020 7702 5331 - **PRESS RELEASE – embargoed until 11.30 on 3 September 2009**

STATEMENT ON BEHALF OF THE FAMILY OF RICHARD GRAHAM LOUDWELL ON THE RELEASE OF THE REPORT CONCERNING HIS CARE AND TREATMENT IN BROADMOOR HOSPITAL

The report of an independent inquiry commissioned in 2005 by Strategic Health Authority NHS London, published today, concludes that individual and systemic failings led to the homicide in April 2004 of Richard Loudwell by Peter Bryan on the male admissions ward (Luton Ward) at Broadmoor Hospital.

The inquiry found deficiencies in many aspects of the care provided to both Richard Loudwell and Peter Bryan and shortcomings at every level within the Trust.

Richard was a vulnerable detained patient who died at the hands of a highly dangerous and mentally disordered fellow patient. An accumulation of individual and managerial failings left these two patients unsupervised on the afternoon of 25 April 2004, when Peter Bryan mounted a sustained and prolonged attack on Richard that staff failed to notice or stop. Richard never regained consciousness and died on 5 June 2004.

The family's response

For the family, this report should be seen in the context of the Medway report[1], which sets how they and Richard and the public were failed before Richard was taken into custody. While in the community, Richard's family tried to get him help, but they were not listened to and were excluded from the decision making process. There were catastrophic failings in the assessment of his risk, the management of his care and a systematic failure of the agencies involved to communicate with each other. Gillingham CMHT is described as organisationally flawed and the area team disfunctional.

However, they were horrified in March 2009, when they were finally given details about what happened to Richard, by way of having extracts from this report read to them. They were truly unprepared for the shocking scale and catalogue of failings at all levels and in all disciplines of staff at Broadmoor which contributed to Richard's death.

Richard's sister says:-

> "Richard's family have never forgotten why Richard was in Broadmoor Hospital and that another family are still suffering from Richard's actions. However, Richard had complex psychiatric and medical needs and once he was taken into custody, we expected that people would be kept safe from Richard, and that he would be kept safe from others".

Richard telephoned his mother from Luton Ward and complained of bullying. In his last call on the day before he was attacked, he told his mother that he feared for his life in Broadmoor. Unfortunately that was shortly realised. Richard's sister adds:-

> "The terrible feelings that this family experienced from when we initially learned of the attack on Richard have turned to anger and cynicism due to the way that we have been treated by the Trust, the long delay in the Trust accepting or apologising for the collective failings that led to Richard's death, and the apparent persistent failure of the Trust to learn the lessons from their failure to keep Richard safe."

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[1] http://www.southeastcoast.nhs.uk/publications/documents/Independent_Inquiry_into_the_Care_and_Treatment_of_RL.pdf

Anonymity
Whilst the report of the inquiry is clearly robust, the family were not involved in the inquiry, and the ability of the inquiry report to fully account for what happened to Richard is diminished by the Strategic Health Authority deciding not to publish the report in full, against the compelling reasons provided by the inquiry panel itself as to why members of staff ***should*** be identified in the published report. The family notes that the NHS London policy that reports should usually be anonymised was only put to the Board in July 2009.

However, in due course there will be an inquest before a jury, which should remedy these shortcomings.

The inquest will be an open and transparent inquiry in which the family are entitled to be involved and to put relevant questions to witnesses. Members of staff will not be afforded anonymity. The family are looking forward to hearing members of staff account to them for how they failed Richard.

The family's solicitor, Kate Maynard, said-

> "The Trust will be represented by experienced counsel and solicitors which will be funded by the taxpayer. Individual members of staff (through their professional associations) are also likely to be expertly represented. Despite the family having no choice in finding themselves engaged in this complex legal process, which is an inquiry that the Coroner is legally obliged to perform with or without the family's participation, unless the Legal Services Commission reverses its decision to refuse to grant them funding for their own professional representation, they are left with the difficult decision whether to try and represent themselves or invest their life savings in legal costs. This state of affairs is deeply unjust. "

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Background
Peter Bryan killed ***his second victim***, Bryan Cherry, on 17 February 2004. He was initially held in HMP Pentonville, and then HMP Belmarsh, where he assaulted staff on 2 occasions and set fire to his cell. On 15 April 2004, he was admitted to Luton Ward of Broadmoor hospital.

On 25 April 2004, he fatally wounded Richard Loudwell in a sustained attack in the dining room of Luton Ward. Richard died in Frimley Park Hospital on 5 June 2004 without having regained consciousness.

On 15 March 2005, Peter Bryan was sentenced to two concurrent life sentences after pleading guilty to two counts of manslaughter by reason of diminished responsibility.

Richard Loudwell was convicted of the manslaughter of Joan Smythe by reason of diminished responsibility on 25 April 2002. He arrived at Broadmoor from HMP Belmarsh on 15 January 2004, and remained on Luton Ward until the fatal attack on 24 April 2004.

Some of the key failings (taken from the report)

1. A systemic failure to supervise patients on the ward
At the time of the attack on Richard no staff were present in the day area, and no staff could see into the dining room where the attack took place. Nine members of staff were on duty on the ward at the time. However, three were on an extended break in the staff room with the door shut, three were in the ward office with the door shut attending to administrative duties, and three were monitoring the bedroom corridor which was out of sight of the day room.

This gave Peter Bryan the opportunity to mount his sustained attack on Richard without being stopped by staff. The inquiry found that had there been a requirement for patients to be kept in sight of staff during association, it is unlikely that any assault on Richard by Peter Bryan would have been prolonged, and it is less likely that he would have received fatal injuries.

The inquiry found that general observations on the ward were conducted in breach of the Trust's policy in force at the time which was that staff should know the location of all patients.

2. A failure to protect Richard from other patients

Richard was remorselessly bullied throughout his time on Luton Ward and the inquiry found that he was not provided with the respect, care and treatment that he was entitled to. He complained about the bullying to staff and a Mental Health Act Commissioner but his complaints were ignored by staff and no changes were made to his care. The inquiry found that Richard should have been placed on continuous observations because he had been subjected to physical assaults, abuse and bullying by other patients. Instead, much of the observation of Richard was defective and half hearted. There was a culture on Luton Ward whereby active engagement with patients was not given sufficient high priority. The inquiry concluded that, if the bullying of Richard had been taken sufficiently seriously, it is unlikely that Peter Bryan would have had had the opportunity to mount a sustained attack on Richard in the dining room without being observed by staff.

3. A failure to assess and manage highly dangerous Peter Bryan

The inquiry found that Peter Bryan was known to be unpredictable and should have been regarded as highly dangerous because there was no obvious explanation for his previous killing. A pre-admission social work report of 7 April 2004 concluded that he was a grave risk to others and required a thorough risk assessment, yet after four days on Luton Ward, on 19 April, Peter Bryan was allowed to associate with other patients on general observations which meant that there was only a requirement that he should be seen by staff about every 15 minutes. The inquiry found that there was no documented reason for this downgrade in his supervision and that the decision could not be justified.

By the time of the assault on Richard, no doctor had carried out a mental state examination or risk assessment of Peter Bryan. Had a risk assessment been carried out, it is likely that Peter Bryan would have been recognised as highly dangerous and placed under the high level of observation that he required.

4. Management failure to identify failings and take remedial action

The inquiry found a conspicuous failure of management to follow up and address concerns about Luton Ward and a weakness in the structure of performance of management at all levels that may have contributed to a context which permitted the deficient performance in Luton Ward at the time of the attack on Richard Loudwell. Critical incident forms were not submitted regarding incidents on the ward, and the inquiry found complacency and a lack of vigilance of patients who were objectively high risk.

The critical incident review and serious untoward incident reviews were both insufficient as neither failed to identify the key fact that no member of staff was in the day room or dining room at the time of the assault and the incident happened without being witnessed by staff. When interviewed by the inquiry panel in June 2006, Chief Executive Simon Crawford appeared to be unable to accept that a collective failure at Broadmoor led to Richard's death.

The inquiry concluded that there was a collective failure in the organisation at virtually all levels to address legitimate concerns about the standard of service provided at ward level. These were either not communicated to management or not addressed if they were.

The Care Quality Commission report into West London Mental Health NHS Trust, published on 21 July 2009, concluded that the systems in place at Broadmoor to keep patients safe were seriously flawed, and that lessons have not been learned from previous incidents. This report focussed on the period from April 2005 (i.e. one year after Richard's homicide):

http://www.cqc.org.uk/usingcareservices/healthcare/concernsabouthealthcare/westlondonmentalhealthnhstrust.cfm