree. In our view the medical staff do not have the right to refuse access to case notes, for the legal ownership in them is vested in the Secretary of State and not in the doctors. One can well imagine the medical reaction if the nurses, for some reason, decided that doctors should not have access to nursing notes.

6.40 It has sometimes been argued by doctors that nurses should not have access to the case notes of patients admitted to hospital who are their near neighbours, or where there might be embarrassment for a patient or member of staff if information became available to nurses on a ward. This is a valid consideration. However, just as most doctors are reluctant to treat close friends or relatives and will often advise the patient concerned to seek another medical attendant, so equally a responsible nurse will express a clear desire to avoid being involved in the treatment of a relative or close neighbour. These, however, are all matters which should be freely discussed at the multidisciplinary ward meetings so that

everyone is aware of the need, indeed, duty, to avoid such a situation. One profession can no longer be dictated to by another. It is our strong recommendation that the case notes should contain medical, nursing, remedial and social work notes for each patient and that subject to the considerations already referred to, they should be available for all nurses.

9. The need for assessment and review of doctors' workloads

6.41 All doctors, including Consultants, working in mental hospitals have heavy workloads, and we have already expressed the view that there is a continuing need for these workloads to be assessed and reviewed. Without assessment of the extent to which, and manner in which, a doctor is coping with his workload it will be very difficult to know whether any adjustment is necessary. Moreover a doctor's workload may be so heavy that under it his standards will imperceptibly fall and he will be unable to keep abreast of current thought and practices.

6.42 Not only is the need for such assessment and review in the interests of the patients and other hospital staff: it is also very much in the interests of the doctors themselves that their workloads should be reviewed and that their problems in providing a satisfactory service within a multidisciplinary team should be recognised. For example, if there had been a clear policy on Heather Ward that Dr. W would attend each week and review one or two patients each time he visited, his inability to do this because of his other commitments would have been brought to the notice of the Medical Executive Committee, with a request that he should be given additional medical help during the time of his greatest need. In turn, the Medical Executive could have used the information brought to it to strengthen their case in asking for more Consultants. Last, but not least, an open discussion of the problem at ward level within the multi-disciplinary teamwork would have ensured two developments which might well have prevented the critique and subsequent developments. Firstly, the junior nurses on the ward would have understood more clearly the Consultant's problems. For example, we were told by Mr. Weston that he thought a Consultant should give an hour a week to each patient on the ward. This is so totally impossible that the suggestion alone tended to discredit some of Mr. Weston's other comments and suggestions. If, however, he had known of the Consultant's problems in more detail, he would not have come forward with such an impossible proposal. Secondly, once it became obvious that the Consultant could not play a major part in developing ward policies, it would have been clear that the onus lay on the nurses to do so, and such time as the Consultant was able to spend on the ward could then have been spent in reviewing those policies and adding or adjusting the medical components. The establishment of agreed ward policies will help the doctors, for where they do not exist, doctors may well be called to deal with repeated minor incidents and problems because there are no agreed guidelines covering common situations.

6.43 The other point of view was forcibly expressed by the Consultant member of the District Management Team who gave evidence to us. (It will be recalled that there are five doctors in this Team and that no member of it has any psychiatric expertise.) He was asked whether he ever felt in relation to any of the 21 hospitals in the District that it would be helpful to receive assistance from someone with experience relevant to a problem. He replied, "No, I don't think so". There followed these questions and answers:-

"Q. You never feel a need to call for an objective view from someone with experience in the specialty you are looking at, and indeed managing?
A. No, I do not think so.

Q. Some people might find it very surprising that you can manage something – I will not say about which you know nothing, because that would be a gross exaggeration, but about which your knowledge is certainly limited? -
A. Yes, but the medical practice in British hospitals is that all Consultants are regarded as equals in the clinical sense, and that Consultants go through a very long process of training. They have to sit higher exams set by the Royal Colleges who have no connection with the Health Service, who are only interested in maintaining the standards of their particular specialty so one assumes that by the time someone has gone through this long period of training and elimination that they are competent to carry out their duty.

Q. Really, it comes to this, does it not, Dr. CT, that it is inconceivable that a Consultant will be appointed in the present system who does not, for the remainder of his working life, carry out his job to the highest imaginable standards?
A. Yes.

Q. Is that really the view of the district management team?
A. Well, it is my view.

Q. Do you think it is shared by your colleagues?
A. Yes."

6.44 This Consultant explained that he served on the District Management Team as a representative of the Consultants.

6.45 It has been Said that the Consultant is accountable to his patient for his performance, but this is no safeguard if the patient is not in a position to call his Consultant to account. At St. Augustine's this is no safeguard whatsoever, and we doubt its efficacy elsewhere, for doctors must know that with the present complicated nature of much medical treatment in all spheres of medicine, many of their patients are quite unable to judge their doctor's competence, or the wisdom of his decisions.

6.46 Neither will a Consultant's conscience save his standards from falling. Most of the problems arise because the Consultants are unaware, whether through forgetfulness or overwork or ignorance of what needs doing, and not because they deliberately turn aside from their duty.

6.47 The Regional Health Authority, as the employer, can use its tortuous disciplinary procedure if a very serious breach of conduct is revealed, or the "three wise men" procedure if it is alleged that a doctor is physically or mentally incapable of carrying out his duties, but neither of these procedures are appropriate for ensuring that acceptable standards of performance are maintained.

6.48 The co-ordination of a Consultant's clinical skills with those of the other professions lies at the heart of the multidisciplinary team work which we have already outlined. It follows, therefore, that although the development and maintenance of a Consultant's clinical skill and competence is his own responsibility, this responsibility must be exercised in the light of the needs of the hospital at which he is working and with the help and guidance of his-colleagues, the Royal College of Psychiatrists and, indeed, the multidisciplinary teams in the hospital.

Much of the review of his workload will occur automatically as a result of the keeping and supplying of the statistical information we have suggested in paragraphs 6.20 – 23. When adjustments in a Consultant's workload are necessary the problem should be referred immediately to the Regional Health Authority as this is the only Authority able to take effective action.

6.49 We are concerned with the problem in St. Augustine's only, and recognise that the problem is a national one. It must, and will, be grappled with on a national scale one day. In the meantime we are satisfied that the medical staff of St. Augustine's recognise he problems, and we hope that they will work out their own scheme to solve them. We hope, for example, that they will agree standards for the review of medication, the means by which it can be checked that the agreed standards are being maintained, and the steps to be taken if they are departed from.

10. A Multidisciplinary framework for the Hospital

6.50 We have already said in paragraph 6.2 that we recommend multidisciplinary teams at hospital, clinical area and ward levels, and that apart from the Hospital Team, those teams should have a coordinating and persuasive but not managerial, role. We now develop this concept in more detail but we emphasise that what we say is not intended to be a blueprint to be slavishly followed. It is intended rather to provide a sound framework on which the Health Authorities and the hospital can build, making such alterations and modifications as seem desirable to achieve sound management of the hospital.

6.51 It will be convenient to look in turn at each of the levels at which we have suggested that there should be multidisciplinary teams. We start at ward level because our proposed structure is best explained by working up from the bottom.

A. THE WARD MULTIDISCIPLINARY TEAM

6.52 1. Composition

We suggest that this team should be composed of:

A Consultant, chosen by his colleagues
The Ward Medical Officer
The Nursing Officer
A Charge Nurse or Ward Sister, chosen by the Ward staff
A representative of Patients Activities, preferably from the Occupational Therapy Department
A representative from Patients Services should attend as necessary.

Members of the junior staff also should attend in rotation as an essential part of learning.
We have no firm view on how many should attend at a time.

2. Responsibility and Task

6.53 (i) The team will have a corporate responsibility to the Clinical Area Team for coordinating the formulation and review of ward policies and standards to be agreed by all the disciplines. The matters upon which policies and standards should be agreed include:

(a) The number of beds on the ward. Admission and discharge rates. The function of the ward.

(b) A programme for up-grading, furnishing and equipment, etc.

(c) A twenty-four hour programme, i.e. time of getting up, times of meals, allocation of time to occupational therapy, social activities, etc.

(d) Off ward activities including outings.

(e) Visitors and visiting activities, including volunteers.

(f) Patients' independence, i.e. for dressing, eating, attending activities, etc.

(g) Admission and management policy for the first twenty-four hours: and, similarly, policy for discharge, including contact with follow-up and community services,

(h) The management of Violence.

(I) The handling of complaints.

(j) The management of medication, physical treatments, E.C.T. etc.

(k) The involvement of and a programme for learners on the ward.

(1) The integration of female and male patients, and the integration of staff.

(m) Housekeeping and catering services and clothing schemes for patients.

(n) Payment of patients' allowances.

(o) Procedures and management responsibilities for dealing with patients' personal possessions and security.

(p) Individual treatment programmes, procedures for recording in patients' notes and for frequency of review.

6.54 (ii) The policies and standards agreed between disciplines at ward level should be consistent with guidance given by higher authority and should be submitted to the Clinical Area Team for approval. If the Ward Team is unable to obtain agreement to a policy or standard it has recommended, the matter should be referred to the Clinical Area Team for guidance. If that team is unable to bring about the agreement of the disciplines it will refer the problem to the Hospital Management Team which, with its managerial role, will able to arrive at and require compliance with a decision. In this way policies and standards for the ward Will be arrived at, preferably by agreement, but in the absence of agreement by the decision of a Team with managerial power.

6.55 (iii) The responsibility for checking and, where necessary, correcting the performance of those responsible for implementing the agreed policies and standards will remain with the individual disciplines, but the Ward Team will have a supporting role, in that where it is informed that individuals have been unable or for any other reason have failed to fulfil their part of the agreed policy or standard, it will draw the attention of the appropriate manager in the relevant discipline to the failure, together with any view the Team may have formed. If that fails to secure compliance with the policy or standard, the Ward Team should refer the matter to the Clinical Area Team who will pass it to the discipline managers at that level, e.g. the Senior Nursing Officer. If this also fails, the problem will pass to the Hospital Management Team.

6.56 (iv) Where the inability or other failure of a Consultant to comply with an agreed policy or standard is referred to the Ward Team we: consider that it should seek help from the Clinical Area Team and the Chairman of the Medical Executive Committee. If they fail to remedy the situation the problem should be passed to the Hospital Management Team. If it fails to obtain compliance, the matter should be speedily passed to the District Management Team and the Regional, Health Authority, which is the only body able to take effective action.

6.57 (v) It will be seen, therefore, that the managerial role of the individual discipline is undiluted. A failure to Comply with an agreed policy or standard will only reach the Ward Team if there has been a failure within a discipline. Even then the aim of the Ward Team will be to encourage the appropriate manager to take appropriate action, and only if this fails will the Ward Team pass the failure to the Clinical Area Team, who in turn will seek to persuade action from the discipline in default. In this way we think that there will be more chance of managers managing, and less chance of problems getting lost or being allowed to moulder within disciplines. The mere knowledge that unsolved problems brought to the attention of the Ward Team will be minuted and if necessary passed up the multidisciplinary team ladder, will in our view be a spur to action.

3. <u>The Team Co-ordinator</u>

6.58 The team will require a co-ordinator who will need secretarial assistance and be responsible for:

(i) preparing agendas for and minutes of meetings: it is to him that requests should be made for an item to be put on the agenda;

(ii) reporting to disciplines any failure to Comply with an agreed policy or standard which has been brought to the attention of the Ward Team;

(iii) reporting back to the Team any continuing failure by a discipline to comply with an agreed policy or standard, and any failure by discipline to agree with a recommendation of the Team;

(iv) sending minutes of meetings to the Clinical Area Team for information, together with a separate document setting out any matters on which the Clinical Area. Team are asked to take action or give advice.

6.59 We consider that the Nursing Officer should be the co-ordinator of the Ward Team. Not only will this help him to fulfil his role, but it also recognises that it is the nurses Who provide the framework for all the activities on the ward. They should be the co-ordinators of the other services at this level.

4. A Team Chairman?

6.60 We do not consider that a Chairman is essential, as the lead in discussion will probably be taken by the member of the team whose knowledge is most relevant to the matter in hand. Each team, however, will evolve its own method of working.

5. Frequency of meetings

6.61 Once ward policies and standards have been agreed we do not envisage more than one meeting each month.

B. THE CLINICAL AREA MULTIDISCIPLINARY TEAM

1. Composition

6.62 We Suggest that this Team should be composed of:

A Consultant chosen by his colleague
The Senior Nursing Officer
A Social Worker
An Administrator
A representative from the Patients' Activities Team

A Psychologist should attend as required, as will others whose presence is considered desirable for the discussion of any particular matter.

2. Responsibility and Task

6.63 (i) The Team will have a corporate responsibility to the Hospital Management Team for co-ordinating agreement between the disciplines on the matters hereinafter set out in sub-paragraphs (a) to (h) and for creating and maintaining the links referred to therein and in sub-paragraphs (j) to (1). This list should be added to or otherwise varied as appropriate.

(a) Approval of ward policies for the wards in the Clinical Area.

(b) Provision of a psychiatric service to the Health District catchment area served by the clinical area.

(c) The balance of the clinical area resources between hospital, day hospital, out-patient and domiciliary psychiatric services.

(d) The estimate of requirements for the clinical area.

(e) The maintenance of liaison with the other clinical areas in the hospital and ensuring that the best use is made of resources, e.g. common use of sick wards, occupational, social and recreational 'facilities. The review of policies at regular intervals. Advising the Hospital Management Team if 'hotel' and support services are at an unacceptable level.

(f) The review of policies at regular intervals

(g) Advising the Hospital Management Team if 'hotel' and support services are at an unacceptable level.

(h) Ensuring that there is a planned development of community services and that the Joint Consultative Committee is kept informed of the needs of the mentally ill in the community.

(i) Maintenance of liaison with the Local Authority Services of the District/catchment area served.

(j) Keeping the Hospital Management Team informed of the clinical area activities and contributing to the whole hospital policy making.

(k) Ensuring that communications flow upwards to the Hospital Management Team and down to the ward teams.

(l) The maintenance of liaison with the Community Health Councils for the Health District/catchment area served.

6.64 (ii) If this Team fails to reach agreement with a Ward Team it has no power to compel compliance. If persuasion fails the matter must be referred to the Hospital Management Team.

6.65 (iii) The doctors in the Clinical Area, who form a Psychiatric Division under the Cogwheel structure, will continue to hold such meetings as they may consider necessary.

3. <u>The Team Co-Ordinator and Chairman</u>

6.66 (i) We consider that each Team should choose its own co-ordinator. He will carry out for the Clinical Area Team similar duties to those summarised in paragraph 6.58 for the co-ordinator of the Ward Team. In addition he will be responsible for maintaining the various links set out above. A full time secretary will be necessary.

(ii) Each Team should choose whether a Chairman is necessary.

4. <u>Frequency of Meetings</u>

6.67 This must be decided in the light of experience.

C. THE HOSPITAL MANAGEMENT TEAM

1. Composition

6.68 We suggest that the Team should be composed of:

The Chairman of the Medical Executive Committee
The Divisional Nursing Officer
The Sector Administrator
The Principal Psychologist
The Principal Social Worker
The Head of Occupational Therapy

6.69 We suggest that the Sector Administrator should be the co-ordinator, but he will probably delegate much of the work to the Unit Administrator who, in any event, will service the Team and should attend all its meetings. Any member of the District Management Team will be able to attend meetings.

6.70 The Divisional Nursing Officer may on occasions like to ask one of the Senior Nursing Officers to attend on his behalf.

6.71 Where appropriate to the matter under discussion, for example a problem peculiar to one Clinical Area or Ward, there should probably be additional attendance at the meeting from that Clinical Area or Ward.

2. Responsibility and Task

6.72 (i) The Team will have a corporate responsibility to the District Management Team for the efficient running and functioning of the hospital under delegated authority from the District Management Team. We envisage that the delegated authority will include the following matters:

(a) Acting in an advisory capacity to the Health Care Planning Team and Support Services Manager.

(b) The preparation of policies and plans for the development of the psychiatric services, and, subject to approval of the District Management Team, ensuring their implementation.

(c) The provision of guidelines within which the Clinical Area Multidisciplinary Teams would be required to prepare operational policies.

(d) The receipt and approval of policies and plans for improvement from ward and clinical area teams and ensuring that they are reviewed and updated at regular intervals.

(e) The co-ordination of the activities of the Clinical Area Teams and of the changes in institutional care and in the level of community care.

(f) The approval of the allocation of resources between the Clinical Area Teams and the correction of any imbalance between them, particularly in relation to bed allocation.

(g) Ensuring that plans and policies are prepared for the development of professions allied to medicine e.g. psychology and occupational therapy.

(h) Ensuring that clinical area teams maintain liaison With appropriate local authorities.

(i) Carrying out fact finding visits to clinical areas and other departments of the hospital.

(j) Ensuring that training programmes are provided to meet the needs of all disciplines within St. Augustines.

(k) Reviewing the District plans for the psychiatric services and ensuring that they take account of any proposals put forward by the Hospital Management Team.

(l) The receipt of the minutes of clinical area and other formal meetings and the taking of such action as may be necessary.

(m) The initiation of changes and ensuring that the hospital is keeping abreast of national trends.

(n) The authorisation of expenditure within the limits imposed by the District Management Team.

6.73 (ii) The authority delegated should be clearly set out in writing. Where there is doubt about the extent of the delegated authority reference should be made to the District Administrator before action is taken. It is possible that the Team will be granted delegated authority (a managerial role) in some matters and a co-ordinating role in others but in our view such a division should if possible be avoided.

6.74 (iii) The Hospital Management Team should meet the District Management Team at regular intervals. After a 'running-in period' we do not suggest that such meetings should occur more than once every six months.

6.75 (iv) If the instructions of the Hospital Management Team are not complied with the matter should be referred at once to the District Management Team

3. <u>The Team Co-ordinator</u>

6.76 We have already suggested that this should be the Sector Administrator who will, in effect, be the Team's Executive Officer. As already indicated in the Ward context, although all minutes will be sent to the District Management Team for information, matters referred to it for a decision or advice should be sent out on a separate piece of paper.

4. <u>The Team Chairman</u>

6.77 We consider that there should be a regular Chairman for the conducting of the meetings.

D. A NURSING COMMITTEE

6.78 In the same way as the Teams referred to above will be helped by the Medical Executive Committee and the Medical Staff Committee, we consider that it could be helped by a Nursing Committee to advise on nursing matters. We recommend that such a Committee should be set up under the Divisional Nursing Officer and that it should be drawn from all levels of nursing staff. We believe that such a Committee will help to fulfil the need of all levels of nursing staff to participate in improving nursing standards and shaping policies in St. Augustines.

11. An Outside Inspectorate

6.79 Dr. Ankers submitted that there is a need for an outside inspectorate and national standards for mental hospitals. We regard both these proposals as outside our terms of reference.

6.80 There is at present a clear duty on the. Regional and Area Health Authorities and on the district Management Teams to see that hospitals for which they are responsible are run properly and that the patients are well cared for. This duty will be more effectively discharged if monitoring is carried out in the manner set out in paragraphs 6.8 – 10.

6.81 An additional check on performance within the present system is provided by the Community Health Council members. In their role as representatives of the public they are expected to direct their attention to the standards of care of long stay patients and they are in a unique position quite independent of management to visit the hospitals and observe the facilities and care provided. We recommend that they should regard it as part of their duty to assess the extent to which action has been taken on these recommendations and the validity of any explanation given for failure to follow any of them.

6.82 In addition we hope that it will be possible for the Hospital Advisory Service to be developed so that it can visit St. Augustine's every three years or so.

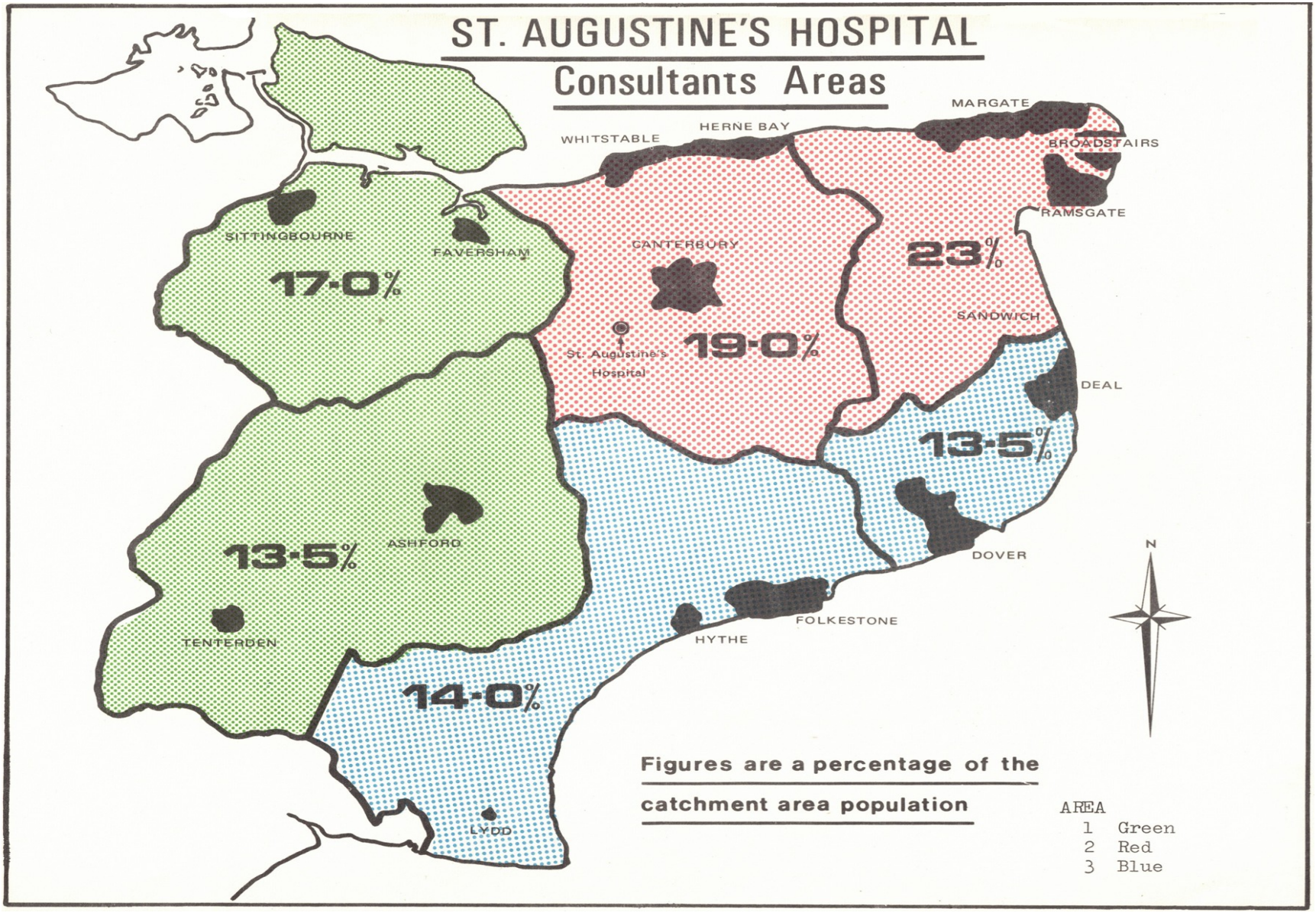
12. Matters that we suggest that the Regional Health Authority should consider drawing to the attention of the Secretary of State

6.83 We respectfully suggest that the Regional Health Authority could usefully refer the following specific matters to the attention of the Secretary of State:

6.84 (i) The need to develop and extend the work of the Hospital Advisory Service, both by ensuring that there are regular visits to psychiatric hospitals, we suggest once every three years, and also by ensuring that it has sufficient back–up facilities to make repeat visits, when necessary, to deal with problem situations.

(ii) The unsatisfactory practice illustrated in Appendix 5 whereby a mental hospital may be compelled against its better judgment to take a patient from a special hospital in order to get a patient admitted to that special hospital.

(iii) The question of how far our advice on the resolution of the management problems in St. Augustine’s should be Applied in other psychiatric hospitals.


ST. AUGUSTINE'S HOSPITAL
Consultants Areas
MARGATE
HERNE BAY
WHITSTABLE
BROADSTAIRS
RAMSGATE
SITTINGBOURNE
FAVERSHAM
CANTERBURY
23%
17·0%
SANDWICH
St. Augustine's Hospital
19·0%
DEAL
13·5%
13·5%
ASHFORD
DOVER
N
FOLKESTONE
HYTHE
TENTERDEN
14·0%
LYDD
Figures are a percentage of the catchment area population
AREA
1 Green
2 Red
3 Blue

Appendix 1

APPENDIX 2

St. Augustine's Hospital,

Chart ham Down,

near Canterbury,

Kent

A CRITIQUE

REGARDING POLICY

by

Dr. William Brian Ankers,
B.So.(Hons.), A.R.C.S., Ph.D.

and

Ollesté Etsello

April 1974

ST. AUGUSTINE'S HOSPITAL

A CRITIQUE REGARDING POLICY

This critique has been written in an attempt to draw attention to and to clarify the present situation in St. Augustine's Hospital regarding policy for the treatment and care of psychiatric patients.

As members of the nursing staff of this hospital, we feel the situation regarding policy, as it exists in the hospital at present, to be an untenable one and one which should not be allowed to persist. The normal channels of criticism within the hospital have proved to be so ineffective and frustrating that we are obliged to try alternative pathways.

The Salmon Report of 1966 states:-

"The starting point is the patient, whose cure or care is the object of the enterprise, and to this end many functions are discharged by very many people working together ... We see the nursing function in hospitals as caring for patients and carrying out treatment under the direction of doctors and in co-operation with other professional and technical staff."

The prime concern is the patient.

In this article the question of what policy exists for such care and treatment of the psychiatric long-stay patient in this hospital, and where the responsibility for this care and treatment rests, is discussed.

One would expect that for the care and treatment of the patient to be of the highest order one would require a system of treatment which would provide for the highest possible standards of assessment, diagnosis, formulation and implementation of treatment policy and care. 'The highest possible standards' one must unfortunately accept do not mean standards which are beyond improvement, but the best standards which can be obtained within the present framework of psychiatric nursing with all its limitations - conceptual, financial, human and otherwise.

What we must ask is this: are we utilising the present facilities, structure and staff of St. Augustine's Hospital to the maximum advantage in terms of treatment and care? The question of what could be done if financial resources were greater, if staff/patient ratios were increased, if staff were more widely trained, etc. is not posed here. Here, at present, we are asking whether we Are using effectively and imaginatively what we have got.

Within this hospital there are three fundamental questions to be asked and answered:

1. What is the hospital's policy for treatment of patients, particularly those in long-stay wards?

2. Who is responsible to ensure that such policy is implemented?

3. What is an acceptable standard of care for patients?

Treatment

It is our contention that the management in this hospital exercise a policy by default with regard to the treatment of long-stay patients in this hospital. They in fact acquiesce to a policy of laissez faire, which results in either the complete absence of policy on long-stay wards, or alternatively, the formulation of policy by nursing staff without encouragement or guidance.

If, as a nurse, you offer patients custodial care, then that is acceptable. If, however, you wish to involve yourself in doing more for the patients in a therapeutic sense, such as trying to offer the patient a co-ordinated therapeutic team to which he is entitled, which should in turn provide the patients with an individual constructive treatment and rehabilitation programme – then that is up to you. If you wish to organise excursions out of the hospital for patients and not allow them to rot in chairs, as some have been doing for years, then that too is up to you – that is your initiative, no-one else's – no-one asked. you to do it. The sad part is that if you don't do it there is no policy implemented that says you should, and no-one will tell you that you should.

The hospital should have;
(a) an effective policy with respect to the general needs of all patients, and
(b) an effective policy with regard to the individual needs of each patient, i.e. the right of the patient to expect a, high standard of care and an individual treatment programme.

For long-stay patients in St. Augustine's Hospital care and treatment are largely of a custodial nature with a heavy reliance being placed upon chemotherapy. For some patients the 'treatment' may well be one of containment. It is a, very sad fact that this hospital allows many of its long-stay patients to slip into a situation where their medication may not be regularly reviewed; often no guidelines are offered on wards to nursing staff regarding a concerted psychotherapeutic approach; and therapeutic activities become almost non-existent. For many the therapeutic community has never existed. The hospital has no clearly defined policy which does not allow patients to vegetate.

A great many long-stay patients have little or no contact with a psychiatrist or with the consultant who is supposed to be responsible for their treatment. Indeed, consultants are sometimes unaware of the treatment that their patients may be receiving. One would expect that responsible medical officers should be leading and directing the psychiatric team; involved in their wards; be introducing and encouraging the implementation of progressive ideas; and ensuring that their patients are not deprived of the best possible treatment available.

Despite the shortage of medical staff and the resulting heavy work load the present situation is unacceptable.

The need for an individual treatment programme for the patient is obvious and yet the hospital operates no policy to ensure that the patients will be discussed as an individual by all disciplines involved in his treatment, nor does it ensure that a treatment programme is decided and acted upon. Such a, treatment programme must involve the patient's needs in terms of medication and therapy, the patient's objectives and our objectives for the patient, and the performance of both staff and patient during such a programme should be periodically monitored.

If this hospital does have a comprehensive treatment policy which is effectively implemented, then why is it that some patients have been left to

stagnate in chairs for years? Why is it that some ambulant patients have not left the hospital and its grounds for years – goodness knows how long, for there is no policy implemented that patients should go out as part of their treatment, nor that records should be kept. A charge nurse of long-standing in the hospital maintains that some patients have not to his knowledge been into Canterbury (the nearest centre of population – 3 miles away) for perhaps 10 years, maybe longer, who knows?

If we are supposed to be treating these patients, then is social isolation within St. Augustine's part of their treatment? Does being mentally ill in the long term mean that one should not visit Canterbury, attend the local cinema, visit a pub or restaurant, or walk through the countryside? Long-stay patients suffer from social and sensory deprivation, which contribute to disorientation and the inability to communicate and interact with ordinary people if they do go into society.

To quote the Annual Report for 1969-70 of the National Health Service Hospital Advisory Service:

"Many hospitals (for the mentally ill) fail to provide an environment which gives either the opportunity or the demand for patients to meet society's normal expectations".

Part of the process of attempting to meet society's normal expectations necessarily involves the patient actually entering into the community to participate in normal activities. In order to do this financial support is required. No finances are apparently set aside specifically for this purpose at St. Augustine's Hospital.

Care

It is our belief that long-term patients do not receive an acceptable standard of care in St. Augustine's Hospital. An acceptable standard of care should encompass:

(a) suitable surroundings that ensure the comfort and self-respect of the patient,
(b) the patient's right to be treated respectfully by staff as an equal fellow human being, so protecting the patient from loss of personal identity, responsibility and initiative,
(c) normal contact with other people and an awareness of patients sexual and emotional needs,
(d) the right of the patient to be kept fully informed regarding the running of the hospital community of which he forms a part; his legal rights and his rights as a resident; and the right to be informed about his treatment insofar as this is practicable,
(e) a dignified life in hospital which takes into account the fact that this is his temporary or long-term home.

In this hospital totally unsuitable nursing staff are permitted to occupy· positions of responsibility on wards where they subjugate patients, disrupt any attempt to create a therapeutic climate, and generally block progress. Such staff are also entrusted – by nature of their seniority – with the training of learners on wards. Mistreatment and malpractice occur and often, when such instances and unsuitable staff are brought to the attention of senior nurses, no action is taken. Generally though, such instances and individuals are not reported due to a false sense of loyalty to ones colleagues, the fear of victimisation, or the difficulty in substantiating such problems.

We feel that the outworn, custodial attitudes of such staff, which might well have been acceptable twenty years ago are still very much in evidence in this hospital because these staff are protected by the authorities out of a false sense of gratitude for their long service or simply because they constitute a regular work force. The nursing administration appears to be incompetent in dealing with such problem's, despite allegations being made by concerned staff. One questions exactly what allegations and evidence must be presented to the nursing administration for satisfactory, appropriate action to be taken.

Who is Responsible?

With the present state of affairs concerning patient treatment policy, who then is responsible for it? Responsibility must lie somewhere in the chain:

Hospital Management Committee --> Consultants and Medical Staff --> CNO --> PNO --> SNO --> NO --> Ward Charges --> Nurses.

Let us start at the shop floor with the nursing staff and ward charges who have day-to-day contact with the patients on the ward. These staff, in that they spend more time than other links in the chain, with the patient, share the major burden of appreciating the patient's needs. The chain:

Ward Staff --> NO --> SNO --> CNO --> H.M.C.,

with the exception of the Consultants and Medical Staff, extends outwards away from the ward and away from the patients. The further along the chain one goes the greater the need for communication with what goes on at ward level. And yet there seems to be a. gulf between ward staff and the higher governing body.

It is our experience that for the lot of the long-stay patient to be more than custodial care, i.e. he enters a therapeutic community and receives an individual treatment programme, requires the ward staff to exercise its own initiative and persistence to a considerable degree. This involves repeatedly calling for interdisciplinary ward meetings to discuss each patient in turn and setting up one's own policy of treatment and then imposing this upon the structure within the hospital and working to get this accepted and consistently implemented. If you are prepared to do this then no-one will stop you - but no-one will have asked you.

In one ward it has now been agreed to discuss one patient a month at an interdisciplinary ward meeting - with 49 patients in the ward this means it will take four years to obtain a full treatment programme.

To quote the Annual Report for 1969-70 of the N.H.S. Hospital Advisory Service:

"The organisation of a psychiatric ward is primarily concerned with the human relationship of the therapeutic team with the patient group."

For the therapeutic team to even show signs of existence requires considerable drive and initiative predominantly on the part of the nurse.

It is asking more than a lot for all nursing staff to be expected to show such initiative, drive and insight in determining and implementing major policy objectives, especially in view of the inevitable criticism of the present laissez faire system which lies with such initiative. Many nurses who are naturally concerned with their careers find themselves compromising their own views for fear of being too outspoken and critical. Many are concerned but few will express it openly. Quite often the nurse with genuine concern and

compassion for the patient finds him/herself so frustrated by the impasse of the situation that he/she leaves for greener fields. Surely, the existence of therapeutic communities on wards, with patients involved with a coordinated team in therapeutic activities, and each patient embarked upon a definite treatment programme is not asking for too much. If it does not exist, as is the case on many wards, then there should be realisation and recognition that it does not exist and procedures implemented to make sure that it does. There should be effective policy to prevent stagnation.

St. Augustine's Hospital appears to be a hospital with day to day tactics but no overall strategy.

Who then is responsible if stagnation does exist?

Surely all of the people in the chain from the D.H.S.S, to ward staff are involved? Although ward staff cannot escape censure we feel that the main responsibility for the situation must lie with the medical and nursing administration and the Hospital Management Committee. The D.H.S.S. is implicated in this responsibility in failing to recognise the paucity of resources in this psychiatric hospital, the abnormally heavy work load placed upon doctors, and the low wage which nurses receive which is itself no incentive.

What responsibility do doctors have for their patients? One would think that consultants have a duty towards their patients in
(a) prescribing and ensuring appropriate treatment,
(b) ensuring a suitable therapeutic environment, and
(c) maintaining contact with each of their patients.

The Salmon Committee on senior nursing structure recommended that nursing policy should be formulated by CNO's and PNO's who would Control or co-ordinate its implementation throughout the group. SNO's and NO's would work out the detailed application of nursing policy in specific areas or units. The actual carrying out of the work would be done by first-line management. Enough said.

The responsibilities of hospital authorities were defined in regulations issued in 1948(;) Regional Hospital Boards, as the Secretary of State's agents, were responsible for guiding and controlling the planning, conduct and development of services in their regions; Hospital Management Committees, as the Boards agents, for administering these services. The functions of members of H,M.C.'s and their officers were summarised in the 'Handbook for members of H.M.C.'s' published in 1966. To quote – "The Management Committee is responsible for the running of the hospital, subject to any direction from the Minister or the Board, and in discharging this responsibility the Committee has a duty to see that the interests of the patient and the public are taken fully into account. If the Committee is to give enough consideration to matters of prime importance it has to delegate responsibility for other matters as fully as possible to its officers and in no way attempt itself to play an executive role … An obligation rests on the Committee to set standards of performance and to see that full use is made of modern management aids … The task of the officers is to manage the affairs of the Group in accordance with the Committees policies … The distinction between the role of the Committee to determine how the hospitals are to be run and that of the officers to undertake their management is important, and, in the interest of efficiency, should be strictly observed".

How far in these terms of reference has the Hospital Management Committee proved equal to its tasks? Although these people are no longer with us, they were the responsible governing body until a few weeks ago.

This article is an attempt to constructively criticise a disquieting situation which exists despite the genuine concern and effort of many people. It is an attempt to clarify a situation which is affecting patients in this hospital now. Some staff in the hospital service are deeply concerned about the quality of care which they offer, and it is as a, result of this concern that this article has been written. It is an attempt to be honest, without tempering such honesty by shielding it in half-truths, which are often made to accommodate people for fear of hurting their feelings.

In conclusion, we would like to summarise the main points of this article and venture to make recommendations which we call upon the new Canterbury and Thanet Health District Authority together with all staff of this hospital to consider.

Summary

1. There is a lack of policy for treatment of long-stay patients.

2. The majority of patients do not receive the benefits of individual treatment programmes.

3. There is an unacceptable standard of care for a great many patients.

4. On long-stay wards the care is primarily of a custodial nature.

5. Far too heavy a reliance is placed upon chemotherapy, and medication is often not regularly reviewed.

6. It is our experience that often no guidelines are offered on the ward to nurses regarding a concerted psychotherapeutic approach to their work.

7. Nurses are not required to implement therapeutic activities on wards. If they take the initiative and do so, then that is up to them. But there is no obligation that they do sO.

8. The therapeutic community does not exist for the majority of patients.

9. Totally unsuitable nursing staff are permitted to occupy positions of responsibility on wards.

10. Mistreatment and malpractice occur in the hospital.

Recommendations

1. General policy objectives for the treatment of long-stay patients should be formulated and instigated.

2. Each patient should have an individual treatment programme.

3. The standard of care should be raised to an acceptable level.

4. The regular review of patients conditions, treatment and. medication.

5. The establishment of therapeutic communities on long-stay wards through the concerted efforts of multidisciplinary teams.

6. The hospital should provide the financial means to support therapeutic activities. Medical staff should show greater involvement at ward level.

8. Ward policies and objectives should be clearly stated so that nursing staff can ensure that they are fully implemented.

9. The suitability of certain nursing staff to work with the mentally ill must be given very careful consideration and where necessary appropriate action taken.

10. The image of remoteness and ineffectiveness of the nursing administration should be dispelled by positive involvement with patients and staff at ward levels as outlined by the Salmon Report.

11. We are concerned that the recommendations contained or implied in Paragraphs 26.1, 361 371 64, 95.21 96s 98, 991 1061 1071 1081 117 and 1251 of the Report on St. Augustine's and St. Martin's Hospitals of November 1971, compiled by the National Health Service Hospital Advisory Services have not been fully implemented.

The final words are taken from the National Health Service Hospital Advisory Service Annual Report of 1969-70.

> "A hospital which has a high morale and is well organised can often accept and make good use of constructive criticism; a hospital with a low morale and major problems may find any criticism difficult to accept and be reluctant to consider change."
>
> "Every professional persons whether he is engaged on therapy or research, bears the burden that, to the extent he fails to do his utmost, he is responsible for the continuing degradation of his fellow human being."
>
> Ullman "Institution and Outcome."

Copies to:
The Secretary of State for Social Services
The Department of Health and Social Security
The Regional Health Authority
The Kent Area Health Authority
Canterbury and Thanet Health District
The Hospital Advisory Service

Within St. Augustine's Hospital:-

Ex-members of the Hospital Management Committee for St. Augustines Hospital
Consultant and Medical Staff
The Nursing Administration
The Lawson School of Nursing
The Psychology Department
Social Workers
The Occupational Therapy Department

St. Augustine's Hospital,
Chartham Down,
near Canterbury,
Kent

A Critique Regarding Policy

Part II

THE EVIDENCE

by

Ollesté Etsello

and

Dr. William Brian Ankers

February, 1975

Dedicated
to the Memory of
Alex Lumelino

…. the Truth is past all commiseration

Maxim Gorky

ST. AUGUSTINE'S HOSPITAL

A CRITIQUE REGARDING POLICY

PART II

THE EVIDENCE

In April 1974 we produced the Critique Regarding Policy on St. Augustine's Hospital and circulated it within the hospital and the National Health Service. This document arose from our discontent and frustration with the state of affairs at the hospital and was critical of the service the hospital was offering to the community. We were at that time - and remain – greatly concerned with the lives and fates of the patients in the hospital and with the standards of care and treatment they receive. We wrote the Critique in an attempt to draw attention to the situation and bring about change.

The authorities have dismissed the case we presented. Although the Critique concerns policy, the authorities have focused on two words in the article, 'mistreatment' and 'malpractice', and insisted that we elaborate on these points. We would stress, as we have always done, that the Critique concerns policy for the treatment and care of psychiatric patients. Mistreatment and malpractice are two aspects of the report which have been used to divert attention from the main themes of the Critique. We feel that this is a tactic of the authorities designed to deflect responsibility from where it truly belongs with the administrative and management bodies onto nursing staff at ward level. We are aware, of course, that the authorities would consider the scapegoating of individual members of staff to be a simple solution to this affair. This would be a distortion of the problem and furthermore would be no solution.

We produced the Critique to expose the grave shortcomings of the hospital. The authorities instead of responding with energetic concern, have attempted to ridicule our criticisms with such dismissive remarks as the contents are immature', and 'the authors are confusing idealism with realism', and by describing the document as suspect and having no substance and the authors as being inexperienced.

Their sole communication to us has been a demand that we supply them with names, dates and corroborative evidence to substantiate our allegations of mistreatment and malpractice. They have shown no concern whatsoever for the main issues of the Critique concerning policy, treatment, care, mismanagement and maladministration.

We have brought into question serious aspects of the hospital's service to the public. What sort of jobs are these people doing that they can so flippantly dismiss the case we presented and state that unless we furnish them with detailed evidence they have no hesitation in refuting our allegations. These people are employed in a health service designed to serve the public.

They have a duty to the patients of St. Augustine's Hospital. The attitude they have shown and their dismissal of the case constitutes an abrogation of their responsibility to the patients of this hospital and to the community at large.

We have faith in the evidence of our own eyes. If we feel that something is wrong we must ask questions until we are satisfied. If we are not satisfied we must take appropriate action. We have stated and reiterate that something is wrong. The authorities have not taken appropriate action.

We have asked for an independent, wide ranging inquiry which would have offered ourselves as well as others at St. Augustine's the opportunity to come forward. This has been refused. We consider this refusal by the authorities to be quite irresponsible and devoid of any real concern for the lives of the patients at St. Augustine's Hospital. He are disgusted at the responses of the official bodies who have attempted to deny and dismiss our criticisms which have arisen directly from our experiences at this hospital. Who are these people to deny what we have seen with our own eyes? He have worked at St. Augustine's Hospital for a total of nearly six years. During this time we have seen, heard of, and been aware of such things as follows.

1. degrading and humiliating treatment to patients.
2. Patients being reduced to passive and submissive states.
3. Patients deprived of their rights.
4. Patients being labelled in derogatory ways.
5. Patients being made to feel and act as inferiors to staff.
6. Patients over medicated.
7. Patients physically assaulted by staff.
3. Patients being given electro-convulsive therapy (E.C.T. - shock treatment) against their wills.
9. The misappropriation of patients monies.
10. The misappropriation of food and other provisions supplied for patients.
11. Patients deprived of their freedom.
12. Patients given inappropriate treatment.
13. The interests of the staff being put before the interests of patients.

He hold the hospital management and the medical and administrative bodies responsible for allowing such outrageous things to exist in this institution. It has been stated that terms such as mismanagement, maladministration, mistreatment and malpractice are vague and unspecific and we have been asked to elaborate on them and spell out exactly what we mean. Although we feel sure that those working within the hospital service know fully well what is meant, we now think it imnortant that we do illustrate our case. On the following pages we shall do this by citing examples reported by nursing staff. We are putting these illustrations in numbered paragraphs as quoted.

REPORTED INCIDENTS

1. (I) A patient who was pacing the dormitory naked during the evening was threatened by a nurse: “If you don't get into bed I'll give you a fucking good hiding.”

(ii) A patient was secluded in a side room for agitated behaviour during the afternoon. At 7 p.m. I took this patient his supper, carrying it through the day room. The same nurse questioned where I was going with the supper and I replied that I was taking it to the patient. “Oh no you're not he stated.” I persisted in taking the patient his supper despite the nurse maintaining that you had to show such psychopaths that you meant business by depriving them of food.

(iii) The nurse arrived on the ward at 9 p.m. A slightly agitated patient was seated at the table. The nurse went over to the patient and repeatedly clipped him round the head saying 'How would you like a therapeutic clip round the head?' each time that he hit him.

(iv) At 7 a.m. after this nurse had been on night duty he told the day staff that a minor cut on his lip was caused by this same patient. Later in the morning, the day staff noticed that the patient had a black eye.

These four incidents relate to one nurse.

2. I was sent to an admission ward to assist staff with a 'violent patient' who was demanding his discharge. Discharge was refused even though the patient was informal. The ward doctor would not come to see the patient but had ordered an injection over the telephone and would come next day. The man was said to be suicidal because he had made remarks such as "I might as well be dead”. The ward staff were taking an aggressive line with him 'You're going to have the needle, etc. He was very upset and it seemed to me that the nurses were making things much worse. I intervened and tried to calm the man down and talk reasonably with him, listening to what he had to say. The S.E.N. in charge of the ward came blustering out, brushed me aside telling me that this was not my affair and ordered her staff to grab him, whereon he was manhandled into a room, pushed over a bed and given the injection.

This man was not violent or dangerous. He was in his mid sixties, small and thin. He was anxious and depressed and needed friendly help and reassurance. The treatment he received was disgraceful.

3. A relief charge nurse took charge of the ward one morning. Patients snapped to it when he was around - he got reaction by ordering patients around. A subnormal schizophrenic patient on the ward habitually went around with his fly buttons undone despite the consistent persuasion of the regular ward staff not to do this. The relief charge nurse told this patient to button his flies and when the patient ignored him and over-talked him he repeated the demand each time hitting him beneath the loner abdomen. The patient still ignored these demands and was told 'You're going into a room'. The patient's arm was twisted hard behind his back in an outstretched manner and in this way he was marched through the day room. I opened the dormitory door and the charge nurse posted this patient twice into the door frame in a vicious manner. With his arm still twisted hard behind his back against the joint he was marched to his side-room where he was pushed in and kicked up the backside.

4. An S.E.N. on the ward staff was sometimes left in charge of the ward. She was moody, unpredictable in attitude to patients and indifferent to their welfare. Examples of her behaviour are:

a) At tea time she was taking food around on the trolley to be dished out, forgot to dish out for twelve non-ambulant and helpless elderly patients. When I reminded her she said 'Well they don't eat much anyway, they don't need to, sitting in their chairs all day and doing nothing. I served six of these patients before she took the rest of the food to throw away.

b) A non-ambulant elderly patient, whilst we were both putting her to bed, the nurse said "I can't stand this one, she plays on my nerves' and slapped her buttocks.

5. On one occasion, the ward charge nurse took a patient who retained her urine and 'dribbled' to the toilet and I saw the ward charge nurse slap her face because she was not urinating. This patient disliked being made to go to the toilet and having her stomach pressed to make her release the urine. If permitted to do it in solitude and in her own time, she would respond favourably to members of staff who did not stand over her and press her stomach. We had been instructed by the ward charge nurse to use this method, though some of us as untrained nursing assistants felt and voiced objections based on fears of causing internal damage through ignorance. This patient would struggle if one attempted to do this.

On another occasion this patient was holding onto a door handle and partially blocking the doorway. The ward charge nurse wanted to go through the door and bent back the patient's fingers with unnecessary force. The patient was crying and saying,"Why are you doing this to me?"

Such behaviour on the part of the ward charge nurse caused considerable concern amongst nursing staff on the Hard.

6. I was sent to this ward much later in my training to assist with E.C.T. (electroconvulsive treatment). A patient in a depressed state was refusing to have E.C.T. although he had previously signed a consent form agreeing to have it. Three nurses went to fetch him and half-dragged, half-carried him into the dormitory struggling and pleading. He was forced onto the bed and the staff all struggled to hold him down. I strongly objected to this and questioned the right of the psychiatrist to administer E.C.T. to an unwilling patient. The psychiatrist and charge nurse reacted angrily, argued the point briefly, then dismissed me by saying "Well, if you are not going to help, go and do so-and-so. E.C.T. was administered. Those present were a psychiatrist, a charge nurse, a staff nurse and two student nurses.

7. Throughout the month that I was on this ward a patient was kept locked in a side room. This seemed a regular practice. He was only let out for a shave every morning, to attend toilet and to sit in the day room for perhaps one or two hours in the afternoon when he was kept under close observation. The patient had all his meals in his room. This room was a small, dull cell with one window which could be blocked by a wooden shutter closed and locked from inside the room. The thick wooden door to the room as locked and contained a peephole. The room had a bed and nothing else. It was bare, smelt of urine and had no heating in it. The explanation given for this 'treatment' was that he was a fire risk and had been violent in the past.

8. In seven weeks on a psycho-geriatric ward I only witnessed and/or aided in a maximum of ten baths. I estimate that on average the non-ambulant patients received only one bath during that time. No regular check or timetable was kept to. The other patients, ambulant but requiring some aid and/or completely able, I estimate to have received a bath at the same rate of 1 per seven weeks (approx.) although they did have daily strip washes 'under the arches'.

9. This was my first ward. On entering the ward on my first day I observed four nurses standing around a patient who was seated. One nurse would extend a hand, inviting the patient to take it and be assisted to his feet. When the hand was accepted and the patient half way to his feet, another nurse put his hand on the patient's head and forced him into a sitting position. This happened a number of times to the amusement of the nurses. The patient was a meek, submissive little man - the sort who has nobody to protect him and would never dare complain. He was being treated as a figure of fun.

10. On one long stay ward there were no therapeutic activities, no occupational therapy, no regular ward outings, no ward aims or individual treatment programmes identified. Just plain custodial care. Nurses did the bare minimum, sat around drinking tea. Patients food was put aside for elaborate meal breaks. Nurses had a bottle of beer (supplied for patients) each evening. The ward was generally dirty. Patients left to sit around and get on with it. There were no ward hand-over meetings for all staff and no ward meetings. The ward was a backwater.

11. Another occasion I recall was of a patient asking me humbly if he <u>had</u> to have E.C.T. (electroconvulsive therapy). He had signed a form of consent when first arriving at the hospital - just in case it was necessary (as the doctor put it) - without really understanding what it meant. Now the doctor informed him that he was to have the treatment and he was quite frightened and had no idea that he was free to refuse this controversial treatment.

12 The ward charge nurse was incompetent and inadequate, stayed in the office all day and had no contact with the patients. The charge nurse disrupted work by keeping a nurse in the office to chat with. Change-over was held in the office between the two ward charge nurses and other staff were not allowed to participate. Criticisms were disliked and discouraged. e.g. suggested that application be made for more flannels, questioning the hygiene of using them on several patients. The answer was that nothing could be done and it was pointless to try.

The ward charge nurse withheld patients' property and ward stock from distribution. Patients' Christmas presents like sweets, biscuits, soap and talc, etc. were locked up in a cupboard in the office and I never saw any distributed. The nursing staff complained quite often that the ward charge nurse withheld good quality soap and talc, locking them in a private locker, and they strongly implied that it was taken home. They would sneak into this locker when the ward charge nurse was not on duty in order to get some soap for the patients. Generally, ward supplie3 of fresh fruit, cheese, cake, were never distributed.

13. On a geriatric ward there were insufficient pyjama jackets despite requisitions being made for more and we were obliged to use shirts or vests instead, or to put old people to bed naked. Unsuitable bedjackets which did not unbutton open were supplied. These were difficult to remove from incontinent patients.

14. A patient on a long stay ward became very disturbed during the day, possibly due to the medication he had been put on by a new ward doctor. In the evening the ward charge nurse warned the nursing administration that he feared there was likely to be trouble with this patient during the night and he advised them to put two night nurses on the ward instead of the customary one.

He was told don't tell us how to look after psychiatric patients and no extra night nurse was placed on the ward. In the early hours of the morning the night nurse on this ward was beaten up by this patient and his head pummelled into a radiator. The nurse was consequently off sick for several weeks, received 29 stitches in his head and was permanently disfigured.

15. An incident on this ward concerned a patient who had been admitted on a section 29 following an attempted suicide by drug overdose, he awoke to discover that he was in a mental hospital and wanted to leave. He was informed by the charge nurse that he was on a section and that he couldn't leave. He was angry and frightened. He resented being there and was hostile to the staff who were keeping him there against his will. The charge nurse was sarcastic and supercilious with him.

He recorded in the man's notes that his behaviour was psychotic. This was plainly untrue.

This practice was not uncommon in the hospital. If a patient was rebellious or hostile to staff, this behaviour would be ascribed to his illness and termed psychotic, or paranoid, or it would be said that he was deluded. Also on this ward I remember patients referring to the night staff who were 'rough' with them, and there was always acute interest in who the night nurse would be.

16. Distress was caused to the more alert patients on one psycho-geriatric ward by the deprivation of their spectacles. They were unable either to read newspapers or watch television, which were their only two sources of occupation and entertainment. All the patients suffered from the absence of any kind of sensory stimulation or occupation or entertainment. There was no occupational therapy.

One woman liked to knit, but was able to do so for only half an hour a week when voluntary workers brought round a trolley of magazines and wool. She had to return the knitting needles and wool when they left the ward. A few of the more able-bodied would have benefited from occupational therapy, outings, and film shows for example. Some of the more confused and ward-bound would have appreciated dancing, records, or ward parties with male patients invited from other wards.

17. I criticised the ungenerous pocket money allowances for patients at a nursing assistants meeting held in Godfrey House at the hospital. I pointed out that I knew of some patients in the hospital who received as little as 30 pence in their hand a week. This was denied by a nursing officer present but supported with examples by a charge nurse present.

18. On a psycho-geriatric ward patients were often put to bed in vests, because there were no nightdresses. Clothing was generally in a dreadful state, torn, old, ill-fitting with no buttons.

19. There were hardly any flannels on a psycho-geriatric ward. Old towels, etc., were torn up to be used as flannels. One flannel was used on maybe ten to twenty old people on <u>all</u> areas of the body.

20. A serious incident occurred involving a student nurse. An old man who was a patient on an admission geriatric ward was found one evening to have a deep cut behind is ear which required six stitches. Two days afterwards I was told by a patient that he had seen this patient struggling in the bath with the student nurse. (This patient had complained to me previously that this same student nurse was in the habit of kicking his feet as he passed him sitting in a chair apparently asleep. I reported this to the charge nurse).

I related the incident to the staff nurse who informed the nursing office. Subsequently two other patients mentioned that they had witnessed the incident. They stated that they had seen the struggle, the patient naked in the bath, and the student nurse outside standing on the floor, that he had punched the old man, and that the old man had fallen in the bath during the struggle.

The police were called in and statements were made by the patients involved. Staff were not officially informed of the outcome, but although the student nurse concerned was taken off the ward, he continued to work on geriatric wards and to finish his training.

21. On one long stay ward you could spend the whole shift tea drinking and chatting with staff. There was no interaction with patients except for medication.

22. I was sent to this ward to assist nurses with a violent patient. The patient had attached another patient. He was in a side room with the door locked when I arrived. Seven nurses were present. They all went to the side room and the charge nurse opened the door and said Right lads, get in there."

The patient was sitting on the bed looking frightened. The nurses went in there and piled on top of him, one very heavy nurse on top of him with his full weight bearing down on his knees which were on the patient's upper chest and neck.

The injection was given.

No attempt was made to talk to the patient or to persuade him (or even ask him) to have the injection.

23. On one psycho-geriatric ward the more helpless old people received only three drinks a day; breakfast, lunch and tea-time. The standard of food was low and the quantity varied, often being inadequate.

24. In one long-stay ward a certain patient nursed a fellow patient who was bedridden for seven years. The former would help change, feed and comfort tie latter and they were friends. Then the hospital was reorganised in 1972 these two patients were put in separate wards. The patient tried to visit his bedridden friend on his new ward but was forbidden to do so by the charge nurse of that ward. This seems to me to be an extraordinary act of unkindness.

25. On this ward, when the students in the Introductory Block were visiting the ward they were given an exhibition of the patients, which was rather like visiting a zoo. Patients were called forth by the charge nurse and encouraged to 'perform' in front of the audience. Certain patients could be teased into performing and this was done. This exhibition was designed to cause amusement and lend prestige to the charge nurse in that it gave him the opportunity of showing how complete was his control over these 'performing' patients. This also happened on another ward.

26. Generally, the staff on this ward had little or no knowledge or understanding of mental illness. I frequently heard the statement “Geriatrics are all right. They're grateful for what they get. But I'd hate to work on any other ward - the rest of the patients in the hospital are a bunch of psychopaths”.

Minimal custodial care was provided - i.e. getting patients up, feeding, potting, strip-washing, etc. There was a rigid routine punctuated by several long tea breaks (seven or eight a day). Both staff and patients were totally institutionalised and unquestioning and did the bare minicar essential.

27. On one long-stay ward there was a patient who had been in the hospital for many years. His case notes show that in his youth he liked going out to the cinema and going for long country walks on his own. After spending several years on a rigidly run, repressive ward, he was fearful of even leaving the ward itself. Then he was moved to this long-stay ward no recognition or treatment of this agoraphobia was offered except through individual nurses' initiatives, who encouraged him to go out and took it upon themselves to go out with him.

28. Clothing was very poor, in bad condition, in short supply, old and torn. There were few geriatric dresses, insufficient nightdresses; pyjamas had buttons missing, woollens were ill-fitting, old and torn; stockings were odd and frequently torn: jackets and trousers were often stained, ill-fitting and old. A lot of fabrics were very inflammable - especially nightdresses. Underwear was often torn, stained and old.

29. When the Department of Health and Social Security authorised increases in patients' pocket money to £1.55 these increases were left to nursing staff at ward level to implement and the Administration did not ensure that such increases had been made. Some patients did not receive these increases to which they were entitled when they should have done so.

30. One ward was notorious in the hospital and two students in my block refused to do their three months' training there. The school did not insist upon it and they went elsewhere.
On this ward there was a strict, heartless, oppressive regime which was carried out obsessively. Of the two charge nurses, one was akin to a dictator and ruled the ward with an iron hand as if it were his world. Patients were moved from point A to point B en block. No individualism was permitted and no freedom existed. From the moment the patients arose in the morning until the time they went to bed their day was an unchanging, number of moves from tables at breakfast to toilets; from toilets to wash-room, from wash-room to the wooden hut outside in the yard where they worked at absurd, monotonous tasks. At mid-morning they were allowed half a beaker of tea each - no more. At lunch the same procedure in reverse went into operation.

In the evenings and over the weekends they sat in rows in front of the television or -ere taken out all together into the yard to walk about. They were not allowed to wander freely at will either on the ward or outside.
The pattern of their existence was strictly controlled and without relief. A nurse on the ward likened them to Toby Jugs sitting on a mantelpiece - just ornaments to be dusted down and moved into different positions.
To me they were chronically institutionalised, completely passive, defeated creatures, degraded and alienated from everything we value as human.
There was nothing on the ward in the way of books, magazines, games, personal possessions, or materials for therapeutic activities. All such things were discouraged. The patients did not go out to the patients' social club and when I insisted on taking some the idea was opposed and a quarrel ensued.

31. The regular S.E.N. on one ward had the appearance and manner of a member of the Gestapo. Coming on duty she swaggered into the ward and with legs outstretched and hands on hips surveyed the state of the ward and the inmates with an arrogant and pitiless glare. She was ill-tempered, impatient and bad-mannered with patients and made it clear that she thought them members of an inferior species. I once heard a young nurse ask her what was the matter with a certain patient. "Oh him", she replied in a loud, disdainful way, “he's a schiz! - Once a schiz, always a schiz!" The person whom this remark concerned heard it clearly.

On another occasion she wanted to give a patient some medication and he didn't want to take it. Nobody was permitted to question any issue with her she didn't make requests - she issued commands. When her commands failed to persuade the patient to comply she started to grapple with him in order to force the tablets upon him. When he lifted his hands in a protective way she shouted that he was fighting her and he was carted off for an injection. This was typical of the sort of monstrous scene she would produce. She would push people around and provoke them and if anyone stood up for himself she screamed that she was being attacked or that the patient was going mad and then the unfortunate patient would suffer for it.

On another occasion there was a young man on the ward who was not in the habit of allowing himself to be pushed around or of cringing to the nursing staff. Standing in the doorway one day she pushed him out of the way, putting him off-balance. He pushed her hack. At this she started a big scene, accusing him of being aggressive and reporting him. As a result of this he was admonished and no doubt the incident was entered in his case notes to his detriment.

None of the staff on this ward liked her presence on the ward and most felt that she was positively harmful and dangerous, but they could do nothing about it because the consultant of the ward favoured and protected her.

32. There was virtually no discussion of policy regarding treatment of individual patients on a therapeutic basis (on this ward), i.e. one patient took to her bed for a period of about four months. There was no discussion of tactics to talk to her, to try and discuss her problems - this was left to the initiative of the individual.

E.C.T. was repeatedly tried though nursing staff felt that after an initial 'recovery' following E.C.T. lasting 3-4 days, she relapsed into a state worse than before. One of the ward charge nurses expressed strong dislike of this patient "She's a typical psychopath, you can't do anything with them'. (her diagnosis was not 'psychopath'). ‘They don't show any gratitude for what you do for them'. One of the ward charge nurses forbade the nursing staff to feed this patient, claiming that this would make her get up. In fact, it made the patient more intractable and hostile, though it was kept up for several weeks despite the objections of junior staff. This patient was fed when the other ward charge nurse was on duty.

Differences in attitude, policy and treatment between the two shifts were very apparent, i.e. one shift would give food to a patient while the other shift would not, one ward charge favoured ward meetings, social outings and tea parties for the patients and the other ward charge did not, one shift would do aseptic dressings in one way, the other shift in a different way, on one shift the patients were allowed a certain flexibility in seating arrangements at the dining tables, on the other they were forbidden to change places; on the one shift patients tended to be given spoons instead of knives and forks - this produced a degree of confusion amongst both patients and the junior staff.

33. One patient - severely subnormal - was kept locked in a chair all day and every day and allowed out only to go to the toilet and to wash and bathe. It was said that he was dangerous and attacked people without warning, biting and scratching. He had previously had all his teeth removed because of his biting habits. To requests to take him out for walks the ward charge replied that he would permit it if he had sufficient staff but he had not. It was recognised to be quite wrong and inhuman to keep anyone locked constantly in a chair but responsibility was passed on to the nursing administration who supplied insufficient staff. And so this patient lived in a locked chair.

34. Patients were deprived of jam, tea, coffee, sugar, soap, Marmite, marmalade, Bovril, Horlicks, Ovaltine, razor blades, etc. etc. Provisions arrived on the ward but were not given to the patients. The ward charge attempted to justify depriving patients of provisions by such excuses as - pertaining to jam and marmalade - that they didn't like it and anyway they would make a mess with it, etc.

The patients' money, cigarettes and sweets were controlled by the ward charge and locked away in a safe in the office to which only he had the key. Only six patients received cigarettes or tobacco. Only two received sweets. The question of the patients money was a mystery and the pay sheets were kept locked away. What was abundantly clear, however, was that the majority of patients were not receiving their money nor were they receiving cigarettes or sweets or anything else in place of their money.

I had on several occasions criticised the manner in which the ward was run and aspects such as that above, but obtained no satisfaction either in replies or actions. I therefore made an official complaint to the Nursing Office. I was told by an assistant matron that the matter would be passed on to the acting Principal Nursing Officer and that he would subsequently want to see me. This did not happen. What did happen was that when I was going off duty that day I saw the acting Principal Nursing Officer in the ward office talking to the ward charge privately. Next day when I arrived on duty I was informed that there was to be a ward meeting to discuss certain problems that had arisen, meaning my complaints. At the meeting were the acting Principal Nursing Officer, the ward Nursing Officer, the two ward charge nurses, the S.E.N. and another student and myself. I was asked what my problems were and I repeated the criticisms I had made the day before. At each point I was interrupted by different members of staff who had formed a united front to combat my criticisms and deny the truth of what I said, to rebuke me for not understanding the 'true' situation, for not realising 'the sort of patients we are dealing with', and for not having the necessary experience, etc.
When I walked out of that meeting I knew beyond doubt that the whole bunch of them were crooked and that corruption started at the top.

35. This was a psycho-geriatric ward of about sixty beds. There were not the proper facilities for nursing geriatric patients. The ward was grossly overcrowded and understaffed and basic nursing only as possible. By this I mean dressing, washing, shaving, feeding and bathing. Everything had to be done hurriedly and superficially. Looking back on it now I think that those poor old men must have thought they were in hell. About half a dozen bottles of beer came up every day for the patients and the staff used to drink these. Clothing was disgraceful. Nothing fitted anyone and there was never enough of anything. Meal times were pandemonium: imagine sixty old people at a meal, most of them confused, disorientated, twenty of whom had to be fed, with only a handful of staff and a limited time to get it done in.

The regular night nurse on this ward had a reputation for being cruel and callous to the patients.

36. On one long-stay ward the regular S.E.N. was a vindictive woman who by virtue of her ignorant presumptuousness and harsh attitude to patients contrived herself into a position of power and influence on the ward. It amazed me that such a person could he employed as a nurse in a psychiatric hospital.

(i) her knowledge of even basic nursing skills was negligible. She was incompetent in handling medication.
She once gave a nursing assistant a tablet of Digoxin to give to a patient without telling him to take the patient's pulse before deciding to give the tablet. When the nursing assistant queried this she was vague and seemed not to realize the implications of giving this tablet.

She regularly overdosed a certain patient with Largactil and encouraged other nursing staff to do so.

She failed to ensure that all patients received their medication and gave and instructed the giving of injections in the wrong manner (certain patients avoided being given injections by her, preferring to be given injections by nurses on the other shift).
As a result of her incorrect bandaging of the ulcerated leg, of a patient his leg condition deteriorated and yet she complained to the Administration that there was no nursing care on the ward, the younger nurses being more interested in taking patients out.

(ii) She subjugated staff and patients on the ward. She was generally disliked by most of the patients and remained aloof from them.
She frequently shouted at patients and on one occasion when she had laryngitis whispered “This is awful - I can't shout”.
At the drop of a hat she would threaten a patient with getting him prescribed extra medication if he displeased her, as for example when a patient asked for orange squash one meal time.

She conveyed her dislike of an informal patient in conversation with him and removed his clothes so that he could not leave the ward - which he was quite entitled to do.
She considerably upset a patient by telling him that he was “a dirty old man”.
She made irresponsible and fictitious remarks at ward meetings and when writing the ward report often exaggerated patients' behaviour and misrepresented the situation.

When left in charge of the ward she would not distribute the full cigarette allowance, she would lock the ward early, and often locked some patients in their rooms early to avoid the responsibility of them being in the day room.

(iii) She was generally unconcerned that patients received the allocated amount of food.
She persistently undercut patients' rations of jam, marmalade, tea and sugar despite her attention being drawn to the laid down allowances. She was always miserly and grudging with patients' food, cigarettes, etc. She siphoned off sugar and tea into her personal locker to give the impression that the ward was short of supplies to encourage nurses to undercut patients' allowances and kept pay sheets in her locker to block attempts by progressive staff to re-allocate patients' money.

She put patients' food aside for staff before serving patients.
She attempted to prevent the distribution of beer on a Saturday evening to all the patients on this ward and refused a patient a bottle of beer telling him that he was only a boy. This patient was twenty-eight.

(iv) This woman always opted for the soft work options and had her own little jobs such as tidying the staff room which she did instead of working with the patients. She interfered with all grades of nursing staff including ward charge nurse and was generally non-cooperative and a parasite on other people's work efforts. Many staff admitted to problems when working with her. She was incapable of teaching student nurses and quite unsuitable for this function and yet was permitted to do this. She did things in her own truculent way, even if it disrupted the patients' lives. She offered a nursing assistant on the ward a brand new jacket from ward stock, saying You might as well have it if you want it as these won't appreciate it'.

37. This ward was described to me by the charge nurse as the refractory ward. It was a locked ward at the time I was there. It was my first ward as a student. On my first day a patient refused to be shaved in the bathroom. Nobody could persuade him to take a shave and the staff seemed to behave as though it was essential. Eventually the charge nurse said something to the effect of “on him”, and the patient was restrained and shaved. All this first thing in the morning surrounded by the other patients.

The next incident involved a young schizophrenic patient who left the table at dinner time before the others and lit a cigarette. The charge nurse shouted at him - he objected to the cigarette. The patient walked out to the toilets - the charge nurse followed and I followed behind to see what might transpire, for the charge nurse seemed angry. The charge nurse grabbed him from behind on the back of the collar and flung him to the ground. I asked what was happening, and the incident ended. I was not at all happy with what was going on in the ward and complained to the charge nurse, accusing him of bullying the patients among other things.

He assured me that he had great affection for them and called the patients into the office, one by one, asking them whether they liked him and whether he was cruel to them, etc. Of course they answered as he wished and he couldn't see the contradiction. He arranged for the ward psychiatrist to talk to me on two occasions. The psychiatrist backed up the charge nurse and derided me.

On this ward there was an oppressive environment. There was no therapy carried out and there were no activities planned. The charge nurse just liked to get the patients out for a walk. To whatever one suggested, the reply would be that it had already been tried and hadn't worked.

All patients had to go to bed at 8.30 p.m. ready for the arrival of the night nurse at 9 p.m. The reason for this was that the dormitory was on the floor above the ward and they all had to be locked in for the night nurse.

38. During change-over meetings there was little or no actual information or discussion re patients. I felt somewhat handicapped by not knowing patients' diagnosis, background or medication. Quite often the ward charge nurse would make derogatory comments about patients either during the change-over or to their face, e.g. you dumbo, I'm sure you're being awkward deliberately'.

The adjective 'dumbo' was used often and patients were sometimes visibly upset by this. The ward charge nurse seemed to particularly dislike the more demented and incontinent patients or those who were regarded as 'awkward'.

39. The ward was characterised by an air of stagnation, the staff by indifference and apathy. No efforts at change and improvement have been made by them: a rigid routine and tea-breaks prevail and predominate. Doctors only visited the ward when called upon specifically to see a particular patient.

40. The hospital hair cutter gave many patients who were incapable of complaining or indifferent, ludicrous haircuts, basin type style. He used to refer to his work as sheep-shearing. With such a haircut, a patient would be instantly recognisable as an inmate of an institution. It gave them the appearance of convicts.

I made a complaint to the nursing administration about this disgraceful conduct and was informed by the then acting Principal Nursing Officer that there as nothing he could do about it as the hair cutter did not come under his control. And so the practice continued.

41. A young man who was sub-normal had been a patient in the hospital since the age of 15. He had grown up in the hospital in an all male environment, and often a very disturbed male environment, having been placed on a long stay male ward in his youth. he has a certain innocence about him and spends most of his time in the ward. He left the ward several times and went to the medical secretaries offices, probably out of curiosity, and just stared at the girls. As a result of this the following 'treatment' was recommended,

(i) Return and confinement to the ward in a dressing gown and pyjamas ----- recommended by the nursing administration.
(ii) If he continued to behave in this way he should be confined to the ward or so heavily medicated that he did not behave in this manner ----- recommended by the doctor.

NO-ONE in authority showed initiative and recommended trying to educate this young man that women should be approached in a polite way or suggested attempting to get him to socialise with women in a reasonable manner. What sort of behaviour would one expect from a sub-normal patient who has grown up on a disturbed male ward? It was left to individual nurses to try and persuade the ward doctor that something positive in the way of education should be done for this young man.

42. When the time came to put some old men to bed on a psycho-geriatric ward, the charge nurse said 'Oh well, time to get these men into their wanking pits'. I was sickened and disgusted.

43. I worked on a male psycho-geriatric ward in the hospital. It was overcrowded and had a heavy work load. Often there was a shortage of staff on this ward so one could offer only a bare routine to the old men.. getting them up, feeding, toileting, changing, medicating and putting them back to bed. The shortage of staff on this ward made everything a rush so patients suffered the indignities of rushed feeding, hurried toileting, etc.

No bed curtains in the dormitory allowed no privacy when patients were undressed and put to bed. It was pitiful to come on at 7 in the morning and see 48 old men peering at you from the serried rows of beds. People humiliated because they were old. As a patient of eighty-three years of age remarked to me “when those old boys wake up each morning and look around them, they must wonder what they fought in two world wars for”.

The bathroom contained two baths without any screens dividing them and often 4 or 5 old men would be in this room at once in various stages of bathing. At times there was a lack of pyjama jackets, vests, ties, socks, patients sometimes having to go to bed in vests alone or naked. The double incontinence of some patients was a known problem, but one still found oneself changing patients who had been incontinent and being obliged to put their urine soaked or faeces stained slippers back on as there were insufficient replacement slippers.

What sort of a 'health service' is this that can allow such indignities? Pillows were always in short supply and if they became urine-soaked were dried out on the radiator before reuse. On another ward I queried what to do with urine-soaked pillows and was told by the charge nurse that they were dried on the radiator. There were not proper facilities on the ward for doing sterile dressings. The ward was drab and impersonal. It was the end of the road for most of these old men and yet they had to tolerate this.

44. This unit (The Industrial Unit) as just not functioning properly. There was no assessment of patients capabilities or suitabilities. There was no review of patients' progress. The system encouraged institutionalisation.
Patients came and did simple, repetitive jobs endlessly for pittances. The pay was from 3/- to £l a week. Pay increases given to good workers were pathetic and insulting, i.e. 2/- a week. Pay was not related to effort or to quality / quantity of work. The pay sheets were kept closely guarded by the charge nurse and we were not allowed to see them. The charge nurse used his privilege in either increasing or cutting pay as a power over the patients.

There were no staff meetings to discuss patients' conditions, requirements, improvement, and suitability for work.

45. There were different methods of treatment on the different shifts. For example, one shift used the aseptic technique with dressings, the other didn't. There was no delegation of duties on my shift. No responsibility was given to students. There was no discussion with the ward doctor. Nursing equipment was kept in the office and when the ward medical officer was in there with the charge nurse we were not allowed to get the equipment, so holding up treatment. The work was routine, caring for the physical side. The psychiatric side was ignored. There was no therapy on the ward.
I spent two months on night duty here.
The regular night nurses rushed everybody to bed as soon as they came on duty. No matter what anyone was doing, as soon as the day staff had gone the television went off and all patients were hurried off to bed. For the rest of the night they did as little as possible. One incontinent round was done. If patients got out of bed in the night they were hustled back.

46. Patients' meals were often sub-standard, cold and delivered late. Once the patients' lunch was delivered thirty minutes late because the Hospital Management Committee wanted their lunch at mid-day. The meals that have been previously prepared for official luncheons have been of such a high standard of cuisine that patients have suffered by being given second best. The patients' Utility Fund has been misused. Money for ward outings has been refused while it has been spent on questionable means.

47. A section 60 patient had, for a long time been making a list of complaints about his medication and treatments and yet he had not been seen by his consultant psychiatrist for over six months. Another section 60 patient, on another ward, was kept in ‘dressing gown order' for <u>eighteen months</u>, despite frequent requests by many nurses to give him the self respect of dressing properly.

48. As far as ward management was concerned the priority was staff. Wards were managed and run mainly for the benefit of staff, with ward routine and tradition suiting the staff. There was never any discussion regarding whether it was suitable for the patients.There was an unspoken rule that staff should have an easy time. Patients had to conform and not disturb the routine. <u>In my experience the patient always came last</u>.

49. The wards are decorated in a dull and shabby way. Patients clothes are shoddy and institutional. A recent consignment of patients' nightclothes were not fireproofed, when the shortage of staff means that only custodial care is administered and many nurses do not have pass keys, one shudders to think what would be the outcome if a major fire were to strike a ward.

50. On admission wards treatment largely consisted of drugs and deprivation. If you deprive a man of his dignity, liberty, his status, his individualism, his contacts, etc. you have reduced him to almost nothing. If, on top of this you medicate him, (i.e. tranquillisers) - then you are really in total control.

51. One consultant, responsible for twenty-four patients on a long-stay yard, neglected his duty to these patients in a deplorable way. He rarely saw any of these patients and repeatedly declined requests by nursing staff to discuss his patients' conditions and treatment. Consequently, these patients were deprived of appropriate treatment.

52. Very little occupational therapy is undertaken on the wards, the industrial therapy unit is more concerned with making money and putting on a good front than in rehabilitating patients and keeping them occupied in a worthwhile way.

53. Drugs were given almost automatically to new admissions. They were often given excessively without proper control and not reviewed. Drugs were also prescribed by a doctor on the word of the ward charge nurse alone - without the doctor even seeing the patient.

54. Entries in patients' case notes made by psychiatrists were generally superficial, unsubstantial and unrevealing. They were often also mere repetition of what had been written before.

55. On no wards in my experience were patients encouraged to clean their teeth and this aspect of personal hygiene was not considered to be a nursing duty. As a consequence of this, on long-stay wards ninety-nine per cent of the patients never cleaned their teeth.

56. Ward medical staff spend very little time on the long-stay wards, seeing perhaps only the dangerously ill patients briefly. It is my opinion that many patients on long-stay wards could be discharged. If the medical staff have their reasons for not doing so then it would seem reasonable to discuss this at ward meetings.

57. E.C.T. (electroconvulsive therapy) was sometimes used as a punitive measure - although it was not openly admitted. I have heard the term ‘punitive E.C.T.' used in the hospital in reference to “that is what a patient needs”. Some psychiatrists had a certain faith in E.C.T. and at times patients were threatened with it.

58. In my experience there was practically no training given to nurses on wards. The great discrepancy between what was taught in the school of nursing and what went on in the wards was notorious. On a ward one was a worker, an attendant, one who kept the routine going. One was not there to learn or train.

59. The overcrowding in wards is well known, but what this means in human terms is that patients are forced to live in extremely difficult conditions, conditions which foster disharmony, and antipathy towards their fellows. It also means that the standards of services and care to which they are entitled are reduced to what at times approaches a bare minimum. These factors create a situation seriously detrimental to the lives of patients.

60. On one ward some patients had not had entries in their case notes for two and a half years, and these entries were only for physical check-ups.

61. On a psychogeriatric ward a blind patient was often teased and slapped around the back of the head by one nurse in particular. This would disturb the patient and cause him to shout out at random, since he did not know who had hit him or where the next blow would come from.The old man's helpless anger amused the nurse. The patient's behaviour (in reaction to such wicked treatment) was described in his case notes as 'paranoid'.

62. On one female geriatric ward the S.E.Ns used to take home the patients' fruit and other items. 'They fill up their bags before they go home'. Also they ate the patients' weekly cheese ration for their breaks, having welsh rarebit.

63. There were many reports and comments from both patients and staff about one ward where brutal incidents occurred. Patients were commonly hit and slapped. One was hit in the testicles with a broomstick. Another told me that when he was on the ward the regular S.E.N. used to 'take it out on me' He said that if the man didn't like you he would have it in for you, and that while there both he and another patient were often hit.

64. On a male geriatric ward the regular night nurse used to hit patients if they got out of bed in the night or if they urinated on the floor. Old men were punched in the stomach, pushed onto beds and kicked.

65. On a long-stay ward a patient got out of bed in the night and went into the day room wanting to make a cup of tea. The night nurse set about him, punched him and chased him back to bed.

66. A patient on this ward flinched or ducked if anyone approached him directly, as if he anticipated a punch or slap. Some nurses who had worked there said that troublesome patients were taken out the back to the toilets for a 'talking to'.

67. A woman was admitted to the hospital and diagnosed as an hysteric. She complained of a pain in her back. E.C.T. was ordered for her. She was unwilling to have this and she was carried struggling by several nurses and porters to the ward for E.C.T. Following administration of E.C.T. she continued to complain of pain in her back. This was investigated and she was found to have a broken back sustained prior to admission by falling down the stairs at home. This woman had been given E.C.T. while her back was broken. She was subsequently transferred to Kent & Canterbury Hospital.

68. A patient, visiting the ward of his female friend, was thrown out of the door by a nurse. He hit the small of his back on the window frame across the corridor. The nurse remarked 'I hope that hurt you'.

69. A young, female patient became disturbed and upset whilst in the Occupational Therapy Department. Despite being talked to and accepting help from a young male nurse, a doctor in an adjoining room was called out of a meting. Because he seemed irritated at being disturbed he summoned the sister of the patient's ward to come to the Occupational Therapy Department with an injection for her. Meanwhile the patient became quieter and less upset. Upon arrival at the Occupational Therapy Department the sister was seen to be angry and agitated at being called away from her ward, 'leaving all the others' and especially getting her shoes very muddy. She had an injection with her and shouted loudly 'Show me where she is', over and over again.
She was shown into the office to divert her from the patient but still insisted that she must give the injection even though she was told that the patient was now quiet. 'I'm not having a wasted journey, getting my shoes muddy just for that bitch…'. Eventually the sister was persuaded to have a cup of coffee to calm her down and to leave without giving the injection. She had been intending to give the injection there and then in front of the other patients.

70. On one long-stay ward, two members of staff were concerned with another member of the ward nursing staff who had repeatedly abused and humiliated patients and was renowned for her continual mistreatment of patients. Feeling that something should be done about the situation, the two staff requested to see a senior member of the nursing administration and informed this person of their concern, giving details of the mistreatment and malpractice perpetrated by this nurse.

The two nurses registering their complaint were told "I know about Mrs. .. We have a Mrs. .. on other wards in this hospital. The two nurses were told that the nursing administration could do nothing about this woman as she would use the Union to defend herself. The nurses emphasised that it was not on to allow, a nurse to carry on in such a way.They were told by the nursing administration that the only thing possible was for them to make life so unbearable on the ward for this nurse, that she resigned. The two nurses pointed out that this recommendation was unreasonable as any such friction between staff would rub off onto the patients. This nurse continued to work on this ward and to continue with her unkindness and incompetence after this complaint had been made.

Even before this formal complaint was registered this nurse was notorious throughout the hospital for her total ineptitude and her hard-boiled vindictive manner.

The incidents described in the previous pages were witnessed by a handful of people. Other members of the staff have witnessed similar things too. Whether they are prepared to openly admit to this is another matter. We do not pretend to know the full extent of the corruption and shortcomings of the hospital, for what we have experienced can only be a fragment of the total picture. However, this fragment is appalling enough in itself and it is only the tip of the iceberg.

These illustrations clearly depict that:

1. The hospital is not what the authorities present it as being.
   It is not a progressive hospital which practises therapeutic concepts in the care and treatment of patients.
   It is a festering institution containing a profusion of shameful and deleterious practices.

2. The hospital does not fulfil its obligations to the community. It does not offer the service which it is obliged by statute to offer.

   It does not care for patients in a humane way, nor does it offer the kind of treatment that patients have a right to expect.

3. The hospital presents a reassuring facade to the public that it is capable of providing a competent service for the mentally ill.

   In fact it has neither the resources nor the right quality staff; neither the proper attitude nor the right aims.

   It is neither competent nor capable of fulfilling its brief.

4. The hospital denies patients basic human rights', decency and respect.

5. Patients suffer indignities which are accepted by the hospital.

   Patients are humiliated by the hospital, which hands out platitudes to try to excuse the inexcusable, to accept the unacceptable.

We indict the hospital Management and the Medical and Administrative Bodies for:

1. The abrogation of their responsibilities in allowing a defective situation to prevail wherein the incidents cited in this document can occur.

2. Failing to provide the kind of service which they are obliged to provide.

3. Failing to set proper standards of performance and failing to control and monitor such performances.

4. Deceiving the general public into a false sense of assurance and complacency by misrepresenting and denying the true situation.

5. Creating a climate in the hospital which discourages open, free discussion, and discourages patients and staff from publicly making criticisms and complaints.

6. The untold suffering, misery and degradation caused to fellow human beings within the hospital under the guise of psychiatric treatment.

Quotes from patients in St. Augustine's Hospital

"They told me I would be here for two weeks. That was forty years ago"
Patient on geriatric ward

"It's not fair it isn't, move that madhouse at Chartham"
Bill Danton

"When I peg out, and I'm in my box I'll be waking up and dreaming about this place for a month afterwards"
Henry Fuller (aged 83)

"If you can't treat me with kindness, don't treat me at all"
Brian Marshall

"Got any bacca? Got a farthing? Bollocks!"
Bill Danton

"They told me I had come here to recover. All I have done since is discover"
Henry Fuller

"I was alright till I came in here"
Long-stay patient

"I wish to be repatriated to Canterbury so that I can be a joy to my mother and I will be self-contented then"
Selwyn Burton

"I tell you one thing pop, we certainly landed in the shit when they brought us in here"
Pincher Martin talking to Harold Link (aged 82)

"If I had known I was coming here I'd have got one of those Prussian guards to stick a bloody bayonet through me"
Patient aged 83

"I tell you, the longer they're in here the worse they get"
Patient on long-stay ward

"That's the trouble, no-one complains. They'll swallow any bloody thing in here"
Patient in the hospital for over 30 years

"Drop a big bomb on Chartham Hospital"

"Give them men a chance"

Bill Danton

APPENDIX 4

COMMITTEE OF ENQUIRY

ST. AUGUSTINE'S HOSPITAL

STATEMENT OF CHAIRMAN – MR. J. HAMPDEN INSKIP QC

The Committee has become increasingly aware, both through visits to wards and from evidence given before us, of a desire for changes in or modifications to the method of taking and implementing decisions in the hospital. We are more likely to arrive at the correct solution if as many organisations, groups and individuals as possible let us know their views as to what changes are necessary. We, therefore, have drafted three short questions:

1. How and by whom should the policy of each ward be decided, and what matters should be included?

2. Is there need for a monitoring and corrective body in the hospital responsible for looking at problem areas and problem wards? If so, could this be a multi-professional body responsible for coordinating the work of the hospital?

3. Have the answers been agreed between the professions? (Not appropriate for answers by individuals or some groups, e.g. students.)

We ask that doctors, administrative staff, heads of departments and COHSE and NUPE and the Royal College of Nursing representatives should consider these questions and give us their answers if possible by the time we return in November. Agreement between all groups is, of course, highly desirable. We also welcome contributions from any other groups, formal or informal, for example wards, students and, just as important, from individuals. Contributions, however short, should be sent to the Secretary of this Panel or direct to myself as the Chairman. We are asking for a copy of this statement with a copy of the questions to be sent to all wards and offices, and if any further guidance is required we will very gladly give it.

Secretary to the Panel:
Mr. G.A. Ferguson
c/o South East Thames
Regional Health Authority
Randolph House
46-48 Wellesley Road
Croydon CR9 3QA

Chairman
Mr. J. Hampden Inskip Q.C.
3 Pump Court
London E C 4

Distribution: All Legal Representatives, Health Authorities and throughout the Hospital (to include all Consultants and other Medical staff, the Sector Administrator, Divisional Nursing Officer, Heads of Departments, all Wards and Noticeboards)

18th September, 1975

Patient EV

This patient was admitted to St. Augustine's in January, 1974 when he was 62 years old. He died on February 14th, 1975 and the second part of the Critique is dedicated to his memory. The manner of his admission to the hospital and his management thereafter, further illustrate the need for a true multi-disciplinary approach, and the problems that can arise when this does not occur.

Towards the end of 1973 Dr. W very much wanted to arrange for patient GT to be transferred from Heather Ward to Broadmoor Hospital. Unfortunately Broadmoor would only agree to accept GT if Dr. W would agree to accept patient EV in return. This kind of exchange between the special hospitals and the General psychiatric hospitals seems quite wrong in principle.

Patient EV had a long history of mental illness since 1950. He had been admitted to St. Augustine's in 1954 and 1955, following threats of stabbing and of attacking his general practitioner with a knife and a red hot poker. He was then diagnosed as suffering from paranoia, and was described as feeling very persecuted and preparing legal action against various people. He was twice discharged into the care of his wife, but in July 1955 he was convicted of murder. Following a reprieve he served ten years in prison before being transferred in October, 1965, to Broadmoor where he was diagnosed as suffering from paranoid schizophrenia and brain damage with epilepsy.

Efforts by Broadmoor to persuade Dr. Q, the Consultant in whose care EV had been in 1954 and 1955, to accept him at St. Augustine's failed. He was therefore transferred to Hellingly Hospital in July, 1969, where he remained until he was conditionally discharged in November, 1970. He was readmitted to Broadmoor in January, 1971, following a quarrel involving a knife.

In the summer of 1973 the Department of Health asked the Senior Administrative Medical Officer of the South East Metropolitan Regional Hospital Board if a vacancy for EV could be found in a hospital in the region. Hellingly was approached, but declined. The letter sent to the Board by a Consultant from that hospital in July, 1973, only came to light after we had concluded the hearing of oral evidence. We quote from it, however, because in our view it contains an excellent summary of the case.

"We do not feel that Hellingly can really offer this patient anything at all, and we are doubtful if in fact a psychiatric hospital is either appropriate or necessary. It must be appreciated that very considerable efforts were made to rehabilitate this patient. Those efforts in fact failed and we can see no way of ensuring that they would not fail again – in fact we feel confident that they would. This would be damaging to both the patient and to the hospital." After suggesting that if he is to leave Broadmoor a hostel under Broadmoor's direct supervision might be appropriate, the letter continues "Transfer to a peripheral hospital seems to us to offer no solution in any direction apart from giving Broadmoor a vacancy. Dr. MO clearly states that he thinks this man is deteriorating so we would not presumably be accepting him with a view to rehabilitation. We know and everybody else knows, that he is extremely manipulative, that he has ample experience of psychiatric hospitals where staffing is difficult and at times precarious, and that he is an ideal manipulator, particularly of comparatively inexperienced staff... We must stress that a person like this has been shown to be inappropriately placed in the conventional type hospital, he does not fit into and is not appropriately

classified as requiring acute admission ward care, he himself does not regard himself as a chronic patient and does not identify with long stay patients in long stay wards, and in any case expectations of and for him are utterly different. This means he is very much on his own in every sort of way."

The decision to admit Mr. EV to St. Augustine's was that of Dr. W alone. It was not discussed at either the Medical Executive Committee or the Area 2 Divisional meeting. If, as Dr. W told us There were some informal discussions with Nursing Officers, we are satisfied that the matter was not gone into in any detail. He discussed the matter with Dr. Q, who had already refused to accept him, and who told him that EV was a most disreputable character. Dr. W's predicament was that he felt he had to get Mr. GT to Broadmoor. He had assaulted two members of the staff quite seriously and was, in the opinion of Dr. W, a potential murderer. Dr. MO at Broadmoor would not accept him except as a swap for Mr. EV. Dr. W discussed the position with Dr. MO and the Nursing staff at Broadmoor and decided to accept him, even though he had no suitable ward for him, and he knew the swap to be hazardous.

Dr. W would never have contemplated accepting Mr. EV if he had not wanted to get rid of Mr. GT. In our view swaps of this kind are wrong in principle and should never be the responsibility of the Consultant alone. The risks are great and the repercussions on other patients and staff may be considerable. There should have been formal discussions involving all the disciplines, and the decision should have been taken in this case by the Hospital Management Committee. In future such decisions should be taken by the Hospital Management Team (see Section 6).

Dr. X, the Divisional Chairman, and now Chairman of the Medical Executive Committee, told us, and we accept, that he was not consulted about the swap. His view was that it was not a matter for decision by the Division. "This is the responsibility of the Consultant concerned, and I would not wish to interfere, and could not interfere, in his clinical work." With that view we disagree profoundly, and after some further questioning Dr. X modified his view to the extent of accepting that there should have been consultation with the other Consultants and nursing staff.

By accepting Mr. EV, Dr. W said "I committed myself to his rehabilitation." We are very doubtful if he thought out what rehabilitation he could provide. A realistic assessment was probably that all that could be done was to say to NT. EV "Keep yourself out of trouble for the next 12 months, and we will try to get you some work outside the hospital." Rehabilitation in any other sense was not viable bearing in mind past attempts and the unsuitability of the wards. If this was Dr. W's intention the position needed to be explained clearly to the staff so that they understood the difficulties and the strictly limited objective. We are satisfied that no clear guidance was in fact given.

After a few days in an admission ward Mr. EV was transferred to Heather, which with its mix of patients, overcrowding and understaffing, already had more than enough problems. Staff understood from Dr. W that Mr. EV had come there "for rehabilitation". From the start they and the Ward Medical Officer made it plain to Dr. W that they regarded the ward as unsuitable. Mr. EV told Mr. AZ that "they promised him that he would be rehabilitated and leave the hospital within a year".

Although Mr. EV was given a single room, he started complaining almost immediately at being in Heather. The Ward Medical Officer, who had already expressed to Dr. W her view that the ward was unsuitable, recorded in the case notes on February 22nd, 1974, "He feels that he should be with people who are less disturbed and with people he can communicate with". In spite of this, his

behaviour was acceptable to begin with. He bought clothes and sold them to the patients, he took an active part in patients meetings, and formed an Increasingly close link with Dr. Ankers who proved a ready victim for his powers of manipulation.

Although he was offered work in the Industrial Therapy Unit and the hospital kitchen, he chose to work in the ward kitchen. In time his behaviour started to deteriorate, his complaints became more vociferous and he commenced to return from outings the worse for drink. Dr. Ankers attributed this to the lack of a rehabilitation programme and an unsuitable environment. A student nurse also told us that there did not seem to be any useful policy for treating Mr. EV, and that he was left alone by most of the staff. Dr. Ankers became more and more emotionally involved on behalf of a man who he felt had already paid his debt to society. He received no counselling from anyone to help him. Mr. AZ warned him that he must not forget that he was a murderer, but this we feel only increased Dr. Ankers' conviction that Mr. EV, was being discarded because of his past, and that nobody really cared.

Mr. EV needed help in letter writing. On June 8th Mr. V asked Dr. Ankers to help him write a letter to his Member of Parliament. At. Mr. EV's dictation Dr. Ankers wrote a letter in which he complained of the unsuitability of the ward, and made serious allegations about members of the staff, including Mrs. Z. Mr. EV handed this letter to Miss BY a week later and an investigation followed in which it was decided that the allegations were unfounded. Shortly afterwards Mrs. Z was moved for her own safety, and Mr. V and Dr. Ankers were shifted to other wards. The letter was eventually handed back to Mr. EV, who did not despatch it to his M.P.

In December Mr. EV attacked another patient and threatened a student nurse with a knife. Application was therefore made to return him to Broadmoor. Dr. Ankers had continued to see a lot of Mr. EV, and on January 12th he and Mr. Weston, who had both resigned from the hospital staff by this time, wrote to the Canterbury and Thanet Health District, the Kent Area Health Authority, the Regional Health Authority, the Community Health Council for the District, the Home Office, Dr. MO and the Health Service Commissioner for England, saying that Mr. EV had been sent to the hospital for rehabilitation, but that he had been placed on an unsuitable ward, and that there had been no treatment programme and no rehabilitation. They summarised their letter thus "We are writing this letter because Mr. [EV] has been denied what he came to St. Augustine's for. Instead he has been offered nothing but custodial care."

The District Management Team obtained reports from Dr. W and the Chief Nursing Officer which they sent to the Area Health Authority whose Administrator replied to the District Administrator "I should guess that Etsello (Weston) and Ankers, while perhaps having to accept the medical evidence in the Consultant's reports, may nevertheless say that the hospital offered no rehabilitation to him on Heather Ward, and that care was custodial with the minimum of treatment. In other words I am not at all sure that the reports answer the points they made in their letter of January 12th, 1975. Have you any views on this yourself?" No reply was received, but the District Management Team sent a message for all staff at the hospital: "The Team did not accept there was any foundation in the allegations contained in the letter [of January 12th] which contained a large number of inaccuracies and uninformed observation."

In his report the Chief Nursing Officer described how Mr. EV had appeared to enjoy organising and participating in ward activities. He continued: "He, however, became associated with Nursing Assistant Mr. Ankers and for a short while with Staff Nurse Mr. Etsello (Weston), both of whom were critical and, indeed, at times hostile towards any form of authority (I understand both

belong to an organisation which does not accept any form of authority) Both of these nurses were apparently not prepared to accept any other opinion than their own as regards treatment prescribed for patients. I think it is fair to say that any disharmony that existed in that ward emanated from the attitude of these two staff members."

It will be apparent from what we have already said how misleading this statement was. Mr. Weston had left the hospital in April, 1974, and it is worth contrasting what the Chief Nursing Officer said in January, 1975, with a reference he had given on him in confidence in June, 1974, to the Senior Nursing Officer (Education) of the Tynemouth School of Nursing. "Mr. Etsello is an intelligent but rather solitary young man with a highly developed social conscience. During the course of his training his ward reports were above average and since completing his training he has worked as a Staff Nurse on a long stay ward where he displayed an interest in the patients' welfare, coupled with a flair for organisation. His health record and time keeping were reasonable and I think he is motivated by a genuine desire for improvement and would recommend him for further training."

One of those documents is thoroughly misleading. That of January, 1975 not only contributed to the District Management Team's rejection of the allegations in Dr. Ankers' and Mr. Weston's letter of January 12th; 1975 but was also the cause of the Regional Medical Officer, who had no first hand knowledge, writing of Mr. EV on February 12th, 1975, "In my view this patient has probably suffered as a result of the influence and contact with Mr. Ankers and Mr. Etsello."

On February 12th, Mr. EV was informed that he would be transferred to Wormwood Scrubs on February 14th. He received 48 hours warning because he had a considerable amount of property which would require packing. On the afternoon of February 13th he saw Dr. W, who formed the opinion that he had been drinking. Dr. W did not say anything to the nursing staff about this, or suggest any modification of his medication.

That evening Mr. EV was visited by Dr. Ankers, who observed that he was pouring a strong mixture of whisky, gin and orange from bottles in his room. He had seen him drinking earlier that day and knew that it was dangerous for him to mix excessive drink with his medication. Mr. EV spoke of committing suicide if things did not work out. Dr. Ankers did not ask the staff if it was wise for Mr. EV to drink more, and he did not report the presence of the alcohol because "I did not want Alex to think that I would report him. Alex was a friend of mine, and I tried to offer him respect within that friendship, and to trust his own judgement."

Dr. Ankers and some friends who had accompanied him left the hospital about 11.15 and warned the nurse on night duty to keep an eye on Mr. EV as they were afraid he might do something to himself, by which the nurse understood they were afraid he might commit suicide. In the early hours of the morning Mr. EV was found dead by his bed. Dr. W in a report prepared for the Inquest said "I assume that he probably killed himself but I do not know."

The post mortem revealed that he had had more than his normal dose of Amylobarbitone and that death was caused by anoxia due to epilepsy and alcohol ingestion. The Coroner's jury returned a verdict of death by natural causes, and added that they did not wish to add a rider as they understood that an enquiry was to be held at the hospital. It is unnecessary for us to question that verdict. It may be that Mr. EV was taking a deliberate risk in the hope of drawing attention to the injustices which he was convinced that he had suffered at the hospital.

Although Dr. W visited the ward about once a fortnight for brief visits, he did not ensure that staff understood what he was trying to achieve with Mr. EV or why. If he had done so we feel that Dr. Ankers might not have got so emotionally involved, but even so Dr. Ankers was at fault in not drawing to the attention of the night nurse Mr. EV's heavy drinking on February 13th, and the presence of the partly consumed half bottles of gin and whisky.

This brings us to the question of hospital policy, or lack of policy, on the consumption of alcohol by patients. In view of his medication it was dangerous for Mr. EV to have more than a double measure of spirits. Dr. W claimed to have told the ward staff that he was not to have any alcohol, other than an occasional light ale on the ward. If this be so, it is hard to understand why he said nothing to the ward staff on February 13th when he suspected Mr. EV had been drinking. He said he relied on word of month for this information to reach all staff, including night staff. He made no entry in the case notes about alcohol because "I have the basic assumption that every patient in the hospital is not allowed to drink spirits, alcohol, so I do not in a sense feel that it needs to be highlighted in each patient's notes". Dr. W modified this and said that he thought that he had been told when coming to the Hospital in November, 1972, that it had been laid down that if a patient was found drunk, the fact should be reported to the doctor.

Examination of the minutes of the Medical Staff Committee in 1972 revealed that the question of drink by patients had been considered at the request of the Chief Nursing Officer. The Medical Staff Committee had replied that patient 'under the influence of drink or drugs' should be reported to the Nurse in Charge and Medical Officer. There was no suggestion that patients should not drink any spirits, although a reminder was issued "of the advisability of warning patients of the possible dangers of combining alcohol with any drugs they are taking. Each individual Consultant will determine his policy towards any individual case."

Although we accept that Dr. W told Mr. Elf that he should not drink any spirits, we do not think that this was sufficiently conveyed to all nursing staff This was the joint responsibility of Dr. W and the Charge Nurses.

In August of 1975 the Medical Executive Committee further considered the question of drink. They stated "There is no objection in principle to patients drinking alcohol socially and in moderation. Indeed this may sometimes be therapeutic. Patients are warned not to mix alcohol with certain drugs, and with one group of drugs in particular they are told (in writing) that alcohol is expressly forbidden."

We consider that there should be a clearly laid down procedure for ensuring that all ward staff are informed of the names of the patients who have been warned not to mix drink with their drugs, and what steps they should take if a patient disregards this advice.