COMMITTEE OF INQUIRY
To investigate how the NHS handled allegations about the performance and conduct of William Kerr and Michael Haslam

Inquiry Chairman: Nigel Pleming,QC

Inquiry Team, 7th Floor, Hannibal House, Elephant and Castle, London, SE1 6TE

The Rt. Hon. Patricia Hewitt MP
Secretary of State for Health
Richmond House
79 Whitehall
London
SW1A 2NS

7th July 2005

Dear Secretary of State,

Report of the William Kerr and Michael Haslam Inquiry

As you will know, I was appointed in September 2002 by the then Secretary of State to Chair an Independent Investigation into how the NHS handled allegations about the performance and conduct of William Kerr and Michael Haslam. I am grateful to my panel members, Ruth Lesirge and Ros Alstead, for their advice and support.

I am pleased to submit my report under the terms of reference of the Inquiry.

Yours sincerely,

Nigel Pleming QC
Inquiry Chairman

Executive summary and Recommendations

General

1 This Inquiry begins in many ways at the end of the factual story. That end was the conviction in 2000 and 2003 respectively of two consultant psychiatrists both working during the 1970s and 1980s in the same psychiatric hospital in York, North Yorkshire. William Kerr was convicted (in his absence, on a Trial of the Facts) of one count of indecent assault, and Michael Haslam of four counts of indecent assault (a conviction of rape was quashed on appeal). The victims in all these cases were vulnerable female psychiatric patients, who had gone to their consultants for treatment, seeking help. In most if not all cases, the effect upon the women of the breach of trust that occurred has been devastating. Although Michael Haslam has been convicted and has served a prison sentence, he has consistently denied any form of wrongdoing in relation to his patients. This denial applies not only to the cases where he has been convicted, but to all allegations made against him by any former patient referred to in this Report. We have no doubt that William Kerr likewise would deny all the allegations that have been made to the Inquiry. It is of course completely regrettable that the concerns and complaints, and these denials, were not examined fully and as contemporaneously as possible. It is regrettable from the perspective of the patients, the two consultants, and from the more general users of the local health service. However, that sense of regret did not dictate or influence the Inquiry. We must deal with the situation as we find it, not as we would wish it to be.

2 At the outset we posed these central questions:

- How could it be that the voices of the patients and former patients of William Kerr and Michael Haslam were not heard?
- Why were so many opportunities to respond and investigate missed?

- How could it happen that abuse of patients, evidenced by the convictions of William Kerr and Michael Haslam, went undetected for so long?

3 In order to attempt an explanation, this Inquiry has sought to examine the events that occurred in the hospitals, clinics and GP surgeries of North Yorkshire, primarily during the 1970s and 1980s.

4 The story that has emerged is not one of a deliberate conspiracy by healthcare professionals knowingly acting to conceal sexual misdemeanours (or worse) of two of their consultant colleagues. It is mainly but not entirely a story of committed and caring doctors, nurses, psychologists and others. But, for a complex of reasons that we attempt to unravel in our Report, no matter how committed and caring they may have been, many nevertheless ignored warning bells or dismissed rumours and some chose to remain silent when they should have been raising their voices.

5 It is also a story of management failure, failed communication, poor record keeping and a culture where the consultant was all-powerful.

6 While the majority stood back, there were, as in all such stories, some who stepped forward, and this account also seeks to examine why even those lone voices were not heard.

7 Above all this is an account of psychiatric patients, many in number, whose concerns and complaints fell on deaf ears. Added to that number were many more patients who, for a variety of understandable reasons, did not make any contemporaneous complaint, but who have found the strength and courage to come forward to the Inquiry. We know that there are others who have chosen to remain silent. As set out in the Report, there are many more alleged incidents identified by former patients than the five counts of sexual assault referred to above. Although, in accordance with our Terms of Reference, we record those concerns and complaints, whether or not raised at the time, we do not – nor could we – make any attempt to decide whether or not any concern or complaint is true or false. That is not our function.

8 Against this background of concerns and complaints that were dismissed at the time as incredible, ignored or simply not heard, we, as an Inquiry, have sought, at all times, to listen.

Nature and chronology of concerns and complaints raised concerning the practice and conduct of William Kerr and Michael Haslam

William Kerr

9 William Kerr started working as a locum Senior House Officer in psychiatry at Clifton Hospital in York in 1965; he was appointed as consultant in 1967, a post he held until his retirement in 1988.

10 During the course of the Inquiry we received evidence indicating that 38 former patients claimed they made disclosures to NHS staff of sexualised behaviour by William Kerr before his retirement. Not one of these led to any investigation of his practice.

11 The number of patients who have subsequently come forward alleging that they were subjected to some form of sexualised behaviour[1] by Kerr brings the total number of those who now make allegations against him to at least 67.

12 The first complaint against William Kerr in North Yorkshire was in his very first year in the post, 1965. This, as with so many subsequent cases, was a concern communicated by a patient to her GP. However, in a pattern that was to be repeated many times, no formal complaint was lodged by the patient with the hospital authorities or with William Kerr's employer, nor did any GP take the initiative to pursue the matter. The complaint progressed no further than forming part of the reserve of knowledge of one particular GP.

13 However, this was not the first time an allegation of sexual misconduct had been raised. William Kerr had left his previous post in Northern Ireland in 1964 after an internal disciplinary hearing concerning an allegation of inappropriate sexual conduct with a patient (the details of which remain unclear).

14 Concerns continued to be raised about William Kerr throughout his career. The accounts we heard from patients were strikingly similar. The allegations were of unscheduled domiciliary visits, or appointments being arranged for the end of clinics when there would be few nursing staff around. William Kerr would then

1 In this Report we have used the phrase "sexualised behaviour" to mean "acts, words and behaviour designed or intended to arouse or gratify sexual impulses and desires".

allegedly expose himself and "invite" patients to perform sexual acts (often of masturbation or oral sex) upon him, sometimes suggesting that this was part of their treatment. A number of patients also alleged that full sexual intercourse took place. A number of women described William Kerr's ability to make them comply with his wishes, leaving them confused and guilty about their own actions and afraid to complain in forthright terms.

15 In many cases the alleged recipients of these complaints, most typically GPs, but also community psychiatric nurses, hospital nurses and consultants, deny or have no recollection of any complaint. One of the major problems facing this Inquiry has been the passage of time since the events in question and the resultant fading memories. It has been difficult to conclude in each case, with any degree of certainty, whether a complaint was made – and if made, to whom, and in what precise terms. Were all these women mistaken when they told us that they raised concerns, that they made complaints? In our judgment the answer is clearly "No". We are satisfied that a significant number of concerns, whether or not raised as formal complaints, were voiced but not heard. Despite what appears to be a marked reluctance by recipients to make any contemporaneous note, even by some who acknowledge that they were very serious complaints of alleged wrongdoing, a few records have survived.

16 In the period prior to 1983, of the 30 concerns alleged to have been raised about William Kerr all but one fell on deaf ears.

17 The exception was the case of Patient A22[2]. In 1979 this patient complained to her GP, Dr Wade, about advances made by William Kerr, who allegedly propositioned her during a domiciliary visit. Dr Wade accepted Patient A22's concerns as being true, and linked the concerns with William Kerr's reputation of "potentially flirting with some [female] patients". It is one of the great ironies in this account that the consultant to whom Dr Wade chose to speak about his concerns regarding William Kerr was Michael Haslam. Perhaps unsurprisingly, given his attitude to sexual contact between patients and doctors, Michael Haslam did not take the matter any further or

2 From here onwards, we refer to the former patients of William Kerr and Michael Haslam specifically. To preserve confidentiality, as far as we can, and anonymity, we have adopted the practice of referring to them by a code. We did this both in correspondence with Inquiry participants and at the oral hearings. To increase confidentiality we have adopted different codes in our final Report.

raise it as an issue with the Regional Health Authority (William Kerr's employer).

18 In 1983 an account of an alleged sexual relationship between a psychiatric patient, Patient A17, and her treating consultant, William Kerr, was disclosed[3] to Deputy Sister Linda Bigwood – not by way of complaint, but as part of the patient's life story. Linda Bigwood, unlike so many of her colleagues, was not prepared to "turn a blind eye", and pursued her concerns about William Kerr's alleged sexual misconduct towards not only Patient A17 but a number of patients, with the hospital authorities, the District Health Authority and beyond that with the Regional Health Authority.

19 Despite letters and meetings setting out her concerns over a period of almost five years involving the most senior NHS managers, and despite the support of her union representatives, no investigation was ever made into William Kerr's practice and he retired in 1988 with a letter of thanks for his "valuable contribution" to the health service in the Yorkshire region. Linda Bigwood, in contrast – and as with many other so-called "whistle-blowers" – in personally raising the issue of how the complaints were handled, herself suffered professional detriment.

Michael Haslam

20 Michael Haslam took up his post as Consultant in Psychological Medicine at Clifton Hospital, York, and Harrogate District Hospital in 1970.

21 During the course of the Inquiry we received evidence indicating that at least eight patients had, during his time in York, raised concerns about his alleged sexual advances towards them. Many of the allegations involved offering friendship and social activities outside the clinical setting, leading later to the development of a personal, sexual, relationship.

22 The number of patients who have subsequently come forward alleging that they were sexually propositioned or assaulted by

3 We have also used the term "disclosure" to refer to information that passed between individuals. Some of those "disclosures" amounted to allegations against William Kerr and Michael Haslam. We make no comment on the veracity of those allegations but regard all such "disclosures" as information that should have been acted upon at the time.

Michael Haslam brings the total number of those who have now made allegations against him to at least 10.

23 The first complaint against Michael Haslam known to us occurred in 1974 when Patient B1 informed her GP, Dr Foggitt, that (allegedly) she had been having an affair with Michael Haslam. However, in a pattern that echoed the response to complaints regarding William Kerr, this was never pursued either by the patient herself or by Dr Foggitt as a formal complaint or as an issue that needed to be reported to health service management – even with the identity of the patient concealed.

24 While the number of patients who raised concerns about Michael Haslam was far smaller than in the case of William Kerr, concerns continued to be raised at intervals throughout his career, notably in 1976 (Patient B2), in 1981 (Patient AB) and in 1984 (Patient B3). It is to be noted that although the expressions of concern are very different from the allegations made in relation to William Kerr, they nonetheless share a striking similarity to each other.

25 Michael Haslam practised a range of treatments not widely known about or used within mental health settings. One such treatment was full-body massage (carried out without a chaperone). The Inquiry heard evidence on how on occasions this was carried out in isolated parts of the hospital or out of hours.

26 In three cases attempts were made to commence a formal complaint by means of letters (in the case of Patient B2, from solicitors) or a written statement. However, in none of the cases did matters progress to an investigation, no patient apparently being prepared to go through with a formal complaints procedure.

27 The stories of Michael Haslam and William Kerr, perhaps inevitably, overlap. Indeed, Linda Bigwood, whose efforts as a whistle-blower were concentrated on William Kerr, also brought concerns about Michael Haslam to the attention of management.

28 In 1987 Patient B5 complained to her GP of being propositioned by Michael Haslam. The GP concerned, Dr Moroney, raised the issue with the hospital management (Dr Kennedy). However, in a now familiar pattern, the disinclination of the patient to proceed with a

formal complaint marked the end of the matter and no investigation of Michael Haslam's practice was conducted.

29 It was not until the complaint by Patient B7 in 1988 of sexual assault that any real attempt was made to collate the previous allegations against Michael Haslam. Even at this stage, no investigation was launched and Michael Haslam was allowed, perhaps even encouraged, to retire from the NHS.

30 Unlike William Kerr, however, Michael Haslam's retirement from the NHS did not mark the end of his medical practice. He continued to work in the private sector and we are aware of at least one complaint that arose relating to the period when he was in private practice.

31 While Michael Haslam left the NHS under something of a cloud (though not according to Michael Haslam, and not known to many within the NHS), he was still subsequently appointed an honorary NHS consultant in 1989 in York. In addition, he was subsequently appointed as the non-clinical Medical Director in Durham. There was no investigation of his practice until the police investigation of William Kerr caused allegations about Michael Haslam to come into the open, prompting an internal NHS inquiry in 1997/98 (known as "the Manzoor Inquiry") and subsequently (following further allegations) a criminal trial. Michael Haslam finally retired from medical practice, and took voluntary erasure from the Medical Register, in 1999.

The procedures then in place for raising concerns about healthcare professionals

32 The systems (and procedures) within the NHS that enabled legitimate concerns and complaints to be raised were in fact part of the problem facing patients and staff from the 1960s through to the present day. The detail of the relevant systems and procedures and their operation is contained in Chapter 31 and Annex 5 of the Report. We describe the barriers that the organisation itself presented to complaints that were raised – see Section 5. We detail, at length, many of the individual specific complaints and how they were handled.

33 Very few patients wanted, or were robust enough, to make a formal complaint. Our clear impression is of a system that was difficult and obstructive. It was neither "user friendly" nor designed to ensure that patient safety was paramount. Those who came through it did so in spite of it, and were left damaged and disillusioned by it. Most never made it through the labyrinth of artificial barriers, unnecessary formalities and plain obstruction to any kind of resolution of issues. Patient complainants largely got nowhere; professional complainants often fared worse, attracting blame, criticism and a degree of professional ostracism that deterred others from following their lead.

34 Nowhere was the voice of the complainant listened to with enthusiasm or support. It is clear that procedures protected the status quo at the expense of much needed reform. It was a situation that changed all too slowly and, without doubt, resulted in damage and frustration for patients and their supporters alike.

Actions taken in response to concerns

35 The uncomfortable reality is that during the NHS employment of William Kerr and Michael Haslam:

- there was no detailed consideration/assessment of any complaint raised about their conduct and practice;
- any remedial action that might have been necessary was not taken, and;
- the consultants continued to practise without restraint, despite concerns having been reported.

The response of GPs

36 The response of GPs, who in many instances were the first and often only recipient of concerns expressed by patients of William Kerr and Michael Haslam, was varied.

37 Deputy Sister Linda Bigwood (one of the few key whistle-blowers in the William Kerr story) described a general concern among Harrogate GPs about William Kerr, such that some refused to refer female patients to him. Despite this, no attempt was made by NHS management at the time (whether at Regional or District level) to investigate whether or not the concerns were true. We are sure that William Kerr would have denied the allegations, but they were not

even put to him for his denial to be recorded. The failure by the local GPs to respond is a striking feature of the William Kerr story. In our Inquiry, some 20 years later, we found only one instance of a GP, Dr Wade, taking any active steps to pursue a complaint about William Kerr. This led Dr Wade, not unreasonably, to William Kerr's fellow consultant Michael Haslam, who did nothing to pursue Dr Wade's concerns. The complaint did not progress further.

38 The first complaint concerning Michael Haslam of which the Inquiry is aware was communicated to a GP, Dr Foggitt. In the same way as GPs had failed to forward their concerns about William Kerr to any higher authority, Dr Foggitt (although he took steps to refer his patient, Patient B1, to another consultant) did not seek to inform the authorities of Michael Haslam's alleged sexual relationship with Patient B1. Michael Haslam denies any wrongdoing in relation to Patient B1, but again the allegations we have heard were not put to any form of test, they were not the subject of any inquiry – they just became part of the unarticulated background to Michael Haslam's practice. On evidence received by the Inquiry, this 1974 allegation was the first; had it been investigated, admitted or found to be true, and suitable action taken, then patient safety might have been secured.

39 The later complaints against Michael Haslam, arising in 1987 and 1988, provoked a very different response from two GPs, Dr Moroney and Dr Moran. This is perhaps explicable by the gradual change of culture that had occurred by this stage. Both Dr Moroney (in relation to Patient B5's complaint) and Dr Moran (in relation to Patient B7's complaint) appear to have recognised both the severity of the allegation and the necessity of referring these matters on to the authorities (in the form of Dr Kennedy). Both were new GPs and, perhaps less restrained by the historical culture of a degree of tolerance towards sexualised behaviour by psychiatrists, were prepared to challenge the status quo.

40 In response to patient complaints and concerns, the first point we make is that many of those to whom they were made did not, or would not, hear them. GPs failed to pass on a complaint or concern. Material and relevant information was not properly received and actioned. Clear messages were ignored, hints were not taken up and silences were not explored.

41 As a culture we can characterise it as unhealthy. Professionals were reluctant to take action against consultants, through either a misguided sense of loyalty or fear of confrontation. Administrators felt powerless, and devised mechanisms to protect themselves, rather than the patients or those who raised concerns. Responsibility for action was fragmented and unclear; policy and protocols were confusing or were incorrectly implemented, if at all. As a consequence, responses at virtually all levels were inadequate and unconvincing. Some of this paucity of response was due to lack of ability or to lack of training; some of it arose through lack of clarity on how best to proceed. Sadly, some of the failure arose because it was easier, perhaps professionally safer, to do little or nothing at all.

42 As a consequence, patients were routinely disbelieved, were thought to have invented or exaggerated their concerns or complaints, and were treated neither fairly nor with the respect their situation required. Health professionals did not, in general, see their role as supporting patients in following through their concerns and complaints unless clear, unequivocal and incontrovertible evidence demanded it. In other words, if there was a possible "other side", or a mere denial by the consultant, the matter did not proceed. Even if there was any forward movement, procrastination and delay helped to diminish the impact of concerns and complaints – with damaging consequences. Nor, in general, did NHS staff initiate action in support of patient safety.

43 The result was that in both cases the consultants, despite considerable and widespread doubts as to the propriety of their behaviour, were able to retire, with some distinction, from the NHS. When it became apparent that all was not as it should be, the GMC was, it seems, unable to do more than grant them voluntary erasure from the Register and allow them to take an unscathed retirement. Indeed, retirement was seen as a solution by the authorities and as an end to a difficult and time-consuming problem. To the former patients it was seen as an escape, a trapdoor to freedom that they were loath to allow either doctor to use. It compounded the sense of injustice and grievance that many of them have told us they felt.

Contributing factors impeding appropriate investigation and action

44 In our view the root causes of this comprehensive failure to attend to patient concerns can be categorised under the following five headings.

Organisational

- Lack of rigour in recruitment and appointment practices
- Failure to examine/explore references
- Power and influence of defensive legal advice
- Poor and fragmented disciplinary procedures
- Lack of standard procedures and consistency for the writing and storage of records
- No formal process for supporting patients
- Several changes of NHS hospital and management structures
- Intermittent shortage of psychiatrists

Cultural

- Consultants had undue power and unclear accountability
- Prime loyalty to medical colleagues and a tolerance of sexualised behaviour
- Lack of knowledge (or acceptance of the knowledge) that doctors might abuse their patients
- No attempt to investigate/explore recurring rumours
- A predominantly male hierarchy of doctors and a predominantly female nursing cohort, which reinforced gender power relations
- Patient fears of retribution, punishment and/or withdrawal of treatment – or other adverse consequences

Structural

- Consensus management, which militated against leadership and pro-activity
- A separation of domains between general practice and hospitals, which made it difficult for GPs to identify how to raise concerns

- A management hierarchy for each function within the NHS, with no overview of the whole
- No requirement for continuous professional development learning or appraisal of senior doctors

Professional practice

- Absence of multi-disciplinary working
- Over-rigid interpretation, or even misinterpretation, of the legal position pertaining to the requirement for patient confidentiality – such that it overrode patient safety
- A belief that doctors could not harm patients – and a reluctance to discuss what was and was not acceptable behaviour
- Willingness to let doctors use therapies that were not understood by, or known to, colleagues and peers
- Lack of supervision/monitoring of domestic visits
- Lack of a structured and monitored appointments system
- Inadequate processes for GPs' sharing of information
- Different codes of practice for GPs and hospital doctors
- A willingness to resolve the issue of "problems with doctors" through retirement, promotion or a move to a different post
- Slowness and opacity of GMC processes

Individual failings

- Hospital doctors and GPs who did not act on concerns or complaints
- Nursing staff who failed to report concerns and ignored patient concerns
- NHS managers who neglected to take action, took a line of least resistance and failed to investigate expressed concerns
- Michael Haslam's failure to pass on concerns expressed by a GP
- A social worker, a counsellor and a psychologist, all of whom failed to report alleged disclosures by patients

- NHS managers who focused on the disciplinary issues raised by the actions of a whistle-blower, but failed to investigate to its conclusion the allegations and disclosures reported

45 So, we ask, how did this culture develop? To the rhetorical question "Do you think allegations of abuse by doctors should be ignored?" there is plainly only one answer, a resounding "No". Yet the culture did develop, or was allowed to develop, and that culture shaped the events upon which we have had to report. At times we felt that the structure of the NHS complaints system rendered the outcome of these events almost inevitable, if only because of the persisting requirement for a patient to be willing to make, and pursue, a formal complaint.

46 As stated, one recurring theme was the interpretation of the term "patient confidentiality" by those who were in a position to react positively to protect patients. All too often it was misunderstood, or used as an excuse to do nothing. We expand on the reasons for this in Chapter 28 of our Report

47 Our overall conclusion on this topic is that the way the NHS handled complaints in the 1970s and 1980s – perhaps even the 1990s – presented considerable barriers, so that all but the most determined and resolute were unable, or unwilling, to scale them.

What has changed?

48 We have detected a significant change – beginning in the 1990s and carrying through to the present day – in both attitudes and systems. The reasons for this change can be found in the pressure from public expectations, the impact of scandals (national and local), and the approach of new and different personnel to the needs of patients. Many professionals who gave evidence to the Inquiry describing their response to concerns and complaints in the 1970s and 1980s stated that they would act differently now. We think that this evidence reflects a broadly held view. Awareness at both a professional and a public level has heightened.

49 There is not only a willingness to change, but there are now in place systems throughout the NHS – some say too many systems – that treat the patient as consumer, entitled to be dissatisfied and to express dissatisfaction. During the time covered by this Inquiry such

systems, if they existed at all, were unclear or unworkable and were at best off-putting and fragmented. As a general statement, it is now true that professionals and patients know they can complain and receive some support, and they are not stigmatised for complaining. It is usual for their complaint to be treated with respect from the outset. In summary, we feel the climate is changing and improving, but patient safety demands that more still needs to be achieved.

50 Complaints systems are not the only way for the NHS to manage poor performance. Other governance systems have recently developed within the NHS, together with regulatory inspectoral bodies such as the Healthcare Commission. We are confident that scope for further improvement is to be found in this wider approach to improving standards, and protecting patient safety by identifying and addressing failings at an early stage, rather than allowing them to go unnoticed and/or unchecked for years, even decades.

51 Whistle-blowing policies for staff have existed since 1997. However, following high profile cases that identified failures to tackle issues highlighted by whistle-blowers (within and outside the NHS), there is greater confidence among some, but not yet all, staff in reporting their concerns.

52 Data from all these sources is now brought together for trend analysis and reported to Trust Boards through clinical governance arrangements. Risk management systems are regularly tested to meet standards by two external bodies – the risk pooling scheme (RPST) and the clinical negligence scheme (CNST).

53 Improved complaints systems, governance techniques, incident and "serious untoward incident" reporting systems all combine to produce this improved position. Serious work remains to be done in relation to ensuring that NHS staff are not only familiar with the systems and techniques but that they understand and appreciate why they are needed, and (most importantly) are prepared to learn and do learn from things that have gone wrong

The future

54 We are required by our Terms of Reference to make recommendations informed by our investigations as to improvements that should be made to the policies and procedures that are currently

in place within the health service, taking into account the changes in procedures since the events in question.

55 The situation is different from that which existed when William Kerr and Michael Haslam were working in the NHS. Further changes have of course occurred since they both retired. Today, mental healthcare is predominantly provided as a community based service within patients' homes and other non-hospital based settings such as resource centres.

56 We have considered the way forward against the following, we trust uncontentious, standard:

> Everyone has the right to be cared for and treated by medical professionals without fear of being subjected to sexual exploitation, sexual advances, and any form of sexualised behaviour.

57 In making our recommendations our guiding principles have been:

- a concern that the sexual abuse of vulnerable adult patients did not end with the retirement of William Kerr and Michael Haslam, and may be far more prevalent than hitherto realised or accepted;
- a recognition that the abuse of patients is, and should be treated as, very unusual, and that the vast majority of healthcare professionals (including consultant psychiatrists) are not and never have been guilty of any form of abuse;
- a recognition that allegations of sexual abuse, of whatever kind, are not all genuine;
- a recognition that allegations of sexual abuse are easy to make, and difficult to refute;
- an acceptance that doctors, and other healthcare workers, are entitled to expect protection from untrue allegations of sexual abuse;
- an acceptance that the complaints systems in place in North Yorkshire (and nationally) during the 1970s and 1980s have significantly changed over the years, and are still changing;

- a recognition that trust between patient and doctor is of central importance. Insofar as it has been damaged by the allegations made in recent years, including the allegations (whether true or not) listed in this Report, then every effort should be undertaken to restore that trust.

58 Although our recommendations are focused largely on psychiatrists, many will have a wider application to all mental healthcare professionals. We have been concerned to discover the lack of attention and resources given to the examination of the prevalence of sexualised behaviour (alleged or established). Such abusive behaviour is recorded neither consistently nor comprehensively. Given that it is the overwhelming view of the profession that an intimate relationship between doctor and patient is always harmful, this situation must be addressed immediately. The kind of behaviour that leads to what may become a charge of sexual assault needs to be detected at an early stage and action taken to prevent it developing into yet more serious and more harmful activity. To this end we feel that a code of ethics for all staff, most particularly in the context of our Inquiry for psychiatrists, detailing what is and is not acceptable, will be a valuable and useful tool for the profession and those monitoring it. We are sure that routinely offering trained chaperones to mental health patients whenever a doctor performs any kind of intimate personal examination is a move that will help address this issue.

59 There is an immediate need to address the issue of recording, storing and destroying records. Different standards apply across the NHS; this leads to confusion and inequity and provides a poor measure of monitoring and control.

60 We have briefly addressed in the Report the issue of discipline for doctors and the way it has recently changed. The new procedures will no doubt be controlled and monitored by the GMC. Given the new sense of transparency in its work, we anticipate that the GMC will report regularly and publicly on its assessment of the impact of the new regime on doctors – particularly in the area of patient abuse.

61 We have made a range of proposals relating to complaints – how they are made, received and processed, both by patients and by health professionals. This area must be addressed urgently if the necessary climate change for the improvement of patient care is to

be effected and maintained. Only when the content of complaints is generally regarded as providing a positive opportunity for improvement will that change be made. This means to us that health professionals acting as Linda Bigwood did should be regarded as people to be treated positively and given support. They are not threats to the NHS, but the essential catalysts that will bring about better patient care and better patient protection – goals to which everyone in the NHS today should aspire. We hope that, taken as a whole, our recommendations will promote and encourage this ongoing process of change.

Core concerns

62 We set out below a full list of the detailed recommendations arising from the evidence and submissions to the Inquiry.

63 The stories of William Kerr and Michael Haslam do not lead to simple answers. We also recognise and make no apology for the fact that the recommendations are wide ranging and, in some cases, represent only the first stage in initiating further discussion. We also recognise that this Inquiry takes its place as part of a wider picture and debate, informed in particular by the Ayling, Neale and Shipman Inquiries. However, we consider it fundamental to a Report of this nature and fundamental to our duty as a panel that the reader is left in no doubt as to what we determine are the key priorities. Impact can be lost in detail. We do not want to lose that impact. We set out below what we see as the "headline" concerns of this Report.

64 Prevention of patient abuse, our first headline, must be the short and long-term goal of all professionals and managers engaged in the care and treatment of the vulnerable – child, young person, or adult. This is and must be the basis of all other recommendations. However, without a clear understanding among those both working in and using mental health services, and a clear consensus as to where the boundaries actually lie between care and abuse, no sensible progress can be made. We have confined ourselves here to the consideration of mental healthcare professionals, though recognising the wider issue of sexualised behaviour or other boundary transgressions between health service users and healthcare professionals across other areas and disciplines.

Prevention of patient abuse

65 Managers, and mental health and social care professionals, must be left in no doubt that the breach of professional boundaries with regard to their patients (service users) is unacceptable, and must always be treated as harmful. Every effort must be made to prevent all patient abuse.

66 There are a number of ways of achieving this change of ethos. We here identify three:

- *Education:* of all staff at all levels on the identification and preservation of proper boundaries, and the harm caused by boundary transgressions, commencing at undergraduate level through all the relevant professions. The message must be reinforced in induction training, in continuous professional development and through employment contracts that detail specifically unacceptable behaviour. The message must be supported by clear and enforceable codes of conduct by NHS Trusts and by the regulatory bodies. There must be clear boundaries, clear sanctions, and no tolerance of the abuse of patients.

- *Promoting the obligation to speak out:* Patient safety requires a culture where speaking out (whether or not categorised as whistle-blowing) is welcomed, where minor transgressions can be addressed at early stages and (if possible) resolved. The NHS must fully support its staff, who in turn must be left in no doubt that the culture of turning a blind eye is unacceptable, and that to stay silent may be to perpetuate and thus participate in wrongdoing. There should be no career detriment for those who speak out to promote patient safety. To support these aims, a clearer knowledge of the requirements and limitations of confidentiality is essential, and must be achieved through continuing education.

- *Promoting knowledge and skills:* Managers must recognise their responsibility in minimising the risk of abuse, and maximising its detection. This responsibility is best fulfilled from a firm base of knowledge, including knowing what treatments and therapies are being used in their organisations, and by ensuring that there is in place adequate supervision of health and social care professionals. There should be systems in place to listen, hear and respond – not confined to formal concerns or complaints, but embracing

consistent and specific but "soft" information. It is not just a case of waiting for abuse to be discovered, and then reacting. Proactivity is required if there is to be any real progress in this area. In order to build on the base of knowledge, and to create a culture in which both staff and patients feel able to speak and to listen, there must be, in addition to formal complaints and discipline structures, an informal channel of communication. It is only through knowledge of what is going on at ground level, together with the skill to monitor staff performance, that managers can truly play their role in ensuring that patient abuse is prevented.

67 Our second "headline" recognises the fact that unless patients are able to come forward to raise their initial concern or complaint, even the most sophisticated system or elaborate support network will lie redundant.

A clear point of contact

68 Patients should have a clear and well-publicised point of contact if they wish to raise a concern or make a complaint about a mental health or social care professional.

69 Where the matter goes from there, and how it is handled and by whom, will require a far more complex and wide-ranging review of the complaints system. However, without the first step nothing can be achieved.

70 We would like to see a situation where any member of the public, if asked what they would do with a serious concern about the abuse of a patient by a mental health or social care professional, would know how to access the first point of contact – as they would dial 999 in an emergency. Whether this should be a national or regional "patient-line" or a dedicated complaints manager in every NHS provider organisation is a matter for debate.

71 We also consider that a similar principle should inform the route for mental health and social care professionals wishing to raise concerns about a colleague or pass on patient concerns.

72 We do not specify whether there should be a single point of contact for *all* NHS complaints – whatever the subject matter; that is for

others to resolve. However, in the area of patient abuse we consider that a single gateway is achievable and helpful, enabling the patient or professional to take the essential first step in getting the concern about patient abuse documented for future reference.

73 But we emphasise that our view is not intended to recommend an exclusive gateway, merely one that is familiar and readily accessible. We do not wish to impede, *in any way*, the raising of concerns or complaints through other routes within, or from outside, the NHS.

74 Our final "headline" is related to the fact that the Kerr/Haslam Inquiry is unique among the various Inquiries we have cited – the others being Ayling, Neale and Shipman – which all looked at the raising of complaints and concerns. The unique feature is that in our Inquiry, all those patients who alleged abuse, were mental health patients. This raises the issue of not only whether the particular allegation of "sexual abuse" needs special handling (because of the sensitivity of the subject matter) but whether, as a matter of routine, such a potentially vulnerable class of individuals requires particular support, and the matters they raise specialised and skilled investigation.

An appropriate response

75 In all cases where a complaint is made or a concern raised by a mental health patient in relation to their alleged abuse by a mental health professional, appropriate support and assistance should be offered.

76 Such support and assistance will require, at least, access to a mental health support advocacy organisation, with the necessary aptitude and independence to advise on appropriate handling of the concern or complaint. The patients of William Kerr and Michael Haslam who raised initial contemporaneous complaints went on to withdraw them or, eventually, declined to pursue matters. Had someone been readily available to step in at the outset of their concern or complaint – "patient champions" as we describe them in the Report – to offer support and mentoring, refer them for appropriate assistance, and (where possible) ensure that any investigation/interview was appropriate to their vulnerabilities, this Inquiry might have been unnecessary.

77 But care and support is but one aspect of the appropriate response by a responsible health service. If concerns and complaints relating to allegations of abuse, raised by mental health patients, are to be investigated effectively, then it is imperative that those who are given the task of responding and initiating any investigation are themselves adequately trained, are equipped with the necessary skills to carry matters forward, and are of such seniority as to ensure that barriers and resistance are overcome. We cannot over-emphasise the need for raised awareness throughout the health service of the particular issues arising in the areas we have been considering. We believe there is a need for a change of culture surrounding psychiatric care, maintenance of patient dignity and personal boundaries, and an informed recognition of the potential for abuse at its highest, and misunderstanding and distress at its lowest: neither of which are conducive to delivering good patient care. Education and a nationally agreed set of guidelines and standards must start this necessary process of change.

Recommendations

78 Our recommendations are set out here without explanation, and without being put into context. The only reference is to the chapter in the Report where they appear. In the text of the Report we refer, where appropriate, to the conclusions that led to the recommendations from the evidence we received. We also reached conclusions from consideration of all the evidence; therefore some of the recommendations do not derive from a single evidential source.

We RECOMMEND that:

Chapter 6

One of the referees in any job application should be the consultant who conducts the applicant's appraisal, their Clinical Director, or their Medical Director.

Chapter 15

Procedures and policies should be put in place, within 12 months of the publication of this Report, to ensure that all NHS organisations are aware of the therapies being undertaken by all staff, particularly those where patients believe clinical

governance committees should be aware of them and making decisions about their use.

Within mental health services no member of the healthcare team should be permitted to use or pursue new or unorthodox treatments without discussion and approval by the team (such approval to be recorded in writing).

In relation to such identified "new or unorthodox treatments", patients should be given written explanations of the treatments, and why their use is appropriate.

The full range of physical, psychological and complementary therapies used by mental health professionals should be recorded and discussed through appraisal/job plans. Trusts should have a clear evidence base and protocols for guiding the use of these treatments.

The NHS should reconsider whether or not statutory regulation should be extended to cover hypnotherapy.

Chapter 17

When appointments to the NHS are considered, references should be obtained from the three most recent employers and those references should be properly checked.

Chapter 24

The Department of Health should develop and publish a specific policy, with practical guidance on implementation, to guide NHS managers in their handling of allegations or disclosure of sexualised behaviour. The policy should address the various issues and difficulties set out above and include examples of good practice, as well as the extended range of options for action that could be applied; where advice and assistance can readily be provided; guidance on record-making and keeping. The guidance should also include a range of preventative measures (for example, specific accessible information for patients on what they should and should not expect in consultations, and whom they can speak to for confidential advice and assistance).

In relation to disclosures of alleged abuse, voluntary advocacy and advice services (independent of the NHS) should be supported by central public funding to offer advice and assistance to patients and former patients (particularly those who are mentally unwell, or who are otherwise vulnerable).

All Trusts should develop, within their Code of Behaviour[4], guidance to reduce the likelihood of sexualised behaviour, and it should be incorporated into the contracts of employment of those staff, or contracts of engagement for all other persons providing mental health services within the NHS.

Chapter 27

Regarding mental health services, the NHS should review the cut-off period for registering a complaint, as well as the criteria for initiating an investigation of an old complaint and the procedures to be applied (see also Chapter 32 Recommendations).

Protocols should be established to ensure that psychiatric patients who raise concerns or complaints in relation to allegations of abuse are not treated in ways that are less favourable than the treatment advised for vulnerable or intimidated witnesses within the framework of *Achieving Best Evidence* (Action For Justice, 2002). Such psychiatric patients should be treated with care, consideration and integrity.

Because medical procedures that require benzodiazepines to be given intravenously (eg oral endoscopy and induction of anaesthesia) are potentially high risk in terms of false sexual fantasies and allegations, these should always be chaperoned (see Chapter 31, Chaperones).

Chapter 28

Trusts' confidentiality policies should include a section on disclosure within therapeutic interactions in psychiatric practice and should be supported by inter-agency information-sharing policies to be used in all cases of patient abuse.

4 See Creating a Patient-led NHS – March 2005.

Dedicated staff should be properly trained to carry out the investigations. This relates closely to the recommendations we make at the end of Chapter 33 regarding investigations generally.

The Secretary of State, within 12 months of the publication of this Report, should commission and publish guidance and issue advice and instruction (preferably in consultation with the professional regulatory bodies and healthcare colleges) as to the meaning and limitations of patient confidentiality in mental health settings. Such guidance should be kept under regular review.

Chapter 29

The NHS should convene an expert group to consider what boundaries need to be set between patients and mental health staff who have been in long-term therapeutic relationships, and how those boundaries are to be respected in terms of guidelines for the behaviour of health service professionals, and the provision of safeguards for patients.

Detailed, and readily accessible, guidance should be developed for medical professionals. The guidance should be framed in terms that address conduct which will not be tolerated and which is likely to lead to disciplinary action. Such guidance, if not provided at a professional regulatory level, should be supplemented by the NHS at an employment level.

Policies should be developed that enable health workers to feel able to disclose feelings of sexual attraction at the earliest stage possible without the automatic risk of disciplinary proceedings. Colleagues must also feel able to discuss openly and report concerns about the development of attraction/overly familiar relationships with patients. These policies should include all grade levels, including consultant.

The Secretary of State, within 12 months of the publication of this Report, should convene an expert group to develop guidance and best practice for the NHS on boundary setting, boundary transgression, sexualised behaviour, and all forms of abuse of patients, in the mental health services.[5]

5 This was also the view of the Ayling Inquiry – see paragraphs 2.30 and 2.31 of the Report.

The terms of reference of the expert group should not be restricted to sexualised behaviour between psychiatrists (or other mental healthcare professionals) and current patients, but should also address former patients.

Chapter 30

There should be detailed research carried out and published by the Department of Health to show the prevalence of sexual assaults, sexual contact, or other sexualised behaviour, between doctors and existing and/or former patients – particularly in the field of mental health.

The Department of Health should urgently investigate and report upon the need for a coordinated method of mandatory data collection and mandatory recording in relation to the area of abuse of patients by mental healthcare professionals.

Chapter 31

Mental health services should provide routine information to patients attending appointments on what to expect from a consultation with a mental health professional. This should apply to consultations in all settings, including home visits.

Where physical contact forms part of the consultation, or where there is a risk of loss of consciousness, there should be a national policy and implementation guidelines to safeguard patients and staff and support the maintenance of appropriate boundaries.

Chapter 32

The NHS should review current records management practice and ensure that a robust set of systems and practices are uniformly applied across the service.

Within 12 months of publication of this Report, the Department of Health should issue guidance as to how and where any disclosure or complaint of abuse by another healthcare professional made to a doctor or nurse should be recorded (if at all) in the patient's medical records and elsewhere.

A protocol should be produced and guidance issued within 12 months of the publication of this Report regarding the collection, collation and retention of data in relation to concerns and complaints covering sexualised conduct by mental health professionals – including, but not restricted to:

- **the name of the mental health professional;**
- **the details of the concern or complaint;**
- **the date of the alleged sexualised behaviour;**
- **the date of the concern or complaint;**
- **if investigated, by whom and with what outcome;**
- **if not investigated, the reason.**

Consideration should be given to the retention period of such data, stating our preference (subject to the advice of the Information Commissioner, and the terms of the Human Rights Act 1998) that such data be retained for the lifetime of the mental health professional. All NHS staff should be made aware regularly that this data is collected and retained.

The current regulations relating to complaints procedures should be amended to enable any person with a concern about the safety and effectiveness of the NHS to be allowed more readily to use the NHS complaints procedure. Further, the time limit applicable from the incidents complained of and the complaint being made should be relaxed.

The Department of Health should review the effectiveness of whistle-blowing policies and initiatives within NHS-funded organisations.

Chapter 33

As a matter of some urgency the NHS should clarify the context in which NHS staff have a positive obligation to inform NHS management of concerns in relation to the suspicion of the abuse of patients.

Policies and guidance should be drawn up to clarify the obligation to investigate (certainly in the case of suspicion of the abuse of possibly vulnerable patients) without the need for a complaint from, or one that identifies, a particular named patient.

Chapter 34

The NHS should, jointly with the appropriate National Standards bodies, produce a standardised complaints system to be implemented in all Trusts/organisations providing services to NHS patients.[6]

Themes and trends arising from the data of complaints, incidents, and patient and carer feedback should be analysed on a regular basis. This should form part of clinical governance and used to give early warning of emerging patterns of risk behaviour, in the interests of patient safety.

Information about the NHS complaints procedure and its relationship to other forms of regulation and clinical governance should be explained to all staff during their induction process and form a core part of continuing professional development programmes. This should include advice and training on how to deal with distressed and angry patients who want to make a complaint.

Frontline staff who receive complaints about issues that compromise patient safety – whether or not in the confines of a therapeutic disclosure – should be under an express obligation to report that matter to a complaints manager (in or beyond their own organisation), whether or not they work for the organisation named in the complaint.

Health and social care commissions should resource independent mental health advocacy as a priority.

6 This may be similar to the published guidance on consent.

Patient Advice and Liaison Services (PALS) and complaints staff should be actively linked into a clinical governance and information sharing network with regular access to data on performance issues drawn from such things as claims, patient satisfaction surveys, audit and peer review.

PALS and complaints staff should have direct access to a line manager at board level and to senior medical staff and they should be appointed at middle management level.

The roles of complaints officer and PALS officer should be distinct.

The Department of Health should introduce permanent arrangements for the provision of independent advice for mental health patients.

The Department of Health should be responsible for ensuring a standardised training programme for PALS and NHS complaints staff.

Those who are given the task of responding and initiating any investigation should themselves be adequately trained, equipped with the necessary skills to carry matters forward, and of such seniority as to ensure that barriers and resistance are overcome.

The revised regulations should require that all formal complaints should be directed to designated complaints managers in PCTs and NHS Trusts.

Formal complaints should be interpreted as any matter that the complainants would like to be treated as formal.

Current regulations should be amended to ensure that it is the duty of complaints officers to investigate complaints in a speedy, efficient *and effective* manner.

Current regulations should be amended to require complaints managers to consider the implications for clinical governance and patient safety of all complaints received. Where a clinical

governance issue arises this should be reported to the relevant line manager and to the board.

Current regulations should be amended, and suitable guidance prepared, to allow and ensure that complaints managers consider the reference of any complaint received which, if true, would disclose the commission of a crime, to the local police force.

Current regulations should be amended to require complaints managers to take statements from all those staff involved in the investigation of the complaint.

Guidance issued under the regulations should clarify what constitutes a full and rigorous investigation, most notably that complaints officers be placed under a duty to raise additional issues for investigation.

All NHS staff should be placed under an obligation to cooperate with investigations carried out by complaints managers.

Where possible, the NHS should give clear advice and guidance on employment protocols following allegations of abuse.

Chief executives acting on the advice of their complaints managers should be given the authority to refer a complaint to the Healthcare Commission for further consideration.

Complainants should be allowed to pursue litigation at the same time as a complaint is being investigated.

The Department of Health should convene a working party to consider what information it is necessary to record about complaints in order for them to be of use in clinical governance, and the circumstances and form in which it is appropriate to record suspicions.

In line with the recommendations of the Shipman Inquiry, a centralised database capable of recording a range of information about the performance of individual doctors should be set up.

Chapter 35

Regulatory bodies (with responsibility for the regulation and discipline of psychiatrists and other mental healthcare professionals) and the Department of Health should be under a clear duty, in the public interest, to share information about disciplinary investigations or other related proceedings. This duty should extend to information known to the regulatory bodies and the Department of Health relating to disciplinary investigations and related proceedings, even if conducted outside the United Kingdom. Consideration should be given to the collection and retention of all information relevant to patient safety, including unsubstantiated complaints, unproven allegations and informal concerns.

The Department of Health should clearly state what information can be included in relation to electronic staff records relating to complaints, proven/unproven incidents, disciplinary investigations and findings. Such a record should be established in standard form and, once established, should move with the individual to reduce the risk of staff evading detection of past misdemeanours. The Department of Health should consider whether or not, and if so how and in what circumstances, any such information should be transferable between the NHS and the private sector.

The Department of Health in association with the National Institute for Mental Health in England (NIMHE) and the Royal College of Psychiatrists should publish guidance in relation to clinical supervision of consultant and career grade psychiatrists.

Any deviation from acceptable practice in mental health services should be identified by the relevant statutory regulatory body and, where appropriate, by Monitor, and a standard, fair and transparent set of rules governing conduct of all mental health NHS staff in all NHS bodies and Foundation Trusts be quickly established.

The Secretary of State should invite the Council for Healthcare Regulatory Excellence (CRHE) to consider (with a grant of additional powers if necessary), in relation to the regulation of healthcare professionals, the application of common standards, practices and procedures so that patient safety can more effectively be protected.

Chapter 36

Within 12 months of the publication of this Report the Department of Health should develop and publish national advice and guidance to Primary and Secondary Healthcare Trusts addressing the disclosure, by patients or other service users, of sexual, or other, abuse with particular emphasis on users of mental health services.

The GP curriculum should be reviewed to ensure that sufficient focus is given to the needs, treatment and care of patients experiencing mental health problems and illnesses and that all GPs should have some exposure to psychiatry.

Mental health issues should be part of the Nursing and Midwifery Council (NMC) Foundation Year 2.

Early consideration should be given to extending the remit of the National Clinical Assessment Service (NCAS) to cover other healthcare professionals, particularly those providing care and treatment in mental health services.

The NHS should review the curriculum content – at all education and training levels – to ensure that medical practitioners are able to undertake appropriate cross-sector working (including within NHS i.e. primary/secondary boundary) as part of their practice.

Those responsible for developing the curricula for education programmes of healthcare professionals should ensure that:

1) **information about and discussion of the ethical responsibilities of healthcare professionals to bring poor performance to light is given due weight and**

2) students are made aware of: forms of regulation and clinical governance operating in the NHS and the ethos which underpins them; the relationship between the different systems; and how they can be accessed.

Professional training includes: compulsory education and training on the maintenance of professional boundaries, awareness of boundary transgressions, sexualised behaviour as unethical conduct, response to expressions of concerns and complaints, complaints systems, what to do if a complaint is made but the person making the complaint declines to take an active part in a formal complaint, as well as the requirements of, and limitations on, patient confidentiality.

Duty of candour

The NHS should adopt and reinforce the recommendations in the Manzoor Report and in *Making Amends*, that there should be a duty of candour imposed on, and accepted by, NHS staff. This duty would mean that there is a responsibility to be proactively informative with patients and with their relatives and carers.

General

In relation to private inquiries for witnesses who make statements, and/or who give oral evidence, legal safeguards should be introduced to grant them immunity from action in relation to their evidence (whether fact or opinion), in the absence of malice.

If not already appointed, a multi-disciplinary committee should be established to collate, consider and report on the recommendations made in this Report, the Shipman Report, the Neale Report, the Ayling Report and the Peter Green Report, insofar as those Reports and the recommendations made in them relate to the common theme of handling concerns and complaints, and to patient protection.

All Strategic Health Authorities should set up a manned telephone helpline (perhaps called a "PatientLine"), where anonymised (or identified) concerns could be received and processed. Any information received through the helpline should be logged and received in confidence (unless there is express identification of the caller) and, if there is sufficient information disclosed, should be discussed with the relevant NHS Trust or PCT. Consideration should be given as to how this information could best be collated either regionally or nationally.

Information for patients

The Mental Health Trusts, together with the Primary Care Trusts, should draw up and distribute patient information leaflets, so that patients referred by their General Practitioners to the care of a consultant psychiatrist can better understand what to expect, and the circumstances – if any – in which the patient can expect to receive any physical examination or treatment from the psychiatrist. This leaflet information should include the following topics:

- **when the patient can expect a physical examination by the psychiatrist;**
- **a description of boundaries, and what is and what is not acceptable behaviour by the psychiatrist;**
- **what the patient is likely to expect in the course of talking therapies (for example, questions and enquiries which some may consider too intrusive and intimate);**
- **what, if anything, is expected of the patient;**
- **the availability of trained chaperones and, if installed, the use of virtual chaperones;**
- **the contact details of the person to whom they may turn in confidence to discuss any issue that may give them concern before, during and after treatment.**