

Report of the Committee of Inquiry into Whittingham Hospital.

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Report of the Committee of Inquiry into Whittingham Hospital

*Presented to Parliament by the
Secretary of State for Social Services
by Command of Her Majesty
February 1972*

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Presented to the House of Commons
by the Secretary of State for Health
in pursuance of a resolution of the House

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FOREWORD BY THE SECRETARY OF STATE FOR SOCIAL SERVICES

I accept generally the conclusions and recommendations of this important and disquieting Report. It reveals inadequate medical and nursing care for a large proportion of patients at Whittingham, misconceived and defective management policies and methods, and suppression of complaints from junior nurses. The Committee reaches the conclusion that many allegations of ill-treatment were justified, and believes that there had been large-scale pilfering, if not more organised corruption, by some members of the hospital staff. This Report also highlights two of the most important problems facing our hospital service today: the proper care and treatment of longer stay and elderly patients in large isolated psychiatric hospitals, and the planning of the transition from services based on such hospitals to services based on general hospital departments.

Coming after other critical reports on psychiatric hospitals, and requests by my predecessors in 1967 and 1969 to Regional Hospital Boards to review conditions for long-stay and elderly patients, the Whittingham Report is especially disturbing reading to a Minister responsible for Health. A situation where there are two standards of care, for shorter stay patients on the one hand and for longer stay and elderly patients on the other, should of course not be allowed to arise. Mismanagement, overcrowding and understaffing are root causes of such dual standards. My Department and others may not have been sufficiently alive to this danger in earlier years but we are grappling with these problems now on a wide front.

The extra money recently announced by the Government will help to raise standards but the problem is not one of money alone. I agree that special attention needs to be given to planning the transition from the old pattern of services based on the large isolated mental hospitals to the new pattern of services based on general hospitals linked with other health and personal social services. General guidance to hospital authorities and local authorities on this was in preparation in my Department before this Committee of Inquiry was set up, and was published in December, 1971. In addition, separate provision is needed for those suffering from mental deterioration associated with ageing who at present are often admitted to mental hospitals. Guidance on this is at an advanced stage of preparation.

Action has already been taken on most of the other recommendations addressed to my Department. Guidance has been issued on arrangements for distributing weekly allowances and other money to long-stay patients, and on safe custody, investment and accounting procedures; this recommends placing the responsibility for the payment and safe custody of such money on hospital finance departments, thus relieving nurses of such duties while preserving their important therapeutic role of helping patients to make the best use of their money. Procedures for audit inspection of the control

of patients' money within wards are being reviewed. New arrangements have recently been agreed with the profession for planning and monitoring hospital medical staffing. These are intended to speed up improvements in medical staffing, particularly in the undermanned specialties and in those regions with relatively low staffing levels.

The recommendation for closer planning co-operation between the Board and local authorities is one that I particularly endorse. Co-operation of this kind is vital and my Department will be discussing with the Board and the local authorities what needs to be done to improve this.

I have discussed the recommendations relating to the Manchester Regional Hospital Board with the Chairman, in particular that calling for the resignation of the Whittingham Hospital Management Committee. In my view it is doubtful whether the integration of the medical and nursing services at Whittingham and at Preston, which is so evidently necessary, can satisfactorily be achieved by reconstituting a separate Whittingham Management Committee. The Board is already exploring the possibility of regrouping under a single Committee the hospitals now managed by the Whittingham and the Preston and Chorley Hospital Management Committees. The Whittingham Chairman resigned in December for reasons of ill-health and a number of other members have submitted their resignations in the course of discussions of the proposed amalgamation. With my endorsement the Chairman of the Manchester Regional Hospital Board is writing to the remaining members of the Whittingham Management Committee inviting them to submit their resignations so that a reconstituted Committee with a fresh membership can be set up, with amalgamation with the Preston and Chorley Hospital Management Committee in mind at an early date.

The Chairman of the Regional Hospital Board has told me that he also accepts in broad terms the other recommendations which call for action by the Board and indeed that action on most of them is already under way. The Board are taking steps to ensure that they receive comprehensive professional representation from the field: and their regional plan for psychiatric services which they have recently discussed with my Department is to provide for adequate day facilities, and for liaison with local authorities. The Board accept the need for services to be developed for elderly patients suffering from mental deterioration and for the needs of existing longer stay and elderly patients in mental hospitals to be given special attention. The Board are also reviewing medical staffing arrangements in the light of the Report. My Department has already approved the creation of two new consultant posts for Whittingham Hospital (which the Board had proposed before the Committee reported) and will consider carefully any further proposals which the Board may make in the light of their review.

Action on the remaining recommendations will fall to the reconstituted Hospital Management Committee and the staff of the hospital, in consultation with the Regional Hospital Board.

As on previous occasions, and like my predecessor, I am concerned for the morale of hospital staff following the publication of a report like this. Once again there is the risk that people may jump to unjustified general conclusions and I wish to stress the enormous improvement which has taken place in the

last twenty years in nearly all psychiatric hospitals. I also wish to pay tribute to the patience and devotion of the great majority of all grades of staff, whether at Whittingham or elsewhere, whose work has so often to be carried out in difficult and unsatisfactory conditions inherited from the past. During my visits to hospitals I have been deeply impressed by the quality of their effort.

I wish to express my gratitude to Sir Robert Payne and his Committee for undertaking the heavy task involved in this Inquiry and for presenting so clear and forthright a Report. What is important now is to put it to the best possible use. It will be my aim to use the lessons of the Report, not to draw morals from past failures and inadequacies at one hospital but to help put the situation right at Whittingham and to make improvements elsewhere.

KEITH JOSEPH,

Secretary of State for Social Services.

7th November, 1971.

The Rt. Hon. Sir Keith Joseph, Bt., M.P.,
Secretary of State for Social Services.

Dear Sir Keith,

As Chairman of the Committee of Inquiry into the administration of and conditions at Whittingham Hospital, near Preston, Lancashire, I am now able to submit herewith the Report of our findings. The members of my Committee are named on the first page preceding the Introduction and the names of those who submitted oral and written evidence to us are given in Appendix I.

I am glad to say that we are entirely unanimous about our conclusions and recommendations, and we have all signed the Report. If there is any further information you or your officers would like, please do not hesitate to let me know.

Yours sincerely,

signed ROBERT PAYNE
Chairman

MEMBERS OF THE COMMITTEE OF INQUIRY

Sir Robert Payne Chairman.

Dr. W. A. L. Bowen, Physician Superintendent, Naburn and
F.R.C.Psych., D.P.M. ... Bootham Park Hospitals, York.

Mr. J. R. Elliott, M.B.E., Associate Director, the Hospital Centre,
F.H.A. King Edward's Hospital Fund for London ; formerly Secretary of East Birmingham Hospital Management Committee.

Mr. R. Kempster, S.R.N., Chief Nursing Officer, St. Crispin Hospital,
R.M.N., R.M.P.A. ... Northampton.

Miss M. B. H. Whyte, M.A., Chairman, Education Sub-Committee of
M.B.A.S.W. the Northern Branch of the National Association for Mental Health ; formerly Lecturer in Social Work, Department of Psychiatry, University of Leeds.

Mr. L. C. Wilcher, C.B.E. ... Member of Oxford Regional Hospital Board ; formerly Chairman, Littlemore Hospital Management Committee.

Secretary Mr. Michael Foster

Assistant Miss Joyce Martin

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1. INTRODUCTION

1. Whittingham Hospital is one of the largest psychiatric hospitals in the country, situated near Preston in Lancashire. The possibility that all might not be well was brought to official notice in the summer of 1969 when an assistant psychiatrist and a psychologist employed there, supported by other members of staff, wrote to the then Secretary of State making allegations of ill-treatment of patients, fraud and maladministration, including suppression of complaints from student nurses.

2. A special investigation of financial affairs at the hospital was quickly launched by a team of auditors from the Department of Health and Social Security. During this investigation financial irregularities were discovered, and further allegations of ill-treatment, victimisation and maladministration came to light, which were referred by the Hospital Management Committee to the police. Exhaustive investigations were carried out at the hospital by the police over a period of about six months ending in June, 1970, and evidence was obtained which resulted in the conviction of two male nurses for theft. Shortly after the conclusion of the police investigations a male nurse assaulted two male patients at the hospital, one of whom died. The nurse was charged with murder and causing grievous bodily harm, convicted of manslaughter and imprisoned. As soon as the trial was over the Secretary of State announced his intention of setting up an Inquiry under Section 70 of the National Health Service Act, 1948 and Section 143 of the Mental Health Act, 1959; and on 15th February, 1971 he appointed us as a Committee

“to inquire into the administration of and conditions at Whittingham Hospital and to make recommendations”.

3. We started work immediately and decided to sit at Preston for as long as might be necessary. We also decided to receive evidence in public and on oath. A firm of local solicitors was appointed to collect and present evidence for us and they interviewed many potential witnesses. We heard evidence from 85 witnesses on 18 days between 14th April and 9th June, 1971: most of them attended our hearing voluntarily but some were compelled to attend by summons.

4. During our Inquiry we heard evidence of dishonesty, ill-treatment of patients and disgraceful behaviour on the part of senior and junior members of the staff at the hospital but all this was denied by the alleged offenders. We learned of administrative shortcomings that reflected little credit on the professions concerned and some of these were admitted. On the other hand, we heard tributes paid to the devotion and loyalty of many of the staff. Our conclusions on all these matters are given later in this Report.

5. Although most of our hearing was held in public—and a great deal of public and press interest was shown in the proceedings—we received a considerable volume of documentary evidence which interested parties asked us

to study, and this we have done. On a few occasions we obtained information privately, as follows :—

- (i) At the conclusion of his evidence we had a short informal discussion with the assistant psychiatrist who had written to the Secretary of State, to form an impression of him and his approach to the matters raised.
- (ii) We singly and collectively paid extensive visits to the hospital at Whittingham and at Ribchester on several occasions and conversed with members of the staff there. We also met the Medical Officers of Health of Preston County Borough and Lancashire County Council. No account has been taken in this Report of anything said in these conversations, except in so far as it was repeated in formal evidence.
- (iii) At his own request we heard evidence from Dr. Lane, the newly appointed Senior Administrative Medical Officer of the Regional Hospital Board, about his tentative views on measures he might recommend to the Board for reorganising services in the Preston area.
- (iv) Having seen and heard evidence from only six members of the Hospital Management Committee, we invited all the members to meet us towards the end of our hearing. All, except one medical member, accepted our invitation and we had a frank informal discussion but did not on this occasion take further evidence from them. We found this meeting most useful and informative and it was attended by the legal and other representatives of various parties as observers.

6. Further details of the evidence we received in public are given in succeeding chapters. We were impressed by the demeanour and apparent honesty of present and past members of the nursing staff, many of them quite young, who told us convincingly of unsatisfactory features of various kinds and we were less impressed by the evidence and demeanour of some of those who denied allegations about them. We also think it right to say that we concluded that many of the complaints might not have arisen but for continuous gross understaffing, both of nurses and consultants, and, although we appreciate the grave difficulties of recruitment, we do not consider that the Hospital Management Committee and the Regional Hospital Board can be exonerated from blame in this respect.

7. We were fortunate in having Mr. Douglas Walker, a local solicitor, to act for us and we are grateful for the work done by him and his firm in assembling evidence and presenting it to us. This undoubtedly saved a great deal of our time and enabled us to hear the story in an orderly and convenient way. We also appreciated the assistance of Mr. Peter Revington, the Solicitor to the Regional Hospital Board, who represented both the Board and the Hospital Management Committee and introduced evidence on behalf of those bodies.

8. Another local solicitor, Mr. D. H. Jones, represented the present and former Group Secretaries, the Treasurer and members of the National

Association of Local Government Officers at the hospital. Shortly before the hearing ended, Mr. Jones strongly criticised the decision to hold it in public, contending that a private Inquiry would have been preferable and would have caused less harm to the reputation of the hospital and its staff—a contention with which we disagreed and so informed him. Nursing staff implicated in the allegations were represented by Mr. E. A. G. Spanswick, Assistant General Secretary of the Confederation of Health Service Employees, with the exception of the former Matron, Miss D. V. Williams, who was represented by Miss Margaret Walpole of the Royal College of Nursing.

9. All the representatives were allowed to examine their witnesses and to cross-examine others, and afterwards each of us put such questions as we thought fit to the witnesses. The representatives addressed us at the conclusion of the evidence given. Every opportunity was given to witnesses whose conduct was criticised at our hearing, and to those who represented them, to answer any allegations made against them.

10. We should like to express our thanks to the Group Secretary of Whittingham Hospital, Mr. Makinson, for his patience and courtesy in attending to our many requests for documentary evidence and in arranging our visits to the hospital.

11. We are indebted to our Secretary, Mr. Michael Foster, and his assistant, Miss Joyce Martin, for their invaluable help throughout our deliberations. Mr. Foster's complete mastery of the considerable detail involved in our work and his flair for lucid expression have much impressed us. Miss Martin's energy and patience ensured our comfort and convenience at all times and we are most grateful.

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100 at Ribchester; of these 86 per cent. had been there more than two years and 45 per cent. were aged 65 or more. As in other hospitals of similar type many were admitted during the old days of custodial care before the therapeutic revolution of the 1950s profoundly changed the approach to treatment in most psychiatric hospitals.

15. These changes in function have been the result of the deliberate policy of the Manchester Regional Hospital Board. This Board pioneered the policy of transferring short-stay treatment to departments in general hospitals which was adopted by the Ministry of Health in the Hospital Plan of 1962. Consequently the plan has been to transfer "active" psychiatry from Whittingham to Preston, a process which was begun by opening the Sharoe Green unit for women and is to be completed by building a 150 bed unit as part of a new district general hospital in Preston. Meanwhile, as Dr. Marshall told us, the Board's plan assumes that Whittingham itself will continue to run down and finally close in "about 15-20 years' time", when hostel provision by local authorities and geriatric provision in hospitals elsewhere will make this possible. How this objective is to be achieved while "long-stay" patients continue to be admitted in large numbers is not clear to us. Nor does it seem to have been clear to the Hospital Management Committee, who in evidence made it plain that they did not accept the Board's policy as being either realistic or practicable. We make further reference to this point in Chapter 5.

16. Faced with this uncertain future, Whittingham continues to attempt to meet the needs of its district for comprehensive mental illness services, along with the Preston and Chorley Group. Out-patient clinics are held at hospitals in Preston and Chorley. In-patients are divided into short-stay, who are admitted to the units at Whittingham or Sharoe Green, and long-stay, geriatric or psycho-geriatric, who are admitted to other wards at Whittingham. Returns indicate that occupations are provided for slightly more than half of all the patients. They suggest that on a working day in 1970, 307 patients would be working in industrial therapy and 311 at handicraft, while 399 had domestic tasks, 86 were in hospital services of various kinds and 7 went out to work. Further education classes would be attended by 50. The rest are, it is said, not occupied because of severe disability (244), disturbed behaviour (107) and senility (467). Links with the local authorities, Preston County Borough and Lancashire County Council, appear almost non-existent and the facilities provided by them for community care seem slight. Although we were told that at least 160 patients were fit to live in the community, given appropriate facilities in the shape of hostels, group homes or boarding-out facilities, the rate of discharge of such patients was about two per year. There is some voluntary work, including a League of Friends. We were told that visiting was unrestricted but in practice the times prescribed for visiting are Saturday, Sunday and Wednesday afternoons between 2.00 and 4.30 p.m.

17. The patients themselves present as vivid contrasts as the buildings or the therapeutic regimes in which they are treated. Those in the admission wards and special units seem much like those in any other modern hospital environment. But many of the long-stay patients show every sign of an absence of medical treatment and constructive rehabilitation. They are, in the Chairman of the Hospital Management Committee's words, "the type who sit around

all day just doing nothing but becoming cabbages". These impressions are confirmed by their shabby, ill-fitting clothes; the airing courts in which they mill around; the parole cards in a variety of colours which appear to be still in use. It is plain that for many of these patients the therapeutic revolution of the 1950s never happened. It seems equally clear that the hospital has been too ready to regard the programme of upgrading buildings—in itself wholly commendable—as an adequate substitute for a therapeutic programme for these long-stay patients. For many of them Whittingham, to all intents and purposes, remains a locked hospital.

18. These impressions, and our conclusions, are elaborated in succeeding chapters.

3. THE COMPLAINTS

19. We were told in evidence that unrest at Whittingham can be traced back to 1965, when two outspoken items appeared in a new hospital magazine, "Contact". One, an article by Dr. Masters (the assistant psychiatrist referred to in the Introduction), reported frustration among student nurses about defects in training on the wards. The other, a letter from a student nurse, complained about the condition of patients in St. Luke's division. These two themes recur throughout subsequent events. The Principal Tutor told us that there was a constant flow of complaints by students from 1965 onwards. Significantly, most of these seem to have related to female wards; and it is noteworthy that the pupil nurses (who train for the grade of State Enrolled Nurse instead of Registered Mental Nurse) seem not to have expressed the same discontent as the students. Neither the nursing administration nor the Hospital Management Committee felt it necessary to make any special investigation of the grievances expressed in these articles or even to respond to them. Indeed at our hearing the Chairman of the Hospital Management Committee said he could not recall them.

20. Smouldering discontent among the student nurses caught alight in the middle of 1967. That year the publication of the book "Sans Everything", by Mrs. Barbara Robb, about conditions in long-stay hospitals stirred up press publicity and a letter was sent from the Permanent Secretary of the Ministry of Health to all Regional Hospital Boards asking them to "satisfy themselves that there are not grounds for complaint in their hospitals". The Chairman of the Manchester Regional Hospital Board thereupon wrote in similar vein on 6 July to Chairmen of Hospital Management Committees in his Region, adding, "I know that, with me, you will be only too anxious to establish that patients in the hospitals in our region are not treated in this way and that you will wish to be personally satisfied that there is no evidence of inhuman treatment in any of the hospitals for which your Management Committee are responsible". With hindsight, we think this wording, which echoed that of the Permanent Secretary's letter, was unfortunate since it implied an expectation of a reassuring response.

21. On 18 July, 1967, the Student Nurses Association held a meeting with the Principal Nurse Tutor in the chair. During their discussion the students made a number of serious allegations of ill-treatment and fraud but, for fear of victimisation, avoided naming persons, wards or individual complainants. The minutes of this meeting are reproduced at Appendix II. The Chief Male Nurse, Mr. Wilson, acted promptly. On 20 July he summoned a meeting of student nurses, which was attended by the Matron and the Principal Tutor. Accounts of this meeting conflict but all agree that it was stormy. According to the student nurses they were told by the Chief Male Nurse that their complaints were material for the law courts and they regarded themselves as threatened with the risk of action for libel and slander; since they were frightened and fearful of victimisation, they refused to particularise their allegations. The Chief Male Nurse, supported

by his Deputy, the Matron and other members of the nursing hierarchy, held that while he may have used the terms "libel" and "slander" he stressed the gravity of the accusations and pleaded for names and details without success. We broadly accept the students' account as the correct version, as the Chairman of the Hospital Management Committee, Mr. Phipps, himself did in evidence. It is a fact that the students piped down and the minutes of their meeting were suppressed by the Chief Male Nurse, the Matron and the Principal Tutor. When the Chairman of the Hospital Management Committee called a meeting on 21 July 1967, which included all senior nurses down to Charge Nurse/Ward Sister level, to discuss the Regional Hospital Board Chairman's letter he asked everyone to report any incident that had occurred or did so in future. He added, in his own words, that since "in a hospital of this size with a vast staff there may well be unknown to me one or two rotten apples in the barrel, would they go and seek out such apples". Neither the Chief Male Nurse, the Matron, nor the Principal Tutor uttered one word of the students' complaints of 18 July. On 26 July the Chairman wrote briefly to the Board saying that he had every reason to believe that Whittingham was free of incidents of this kind. In an earlier letter to the Regional Hospital Board Chairman, dated 7 July, he had also undertaken to write a personal letter to all members of the hospital staff and to arrange a refresher course on care of the elderly; but these intentions were not fulfilled.

22. The Chief Male Nurse, as he told us, subsequently tried to get to the bottom of the complaints. He held a further meeting on the male side with both charge nurses and students. Since this achieved nothing he detailed one of his senior assistant chiefs (who was subsequently convicted of theft) to speak to selected male students but they refused to give details. the Matron did no more than make inquiries through two senior nurses which also came to nothing. But neither Mr. Wilson nor Matron ever reported the complaints to the Hospital Management Committee and Matron could not recall that they ever discussed the matter further. Both the Chairman of the Hospital Management Committee and Mr. Makinson, the Group Secretary, insisted that they heard no word of them until the auditors unearthed the minutes of the students' meeting at the end of 1969. From this can be traced the origin of a dissident party.

23. A second element was introduced in March, 1968, with the arrival of Mrs. Patricia Bunn as Principal Psychologist. She lived with her children in a flat in the female Nurses' Home and was closely associated with the training school. According to her own account she was from the first appalled by the situation in many of the long-stay wards and it was natural that she should rapidly become identified with the dissident students' interest. Mrs. Wilson, the Chief Male Nurse's wife, who was warden of the Nurses' Home, claimed that it was at this time the happy atmosphere of the Home began to deteriorate.

24. We now come to the crucial rôle of Dr. Masters in these troubles. At our hearing he was acknowledged on all sides, without dissent, to have been a dedicated, conscientious, energetic and highly promising young doctor. Dr. Masters had arrived at Whittingham as a Registrar in 1961 and, since his appointment as a Medical Assistant in Psychiatry, he had been attempting

to stir up the stagnant therapy in wards of which he had day to day charge by unlocking doors and starting active rehabilitation. In this, he felt, he encountered resistance from the nursing administration on the female side and particularly from the Sister in charge of ward 16. By 1967 he was also, significantly, the doctor who made the major medical contribution in the nurse training school and early in 1968 became a member of the Nurse Education Committee. It was therefore natural that he should receive the confidences of the student nurses and of Mrs. Bunn. When, later in 1968, he encountered opposition from the nursing administration on the male side and, as he felt, met apathy from the responsible Committees, he began to lend these grievances a sympathetic ear and to make common cause with Mrs. Bunn. Early in 1969 he became Secretary of the Medical Advisory Committee.

25. Further trouble arose in October, 1968 when Dr. Masters raised on the Nurse Education Committee students' grievances about training conditions and faulty lines of communication. This Committee referred the matter to the Nurse Procedures Committee, who met in November and, after an acrimonious discussion, by a majority vote passed a resolution that "the allegations are without foundation and we as a Committee reject them in no uncertain terms". Two days later the Chief Male Nurse and Matron called a meeting of student nurses. Interpretations of this again conflict. The student nurses held that they were told in the words of one of them (a prize winner), "If you don't like the way things are, you can shut up or get out". According to the nursing administration, Mr. Wilson asked the students to use the ordinary channels of communication which were open to them—their union, C.O.H.S.E. (which, all the evidence suggests, was closely identified with the male side of the nursing administration), the Joint Consultative Committee (which rarely met) or their own seniors, the charge nurses or ward sisters (the staff to whose conduct they objected). Following this meeting, 48 or 49 letters were written, including two from Deputy Sisters, via the Nurse Training School to the Hospital Management Committee. 44 of these were received. The Hospital Management Committee then decided to set up a "Sub-Committee of Enquiry" to hear the complaints. On 5th December, there was a preliminary meeting between nursing heads and Dr. Masters at which he was accused of interfering in students' affairs and told he would have to withdraw his allegations. On 6th December, the Sub-Committee of Enquiry, which consisted of Hospital Management Committee members, the heads of the nursing administration and their deputies, representatives of C.O.H.S.E. and Dr. Masters, assembled to meet representatives of the students. Dr. Masters was again asked by the nursing administration either to "prove" his allegations or withdraw them and apologise; but after discussion with the students the Chairman promised that their complaints would be investigated and a further meeting held. No meeting was held until July, 1969, and the so-called "Enquiry" seems to have run into the sand.

26. The denouement began in June, 1969. In response to a suggestion by Mrs. Wilson, the Warden, that they should form a social association, the women residents of the Nurses' Home set up a Residents and Tenants Association and invited Mrs. Bunn to be Chairman. They wrote a polite

letter to Mrs. Wilson informing her of this and asking for various items of equipment. Most of these requests were promptly dealt with by Matron but Mrs. Wilson took umbrage ; and it was at this point that her husband, the Chief Male Nurse, chose to exhibit in the hospital a facetious notice referring to Mrs. Bunn and her associates as " the Bunnies " and signed " Bill Shakespeare ". Dr. Masters and Mrs. Bunn immediately set about investigating the authorship and, when it was acknowledged by the Chief Male Nurse, they demanded a full public apology. This was refused. The Hospital Management Committee Chairman saw Dr. Masters and Mrs. Bunn and, when they declined to accept anything less than a public apology, he told them that they could leave the hospital as far as he was concerned. The day after this, 18 July, Dr. Masters wrote to the Secretary of State.

27. When the Hospital Management Committee finally heard, through the auditors, of the suppression of the students' complaints of July, 1967, they reprimanded the Chief Male Nurse and the Matron. Both subsequently retired, aged 59 and 61 respectively. They were replaced by a new Chief Nursing Officer on 1 January, 1971, within one month of the Secretary of State's announcement of the Inquiry.

28. This brief summary is necessarily selective but we believe it is a fair record of the main events in the troubles of Whittingham as recounted to us in evidence. We do not seek to absolve the complainants entirely from all the faults attributed to them—particularly impulsiveness, administrative inexperience, general restiveness or, in the case of some individuals, an inclination to make trouble. But we are in no doubt that they were in the right and that the hospital management paid too little attention to their grievances. The following general conclusions seem to us inescapable :

- (1) a large part of the student body at Whittingham made serious complaints, headed by those who were agreed in evidence to be the most go-ahead (they included, for example, prize winners) ;
- (2) the student body felt profound distrust for the nursing administration and the established machinery for consultation ;
- (3) the nursing administration had an authoritarian outlook and were suspicious of any suggestion that nursing procedures and conditions could be improved ;
- (4) the nursing administration failed to report to the Hospital Management Committee very serious complaints about patient conditions in 1967 and to take the initiative in investigating serious complaints about training in 1968 ;
- (5) the Hospital Management Committee and their administrative staff failed to carry out a proper investigation of serious complaints when they were made.

29. We now turn to the detailed complaints about conditions at Whittingham made to us in evidence. These allegations, which were extensive, provided detailed support for the students' complaints of July, 1967 and October, 1968 and they added many others, particularly in respect of fraud and maladministration. Most of these allegations were denied by the hospital staff concerned. Since there are so many, we group them together for convenience, irrespective of source, under three heads—care of patients, organisation of services and financial control.

(A) Care of patients

30. There was general agreement that many wards in the hospital, particularly in the admission unit, were well run and provided a high standard of care. The specific allegations of ill-treatment though extensive, were limited to four long-stay wards, two male and two female ; and most relate to a single female ward. All concern the period before or round about 1967, when the students made their original complaints (reproduced at Appendix II). These allegations and our conclusions about them are summarised below.

31. *Ward 16.* The main allegations were as follows :

- (i) patients left untreated and without adequate occupation ;
- (ii) patients regularly given bread and jam for breakfast and tea, whatever the menu ;
- (iii) patients regularly being given spoons only at lunch-time and never knives or forks for any meal ;
- (iv) patients' food being mixed up and served as slops ;
- (v) patients regularly seriously restricted in fluids at and after meal-times ;
- (vi) patients regularly put to bed in vests, and queueing on the stairs while waiting for baths ;
- (vii) certain patients frequently locked in a room under the stairs ;
- (viii) patients frequently locked out in an airing court in inadequate clothing regardless of the weather ;
- (ix) certain patients frequently locked in a washroom.

Ward 16 is a "three-decker" ward of the old style. We wish to emphasise that it had, and still has, totally inadequate washing and lavatory facilities and has been grossly understaffed for many years. There was disagreement as to whether its patients were specially difficult to treat but in our view this was not a material factor. Until September 1969 the ward was under the charge of a sister who had served in the ward continuously for no less than 47 years—ever since her qualification as a trained nurse, when methods of care in mental hospitals were very different. Her deputy was an enrolled nurse from the continent who had never received any formal training or instruction and served on the ward for eleven years. The Ward Sister was subpoenaed but furnished a medical certificate that she was unable through sickness to attend our hearing ; she submitted a written statement afterwards. Her deputy, who had left the hospital early in 1970, returned to give oral evidence. With one exception all the allegations were denied.

32. Allegations (i)-(v) relate mainly to 40 or 50 of the least active and most institutionalised patients on the ward—known, according to the student nurses, as "the dozy side"—during the period 1964-67. The reason for the bread and jam diet was that many of these "dozy" patients were doubly incontinent ; and they were not given cutlery because they had long since forgotten how to use it. The witnesses who made these allegations were mainly student nurses who had served on Ward 16 at different times but they included a porter and, in some instances, Dr. Masters and the Deputy Matron. All the allegations, except (iv), were supported by at least two reliable witnesses. The locking of patients under the stairs was supported by five witnesses and, although vigorously denied by the deputy, it was

admitted in the Ward Sister's evidence, her reason being that for short periods a difficult and mischievous patient had to be kept out of the way. We think it profitless to go into the details of these allegations since they relate to a period several years ago and we are satisfied, from visiting the ward, that conditions there are now much improved. However, we are in no doubt that these allegations are substantially correct. We comment on the reasons for the disastrous situation in this ward, which clearly persisted for years, apparently unknown to the Hospital Management Committee and ignored by the medical and nursing administration, in Chapter 6.

33. *Ward 35.* The allegations affecting this female ward, by two student nurses, concern two incidents involving patients being dragged by the hair. These allegations were denied by the nurse concerned and, while we do not doubt the honesty of the witnesses, we are not convinced that events occurred precisely as related to us. We consider that inevitably ill-temper and roughness has been shown from time to time by hard pressed nurses working in difficult conditions and without the resources of rehabilitation necessary for long-stay patients.

34. *Ward 3.* The main allegation, made by one student nurse who some years ago left the profession, was that "wet towel treatment" was sometimes used in 1963-64 to restrain violent patients: this involved twisting a wet towel round a patient's neck until he lost consciousness. The same witness also alleged that a patient had been punched in the stomach and locked in a storeroom. These incidents were flatly denied by the nurses involved. One of them was the nurse, referred to in the Introduction, who is currently serving a sentence for manslaughter committed in hospital; another had left the hospital before our Inquiry and could not be traced. The witness appeared honest, his accounts did not seem invented and we accept his evidence on the first allegation. On the second incident we feel there was scope for misinterpretation of what the witness saw and we are not prepared to find that it took place as related to us.

35. *Ward S2.* The allegation was made by another witness, who has also left the hospital, that male nurses poured methylated spirit onto the slippers of one patient and the dressing-gown pocket of another and then set it alight. This allegation was also flatly denied by the two nurses involved, one of whom, again, was the nurse now serving a sentence for manslaughter committed in the hospital. Here also, the witness appeared honest and his account truthful, and we accept his evidence.

36. We think it only fair to record that no evidence on any of these specific allegations about individual wards was offered by patients themselves, although notices about our Inquiry were displayed throughout the hospital. However we are satisfied that this fact is adequately explained by the age, condition and degree of institutionalisation of the patients concerned and the lapse of time; it does not in itself cast doubt on the truth of the allegations. We did not seek to press the patients concerned to give evidence, which we felt would be of doubtful assistance and would cause them needless pain.

37. There were also more general allegations of defective care affecting long-stay wards. Dr. Masters alleged that in various parts of St. Luke's division, where he was in day to day charge, the female wards were effectively

locked in the old-fashioned custodial style, that there was little activity for patients and that his efforts to change matters were resisted. He also found that some rooms in winter were excessively cold and damp with temperatures of 46° or less. Student nurses alleged that there was persistent rough treatment in some wards and that there were instances of restraining patients by tying them in chairs. They also alleged that on some female wards cockroaches were common in the late 1960s and one gave a graphic description of these creatures crawling over patients' beds. Occasions when patients were bathed with long mops, quoted in the students' complaints of July, 1967, were also mentioned at our hearing. Letters from several patients made vague and unspecific complaints which supported some of these allegations.

38. The new Catering Manager described, without much contradiction from other witnesses, the inadequacy of diet, kitchens and cooking equipment on his arrival in November, 1970. It appears that choice of diet was effectively in the hands of the Supplies Department and depended much too heavily on what was available in the market gardens. For this reason ward staff were in the habit of using patients' money to buy stocks of tinned and other foods to improve the patients' meals and, as we heard for ourselves in evidence, some nurses were quite unaware of the fact that they were entitled to order special diets for those who needed them. We discuss the inadequacies of catering more fully in Chapter 7.

39. There was insufficient evidence at our hearing on the therapeutic atmosphere and ward conditions in the period 1967-69 to enable us to comment in detail on these more general allegations but the impressions gathered from our visits certainly tend to confirm Dr. Masters' picture. The fact that so much of the hospital remains largely custodial even today points to the conclusion that two or three years ago therapeutic activity was almost non-existent in many long-stay wards at Whittingham. It was clear to us from the evidence that much, if not most, of the progress in introducing rehabilitation of long-stay patients had taken place after 1967. We were told that the recruitment of occupational therapy staff, and the encouragement given to their activities, had changed out of all recognition in the last year or two and this is confirmed by the staffing returns.

40. In summary, we feel that there was credible evidence of serious malpractices in certain wards in the hospital, but that this was largely a result of overwork, bad conditions and lack of medical treatment and supervision. Staffing, both medical and nursing, was plainly inadequate ; and old-fashioned methods of care were retained which should have been superseded. It was particularly inexcusable that a Sister was allowed to remain on the same ward for 47 years, ever since she qualified as a Registered Mental Nurse, and that Matron should have recommended extension of her service on the same ward up to the age of 70 ; likewise that her totally untrained deputy should remain there for 11 years, often in charge of well-trained third year student nurses. In such conditions staff can become as institutionalised as patients and we feel unable to apportion the blame among individuals. We feel strongly that main responsibility for the situation must lie with the medical and nursing administration and that the Hospital Management Committee and Regional Hospital Board cannot escape censure.

(B) Organisation of Services

41. Criticisms and complaints of the organisation of services made to us at our hearing stemmed from the student nurses' complaints of 1968 about training conditions and, although they extended to cover the management structure as a whole, they were mainly concentrated on the nursing administration. The main points made were:

- (i) the H.M.C.s failure to provide adequate guidance and to monitor services ;
- (ii) failure to provide adequate medical staff ;
- (iii) inadequate nursing staff on many wards ;
- (iv) wards too crowded and ill-equipped to carry out nursing procedures;
- (v) inadequate training on wards ;
- (vi) inadequate communications
 - between training school and administration,
 - between male and female administration,
 - within the female administration,
 - between junior and senior staff,
 - between the nursing administration and the occupational therapy department ;
- (vii) haphazard deployment of nursing staff ;
- (viii) petty restrictions in the Nurses' Home ;
- (ix) suppression of student nurses' complaints ;
- (x) extensive use of virtually untrained nurses in charge of wards for long periods ;
- (xi) disfavouring those who did not indulge in financial irregularities ;
- (xii) ineffective co-ordination between various therapy departments ;
- (xiii) inadequate links with community facilities ;
- (xiv) unsatisfactory handling of the psychologist staff.

These allegations seem to us largely justified by the evidence. However, our own examination of the hospital organisation was much more extensive and for convenience and clarity we consider them in the succeeding Chapters 4, 5, 6 and 7.

(C) Financial Control

42. The students' complaints of July, 1967 (reproduced at Appendix II), alleged that cigarettes were appropriated from patients and sold back to them at inordinately high prices ; that hospital and patients' goods, such as cereal and tinned foods, were removed ; and that patients' money was appropriated by nursing staff for their own use. The reports of the audit investigation of 1969-70, which we deal with in more detail in Chapter 8 and which are reproduced at Appendix VI, lend substance to these allegations by drawing attention to a general collapse in the system of ward records for patients' money and to a large discrepancy between the total amount of money issued to patients and the amount spent locally. Evidence at our hearing, which varied in quality, confirmed and amplified the students' complaints. Some of the allegations were general ; others related to specific individuals, particularly the former Chief Male Nurse.

43. One witness who much impressed us—he had taken a prominent part in the students' complaints of 1967 but had also served as a member of the local branch executive of C.O.H.S.E. and on the staff side of the Joint Consultative Committee and was generally reputed one of the ablest students—told us, "Sometimes a certain amount was allocated for a certain patient to be spent on cigarettes but the amount of cigarettes the patient got did not seem to match the amount of money . . . I discussed it privately with other students . . . and we had meetings about it to decide if the rest of us had got similar experiences . . .". Asked, "Had they?" he replied, "In the main, yes". Similar comments were made by other staff and more specific evidence was given by a Charge Nurse who made detailed allegations about organised thefts of patients' money and went on to say, "In the mess rooms . . . it is common belief that anybody that does not co-operate in corruption does not succeed". Another witness made accusations about misappropriation of hospital property by the former Chief Male Nurse but we considered his evidence unreliable. A further witness, who had made similar allegations, chose to withdraw them for reasons best known to himself when he gave evidence; while another, who we believe may have been honestly mistaken in what she saw, accused the Chief Male Nurse of appropriating property from the Nurses' Home. There were allegations about other staff, ranging from serious to trivial. These extended to the former Group Secretary, Mr. Higgs, who was accused of regularly appropriating market garden produce, but it was clear from his evidence that he was simply removing vegetables grown on his own allotment. However, the most sweeping allegation was put forward by the present Group Secretary, who quoted the words to him of one of two very senior nurses, who were both convicted of stealing suits and both of whom gave evidence to us accusing each other of being the originator of the theft: "You know, Mr. Makinson, everyone at the hospital is in the racket [that is of patients' money]. . . . Just everyone. You don't need me to tell you who these people are. All you need to do is take a look around and see which of the staff change their cars every year, and which of the staff go abroad for holidays every year, and who take their wives out two or three times a week dining, and who have built bungalows recently. . . . I am not saying any more: I have said too much already; and if I am ever challenged on this I will deny that this conversation ever took place". All the allegations were consistently and firmly denied by those concerned while other staff maintained they had no knowledge of irregularities of this kind. The Chief Male Nurse and his Deputy in particular insisted that they knew of no such incidents—apart from the few dealt with in the courts.

44. Our conclusion was that some of the allegations about individuals, which produced completely conflicting statements by different witnesses, were backed by insufficient evidence to be fully convincing and that others had adequate explanations of an innocent kind. This view is consistent with the result of the extensive audit and police investigations which led to only two prosecutions. On the other hand, our conclusion about the general allegations is that the collapse of the system of ward records, so clearly demonstrated in the audit reports, presented opportunities too tempting to resist and led to large-scale pilfering of patients' money in the past. This conclusion is supported by the fact that the Hospital Management Committee were unable to offer an adequate explanation for the large discrepancy, shown by the

auditors, between the total amount of money issued to patients and the amount spent locally. How far the corruption extended to the rest of the life of the hospital, and was deliberately organised, it is not possible for us to determine so long after the events and within the compass of our Inquiry. But Mr. Makinson's quotation from the statement of a senior nurse bore the stamp of truth and was corroborated by too much other evidence to be dismissed as idle rhetoric or the embittered effort of one who had been punished to involve others in his own fall. We believe that this state of affairs was not unrelated to the suppression of the students' complaints and was only brought to an end by the audit investigation and the measures taken by the Treasurer's Department, with which we deal in more detail in Chapter 8.

4. THE MANAGEMENT STRUCTURE

45. The responsibilities of hospital authorities are defined in regulations issued in 1948. Regional Hospital Boards, as the Secretary of State's agents, are responsible for guiding and controlling the planning, conduct and development of services in their Regions; Hospital Management Committees, as the Board's agents, for administering these services. The functions of members of Hospital Management Committees and their officers are summarised in the "Handbook for Members of Hospital Management Committees" published in 1966. "The Management Committee is responsible for the running of the hospital, subject to any direction from the Minister or Board, and in discharging this responsibility the Committee has a duty to see that the interests of the patient and of 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 to 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 Committee's 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 by these criteria has the Whittingham Hospital management structure succeeded?

46. Whittingham Hospital Management Committee consists of 15 members of whom details are given in Appendix III. They were said by the Chairman of the Regional Hospital Board to be the best psychiatric Hospital Management Committee in the Manchester region. Certainly they do not lack experience. Six have been members for ten years or more; and of these three, including the Chairman, have been members for fifteen years or more. One, the Chairman of the Nurse Education Committee, has served since 1948. Six are over 65 and three over 70. The long periods in office of key members, and their ages, may not be unconnected with the comments that follow.

47. The sub-committee structure is complex and, surprisingly, shows no change in the light of advice from the Farquharson-Lang Report on the rationalisation of hospital management structures, circulated under H.M.(66)28. This structure is set out at Appendix IV. There are no less than six sub-committees. Apart from Establishment, Finance, Planning and Estates and Statutory, there are special recently set up sub-committees on "Catering and Visiting" and "Patients' Rehabilitation and Visiting". There is a Joint Consultative Committee, consisting of management and staff sides (including student nurses), and a Nurse Education Committee, whose Chairman since 1963 has been Mrs. Goodwright, which itself has a Nurse Procedures Sub-Committee. Medical policy is dealt with by a Medical Advisory Committee consisting of the hospital consultants; its Chairman until March 1971 was Dr. Silverman of Blackburn Hospital, who had no clinical commitments at Whittingham and only one session per week for administrative purposes only.

Mr. Phipps told us that the Medical Advisory Committee made requests and recommendations to the Hospital Management Committee, who took the ultimate decisions. In addition there is a "Principal Officers' Meeting", comprising the Group Secretary, all consultants and (until they were replaced by a Chief Nursing Officer) the twin nursing heads—the Chief Male Nurse and the Matron. This appears to have taken over some of the policy functions normally exercised by the Medical Advisory Committee.

48. The complexity of the committee structure in our view has greatly handicapped the conduct of business. First, it is by no means clear where the responsibility for decision on major issues lies. Secondly, many matters need reference to more than one sub-committee and this inevitably entails delay and difficulty in reaching decisions. Thirdly, it imposes an unnecessary burden of work on both members and administrative staff. Farquharson-Lang recommended two, and certainly not more than three, sub-committees; but although the Hospital Management Committee discussed the Department's advice at the time no recommendation for any fundamental change was made. In giving evidence, the Chairman of the Hospital Management Committee, Mr. Phipps, did not recall this advice and said that in his view "the more committees you have the more involved you are".

49. This apparently explicit acknowledgment of "administration by labyrinth" is confirmed by examination of the minutes of the Hospital Management Committee and its sub-committees in recent years. The picture is of vague policy formation, splintered decision-making, inadequate delegation to officers and no systematic monitoring of performance. In fact the management structure represents very much the kind of administration criticised by Farquharson-Lang. Instead of discussing major policy objectives such as unlocking doors, opening up airing courts and progress in extending rehabilitation to all patients, the minutes are packed with day-to-day decisions on trivia such as tenders for loads of gravel and purchases of lavatory basins or flower and vegetable seed. The programme for up-grading wards has been pushed forward with vigour, and this is greatly to the Hospital Management Committee's credit, but it is difficult to discern its link with any planned therapeutic programme. Certainly there seems to have been no recognition how far Whittingham had drifted behind the tide of progress in psychiatry.

50. Minutes of Hospital Management Committee meetings often seem so brief and elliptical as to convey no meaningful consideration or decision. Indeed it is possible to read some of them without discovering what subjects were under discussion and what decisions were reached. Reference between the various sub-committees seems too often to have been a substitute for grasping nettles. An example is the students' complaints about training conditions of October 1968. These were referred from the Nurse Education to the Nurse Procedures Committee; rejected as unfounded; re-opened by the Hospital Management Committee itself as a result of written protests via the Training School; considered by a "Sub-Committee of Enquiry" which met once and promised investigation; and then "lost". There are other instances of lack of effective action. The students' complaints of July 1967, when the auditors eventually brought them to light at the end of 1969, were placed before the Hospital Management Committee; the

Committee reprimanded the Chief Male Nurse and the Matron ; but the opportunity to deal with the problems raised was missed. The functions of some sub-committees seem to have been oddly exercised. The Nurse Procedures Committee has been less involved in standardising "procedures" than in dealing with training and other matters more appropriate to an Education Committee. Hospital Management Committee members of the Catering Sub-Committee rarely visited wards during mealtimes. The Rehabilitation Sub-Committee included no occupational therapists ; nor did it co-ordinate rehabilitation activities or even meet the therapists regularly. The Joint Consultative Committee seems to have met only rarely.

51. More striking still was the lack of co-ordination—in some cases even communication—between different parts of the management structure. The assurances we were given that the Hospital Management Committee Chairman and the Group Secretary were not informed, and learned nothing, of meetings called by the student nurses and the nursing administration about serious allegations of ill-treatment are almost incredible when those concerned were in daily contact. More serious was the lack of effective advice from the Medical Advisory Committee to the Hospital Management Committee. The Chairman of the Hospital Management Committee said in evidence that he consulted the Group Secretary about everything ; he also frequently consulted the Chief Male Nurse and the Matron, who attended Hospital Management Committee meetings. But he never consulted Dr. Silverman "except on one or two occasions when I had definite problems" during the eight years while the latter was Chairman of the Medical Advisory Committee. The fact that Dr. Silverman had only one session per week at the hospital no doubt made it difficult for them to meet. This failure of communication substantially contributed to the therapeutic inertia on long-stay wards which gave rise to the students' complaints of July 1967. We deal with the question of medical leadership, or the lack of it, in Chapter 5.

52. In this complex structure, with a serious weakness at this critical point, the Group Secretary's role was crucial. Our assessment is that Mr. Makinson (who succeeded Mr. Higgs in May 1967, shortly before the students' complaints) did a loyal and conscientious job in matters of routine but, perhaps because he was burdened with so many problems arising from lack of effective medical leadership, contented himself with keeping the administrative machine running with the minimum of trouble rather than seeking to identify policy objectives, solve essential problems or correct the basic weaknesses of the management structure.

53. We recognise that this examination of the management at Whittingham concentrates on structural weaknesses and operational inefficiency to the exclusion of much good and effective work. Nevertheless we feel that these defects are so serious that radical reorganisation is needed, as a matter of urgency, to give the hospital a fresh start. We have no doubt that the essential basis for this is the reconstitution of the Hospital Management Committee. We have considered the possibility of amalgamation with the Preston Group. However attractive in principle this might appear, it is not in our view desirable. It would probably take a year or more to carry out and the work involved, which would distract attention from the main task of reorganising the hospital itself, would be overtaken by the

further reorganisation resulting from setting up new area health authorities in April 1974 (as proposed in the Consultative Document "National Health Service Reorganisation" of May 1971). We therefore consider that the existing Hospital Management Committee should be dissolved, if possible by the voluntary resignation of the members, and a new committee of about eight set up, partly drawn from the existing committee, partly from the Preston Group and partly from new members. This body should work closely with a "Professional Executive", charged with responsibility for day-to-day management, consisting of the Medical Chairman, the Chief Nursing Officer, the Group Secretary and senior members of other disciplines, and also with the Social Work Directors (or their representatives) from Preston Borough and Lancashire County. All these professional people should be invited to attend Hospital Management Committee meetings. We also recommend that the number of sub-committees be drastically reduced in line with the recommendations of the Farquharson-Lang Report. Indeed it may be found from experience that, with such a small Hospital Management Committee, the need for sub-committees will disappear.

54. Recent changes in the Chairmanship of the Medical Advisory Committee and in the leadership of the nursing administration should help to create a strong Professional Executive. Given the reorganisation and delegation of functions we advocate, the existing administrative staff should prove adequate for their task (details are given in Appendix V). We hope that the Group Secretary, after several years in such a difficult situation, will have a fresh opportunity, within the new Professional Executive, to develop a more positive approach to modern management. These and other measures which will assist in strengthening the medical and nursing administration are dealt with in the two succeeding chapters.

5. THE DOCTORS AND THEIR POLICIES

55. In Chapter 4 we referred to the lack of effective medical leadership at Whittingham resulting from the Chairman of the Medical Advisory Committee having little connection with the rest of the management structure and none at all with the treatment of patients. The choice of Dr. Silverman as Chairman, when the last Medical Director resigned for reasons of health in 1963, was made by the Manchester Regional Hospital Board. From some points of view this may have appeared a very reasonable choice. Dr. Silverman had been partly employed at Whittingham and for some years had also been a noted exponent of the Board's policy of transferring psychiatric treatment from specialist hospitals to departments in general hospitals. He would have seemed to possess the status, the experience and the right approach to guide the run-down of Whittingham. But even at the time of his appointment as Chairman he had only two sessions per week at the hospital and over the years his clinical commitments had ceased. Although he has been given one session per week for administrative purposes only, this has not, in our view, been enough to keep him in touch with the hospital's problems. Dr. Silverman informed us that he had stayed on only at the request of the Board and his fellow consultants because there was no other obvious candidate. Shortly after our Inquiry was announced he ceased to be Chairman of the Medical Advisory Committee—he told us he did not stand for re-election—and was replaced by Dr. Oakley, who is employed full-time at Whittingham and Sharoe Green; and we were glad to hear the Chief Nursing Officer tell us, "The consultants are now coming in to formulate policies where I do not think they did so in the past". We feel that the acceptance for so long by the Board, the Hospital Management Committee and his colleagues of a virtually absentee Chairman who was heavily committed elsewhere was profoundly mistaken.

56. From the evidence given us we were left no room for doubt that the medical staff had no clear and co-ordinated medical policy; and that this deprived the Hospital Management Committee and nursing staff of vital advice and left the hospital as a whole with no coherent strategy. As Dr. Silverman said, "There are two ways of conducting a retreat, a systematic one and a higgledy-piggledy one, and one's job . . . is to make sure that the run-down is supervised and systematic". But there was little sign that the Medical Advisory Committee were exercising generalship of this kind. The Committee was a forum for discussion of routine problems rather than an organ for initiating policy. The Cogwheel turned but, so far as the management structure was concerned, it had no effective teeth; and much of its role seems to have been taken over by the Principal Officers' Meeting. As the new Chief Nursing Officer put it, "There was no medical administration as such: the nursing administration was divided: so the co-ordinator was Mr. Makinson". One of the consultants agreed in evidence that it was no way to run a hospital, but that nothing had been done to put matters right. This vacuum was the fundamental weakness of the hospital. In our view it contributed to the situation which gave rise to the students' complaints of

July 1967 and led to the retention of outworn methods of custodial care on long-stay wards of which we saw so many signs on our visits.

57. One example of the lack of medical co-operation, of which Dr. Masters and Dr. Silverman both told us, was in the deployment of beds among consultants. Each has been working in several different parts of this large and scattered hospital; and it has taken five years—from 1965 to 1970—for them to reach agreement on rationalising the distribution of wards. Another was the absence of any geographical distribution of patients. Each consultant has dealt with the whole catchment area and this had made it impossible to develop the identification with specific districts and links with community facilities, such as shared medical sessions, that are essential to an efficient psychiatric service.

58. But perhaps the most lamentable feature of Whittingham's medical organisation has been the low level and uneven distribution of staffing. Although five consultants work at the hospital, because of outside commitments there are in reality fewer than three to care for its 2,000 patients. Even more disturbing is the fact that little more than the equivalent of one whole-time consultant's services is devoted to the care of the 86 per cent. who are "long-stay".

59. Dr. Oakley and Dr. Glynn run the admission unit of 240 beds at Whittingham and the equivalent female unit at Sharoe Green (100 beds) in the Preston Group; they deal with no long-stay wards. Dr. Parker also has responsibility at Preston (6 sessions per week) in addition to his charge of 292 long-stay beds and the medical electronics unit at Whittingham (3 sessions). Dr. Robinson is the only consultant to work almost full-time on long-stay patients (10 sessions) and he is required to look after no less than 780 beds at Whittingham and 100 "rehabilitation" beds at Ribchester. Most remarkable of all, is the case of Dr. Denmark, who has eight sessions per week at Whittingham, of which seven have been allocated to his deaf unit of 26 beds and only one to 625 long-stay beds. In support, at 30 September 1970, there were only one part-time medical assistant and three registrars, also part-time, but no less than eleven general practitioner clinical assistants. Details of this staffing are set out in Appendix V. On the other hand it has to be recognised that the Manchester Region as a whole has only 0.94 consultants in mental illness per 100,000 population in comparison with a national average of 1.45 and the Department's target of 1.66.

60. From the evidence given at our hearing it was clear that neither the Hospital Management Committee nor the Regional Hospital Board officers fully appreciated the gross inadequacy of this level of medical staffing; or, if they did so, had done enough to press their concern. Dr. Silverman agreed with Dr. Denmark and Dr. Masters that consultants did not visit long-stay wards because of their heavy commitments elsewhere and acknowledged that Whittingham "could probably utilise another two consultants quite happily"; but he was not prepared to admit that Whittingham was grossly understaffed in comparison with, say hospitals in the south of England. He said that there had been a delay at the Board of more than two years about the job specification for a new consultant post, the difficulty being that without "acute" work as an inducement, it would be very difficult to attract anyone

to the post. Dr. Marshall, the former S.A.M.O., would go no further than saying, "Of course one would like more but quality, I think, is as important as quantity". He felt that for many long-stay patients the services of general practitioner assistants was all that was needed. He did not feel that the Board had unduly delayed drawing up the job specification; nor did he appear to think that medical staffing was seriously inadequate on the basis of under three consultants for 2,000 patients.

61. Our own view, contrary to that of the Regional Hospital Board and the Hospital Management Committee, is that rehabilitating long-stay chronic or psychotic patients is no less complex and demanding a task, and requires at least as much specialised psychiatric skill, as the treatment of short-stay patients; and that the Board should not have acquiesced in a policy of medical *laissez faire* which left the care of patients, their physical health apart, to nurses, subject to an annual medical checkup and occasional visits. It was perhaps only to be expected that, without the consultant strength to organise active rehabilitation for more than a fraction of the long-stay population, minimal care has been the lot of most long-stay patients during their years at Whittingham. But it astounded us, on our visits, to see such abundant signs of locked doors between wards or even, within the old three-decker wards, locked doors between different areas, with nurses brandishing large bunches of keys; the still persisting use of airing courts and, in some parts of the hospital, of the antiquated parole system; and the pitifully inadequate use of the hospital's beautiful and spacious grounds.

62. We also feel that the Board's planning has been at fault. From the evidence of Dr. Marshall, the former S.A.M.O., we are sure that the Board are aware of the complex problems that arise from running down specialist mental illness hospitals and replacing them by departments in general hospitals. But it is by no means clear that they have so far thought out the solutions and incorporated them in their planning. It is not enough to say that, with the opening of district general hospital units "Whittingham can close in 15-20 years". Deprived of its remaining short-stay patients by the establishment of psychiatric units at Sharoe Green and Preston, as planned, Whittingham can certainly run down so far as this category of patient is concerned. But the admission to Whittingham of long-stay patients continues; that of elderly patients rises as longevity in Lancashire, as elsewhere, continues to increase; and without alternative provision for these patients the closure of the old hospital will remain a pipe-dream. Instead, a "two-tier" system of psychiatry will be perpetuated, with therapeutic activity concentrated on the short-stay patients in the new psychiatric units while the accumulation of long-stay patients at Whittingham receives no more than residual care. This system is as demoralising for staff as it is bad for patients and we were glad to hear from the new Senior Administrative Medical Officer that he was fully appreciative of the need to make provision for all categories of patient in the current reorganisation of services in this part of Lancashire.

63. Certainly, up to the present, as we noted in Chapter 2, the Board seem not to have convinced the Hospital Management Committee that their policy of running down and closing Whittingham will ever be carried out. The Chairman of the Hospital Management Committee said in evidence,

"We pay no attention whatever to the statement made that in 15-20 years' time Whittingham will be closed . . . I think there will always be a need for asylum in the truest sense of the word". Many of the staff in evidence expressed equally frank disbelief. Whittingham has for some years been accepting from other hospitals categories of patients, such as those requiring special security, which they are unwilling or unable to provide for, and the Board seem not to have attempted to prevent this. Indeed the Group Secretary described to us extensive plans for diversifying the activities of Whittingham which, with the continued upgrading, would enable the hospital to continue indefinitely. The fact is that up to the present the Board and the Hospital Management Committee have been pursuing fundamentally conflicting policies.

64. In our view the first step in sorting out the medical organisation and policies is for the senior medical staff, together with representatives of other medical staff, to constitute a Medical Executive Committee, electing a Chairman whose appointment should be subject to yearly renewal. The Chief Nursing Officer and other professional heads, including local Directors of Social Services, would no doubt be invited to attend as appropriate and it would ease communications if the Group Secretary were to be appointed its Secretary. This Medical Executive Committee should be closely linked with the rest of the management structure through the Professional Executive described in Chapter 4.

65. The second requirement is a substantial increase in numbers of consultants and their supporting medical staff. At least four additional consultants are needed, together with support from a geriatrician in the Preston Group.

66. The third is the reorganisation of the whole medical staff. Each consultant should have a share of long- and short-stay patients; and this should be achieved by forming "multi-disciplinary therapeutic teams" consisting of consultants and their medical staff, nurses, social workers, psychologists and occupational therapists, each responsible for a defined geographical district. Some may be based at Whittingham, some in general hospital units in Preston and later, perhaps at Chorley.

67. Lastly there should be a clear plan for the hospital's future, co-ordinated by the Hospital Management Committee and agreed with the Regional Hospital Board, based on evaluation by statistical analysis of existing patients and their future needs. This should include, for the short term, a co-ordinated rehabilitation programme for all long-stay patients—which we see as an important creative task, not an unattractive residual exercise; for the medium term, diversification of patients to make maximum use of the hospital as its numbers of psychiatric patients run down; and, for the long term, replacement of the hospital as and when required. The work of the deaf unit should be dovetailed into this plan, whose aim should be to integrate all psychiatric services for the Preston area. It should provide for the gradual cessation of admissions to Whittingham, district by district, as new units open in general hospitals, and should allow for alternative provision for elderly mentally ill patients so as to avoid the accumulation of long-stay psychotic, elderly confused and geriatric cases at Whittingham.

In so far as psycho-geriatric assessment facilities will be needed these should be, not at Whittingham, but in the Preston Group. Ribchester is, in its size and situation, a useful hospital that deserves continuation, perhaps for geriatric patients in the long term. When the plan is completed it should be published in the hospital and explained to the staff. In this way the Board, the Hospital Management Committee and all their officers and professional people, with the other hospitals concerned, will be working together towards a common objective.

6. NURSING CARE AND CONDITIONS

68. We indicated in Chapter 3, and we should like to emphasise, that the specific allegations of ill-treatment made at our hearing were limited to four of the long-stay wards. We have no reason to doubt that, as in all psychiatric hospitals, the great majority of nurses on the wards, whether in 1967 or 1971, have been conscientious and kind to their patients. In this sense we have no reason to disbelieve the new Chief Nursing Officer's statement in evidence: "I found the standard of nursing at Whittingham Hospital to be very good in comparison with other hospitals . . . I was quite amazed that the standard was so high in most of the areas". A deputy sister, who was one of the complainants during our hearing, wrote a letter to a newspaper in 1970 to say, "I was on practically all the female wards and with only a few exceptions the nursing staff worked with patience and good humour. . . . Just because a few of the apples are bad it does not mean the whole barrel should be condemned". Many staff made the same point at the hearing and we accept it.

69. In therapeutic terms, however, we have no doubt that the standard of nursing has been—and remains—very variable. On the one hand there is the good work being done, as we saw for ourselves, in the admission wards, the deaf unit and the rehabilitation units for men and women respectively at Ribchester and Cameron House. On the other hand there is the picture, in some long-stay wards, of patients dozing away and, in the Hospital Management Committee Chairman's words, "sitting around all day just doing nothing but becoming cabbages". In between these extremes there are wards in which a good deal has been done to keep patients occupied, both socially and in activities hopefully intended to make for their rehabilitation. Yet for all the credit reflected by these activities on those immediately responsible for initiating and organising them, and notwithstanding the fact that we found the morale of the nursing staff to be surprisingly high despite the traumatic events of recent months, we are left with the general impression of a hospital whose nurses have had all too little encouragement and opportunity to break away from a predominantly custodial role which is now little more than a blur in the memory of their colleagues in many psychiatric hospitals elsewhere.

70. The primary reason for this state of affairs is to be found in the lack of medical policy and staff described in Chapter 5. One effect of this is that the doctors have found it extremely difficult to supply the initiative and drive which traditionally should come from them if new nursing procedures and methods are to be generally accepted; and it has had the further effect of leaving the nursing chiefs with an unusually dominant role, particularly in long-stay wards. It follows that although both of them have now retired and no longer exert an influence on the course of events at Whittingham, we are bound to consider how they exercised their roles.

71. Until the appointment of a Chief Nursing Officer on 1 January, 1971, Whittingham's nursing structure was the traditional one in psychiatric hospitals: two separate hierarchies, headed by a Chief Male Nurse and a Matron for separate male and female nursing staff, running separate wards for male

and female patients. When the post of Medical Director was abolished in 1963, co-ordination of the two sides seems to have become largely the responsibility of the Group Secretary, though the Principal Officers' Meeting has also had a role in this. From the evidence given us it seems clear that the two sides worked in harmony in running their respective wards and, to a limited extent, co-operated in joint arrangements for patient activities. Both were conducted in the traditional authoritarian manner. Responsibility was concentrated at the top rather than distributed downwards in the way that is now becoming generally accepted. Both Chiefs kept in touch with ward situations by "ward rounds" rather than regular meetings with ward staff. But each had totally different styles. The Chief Male Nurse made it clear that he and his deputy played "Box and Cox" on the same field of work. On the female side the Deputy Matron, whose evidence we accept, said that since her appointment in 1964 (and before the arrival of the Chief Nursing Officer) she had had no job at all. Direction was wholly concentrated in the hands of the Matron, who worked with great devotion up to 12 hours a day 7 days a week and there was no proper delegation of functions. The routine of the male side was, given its narrow outlook, reasonably efficiently conducted. There were daily meetings with "sub-officers", that is the senior assistant and assistant Chief Male Nurses. "Change lists" for student nurses, that is lists switching them from ward to ward—who constituted, we were told, about one third of the labour force—were prepared regularly. The Chief Male Nurse clearly knew how the male divisions were being managed and was in close control from an organisational, if not a therapeutic, point of view. On the female side the situation was very different. Tributes were paid to the kindness of Matron in personal matters but we have no doubt that her staff were badly organised. There were no regular meetings of any kind: Matron, as she expressed it, relied on "personal contact". Change lists for student nurses were haphazard, irregular and made without due notice. It seems clear that Matron, bogged down with paper-work in her office, had insufficient grasp, either personally or through her subordinates, of what was going on in the wards. The Sister plainly ran ward 16 in her own way without let or hindrance: although Matron claimed to be well acquainted with the patients, she had no knowledge of the "bread and jam" regime for the "dozies" on that ward. The same lack of control seems to have existed elsewhere on the long-stay wards where doctors, on their own admission, rarely appeared.

72. Co-ordination with other staff has been inadequate owing to the absence (until the new Chief Nursing Officer took over) of multi-disciplinary teams at ward level. Indeed the Chief Nursing Officer told us that there was no regular means of communication with medical staff at this level. The admission unit apart, we were told that there was constant resistance on the female side to the intrusion of occupational therapy staff while on the male side they were only beginning to be used at the time of the Inquiry.

73. The problems of nursing administration have certainly been great. Nurse staffing at Whittingham has been almost as inadequate as medical staffing and the inadequacies of distribution in some ways similar. Details are given in Appendix V. The deaf unit of 26 beds has been heavily staffed; the St. Margaret's admission wards, Cameron House and Ribchester to all appearances are adequately manned; but most of the long-stay wards are seriously

under-staffed. Matron told us that she tried to keep one trained sister on each ward but many of the deputies were without the benefit of formal training. On ward 16 the Sister had, according to her own account, her S.E.N. deputy and never more than four nurses, trying to cope with (in 1969) 126 chronic and psycho-geriatric patients, many of them doubly incontinent. Clearly her problems were not unique. On the male side the hospital was always 150 below its "ideal" and 20-30 below its "financial" establishment. Both Board and Hospital Management Committee made it clear that this was not for lack of finance or efforts in recruitment. Consequently there has been a large influx of nurses from abroad to fill the gaps in their ranks. Many nurses were recruited from Mauritius, Italy and Spain and some of those we heard in evidence were foreign. Another measure was the continuation of nurses past retiring age: one Sister, for example, was recommended for extension of service and finally retired when she was almost 70. In our view one of the main reasons for failure to attract or retain enough nurses was the fact that the large majority of long-stay chronic or psycho-geriatric patients were not receiving the active rehabilitation that would have enlisted the interest of staff. Another was the lack of "acute" work, which could have been remedied, given the agreement of the Preston Group, by integrating nurse staffing and training at Whittingham with the acute unit at Sharoe Green.

74. In this situation of severe staff shortage it is remarkable that the hospital pursued a policy of making all promotions from within the hospital up to Charge Nurse/Ward Sister level. Ostensibly this was to encourage junior nurses, particularly students, to stay. In this it was conspicuously unsuccessful. The main result has been to produce an inbred nursing community shut off from outside influences, clinging to outworn methods and resistant to new ideas. Promotion seems to have been based on very hit or miss methods with no advertisement of posts or formal applications, and certainly no system of appraisal through regular written reports. Until some years ago promotions had been made by an Hospital Management Committee sub-committee on advice from nursing heads; since then we were told that they had been carried out by a panel of "sub-officers", but their deliberations were unannounced and in private and no interviews were held. Posts above Charge Nurse level were advertised outside the hospital; but it was interesting that only two of the nursing administrators in post on the male side at the time of the Inquiry had been recruited from outside. The system produced some strange results. One nurse who gave us evidence on fraud—a man of evident and acknowledged honesty and a hard worker—took 29 years, until 1970, to achieve promotion to Charge Nurse. On the other hand the Deputy Chief Male Nurse was promoted to Assistant Chief direct from Staff Nurse, so missing the normally vital experience at Charge level. In short, an inbred nursing community was dominated by a self-perpetuating oligarchy.

75. The nurse training school we considered one of the brightest features of the hospital. The buildings are modern and attractive and the teaching, by all accounts, good. The basic grievance of student nurses was the gross discrepancy between techniques they were taught in the school and obsolete practice in many wards. As one student nurse, a prize winner, put it, "During two years ward experience I have been allocated only to

geriatric and long-stay wards with no opportunity to work with newly admitted and acute disturbed patients or occupational/industrial patient units. I have had little or no experience in modern treatment and patient care. . . . Ward allocation of student nurses is not adequately considered in relation to the requirements of nurse training. . . . I feel that the nursing administration from Ward Sister level upwards cannot direct enough time to help student nurses in training . . .". From all we heard in evidence—from the Hospital Management Committee Chairman, the nursing chiefs and the older charge nurses as well as the students—and from our impressions on visiting the hospital, we were in no doubt that this type of complaint was to a large extent justified.

76. Another serious complaint arose from the practice of "relieving", that is of students being loaned to other wards short of nurses from those to which they were officially allocated under "change lists". Students alleged that this was carried out to such an extent, particularly on the female side, that the lists themselves were meaningless and consequently students did not obtain a balanced programme according to General Nursing Council training specifications. Matron said in evidence that "relieving" was for periods of 1-3 weeks in a three month period and that shortage of staff made the practice inevitable. We have no doubt that here too the students were justified, though the difficulties of the nursing administration on both sides must be acknowledged. We also believe that some of the wards entered on the students' records as "acute" contained a proportion of long-stay patients and that this contributed to the students' grievances.

77. The standard of residential accommodation for nurses varies but was not the subject of complaint at our Inquiry. The women's is very good while the men's, though less satisfactory, is being upgraded. Complaints were limited to various problems in the female nurses' home and as they have since been met, they do not seem to us now to be of great importance. The main trouble related to keys and hours and seems to have arisen about the time of Mrs. Bunn's arrival, with her daughters, to live in a flat at the home. A group of student nurses objected to the prevailing rule that they should be in by 11.30 p.m. or apply to the Warden for a key if they wished to stay out later (the time was 10.30 for those under 18, who had to ask their parents' permission to be out after that time). This rule they felt to be an unwarranted intrusion into their private lives. There was a significant divergence here between students and enrolled nurses and between native born and foreign girls. There were no complaints from the foreign girls, perhaps because they were accustomed to a more restrictive attitude to young people. We believe there is some substance in the Warden's contention that trouble in the Nurses' Home was stimulated by Mrs. Bunn's arrival, though we think that the Warden, herself a kindly person, took an unduly simple view of matters and was out of touch with the feeling of the students. It is clear that Mrs. Wilson resented the intrusion of Mrs. Bunn, a younger woman with children of her own, who immediately established a closer personal relationship with the girls. The students' grievances were met in September 1970 by providing keys to all student nurses over the age of 18 and in our view the main lesson that emerges is that the appointment of the Chief Male Nurse's wife as Warden was a

mistake since it emphasised the authoritarian control of the nursing administration on the lives of these young people.

78. We commented in Chapter 3 on the paucity of complaints from patients about ill-treatment and this extends to conditions generally, whether past or present, at Whittingham Hospital—despite notices about our Inquiry exhibited in all wards and main centres of the hospital. The Group Secretary told us in evidence that the volume of complaints was small and we accept this, which we believe is a common feature of psychiatric hospitals. He also told us that the official guidance for handling complaints from patients is complied with and we have no reason to doubt his assurances. As regards complaints from nursing staff, however, it will be clear from our conclusions in Chapter 3 that we regard the method of handling staff complaints at Whittingham as one of its most serious administrative defects. As the Principal Tutor told us, "There was a persistent feeling through all the staff on this, if you brought anything to light, if you dared to step out of line by doing things, then you stood on your own feet and took the consequences". This was supported by several other witnesses, one of whom said, "If you complained about anything you got classed as a trouble-maker . . . People could be funny with you", while another commented, "The atmosphere of the hospital at that time (1967) was such that you just did not criticise anything". At our hearing we were assured by nurses of all grades, including ex-student nurses who joined in the complaints of 1967–68, that the whole atmosphere of nursing at Whittingham had changed since the appointment of the new Chief Nursing Officer early this year, that there was much greater delegation of authority and that there were now satisfactory channels for the communication of complaints. We were greatly impressed and generally satisfied by these assurances and, since a special Committee has recently been set up under the chairmanship of Mr. Michael Davies, Q.C., to look into the whole question of complaints procedures for staff and patients, we merely leave our conclusions on record and do not consider it appropriate to make a specific recommendation on the matter in this report.

79. Granted that the authoritarian rigidities of the old nursing administration have now been dissolved, we believe that much remains to be done. In our view the nursing staff needs to be substantially increased and to open itself to outside influences; the process of delegating authority and opening of communications should continue; work on the wards should be integrated in multi-disciplinary teams; and training in the nursing school should be co-ordinated with work on the wards. To this end we feel that the first need is to integrate the nursing structure of Sharoe Green with that at Whittingham in one division under the new Chief Nursing Officer. This will provide a proper balance of "acute" with long-stay work which will result in a better training programme for students and better prospects of recruiting and retraining trained nurses. The next requirement is that selection and appointment procedures for all posts should be brought into line with the recommendations of the National Nursing Staff Committee, including the use of external assessors where appropriate. Especially we would stress the need for all posts at Charge Nurse or above to be advertised outside the hospital. This would remove any suggestion of bias or excessive reliance upon internal promotion, encourage a healthy in-and-out flow of staff and open up Whittingham to changes in methods of psychiatric nursing in the country generally.

Extension of service after the normal date of retirement should be carefully reviewed. The recommendations in the Report of the Committee on Senior Nursing Staff Structure (Salmon), which is beginning to be implemented by the appointment of the Chief Nursing Officer for an integrated nursing administration and the development of Grade 9 posts, should be put into effect as soon as practicable. As soon as possible after the completion of the Salmon structure a staff appraisal and counselling scheme on the lines recommended by the National Nursing Staff Committee should be introduced. The appointment of a Domestic Manager (now made) to recruit and organise domestic workers should greatly relieve the pressure on nursing staff and release more time for strictly nursing functions. Multi-disciplinary therapeutic teams have already begun to be set up and this process should continue to cover all wards and all professions concerned with patients. Training for both student and pupil nurses should be brought into the wards and co-ordinated with the nursing school so that procedures taught in the school are implemented in practice in the wards. In-service training should be instituted for those nurses who have had none.

80. Lastly, we note that the General Nursing Council have not inspected Whittingham since 1961 and we feel that they should be invited to carry out a full inspection of the hospital.

7. FUNCTIONS OF OTHER STAFF

81. There are many categories of staff, apart from medical and nursing, and we do not propose to comment on them all. In this Chapter we mention five groups: those concerned with occupational therapy in its widest sense; psychologists; social work; voluntary work; and supporting services.

82. Occupational therapy services in their widest sense (that is including industrial therapy) have so far been fragmented and unco-ordinated. They consist of a number of small groups and individuals working virtually in isolation from one another. They tend to be called in when thought necessary by consultants; but since they do not form part of therapeutic teams it is not easy to see how their work can be linked into a properly designed therapeutic programme for patients. With the exception of industrial therapy, which is run by nurses and supervised by the nursing administration, these groups and individuals are responsible only to the Group Secretary under the general aegis of the Hospital Management Committee's recently set up "Resocialisation Group". As we noted in Chapter 4, the Hospital Management Committee's Rehabilitation Sub-Committee has paid little attention to occupational therapy in the past, though in the last year or two they have taken to paying the department visits three or four times a year.

83. The occupational therapy department includes 23 occupational therapists of whom seven are qualified. Numbers have gradually increased since the present head of the department was appointed some thirteen years ago, when there were five in post. Up to about four years ago the department was concerned mainly with the female side; and, until very recently the bulk of its work has been concentrated on patients in the admission unit, most of whom are in hospital for a matter of a few weeks, while virtually no attention has been paid to the long-stay patients who might be there for many years. This has been due partly to the small size of the unit in relation to the hospital, partly to the fact that the doctors in charge of the admission unit were the most eager to make use of the occupational therapy services and partly because of opposition from the nursing administration on both the male and female sides. Matron especially had for some years been at loggerheads with the occupational therapy staff; and the male side seem to have resented their intrusion into a field occupied by their own industrial therapy department. A few months ago a good, if belated, start was made on resocialising long-stay male patients in St. John's division and it is hoped to develop this work gradually throughout the long-stay wards. Other activities include a housecraft section, games, dancing, dressmaking and discussion groups. Working separately from this department is a recently appointed social therapist, who carries out educational programmes and organises visits and dances for small groups of long-stay patients. Her work overlaps the field of the occupational therapy department and the social and recreation officer, but we were unable to discern any real co-ordination of approach.

84. The industrial therapy department is entirely separate from the occupational therapy department although, here again, their fields of work overlap.

This department has been concerned almost entirely with the male side and it is staffed and run by the nursing administration. At Whittingham there are now ten full-time and eleven part-time staff and between 250 and 300 patients are employed in work such as joinery, woodwork, painting and industrial sub-contract work, although this last appears to be not very well developed. At Ribchester there is an excellent unit, separately run by two full-time and two part-time staff, which carries out an impressive programme of industrial sub-contract work for another 100 patients; and, in our view, this might usefully serve as a model for the development of sub-contract work at Whittingham itself. Working on his own, there is a social and recreation officer, a nurse, who was appointed in 1967. He organises outings, dances, bingo, holidays and Local Education Authority classes; he also runs a recreation club and a patients' "Century Club".

85. It seems to us that the work of this important group of staff, all devoted to occupational therapy services in their widest sense, should be brought together in one department and made responsible to a professional Re-socialisation Group. This body should be represented on the Professional Executive which we recommend in Chapter 4. Its members should be incorporated into the multi-disciplinary therapeutic teams which we recommend in Chapter 5, so that their functions can be integrated into treatment programmes for patients, and their work should be rationalised to put an end to the overlapping that exists at present. The emphasis should be turned away from short-stay towards the long-stay patients and the work expanded to provide activities for all patients who are capable of benefiting from them.

86. At present there is only one Principal Psychologist, Mrs. Patricia Bunn, on the staff of the hospital; a junior post is vacant and it is hoped to fill this in due course. Mrs. Bunn's appointment in March, 1968, has led to a good deal of trouble and, in our view, mismanagement. The initiative for her appointment came from one consultant who wanted a full-time psychologist for the deaf unit, but agreement was obtained from the Department of Health and Social Security only on condition that her responsibility was for the hospital as a whole. The terms of her appointment were therefore an uneasy and ambiguous compromise which gave Mrs. Bunn "overall administrative responsibility for the psychological services of the hospital together with special duties relating to the psychiatric deaf unit". It was on the interpretation of these responsibilities that the dispute turned. The consultant, backed by the Hospital Management Committee, expected Mrs. Bunn to devote herself virtually full-time to the deaf unit. Mrs. Bunn, on the other hand, found it increasingly difficult to reconcile herself to a rôle restricted to 24 deaf patients while the needs of some 2,000 other patients were neglected and, at the request of other consultants, took on work elsewhere, particularly in the admission unit. At the time of Mrs. Bunn's appointment there was also a basic grade psychologist in post but she left after a few months and another psychologist, appointed during 1969, also left owing to housing difficulties. It would give needless pain to go into details of this wrangle, which is only a minor aspect of the troubles at Whittingham. Whatever the correct interpretation may be of her terms of appointment it is clear to us that Mrs. Bunn's interpretation of her responsibilities to patients as Principal Psychologist at the hospital was in substance right and the Hospital

Management Committee's wrong. The Committee's reaction, however, was to ask Mrs. Bunn for her resignation in November, 1969; this she did not submit and we were told at our hearing, some 18 months later, that the request still stood. This position seemed to us very unsatisfactory and our Chairman asked for it to be reconsidered and clarified in the light of the evidence submitted at the hearing. At a later stage of our Inquiry the Hospital Management Committee withdrew their request for Mrs. Bunn's resignation and informed us that they hoped to appoint another psychologist to undertake clinical work in the deaf unit.

87. In our view it is important that the psychologists at Whittingham should form one department, that they should each play an appropriate part in multi-disciplinary teams and that their work should be integrated into the hospital's therapeutic programme for patients as a whole.

88. Social work can be said to be one of Whittingham's poorest features. This large hospital with its many problems of rehabilitation and disposal of patients after treatment has now abandoned any establishment of social workers, we were told, because of the unlikelihood of getting applications and also perhaps with a hopeful eye on the new social service departments of the local authorities, Preston County Borough and Lancashire County Council. Links with these are insufficiently formed but good working relationships are preserved as far as possible by the liaison work of one full-time untrained social worker who carries the responsibility for the financial and personal problems of some 1,900 patients. Of these between 100 and 200 could probably be discharged were there facilities in the community to receive them but the local authorities concerned have not yet managed to make sufficient provision, though there is beginning to be some advance. This aspect needs consultation between the local authorities in Whittingham's catchment area and those responsible at the hospital. In addition there is also a psychiatric social worker working part-time at Whittingham almost entirely on a psycho-therapeutic level with groups of patients and individuals from the admission unit. The deaf unit has its own full-time social worker, who has no involvement with the rest of the hospital.

89. In the light of the multi-disciplinary therapeutic team concept we have stressed elsewhere the need might be defined initially as six social workers, including a suitable principal social worker, professionally trained and with a grasp of medico-social teamwork, to co-ordinate the inside work and build up relationships with the supportive services outside the hospital. These social workers may be employed by the hospital or the local authority, as appropriate, provided it is recognised that psychiatric patients need continuity of care and that frequent changes of staff are in this respect unhelpful and disconcerting to staff and patients alike.

90. Voluntary work at Whittingham is also comparatively underdeveloped. There is a League of Friends active in a traditional way, until recently under the chairmanship of the wife of the Hospital Management Committee Chairman. Voluntary involvement, in the sense of sixth-formers from schools working in the wards and regular visiting by local societies, has not so far made much headway. We feel that the appointment of a paid organiser of voluntary services would help in this and would greatly strengthen links with the community generally.

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This Gilbertian defence, we understand, no longer applies since tanker disposal has become available in recent years. It is clear to us that neither the farms nor the market gardens contribute to the standard of food, to economy in purchasing or to the rehabilitation of patients; and, while we were told that the farms were profitable, no account was taken of the invested capital. We feel that both farms and market gardens should be disposed of as soon as possible.

8. FINANCIAL CONTROL

96. In our Introduction we referred to the extensive audit investigation launched by the Department in September, 1969. The Interim and Final Reports produced by the auditors are at Appendix VI. These comprehensively cover the problem of control of patients' money at Whittingham and we wish to associate ourselves with their findings. We have already considered the allegations of fraud in Chapter 3. In this Chapter we do no more than comment briefly on the general question of financial control, discuss further evidence that was brought out at the hearing and add our own recommendations.

97. It was pointed out to us in evidence that control of patients' money has proved a perennial problem wherever there are large numbers of patients, many of whom are incapable of themselves looking after their money, and over-burdened nursing staff whose primary task is the health of the patients, not their financial affairs. So far, apparently, it has not proved possible to devise any system under which nurses are not involved in handling patients' cash. The general aims of control have been to reduce the amount of money circulating in wards to the amounts which patients require and to arrange satisfactory accounting procedures for money so handled. Payments have been made to patients from various sources:

- (1) patients' own private money ;
- (2) social security benefits ;
- (3) pocket money for indigent patients ;
- (4) reward payments for work done.

Until recently the system at Whittingham has been for cash to be delivered to wards from the Treasurer's Department and signed for by the Charge Nurse in books and schedules provided ; and then issued to patients, who either sign for it themselves or have staff sign on their behalf. We understand that there have been no comprehensive written instructions for handling cash on the wards: nurses said in evidence that they knew of none and had received only brief oral instruction.

98. Plainly this system was wide open to abuse ; and abused it has been at Whittingham Hospital. Audit enquiries showed that the ward records were almost valueless. In some cases amounts had been signed for by patients but not received ; the original entries were frequently scratched out or otherwise altered ; although schedules certified that payments had been witnessed, witnessing had been only rarely carried out ; and in any case it was common for patients to hand money back to nursing staff. It has been the practice for nurses to use cash received from the Treasurer to buy cigarettes, sweets, clothing and many types of food and drink for patients from the hospital shop or even from outside the hospital ; and while some wards kept records of this others kept none. It has also been the custom for nurses to sell to patients cigarettes bought either privately or from the hospital shop.

99. Since the hospital is comparatively isolated, opportunities for expenditure of patients' money outside have been limited ; and the auditors found that there had been a steady decline over recent years in the volume of shop-takings compared with the amounts of patients' allowances. In 1968-69 £91,000 was issued from all sources for patients' use ; yet the total takings of the hospital shop were only £42,000. The remaining £49,000 is not easily accounted for. At the hearing the Group Secretary produced information about cash spending outside the hospital shop by Whittingham patients during 1970-71 which suggested that £26,000 could have been used for purchases in local shops, expenditure in local clubs and public houses and a variety of other activities from day trips to jumble sales. This, however, still leaves a substantial sum unaccounted for—even if it can be assumed that expenditure in this later year was much the same as expenditure in 1968-69.

100. It is clear to us that the system has been so open to abuse that it would be virtually impossible for unscrupulous staff to resist their opportunities. The Police Superintendent told us, "As for the payments to patients, I feel any determined person could have made quite a good living from these with very little fear of detection". The extensive audit and police investigations of 1969-70 yielded only two cases where prosecutions could be undertaken for theft. But the facts set before us point towards large-scale pilfering, if not more organised corruption, and are consistent with the students' complaints of July, 1967, and the evidence of the witnesses quoted in Chapter 3.

101. As the former Treasurer told us, the main aim of any system of financial control must be to reduce the amount of cash flow to wards and ensure an adequate system of signing for money which minimises the risk of fraud. It is not possible to remove the risk entirely: as the Group Secretary said in evidence, "In every hospital there is bound to be a point where accounting ends and integrity begins". Since the audit investigation began the Treasurer's Department have themselves taken steps to reduce the cash flow to wards, mainly by crediting more money to patients' accounts, improving and regularly checking ward records and preparing financial instructions for nurses. The auditors have now recommended that further steps be taken. These are:

- (1) improving assessment of patients' needs ;
 - (2) expanding the banking service to as many patients as possible ;
 - (3) introducing a system of vouchers for purchases from the hospital shop ; and
 - (4) ensuring secure delivery to patients of social security payments, etc.
- We welcome these measures and hope that the Treasurer's Department will be strengthened to allow them to be implemented as soon as possible.

102. We understand that, as a result of the special audit investigation at Whittingham, the Department of Health and Social Security are currently preparing advice to hospitals generally on the control of patients' money. The main aim will be to reduce the cash flow to wards by crediting social security benefits, pocket money and reward payments directly to patients'

accounts and arranging banking facilities for as many patients as possible. In this way nurses' handling of cash will be reduced to a minimum though in the case of seriously incapacitated patients, they will still need to handle goods obtained on the patient's behalf. We welcome this much needed advice, which anticipates any general recommendation on our part, but we would express the hope that nurses will be able to retain and develop their strictly therapeutic rôle of helping to assess patients' capacity to handle money and to guide the spending of it.

103. A further weakness in the system of financial control found by the auditors was the apparently excessive levels of overtime of some ancillary staff. Details are set out in the Final Audit Report (Appendix VI). Especially notable are the workers on hospital farms, who were paid overtime for the six months up to 27 September, 1970, at an average rate of £19 per week and the 112 building and engineering workers who received more than £5 per week. This was defended to us in evidence as being necessary to retain the services of staff in competition with higher rates of pay elsewhere. We would associate ourselves with the auditors in recommending that overtime should be more strictly controlled for the future. We have already recommended, in the previous Chapter, the sale of the farms, which the hospital cannot hope to run with full economic efficiency.

104. Finally we would comment on the question of audit inspections. We have no reason to suppose that the special investigation of 1969-70 was carried out with anything less than exemplary thoroughness, but it seems to us extraordinary that routine audit inspections carried out each year previously did not extend to ward level, where they would have easily detected the complete collapse of financial control, and that the decline in the volume of shop takings compared with the amount of patients' allowances was not seen to point to the need for more detailed examination of the hospital's accounts. The auditors who gave evidence could not be certain from their records that their colleagues had not discussed these matters orally with the Treasurer's Department but it is perfectly plain to us from the evidence that if defects on this scale had been discovered there would have been written communications in the strongest terms. We do not underestimate the complexity of the problem but we think that measures should be taken by the Department to ensure that routine audit inspections at psychiatric hospitals cover the aspects of financial control that have been found so grossly defective at Whittingham Hospital.

9. CONCLUSIONS AND RECOMMENDATIONS

105. Whittingham is indeed a "hospital of wide contrasts". On our visits we noted that two thirds of the physical structure has been upgraded to reasonably modern standards while the rest is still poor. The admission unit at St. Margaret's, the rehabilitation units at Cameron House, Ribchester and St. Margaret's and the Nurse Training School are clearly well equipped and modern, but many of the long-stay wards provide very unsatisfactory accommodation and have especially poor sanitary arrangements. Day facilities are limited. A considerable effort has been made over the last two years to improve conditions for patients, perhaps under the impact of events which led to our Inquiry, but in the long-stay wards there remains much evidence of old-fashioned methods reminiscent of the custodial regime of the past and remarkably little evidence of the revolution in psychiatry of recent decades. Many of the long-stay patients—psychotic, elderly mentally confused and geriatric—do not seem to be receiving adequate treatment or rehabilitation, though the unit at Ribchester is a shining exception. There is an occupational therapy department, recently much expanded, but it is largely concerned with short-stay patients. Diet has until recently been over dependent on the market gardens and a number of farms which the hospital still retains. Very few patients are discharged each year from hospital and this is partly due to a marked lack of local authority facilities for after care. (We were struck by the fact that although local authorities were invited to give evidence none did so, with the exception of the Medical Officer of Health of Preston who submitted written material.) In all this Whittingham may not be unique but it is certainly an extreme example of a hospital that has failed to keep up with the times.

106. It is clear that there was a failure by the hospital management to investigate the conditions which led to the students' complaints in 1967 and 1968. The allegations of ill-treatment made to us in evidence relate to four long-stay wards during a period several years ago but many of them, including those about Ward 16, have been shown to be justified. We believe that these bad practices were primarily the result of unsatisfactory conditions, shortage of staff and inadequate supervision. It was inexcusable that one nurse, who became Ward Sister, should remain on the same ward with between 100 and 200 patients for 47 years, ever since her qualification; and that her untrained deputy should remain there for 11 years. We are unable so long after the events to reach a firm conclusion on some of the more general allegations of defective conditions in the past, though present inadequacies lend them some substance, but we believe that until recent years the complete collapse in the system of ward records of patients' money, demonstrated by the special audit investigation of 1969-70, has led to large-scale pilfering, if not more organised corruption, by some members of the hospital staff.

107. The management structure has not proved equal to its task. We believe that the individual members of the Hospital Management Committee are both conscientious and devoted to the hospital but their performance as

an entity has left much to be desired. Some members have had over-long periods of office: one has served for 25 years. The Committee has paid too much attention to administrative detail, which ought to have been delegated to officers, and too little to major policy issues in monitoring standards of patient care. They have become blind to the extent that Whittingham has fallen behind the times and they have been too ready to dismiss constructive criticism as a disloyal attack on the hospital. There are too many committees with overlapping terms of reference and staff communications have been poor. The administrative staff, though loyal, conscientious and hard working, have been content to regard themselves as passive tools of management rather than active planners and producers of ideas. The result has been a hospital with day to day tactics but no overall strategy.

108. Until recently the Hospital Management Committee have been hampered by a most unfortunate lack of medical advice and guidance and they have failed to realise this. The Chairman of the Medical Advisory Committee had no clinical responsibilities and only one session per week at the hospital for administrative purposes; he was thus insufficiently in touch with its affairs. His Committee functioned as a forum for discussion of routine problems and entirely failed to co-ordinate, much less formulate, medical policies. The consultants have been left to go their separate ways, concentrating on "acute" work and extra-mural commitments to the detriment of long-stay patients. The level of specialist medical staffing has been insufficient to deal adequately with the problems of rehabilitation and the position of one consultant, who is required to cope with 625 long-stay patients during one session per week, is deplorable and almost beyond belief.

109. Consequently long-stay wards in Whittingham have been left to the care of nurses without adequate medical direction. Standards of nursing in many parts of the hospital are very good but elsewhere less satisfactory. Staffing has been inadequate and many of the enrolled nurses, who form a large proportion, have never received any formal course of training. Opportunities for secondment or exchange have been meagre, the reason given being the shortage of staff; and promotion has been almost entirely restricted to those within the hospital. This has tended to isolate Whittingham from the main stream of change in psychiatry. The nursing administration, before the appointment of the present Chief Nursing Officer, has been too authoritarian and resentful of criticism, and there have been faults of organisation and supervision. Nurse training, especially on the female side, has been handicapped by ill-considered deployment of students, who were deprived of a proper variety of experience, and a complete absence of co-ordination between the methods of the training school and practice on the wards.

110. In all this the Board must bear a share of blame. They have pioneered a plan of opening psychiatric units in general hospitals which has been generally accepted as desirable for the whole country. But their plan is no more than half a policy when the problem which it entails of running down and closing existing out of date hospitals has not been fully thought out. Without adequate recognition of the continuing need for alternative accommodation for elderly long-stay patients, an old hospital can never close. Appreciation of this fact has led to a frank disbelief

and dichotomy of aim between the Board and the Whittingham Hospital management. Worse, there is a danger that it could lead to a two-tier system of psychiatry—well staffed “acute” units and “long-stay dumps” which are professionally unattractive and hence understaffed, yet indispensable. Nor are we satisfied that the Board have fully informed themselves of the grave inadequacy of medical staffing which is one of the root causes of Whittingham’s problems.

111. We note that in spite of the comprehensive returns of staff and facilities submitted annually to both the Department and the Board, deficiencies shown at Whittingham have apparently led to no positive action. More surprising still we note that, before the special audit investigation, repeated routine inspections by auditors failed to reveal either the collapse of control of patients’ money at ward level or the decline in the volume of shop takings compared with the amount of patients’ allowances. There has been no inspection of the hospital by the General Nursing Council since 1961.

112. These conclusions lead us to make the following recommendations:

The Department

1. The Department are, we understand, about to issue guidance on the problems of transition from mental illness services based on specialist psychiatric hospitals such as Whittingham to those based on units in general hospitals. Further thought and advice are urgently needed on provision that will have to be made for elderly long-stay patients who cannot be permanently accommodated in these new general hospital departments.

2. There is a need for improvement in procedures to deal with complaints from staff and patients: we refrain from making a more specific recommendation because, since our Inquiry began, a special Committee has been set up to look into complaints procedures.

3. The Department are now preparing new guidance on the control of patients’ money which will avoid the retention of large sums at ward level. We welcome this but hope that nurses will be able to retain and develop their therapeutic role of participating in the assessment of patients’ capacity to handle money and guiding them in spending it.

4. Since audit inspections at Whittingham before 1969 apparently failed either to detect the collapse in the system of ward records of patients’ money or to investigate the decline in volume of shop takings compared with the amount of patients’ allowances, audit inspection procedures generally should ensure that matters of this kind are properly examined in future.

5. Deficiencies in staffing at Whittingham Hospital shown in annual returns to the Department and to the Board have not resulted in action to remedy them and we consider that monitoring arrangements need re-examination.

6. We note the absence of local authority facilities in the Whittingham catchment area and consider that the Department should take steps to promote closer co-operation between the Regional Hospital Board

and the local authorities concerned in planning the development of services for the area.

Regional Hospital Board

7. In the light of our findings we consider that the Board have suffered from a lack of advice from the field. The Board should establish a multi-disciplinary advisory panel containing comprehensive professional representation from the field to advise them on current problems in developing psychiatric services in the Manchester Region.

8. The Board should review its monitoring of staffing levels in psychiatric hospitals.

9. The Board's programme of reorganising mental illness services should emphasise factors which seem to us not to have been adequately recognised and are essential to the implementation of their policy:

- (i) the need to provide day places as well as beds in new district general hospital departments,
- (ii) the need for effective liaison with those responsible for supporting community services—hostels, day centres, group homes, old people's homes and social work support—and
- (iii) the need for a positive policy for long-stay and elderly patients in mental illness hospitals, including alternative accommodation for such patients when existing specialist hospitals are replaced in the course of time.

10. At least four new consultant psychiatrists should be appointed to Whittingham Hospital, with appropriate junior staff, and in making appointments the special needs of long-stay psychiatric and geriatric patients should be borne in mind. There will need to be an equitable reallocation of sessions to ensure that all consultants obtain a suitable variety of work.

11. The present members of the Hospital Management Committee should be invited to resign and the Committee reconstituted. In view of the pressing need to reorganise services at Whittingham, a small committee of about eight should be set up pending the establishment of an Area Health Board covering the Preston area. There is a need both for fresh blood and for continuity; and also for close links with the Preston and Chorley Hospital Management Committee and the Directors of Social Services for Preston County Borough and Lancashire County.

The Hospital

12. The new Hospital Management Committee should carry out a thorough review of the reorganisation of services needed at Whittingham Hospital.

13. The new Hospital Management Committee should be responsible for drawing up a plan for the hospital, on the lines set out in Chapter 5, which should be agreed with the Regional Hospital Board and made known to all hospital staff.

14. There should be a drastic reduction in the number of sub-committees. With a small Hospital Management Committee we doubt the need to have any standing sub-committees at all.

15. The new Hospital Management Committee should maintain close liaison with the Preston Group to co-ordinate policy, particularly in relation to the admission unit at Sharoe Green and to plan a new service based on general hospitals at Preston and Chorley.

16. The senior medical staff with clinical sessions at the hospital, together with representatives of other medical staff, should constitute a Medical Executive Committee, electing a Chairman whose appointment should be subject to yearly renewal. The Chief Nursing Officer and other professional heads, including the local Directors of Social Services, would no doubt be invited to attend as appropriate. It would ease communications if the Group Secretary could be appointed its Secretary. The Committee's task should be to co-ordinate medical policies not only for Whittingham Hospital, including Ribchester, but also the psychiatric unit at Sharoe Green and the out-patient departments and new psychiatric facilities planned for the Preston Group.

17. The Group Secretary, the Chairman of the Medical Executive Committee and the Chief Nursing Officer, with other appropriate professional heads, should constitute a Professional Executive with delegated authority for day-to-day management of the hospital. They should maintain close liaison with the local authority Departments of Social Services. Similar co-ordination at other levels should be achieved by setting up multi-disciplinary therapeutic teams, consisting of doctors, nurses, social workers, psychologists and occupational therapists.

18. The employment of general practitioners should be rationalised to cover the day-to-day needs of long-stay patients: but their valuable contribution should not be regarded as a substitute for specialist services.

19. The Chief Nursing Officer should become head of a co-ordinated psychiatric nursing division, including Ribchester, Sharoe Green and the future hospital department at Preston. The current reorganisation of nursing staff on Salmon Report lines should continue within this framework.

20. Training for student and pupil nurses and experience of trained staff should be arranged in co-ordination with Sharoe Green and the new Preston hospital facilities to give adequate variety in all types of patient care.

21. Procedures for the selection and appointment of nursing staff (including internal promotions) should be brought into line with the recommendations of the Report of the National Nursing Staff Committee and a staff appraisal system, as recommended by that Committee, introduced as soon as possible. In particular, all posts at Ward Sister/Charge Nurse level or above should be advertised outside the hospital.

22. The extension of service after retirement age should be most carefully considered in each individual case and regularly reviewed.

23. The General Nursing Council should be invited to inspect Whittingham Hospital.

24. Domestic duties should, so far as possible, be separated from nursing duties and a special programme started for recruiting and training domestic workers.

25. Psychologists employed at the hospital should form one department and their work should be integrated into the therapeutic programme as a whole.

26. A strong group of social workers should be recruited in association with the Local Authority Social Service Departments of Preston County Borough and Lancashire County and services built up along the lines set out in Chapter 7.

27. All occupational services, including industrial therapy, should be effectively co-ordinated under the aegis of a professional Resocialisation Group. They should be expanded, with the emphasis on industrial therapy, to provide activities for all patients who can make use of them.

28. The Treasurer's Department should be strengthened to enable the measures recommended in the audit reports to be implemented as soon as possible.

29. The inner catchment area of Whittingham Hospital coincides with that of the Preston Group. This should be split into defined districts, each with the responsibility of a single multi-disciplinary therapeutic team.

30. Admission of patients from outside Preston and its surrounding district (the inner catchment area) should cease as soon as possible.

31. In so far as a psycho-geriatric assessment unit would bring relief to Whittingham, we consider such a unit should be provided in Preston, not at Whittingham itself.

32. There should be a crash programme to update sanitary facilities in all wards that have not been upgraded.

33. The complement of building and engineering staff should be reviewed.

34. Overtime worked by building and other staff should be more strictly controlled.

35. Farms and market gardens should be sold as soon as possible.

36. There should be a simple and attractive information booklet which should be given to each patient and his relatives on arrival specifying, among other things, the procedure for making suggestions and complaints.

37. Truly unrestricted daily visiting, which does not exist at present, should be introduced as soon as possible.

38. To assist visiting by relatives and recruitment of staff there should be a considerable improvement in transport facilities to and from Preston and the surrounding area.

39. A paid co-ordinator of voluntary services should be appointed and local community participation in the hospital's activities developed by every possible means.

40. The out-dated aura of seclusion at Whittingham should be dispelled by positive public relations activity. A member of the administrative staff, with suitable qualities, should be given a special responsibility for liaison with the press so as to cultivate constructive public interest in the life of the hospital.

ROBERT PAYNE.

ARTHUR BOWEN.

JAMES ELLIOTT.

R. KEMPSTER.

MARION B. H. WHYTE.

L. C. WILCHER.

29th October, 1971.

APPENDIX I

EVIDENCE RECEIVED BY THE COMMITTEE

A. PERSONS WHO GAVE ORAL EVIDENCE

Manchester Regional Hospital Board

Alderman T. Hourigan—Chairman.
Mr. F. Pethybridge—Secretary.
Dr. A. J. Lane—Senior Administrative Medical Officer.
Dr. F. Marshall—Former Senior Administrative Medical Officer.
Mr. J. Emlyn Jones—Treasurer.
Miss G. B. Williams—Regional Nursing Officer.

Whittingham Hospital Management Committee

Mr. F. Phipps—Chairman.
Dr. J. D. Glynn—Consultant.
Miss M. Hardacre.
Mr. B. Johnson—Chairman, Planning and Estates Sub-Committee
Mrs. L. A. Goodwright—Chairman, Nurse Education and Finance
Sub-Committees.
Mr. F. Makinson—Group Secretary.
Dr. D. P. Oakley—Consultant.

Staff of Whittingham Hospital

Mr. J. F. Abbott—Chief Nursing Officer.
Mrs. A. Boulter—Deputy Ward Sister.
Mrs. P. Bunn—Principal Psychologist.
Miss E. Coulton—Student Nurse.
Dr. J. C. Denmark—Consultant.
Mrs. E. Eckton—Ward Sister.
Miss M. Gillings—Ward Sister.
Dr. J. D. Glynn*—Consultant.
Mr. G. D. Gorton—Catering Manager.
Mr. T. Hamer—Assistant Chief Male Nurse.
Mr. R. Haresnape—Charge Nurse.
Mr. T. Henderson—Social and Recreation Officer.
Mrs. L. M. Higson—Social Therapist.
Miss M. M. Holden—Social Worker.
Mrs. K. W. Hudson—Psychiatric Social Worker.
Mrs. J. A. Inglis—Head Occupational Therapist.
Miss F. M. Knapman—Deputy Ward Sister.
Mrs. J. Leeming—Night Superintendent.
Mr. J. Lindsay—Principal Nurse Tutor.
Mr. P. Maddison—Registered Mental Nurse.
Mrs. M. Martin—Nursing Assistant.
Mrs. I. E. Matthews—Deputy Matron.
Mrs. L. Moiser—State Enrolled Nurse.
Mr. R. Newton—Senior Assistant Chief Male Nurse.
Miss E. A. Nicholson—Student Nurse.
Dr. D. P. Oakley*—Consultant.
Mr. J. J. Rafferty—Nursing Assistant.
Mr. J. Rhodes—Charge Nurse.

* Also member of Hospital Management Committee

Dr. W. A. M. Robinson—Consultant.
 Mrs. N. Scott—Chief Pharmacist.
 Mr. W. E. Shepherd—Charge Nurse.
 Dr. M. Silverman—Consultant.
 Mr. F. Slater—Head of Industrial Therapy Department.
 Mr. L. Thomas—Deputy Chief Male Nurse.
 Mrs. P. Timoroksa—Ward Sister.
 Mr. C. N. Tucker—Charge Nurse.
 Mrs. J. Turner—Pupil Nurse.
 Mrs. M. Tyson—Temporary Warden of the Nurses' Home.
 Mrs. H. Urquhart—Ward Sister.
 Mr. K. Watkinson—Night Charge Nurse.
 Mrs. A. Wilkinson—Ward Sister.
 Miss M. Williams—Ward Sister.
 Mrs. L. Woods—Ward Sister.
 Miss M. Farrington Wood—Deputy Ward Sister.

Former Staff of Whittingham Hospital†

Mr V. Beecroft—Student Nurse.
 Mr. A. Collins—Student Nurse.
 Mrs. L. Collins—Registered Mental Nurse.
 Mr. F. J. Fraser—Treasurer.
 Miss C. Frediani—Deputy Ward Sister.
 Mr. M. Geoghegan—State Enrolled Nurse.
 Mr. J. F. Giddins—Student Nurse.
 Mr. M. Guy—Registered Mental Nurse.
 Mr. W. A. Higgs—Group Secretary.
 Dr. A. B. Masters—Medical Assistant in Psychiatry.
 Mr. J. I. Maudsley—Senior Assistant Chief Male Nurse.
 Miss A. McBriar—Student Nurse.
 Mr. J. Nelson—Painter.
 Mrs. L. P. Philson—Registered Mental Nurse.
 Mrs. L. A. Turner—Cadet Nurse.
 Mr. W. Wearden—Charge Nurse.
 Miss D. V. Williams—Matron.
 Mrs. M. I. Wilson—Home Sister.
 Mr. W. G. Wilson—Chief Male Nurse.

OTHERS

Mrs. M. Baron—Member of the public.
 Superintendent A. Collins—Detective Superintendent.
 Mr. F. Howard—Patient.
 Mr. S. Lightfoot—Chairman of League of Friends.
 Mr. J. F. Mann—Auditor.
 Mr. L. G. Scott—Auditor.

**B. PERSONS WHO GAVE WRITTEN EVIDENCE READ OUT
 AT THE HEARING**

Mrs. M. P. Caton—Ex-Nursing Assistant.
 Mrs. M. Kirkham—Ex-Deputy Sister.
 Mr. J. Sutton—Member of the public.

† Grades given are those applying before departure from the hospital.

C. PERSONS WHO PRESENTED WRITTEN EVIDENCE

Mr. Makinson, Group Secretary

- (i) Introductory booklet to hospital.
- (ii) Extract from Standing Orders of H.M.C. giving terms of reference of sub-committees.
- (iii) Committee Structure, June 1971 (reproduced as Appendix IV).
- (iv) Minutes of H.M.C., Committees and Sub-Committees, 1967-1970.
- (v) Memorandum by Group Secretary to H.M.C. on revision of Committee Structure, 8 January 1969.
- (vi) Allocation of beds to consultants during 1965, 1967 and 1971.
- (vii) Revision of clinical teams as from Monday, 8 February 1971.
- (viii) Documents on Nurse Recruitment—extracts from Principal Tutor's report to Nurse Education Committee, 3 July 1968; minutes of Nurse Education Committee meetings, 3 July 1968 and 2 October 1968.
- (ix) Minutes of meeting of Nurse Procedures Committee, 11 November 1968.
- (x) Extracts from minutes of H.M.C. about complaints from nursing staff, 27 November 1968.
- (xi) Report by Group Secretary to Establishment Sub-Committee and Nurse Education Committee on nurses' complaints, 6 December 1968.
- (xii) Minutes of H.M.C.'s Sub-Committee of Enquiry, 6 December 1968.
- (xiii) Letter to Group Secretary from four Ward Sisters, 9 December 1968.
- (xiv) Letter to Group Secretary from Deputy Sister Bright, 11 December 1968.
- (xv) Letter to Chairman of H.M.C. from Dr. Masters, 3 July 1969.
- (xvi) Notes of a Special Meeting of the H.M.C., 26 August 1970.
- (xvii) Extracts from staff records of Nurse Geoghegan.
- (xviii) List of complaints, incidents, etc., at Whittingham Hospital, 1966-1970.
- (xix) Ward records and report books.
- (xx) Estimate of cash spending by patients outside hospital, 1970-71.
- (xxi) Documents about the appointment of the Principal Psychologist.
- (xxii) Statement by H.M.C. about the Principal Psychologist, 25 May 1971.
- (xxiii) Note of procedures for dealing with patients' complaints.
- (xxiv) Minor building and repair schemes, 1971/72.
- (xxv) Liaison between Whittingham Hospital and local health authorities.
- (xxvi) Statement about gardens, ornamental grounds, etc.
- (xxvii) Timetable of bus service between Preston and Whittingham.

Dr. A. B. Masters, former Medical Assistant in Psychiatry

- (i) Extracts from Hospital Journal "Contact", January 1965 and November 1965.
- (ii) Minutes of Extra-Ordinary Meeting of Student Nurses' Association (reproduced at Appendix II) 18 July 1967.
- (iii) Letter to Group Secretary on cold rooms, 1 December 1969.
- (iv) Letter to Group Secretary on cold rooms, 10 December 1969.
- (v) Letter to Group Secretary on administration of paraldehyde, 2 July 1969.
- (vi) Letter to Group Secretary on Ward 16, 22 July 1969.
- (vii) Notice by "Bill Shakespeare" published by Chief Male Nurse, May 1969.
- (viii) Notice on administration of paraldehyde, 30 June 1968.
- (ix) Table showing bedroom temperatures in nurses' home.

Mr. W. G. Wilson, former Chief Male Nurse

Plan for rehabilitation of male patients, 25 October 1967
Extract from local journal, January 1971.
Bills, etc.

Miss D. V. Williams, former Matron

Correspondence with Dr. Masters about a student nurse, January-February 1970.
Rota for student nurses, April 1966.
List of newly qualified female staff, July 1966-December 1970.
Two letters from members of the public.
Programme of ward teaching, May 1968.

Mrs. I. E. Matthews, Deputy Matron

Change lists for student nurses, December 1970.

Miss J. Healy, Ward Sister

Statement of experience and conduct of Ward 16.
Letter from former nurse.

Mr. T. H. Henderson, Recreation Officer

Programme of patients' activities.
Programme of evening classes.
List of aims of resocialisation.

Mrs. P. Bunn, Principal Psychologist

Letter of appointment, 1 March 1968.

Dr. J. C. Denmark, Consultant.

Letter, 4 June 1971.

Mr. F. J. Fraser, former Treasurer

Form of ward record for patients' money.

Notice about patients' accounts, 30 January 1963.

Statement of patients' balances.

Mr. G. D. Gorton, Catering Manager

Examples of current patients' menus, May 1971.

Medical Officer of Health, Preston C.B.

Liaison between Manchester Regional Hospital Board and Local Authorities.

Mr. Higgs, former Group Secretary¹

Study Day Conference for Senior Nurses, 11 December 1963.

Two booklets on patient care and rehabilitation, 1961-64.

Paper on future capital requirements, January 1961.

A number of other letters and statements were received from persons, most of whom were not called upon to give oral evidence.

APPENDIX II

THE STUDENTS' COMPLAINTS OF JULY 1967

Extra-Ordinary Meeting of the Student Nurses' Association held in the Teaching Department, Cameron House, Whittingham Hospital, on Tuesday, 18 July, 1967, at 2.15 p.m.

Meeting opened 2.15 p.m.

45 student nurses present.

The Chairman explained that the purpose of the meeting was to consider patient care at Whittingham Hospital in relation to recent Press statements on malpractices in patient care, arising from the publication "Sans Everything". The Chairman opened the meeting to general discussion from the floor of the meeting. The following points were raised:—

- (a) That statements may lead to prejudice and discrimination against members of the nursing staff giving evidence of malpractice. The members of the meeting expressed strong feelings that this would influence discussion, work and career situations.

It was moved that any resolutions or circumstances put forward should not use names of hospital personnel.

- (b) Several student nurses moved that discrimination in serving of patients' diets arose in the ward—"That some patients are not allowed a balanced diet, being denied certain constituents of diet because of incontinence", and that mid-day meals on some wards were all mixed together, then served to patients.

The following complaints were put forward:—

That many patients were put to bed too early in the evening. The students could not reach agreement that this was due to staffing circumstances or that this was actual malpractice.

A resolution was moved, seconded and unanimously approved, "That the question of malpractices at Whittingham Hospital could be the subject of investigation".

Fourteen student nurses admitted that alleged instances of cruelty had arisen, but refused to substantiate incidents due to fear of discrimination.

Some patients who are incontinent are bathed with long mops.

Cigarettes removed from patients after visiting. Relatives left 180 Embassy tipped cigarettes or Woodbines. Patient rationed to 2 cigarettes per day. Cadet tipped cigarettes sold to patients at 2s. 1d. instead of 1s. 9d.

Patients struck with key strap (some knotted) with or without cause.

Removal of goods from the hospital by various grades of hospital staff, which goods are intended for patient care and hospital care. Examples are cornflakes and tinned foods.

Indigent moneys of patients spent on patients' behalf, but goods do not reach patients. One patient is recorded as having had purchased on his behalf 24s. worth of Steradent in one month.

Patients made to sleep in vests instead of night clothes if they are incontinent on some wards.

Patients locked in coal-house or bathroom in one ward all day.

Patient struck on head with fish slice, because she could not use a knife and fork.

Agitated patients tied by bed sheets.

On geriatric wards at St. Luke's, patients in bed are being tormented and/or abused for amusement of staff.

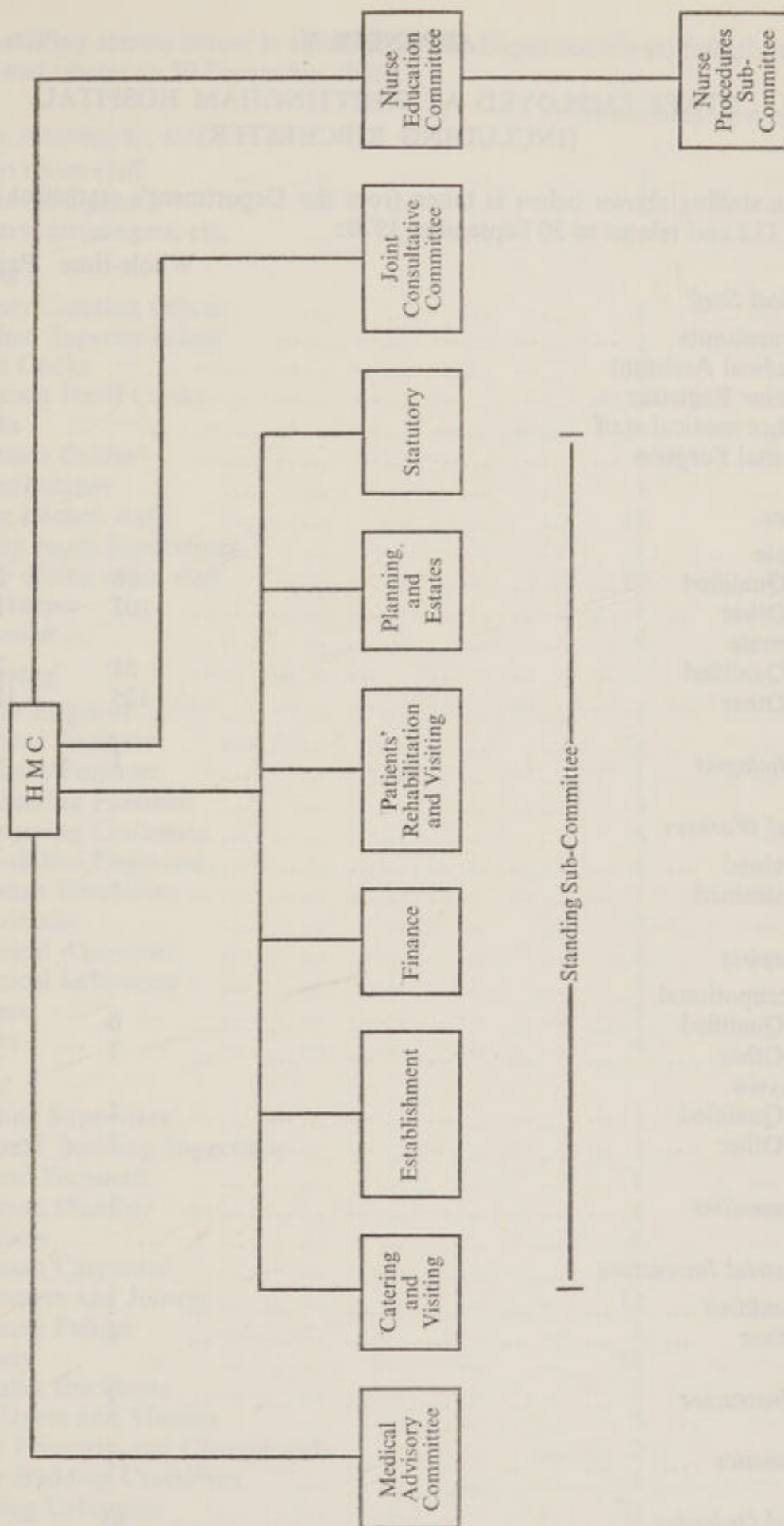
The above statements are given in the actual wording of the student nurses.

APPENDIX III

MEMBERS OF THE HOSPITAL MANAGEMENT COMMITTEE

<i>Name</i>	<i>Date of Appointment</i>	<i>Appointment Expiring</i>
Mr. F. Phipps, J.P. (Chairman)	24.7.1956	31.3.1972
Alderman J. W. Geere, J.P., C.A.	25.5.1957	31.3.1973
Dr. J. D. Glynn, L.R.C.P. and S.I., D.P.M. ...	1.4.1967	31.3.1973
Mrs. L. A. Goodwright, M.B.E.	25.5.1948	31.3.1973
Miss M. Hardacre, S.R.N., S.C.M., H.V. ...	1.4.1964	31.3.1973
Dr. J. Hilditch, M.B., Ch.B., D.P.H.(Vict.), F.R.S.H.	23.4.1957	31.3.1972
Rev. Canon A. Hodgson	22.1.1963	31.3.1973
Mr. B. Johnson	26.2.1952	31.3.1973
Dr. J. Lord, M.C., M.B., B.Ch., B.A.O. ...	25.4.1967	31.3.1973
Mr. J. Lund, J.P.	24.5.1966	31.3.1974
Mr. D. G. Mather, J.P., K.S.G.	23.5.1967	31.3.1974
Dr. D. P. Oakley, M.D., D.P.M., J.P.	1.4.1968	31.3.1972
Mrs. K. M. O'Riordan, M.C.S.P.	28.5.1957	31.3.1972
Sir Herbert Pollard, K.B., C.B.E., O. St. J., F.C.A., F.I.M.T.A., L.L.C.M.	1.4.1963	31.3.1972
Mr. J. Smith, M.B.E., J.P.	1.4.1962	31.3.1974

APPENDIX IV THE COMMITTEE STRUCTURE OF WHITTINGHAM HMC*



— Standing Sub-Committee —

* Provided by the Group Secretary

APPENDIX V

STAFF EMPLOYED AT WHITTINGHAM HOSPITAL (INCLUDING RIBCHESTER)

The staffing shown below is taken from the Department's statistical return SBH 112 and relates to 30 September 1970:

							Whole-time	Part-time
<i>Medical Staff</i>								
Consultants	...	...	...	...	...	...	—	6
Medical Assistant	...	...	...	...	...	...	—	1
Senior Registrar	...	...	...	...	...	...	1	2
Other medical staff	...	...	...	...	...	...	—	11
Dental Surgeon	...	...	...	...	...	...	—	1
<i>Nurses</i>								
Male								
Qualified	...	...	...	...	...	...	86	20
Other	...	...	...	...	...	...	103	14
Female								
Qualified	...	...	...	...	...	...	51	27
Other	...	...	...	...	...	...	125	183
<i>Psychologist</i>	...	...	...	...	...	...	1	—
<i>Social Workers</i>								
Trained	...	...	...	...	...	...	—	1
Untrained	...	...	...	...	...	...	1	—
<i>Therapists</i>								
Occupational								
Qualified	...	...	...	...	...	...	6	—
Other	...	...	...	...	...	...	7	4
Physio								
Qualified	...	...	...	...	...	...	1	—
Other	...	...	...	...	...	...	1	—
<i>Chiropodists</i>	...	...	...	...	...	...	1	1
<i>Industrial Instructors</i>								
Qualified	...	...	...	...	...	...	1	—
Other	...	...	...	...	...	...	6	—
<i>PE Instructor</i>	...	...	...	...	...	...	1	—
<i>Domestics</i>	...	...	...	...	...	...	11	15
<i>Ward Orderlies</i>	...	...	...	...	...	...	30	1

The staffing shown below is taken from the Department's statistical return SH 13 and relates to 30 September 1970:

						Whole-time	Part-time
<i>Porters, messengers, etc.</i>							
Linen room staff	...	...	...	...	...	1	—
Other ASC grades	...	...	...	...	...	2	4
Porters, messengers, etc.	...	...	...	...	...	35	—
<i>Catering</i>							
Deputy Catering Officer	...	...	...	...	...	1	—
Kitchen Superintendent	...	...	...	...	...	1	—
Head Cooks	...	...	...	...	...	2	—
Assistant Head Cooks	...	...	...	...	...	3	—
Cooks	...	...	...	...	...	14	1
Assistant Cooks	...	...	...	...	...	9	—
Baker/Butcher	...	...	...	...	...	1	—
Other kitchen staff	...	...	...	...	...	15	—
Dining room Supervisors	...	...	...	...	...	1	—
Other dining room staff	...	...	...	...	...	10	7
Storekeeper	...	...	...	...	...	1	—
Storemen	...	...	...	...	...	4	—
<i>Engineering</i>							
Group Engineer	...	...	...	...	...	1	—
Hospital Engineer	...	...	...	...	...	1	—
Assistant Engineer	...	...	...	...	...	1	—
Engineering Foremen	...	...	...	...	...	3	—
Engineering Craftsmen	...	...	...	...	...	6	—
Semi-skilled Engineers	...	...	...	...	...	6	—
Foreman Electrician	...	...	...	...	...	1	—
Electricians	...	...	...	...	...	7	—
Electrical Assistants	...	...	...	...	...	2	—
Electrical Labourers	...	...	...	...	...	3	—
Stokers	...	...	...	...	...	7	—
Others	...	...	...	...	...	4	—
<i>Building</i>							
Building Supervisor	...	...	...	...	...	1	—
Assistant Building Supervisor	...	...	...	...	...	1	—
General Foreman	...	...	...	...	...	1	—
Foreman Plumber	...	...	...	...	...	1	—
Plumbers	...	...	...	...	...	6	—
Foreman Carpenter	...	...	...	...	...	1	—
Carpenters and Joiners	...	...	...	...	...	12	—
Foreman Painter	...	...	...	...	...	1	—
Painters	...	...	...	...	...	18	—
Foreman Bricklayer	...	...	...	...	...	1	—
Bricklayers and Masons	...	...	...	...	...	5	—
Other Foreman and Chargehands	...	...	...	...	...	2	—
Other Building Craftsmen	...	...	...	...	...	1	—
Building Labourers	...	...	...	...	...	22	—
Others	...	...	...	...	...	2	—

Farms, Gardens and Ground Maintenance

Farm and Estate Manager	...	...	...	...	...	1	—
Other farm staff	...	...	...	...	...	7	—
Head Gardener	...	...	...	...	...	1	—
Gardeners	...	...	...	...	...	19	—
Groundsmen	...	...	...	...	...	6	—

Laundry

Laundry Manager	...	...	...	...	...	1	—
Assistant Laundry Manager	...	...	...	...	...	1	—
Laundry Staff	...	...	...	...	...	20	4

Other

Drivers	...	...	...	...	...	8	—
Telephone Operators	...	...	...	...	...	2	—
Fire Safety Officer	...	...	...	...	...	1	—
Tailors, Shoemakers and Barbers	...	...	...	...	...	6	—
Nursing Cadets	...	...	...	...	...	9	—
Basketmaker	...	...	...	...	...	1	—
Bookbinder	...	...	...	...	...	1	—
Printer	...	...	...	...	...	1	—
Upholsterers	...	...	...	...	...	2	—
Security Officer	...	...	...	...	...	1	—
Shop Manageress	...	...	...	...	...	1	—
Shop Assistants	...	...	...	...	...	4	—
Garage Foreman	...	...	...	...	...	1	—
Motor Mechanics	...	...	...	...	...	2	—

Professional, Technical, etc.

Chaplains	...	...	...	...	...	1	6
Dark-room Technician	...	...	...	...	...	1	—
Electro-encephalography Technicians	...	...	...	...	...	2	—
Medical Laboratory Technicians	...	...	...	...	...	2	—
Medical Students and Juniors	...	...	...	...	...	3	—
Ophthalmic Optician	...	...	...	...	...	—	1
Pharmacist	...	...	...	...	...	1	—
Pharmacy Technicians	...	...	...	...	...	3	—
Post Mortem Room Technician	...	...	...	...	...	1	—
Radiographers	...	...	...	...	...	—	2

The staffing shown below is taken from the Department's statistical return SH 6 and relates to 30 September 1970:

						Whole-time	Part-time
<i>Administrative and Clerical</i>							
Group Secretary	...	...	...	...	...	1	—
Deputy Secretary	...	...	...	...	...	1	—
Treasurer ...	...	...	...	...	...	1	—
Hospital Secretary	...	...	...	...	...	1	—
Senior Administrative staff	...	...	...	...	...	2	—
General Administrative staff	...	...	...	...	...	6	—
Higher Clerical staff	...	...	...	...	...	9	—
Clerical staff							
Full duties	...	...	...	...	...	9	1
Routine duties	...	...	...	...	...	3	5
Personal Secretaries	...	...	...	...	...	4	—
Shorthand typists	...	...	...	...	...	5	1
Copy typist	...	...	...	...	...	1	—
Area Supplies Officer	...	...	...	...	...	1	—
Deputy Area Supplies Officer	...	...	...	...	...	1	—
Higher Clerical Officer	...	...	...	...	...	1	—
Clerical Officer	...	...	...	...	...	1	—

APPENDIX VI

AUDIT REPORTS

(1) EXTRACT FROM INTERIM REPORT

A special audit, which commenced on 29 September 1969, is still in progress and is concerned principally with accounting for patients' money, especially the money issued from hospital and other sources for patients' pocket money and comforts.

Patients' money

(a) General Outline

It will be of assistance if a general outline of the arrangements is first given.

Money is received by the Treasurer from a number of sources on behalf of patients and is paid by him into the Committee's bank account, ledger accounts being maintained to show the extent of each patient's holding. Other patients who have no income from social security or from other official or private sources or balances from which they can draw, receive pocket money directly from hospital funds. Patients performing tasks around the hospital also receive rewards from hospital funds.

By far the greatest amount paid to or for patients is by way of weekly payments of pocket money, made by the Treasurer to ward staff, for distribution to patients or for spending on comforts for the patients. There are, of course, other withdrawals, e.g., for purchases of clothing and for purposes such as the payment of rent, insurance premiums, etc., by the Treasurer on behalf of patients, or for special purchases, but these are minor and subsidiary to the outgoings of pocket money. These amount to approximately £91,000 per annum, derived from the following principal sources:—

	£
Patients' own private money	15,000
Social Security benefits	14,000
Payments to indigent patient and for rewards	62,000
(From hospital funds—amount quoted is for financial year 1968–69.)	

Money thus paid by the Treasurer is handed over to ward nursing staff, in bulk for each of the 50 wards of the hospital, and the responsibility for disposing of it is then in the hands of the nursing staff.

(b) Assessing of Patients' Needs

In theory, patients' needs are decided by hospital medical officers. In practice, it has been found that medical officers' assessments depend largely on the advice of nursing staff who draw up, at monthly intervals, schedules of names of patients and the amounts which, in the opinion of the nursing staff, patients can appreciate; medical officers see and sign these schedules. Three medical officers were interviewed and admitted that they gave only

cursory attention to the schedules and several were seen which had been signed but which contained no entries at all.

(c) Distribution of Money

Money is distributed mainly on three days of the week by an officer of the Treasurer's Department and is handed over to nurses in charge of wards, the weekly amounts varying from as little as £1 for a ward to over £100 for certain wards. Schedules and books are used to record the distribution of the money and carry signatures of patients and staff.

Enquiries showed that, as accounting documents, these records were almost valueless because:—

- (i) some nursing staff had signed patients' names for them ;
- (ii) some amounts had been signed for in full by patients but had never been received by patients, or had been received only in part by them ;
- (iii) the records contained numerous alterations which had been made in an improper manner, e.g., by scratching out original entries, and which had not been authenticated in any way ;
- (iv) although the schedules contained completed certificates stating that payments to patients had been witnessed, enquiries revealed that, in practice, the procedure of witnessing was carried out on rare occasions only.

It also emerged that it is a common practice for patients to hand either the whole or part of their pocket money back to ward nursing staff.

(d) Comforts in kind

It is the practice for ward nursing staff to buy cigarettes, sweets, clothing and other articles from the hospital shop and, in some cases, from outside the hospital, using part of the cash received from the Treasurer. Some wards keep lists of the distribution to individual patients of cigarettes, sweets, etc., but these records were found to be generally out-of-date and ill-maintained ; other wards keep no records at all.

The total requirements of each ward are listed, either by ward staff or by hospital shop staff, in shopping books, which the shop staff use for making up orders. Such purchases are mainly on a cash basis, but some discrepancies were observed between ward shopping books and the shop till roll. These may have arisen, although this could not be established conclusively, from the practice of the shop in allowing some purchases on credit ; please see later remarks concerning the shop.

Enquiries revealed unsatisfactory features concerning the distribution of comforts. For example, a charge nurse gave three conflicting accounts of the manner in which cigarettes were distributed on his ward. On another ward, cigarettes were included in the ward distribution list for patients who were said by some members of the ward staff not to smoke or to smoke very rarely.

It also emerged that some members of the nursing staff sell cigarettes to patients ; it was stated by ward staff during interview that the cigarettes

were either obtained privately or were drawn from ward stocks bought from the hospital shop from patients' pocket money. No records of these transactions or of the disposal of the cash from sales of ward stocks exist on some wards and, on other wards, records are unsatisfactory.

(e) Purchase of Clothing

In addition to cigarettes and sweets, articles of clothing, e.g., nightdresses, are purchased by wards from the hospital shop. Other purchases are made from local firms which visit the hospital and hold sales, such purchases being paid for centrally by the Treasurer, and further purchases from outside suppliers are made by nursing staff from cash saved on the wards.

On one male ward, clothing purchased from a local firm in September, 1969, could not be produced at the time of the first visit to the ward but was produced at the second visit; articles purchased from the same firm in March, 1969, have still not been produced.

Attempts on other wards to link specific purchases with the articles of clothing were frustrated because of the large quantities of clothing held and the impossibility of identification. For example, on one ward of 30 female patients, 159 nightdresses (which were in addition to those in use and at the laundry) and other clothing, were stored in wardrobes, were not marked with patients' names and were used on a communal basis.

(f) Purchases of Provisions

Purchases from the hospital shop by ward staff for patients included jam, meat paste, fruit cordials, tea, coffee, sugar, salmon, tinned chicken and tinned ham which, it was stated by nursing staff, were used to supplement the normal hospital diet or to replace unsuitable dishes supplied by the hospital kitchens.

(g) Hospital Shop

There is a main shop known as The Lawns and two small branch shops known as St. John's and St. Margaret's. The following references to the shop are to the aggregate takings, accounts, etc., of all three branches, except where indicated.

- (i) A deficiency of £625 1s. 1d. found early in 1969 was the subject of a Sub-Committee of Inquiry at which the former shop manager who retired from the full-time post in November, 1968, but who continued to be employed as a part-time assistant stated that he had falsified stock returns of the shop for a number of years. His appointment was terminated in July, 1969.
- (ii) Reference has already been made to discrepancies between ward shopping books and shop till rolls. Statements have been made by both ward and shop staff that these may be due to credit having been allowed by the shop on occasions but these statements could not be substantiated in any way, and no records of such debts were produced.

- (iii) During the currency of the special audit, the Treasurer discovered that the retail price control account of the shop showed the following deficiencies:—

			£	s.	d.
1 April–30 June, 1969	...	...	38	7	2
1 July–29 September, 1969	...	...	425	11	4
1 October–24 November, 1969	...	...	119	16	3
25 November–29 December, 1969	...	...	63	16	4
Total deficit			647	11	1

These deficiencies are the subject of investigations by the police.

- (iv) There has been a steady decline over a number of years in the size of the shop takings compared with the amounts of patients' allowances. For example, in the financial year 1955–56, allowances paid from Committee funds amounted to some £20,000 and total shop sales were £28,000. In 1968–69, patients allowances from Committee funds alone were £62,000 (an additional £29,000 being drawn for patients from social security and private sources) and total shop sales were £42,000.
- (v) In a period of 8 weeks following the start of the audit enquiries (and before the start of the Christmas spending period) shop takings increased by an average of £93 per week, a rise of about 11 per cent. A further comparison of takings in the period of 20 weeks from 29 September, 1969, to 13 February, 1970, compared with the period of 20 weeks prior to the commencement of the audit, shows an increase of an average of about £120 per week, after taking account of an exceptional factor arising from a change in the method of purchasing of comforts by Ribchester Hospital (which is an ancillary hospital to Whittingham Hospital).

(h) Outlets for spending by or for patients

As has been outlined, £91,000 was issued from all sources for patients' pocket money and comforts in the financial year 1968–69 and the total takings of the hospital shop were £42,000. The latter sum includes an indeterminable amount from spending by staff on their own account and from visitors. There is, therefore, a sum of at least £49,000 which, in that financial year, was not spent by or for patients in the hospital shop but which must have been disposed of in other ways.

Other outlets for spending are in shops and public houses in the adjacent village of Goosnargh, in Preston, which is about 7 miles distant, and during organised outings to Blackpool and other places of entertainment and recreation. Purchases of clothing from pocket money cash were referred to at (e) above.

Information provided by the chief male nurse and by the matron on 8 October 1969, showed that, of 1,964 patients then in the hospital, 333 might be allowed to travel as far afield as Preston but only on authorised

occasions and normally for particular purposes ; a further 320 might pass outside the hospital to Goosnargh (where they might spend for other patients as well as themselves), but that the 1,311 remaining patients were confined to the hospital, except for organised outings. In view of the high proportion of patients who are so confined, it is unaccountable why well over half of the pocket money of all patients has been disposed of in other ways than through the hospital shop. A further and detailed census of the parole classification and pocket money of all patients is being undertaken, in an endeavour to throw further light on this unresolved question, but the results of this survey are not yet available.

(i) Possibility of irregularity

Many interviews have been conducted in an endeavour to establish whether or not patients have been receiving the full value of the cash and goods issued for them. Most of the officers of the Committee have given full co-operation but a number have not done so and their answers to questions have been evasive, uninformative and generally unsatisfactory. In view of this and of the situation already outlined, the assistance of the police has been sought ; their enquiries are proceeding currently.

Matters for Consideration by the Committee

The matters dealt with above cast doubt on the effectiveness of hospital policies in relation to the financial aspects of the care of patients. The matter is clearly a complex one involving medical, nursing, administrative and financial considerations. The comments which follow are intended to identify features of the arrangements which deserve urgent review.

General Principles and Criticism

A salient fault of the present system is that much of the cash issued by the Treasurer to wards is never handed to patients but is passed back to the shop by nursing staff in exchange for goods, and is then paid in by the shop to the Treasurer. This is a cycle which involves the handling of unnecessarily large amounts of cash and it should be replaced by some alternative system which will provide comforts for these patients by means not involving the handling of cash.

Charge nurses and ward sisters have carried the prime responsibility for assessing the needs of their patients for pocket money and for effectively deciding, thereby, the amounts of cash which have been issued to them by the Treasurer. From interviews conducted with senior nursing staff and with medical staff, it has appeared doubtful whether the checks made by such staff have been in sufficient depth to provide adequate assurance that amounts issued have been reasonable and compatible with the needs of the patients.

Although the difficulties inherent in the situation are recognised, the accounting for the pocket money, after its issue to ward staff, has been lax, and supervision of accounting aspects has been weak. Comprehensive financial instructions for the control of patients' money do not exist. The last instructions were issued in 1963 and dealt with a few specific aspects only.

(2) FINAL REPORT

The audit of the accounts of the above-named Committee and its officers for the year ended 31 March, 1970, has been completed.

1. Patients' money

(a) *Special Audit*

An interim report dated 23 February, 1970, described a special audit which was then in progress, criticised the arrangements for handling patients' money and made suggestions for improving those arrangements; the special audit was concluded on 29 May, 1970, and visits of short duration have been made subsequently.

From January to May, 1970, the enquiries were conducted in close co-operation with the police, whose report, it is understood, has been submitted to the appropriate authority. The audit, so far as it was concerned with the possibility of fraud, has been inconclusive in that irregularity has not been proved, other than in respect of two members of the nursing staff who were convicted on charges relating to patients' clothing.

Reference has already been made in the interim report to evasive and uninformative replies to questions by some members of the staff. In the course of the very detailed enquiries, numerous matters of accounting have not been explained. In all the circumstances, it is not possible to regard this aspect of the audit of the accounts for the year ended 31 March, 1970, as having been completed satisfactorily.

(b) *Financial measures initiated by the Treasurer*

The following measures have been initiated by the present Treasurer, who took up post on 9 March, 1970, or by his predecessor.

- (i) A "direct savings scheme" was introduced on 7 February, 1970, for some female patients, by which a part of the allowances paid from the Committee's funds (indigent and reward allowances) is retained at source and credited to the patients' accounts instead of being issued in cash. The total amount of this retention is currently about £80 per week;
- (ii) Balances of cash held at ward level have been reduced and cash is now held in ward safes. A standard form of ward cash book is being introduced and ward cash and records are being subjected to test checks by the internal auditor;
- (iii) Details of purchases of cigarettes, sweets and other small goods from the hospital shop are now entered in ward shopping books and receipts from the cash register in the shop are being attached to the books; spot checks are made by the internal auditor;
- (iv) Purchases of clothing and of special articles from the hospital shop are now being made on a credit basis, subject to settlement by book transfers by the Treasurer. About £75 per week is being spent currently in this way;

- (v) Invoices for clothing purchased from outside shops are examined and certified by nursing heads of divisions, who are also responsible for seeing the articles purchased and for ensuring that they are marked properly ;
- (vi) In the Treasurer's Department, posting of transactions are mechanised and consideration is being given to the possibility of recording by computer. Facilities are available in the Department for patients to deposit and withdraw cash.

(c) Financial measures proposed but not yet implemented

- (i) Office accommodation is to be improved to encourage a further increase in personal banking by patients ;
- (ii) It is hoped that a senior administrative officer, to be responsible to the Treasurer for patients' money, will be appointed early in 1971 ;
- (iii) Nursing staff heads of divisions are being encouraged to take a closer interest in the control of patients' money at ward level. A Chief Nursing Officer is expected to take up post early in 1971 ;
- (iv) It is planned that payments of pocket money to patients at ward level will be reduced to one occasion per week, irrespective of the source of the money, instead of the present three times per week. Revised forms for recording payments have been drawn up ;
- (v) A credit system is to be introduced, starting on the male side of the hospital, for purchases of cigarettes and sweets from the hospital shop. Similar action is to be taken on the female side of the hospital when certain problems connected with purchasing of toilet requisites have been resolved. This measure will be likely to reduce the flow of cash by from one-third to one-half ;
- (vi) Reward money earned by working patients in departments, such as the laundry, is to be paid to them in the departments and not on the wards ;
- (vii) Financial instructions are to be issued.

The measures referred to at (b) and (c), when implemented in full, should result in a substantial improvement in control.

(d) Further measures recommended

Detailed suggestions were made in the interim report and are summarised at (i) and (ii) below. (iii) is a new point.

- (i) A fundamental change is desirable, aimed at providing arrangements whereby as many patients as are capable draw their cash directly from a hospital "bank" or, if they are not capable of handling cash but can visit the shop, their goods from the shop by means of personal vouchers. Efforts are being made in this direction [see (c) (i)].
- (ii) Although some measures have been taken, including the regulating of social security benefits of about 220 patients, there is a need for improvement in the frequency and effectiveness of the assessing

of patients' needs and in the adjusting of official allowances to accord with those needs.

- (iii) There is no apparent control over drafts for social security benefits addressed to individual patients. At present, such drafts, which are clearly recognisable as such, are received with the general post and distributed with patients' other letters. Controls should at least ensure that remittances are delivered safely to patients.

2. Hospital shop

The deficiencies referred to at paragraph g(iii) of the interim report have abated but have not disappeared. In the financial year ended 31 March, 1970, the total net deficiency was £700 15s. 8d. (a further £53 4s. 7d. to that already reported for the period to 29 December, 1969). In the period 1 April to 7 October, 1970, the total net deficiency was £104 10s. 11d.

3. Other aspects of the special audit

Enquiries into other aspects of expenditure of the Committee, referred to in the concluding paragraph of the interim report, were subjected to a few preliminary enquiries only at audit and were handled in greater depth by the police.

4. Overtime

During the course of the audit, very high levels of overtime among some sections of the staff were observed. The following is an extract from details prepared by the Committee's officers for a period of 26 weeks up to 27 September, 1970:—

Section of staff					Average Number weekly paid staff	Total overtime paid £	Average weekly overtime per person £ s. d.		
Building and Engineering	...	...	...	...	112	15,645	5	7	0
Domestic	...	...	...	...	90	9,160	3	18	0
Catering	...	...	...	...	62	6,263	3	18	0
Farm	...	...	...	...	7	3,503	19	5	0
Boiler House	...	...	...	...	7	2,074	11	8	0
Grounds and Gardens	...	...	...	...	26	3,349	4	19	0
Printers	...	...	...	...	2	353	6	15	0
Transport	...	...	...	...	10	1,890	7	5	0
Telephonists	...	...	...	...	4	546	5	5	0
Upholsterers	...	...	...	...	2	390	7	10	0
Security Officer	...	...	...	...	1	231	8	18	0
TOTALS	...	...	...	...	323	£43,404			

It appears that enquiries should be directed into the reasons for these levels of overtime and as to whether it is justified. The Committee should require that authority should be given to overtime at an appropriate senior level

before it is worked and that details of and reasons for it should be reported to them at intervals.

5. Statements of account

Statements of account have been produced to me and, after receiving such information and explanation as I required, I have certified them as a correct record of the transactions of the Committee.

It is desired to acknowledge the courtesy and attention of the officers of the Committee throughout the audit and of the Chairman in attending audit discussions on several occasions.

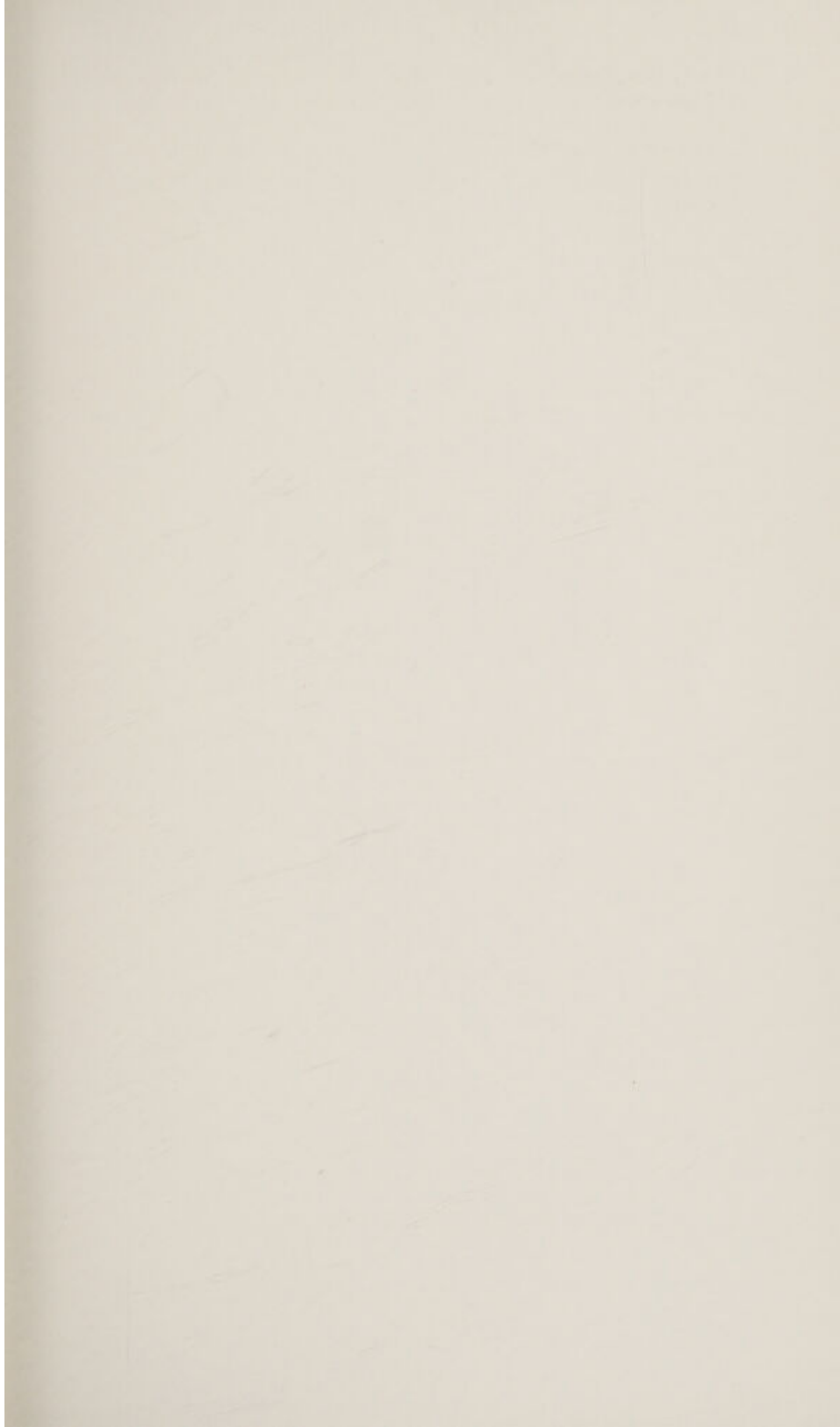
J. F. MANN,

Auditor.

No. 2 Audit Area,

Manchester.

26th January, 1971.



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