IN THE MATTER OF THE LAMPARD INQUIRY

STATEMENT OF GARY STOBBS IN RESPONSE TO THE RULE 9 (5) REQUEST

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1. I, Gary Stobbs whose address for the purpose of this statement is c/o Priory, 80 Hammersmith Road, London W14 8UD will say as follows below.

2. I have been a qualified registered mental health nurse (RMN/DipHE) since December 1997 and have a post graduate diploma in health care services management (2005).

3. I joined Partnerships in Care (PiC) in 2012 as the Hospital Director of The North London Clinic (now known as Priory Enfield) and then transferred to Kneesworth House as the Hospital Director in 2016. I left the Priory Group in December 2020 to work as the Hospital Director at St Andrews Healthcare in Essex before returning to Priory in August 2021 as a Regional Director. Following a restructure in January 2022, my role changed to Managing Director for the East region of health care within Priory and I remain in this post at the time of submitting this statement.

4. I have prepared this statement in response to a request for evidence from Priory pursuant to Rule 9 of the Inquiries Act, referred to by the Lampard Inquiry as request 'Rule 9(5)' dated 28 January 2025. The focus of the Rule 9 (5) request is, in summary, data regarding harm arising from absconding incidents arising over a 24-year period at the mental health facilities owned by Priory in Essex (which includes certain services which were formerly owned and operated by PiC until they transferred to Priory in November 2016).

5. This statement is based on the information currently available to me both as a result of my recollection of past and current roles within Priory (and previously PiC) and with the benefit of (i) having consulted with relevant members of my team and other colleagues to assess the extent of organisational memory and (ii) searches of both hard copy and electronic data held by Priory, outlined in more detail below. As indicated within this statement, in certain areas such searches are ongoing. I confirm that I understand my ongoing duty to the Inquiry to provide further disclosure of any such data arising from those ongoing searches which is relevant to this Rule 9 request.

6. Please note that Priory merged with PiC in 2016 and there are limited records available to review in respect of the PiC sites prior to that date but enquiries remain ongoing in relation to paper-based archives. Please also note that following a strategic review, Oaktree Manor ceased operations and closed in September 2019.

7. To date we have completed searches on local and shared drives at all Hospital sites and within centrally saved folders using key words to support locating information (such as "abscon*" to ensure we pick up both "absconding" and "absconsion"). We have also searched on ex-employee's personal local drives (eg former Hospital Directors and Divisional Service Line Directors who worked centrally). Searches have also been undertaken both at site and in central archiving locations for any historic paper records.

8. Long-serving colleagues have explained to me that prior to 2012, both PiC and Priory operated a paper-based incident reporting system utilising "IR1" forms. We have reviewed our archives and found IR1s for eight absconding incidents at Suttons Manor for the period May 2007 to July 2013; one absconding incident for Oaktree Manor in 2009; and five absconding incidents for Elm Park for the period 2006 - 2010. Searches of hard copy archives are ongoing and if any relevant documents come to light we will of course update the Inquiry.

9. Our review of the located IR1s established that all patients returned safely to the unit (either with or without the involvement of the police) and the incidents were therefore graded as low risk. There is no indication that a substantive investigation report (such as an RCA or equivalent) was required or prepared in relation to the NHS funded patients who absconded. Our archive searches have also revealed one patient absconded from Priory Chelmsford in 2004 and subsequently appears to have taken their own life but we have ascertained that this patient was privately funded and is therefore outside the Inquiry's Terms of Reference and outwith the Rule 9(5) to which this statement responds.

10. In respect of electronic data, relevant data has been retrieved from three incident reporting systems being;

    a. the current system, Datix, which is a Priory-wide reporting platform;
    b. E- compliance which was used by Priory between 2012 and 2019; and

c. IRIS which was used by PiC sites for the period 2014 to August 2019 when they moved to the Datix system.

11. The incident grading categories for the electronic incident reporting platforms referenced above are broadly similar and are based on the level of harm or injury actually sustained by the patient or service user. The lowest level is "no harm" and/or "near miss". The highest level is "death". There are intermediate categories where the terminology is slightly different for the three systems but the overall approach is the same. These gradings are again based on the level of harm being "minor" or "low" with further gradings increasing up the scale to "moderate" and "severe" or "serious".

12. We have recorded near-misses on the template where they are reported as such and also included where an incident is reported as "no harm" (on the basis that this can be considered to be equivalent to a "near miss").

13. The categorisation of "near miss" and "no harm" for the purposes of Priory incident reporting are based on clinical judgement but our incident reporting systems provide guidance on what these mean and they are in line with NHS gradings where "no harm" may also be called a "near miss" where harm is prevented. Whilst most of our near misses are categorised as low in grade and have no harm caused, all are reviewed by the Hospital Director as part of the Datix sign off process.

14. Please note that there have been several internal discussions about how to define what is meant by an "absconsion" or "absconding" and the optimal way to ensure this can be tied back to internal reporting data reliably for the benefit of the Inquiry.

15. For these purposes, our starting point is that an absconding means either that (i) a patient has left not just the hospital ward or building but has left the hospital grounds without permission; or (ii) a patient has during a period of escorted leave outside the hospital grounds, left their escort without permission. We have therefore not currently included in this data sets those patients who are late returning from authorised leave (but who then return unharmed).

16. An attempted absconsion (where the patient does not leave the site and there is also no harm sustained) is also not included in our data sets (though is reported on Datix under the category of attempted abscond). We consider a "near miss" absconding defines a situation where, following an absconsion (as defined in paragraph 15), a patient has returned voluntarily and there has been no harm to the patient. Conversely an absconsion categorised as "serious" is where a patient has

absconded and has come to or caused serious harm (such as being admitted to a general hospital for an injury or attacking a third party).

17. However, we recognise that this interpretation of a near miss may need to be assessed further by the Inquiry and we will of course be ready to provide further information and data sets if an alternative approach to absconding to that summarised above is preferred.

18. Absconding incidents are reported via the use of the incident reporting systems (summarised above – currently Datix). They are initially subject to a local investigation i.e. a formal assessment and review at site level by the clinical and management team and findings from this review would be discussed at site as part of Ward Rounds (ICRs) with the Clinical Team and referred upwards via the 24-hour notification system referenced below.

19. In all cases of absconding incidents, there would be immediate actions taken at site to locate the patient (local searches and calls to relatives) and the incident would be reported to both the Hospital Director and Managing Director (or senior executive on call) for further advice and support to be given. There is in place a missing person's checklist (GS/01) to refer to at all sites which advises on which agencies are to be contacted and these actions are then accordingly documented on this form. There is also a missing patient information sheet (GS/02) for completion which is provided to the Police.

20. As such, there are a significant number of absconding incidents where a substantive investigation (such as an RCA or equivalent) is not required, as the incidents generate immediate actions and local patient-specific learning or alteration in clinical management of risks with respect to a specific patient or ward (for example reviewing a patients leave whilst presenting at increased risk and updating keeping safe care plan) but do not indicate an area of wider learning or change in practice.

21. In all cases of actual absconding (as defined above), in addition to a Datix entry, a 24 hour report should also be prepared by the Hospital Director, Director of Clinical Services or Ward Manager (based on the standard template) which is circulated by email around key internal stakeholders including the CEO and members of the central Quality team to ensure notification within 24 hours. The criteria for "upwards reporting" are set out in the Priory incident management and reporting policy (GS/03).

22. The 24-hour report has had various iterations during the 24 years and was previously called an "SIR" (Serious Incident Report), “SBAR” (Situation, Background, Assessment, Recommendation – first used in 2014) but is now referred to as a 24-hour report. The report has a section “further action required” following on from the Datix report which references immediate actions taken and longer-term actions to be taken in the future. These will be clinically led and focussed on the patient and/or ward as explained above.

23. Following a 24-hour report, a further 72-hour fact finding report (providing more detailed information about the incident) would be prepared (if deemed required on review by the Hospital Director and Associate Director of Clinical Services) and a Team Incident Review (TIR) report may be completed depending on the seriousness of the incident. The site may prompt a TIR if clearly required but all 72 hour reports are reviewed weekly during a call chaired by the Divisional Director of Quality and a decision is made via the reviewing panel team as to whether a TIR is required, or if a substantive investigation is needed. The panel includes Associate Directors of Quality for their respective regions and Service line leads (eg Forensic line, CAMHs, Acute).

24. TIRs are due for final review within 14 days of a request for a TIR being made in relation to an incident, and may include feedback from key interested parties such as patients and family members in addition to other key stakeholders where appropriate. The TIR will also have recommendations for actions to be taken by the relevant site.

25. Senior members of the Central quality and compliance team and from the relevant clinical service lines (acute / forensic / PICU / CAMHS) would also be involved in TIR meetings where it is agreed additional oversight and support around the incident may be required**.** This support may be via the Regional Team compromising the Managing Director, Quality Improvement Lead and Associate Director of Quality, Service Line Network Director or via specific support from centrally based colleagues with the required expertise (eg Infection Control Lead)

26. Where areas for improvement are identified from a TIR (or substantive investigation such as an RCA or equivalent), an action plan will be drafted by the site. Site leaders are to bring key internal stakeholders together to review the recommendations made and agree appropriate actions. The action plan (GS/04) will include timescales, responsibilities and review dates and is typically incorporated in a wider Site Improvement Plan (SIP) which is implemented and managed by the HD at the relevant site with oversight from the regional Managing Director.

27. In respect of the data requested by the Inquiry to be inputted into the template provided, this is exhibited at GS/05. But please note the following additional comments below.

28. With reference to our review of the data held electronically and paper-based records retrieved from archives, I can confirm that for the 24 years' relevant period for NHS-funded inpatients at the Essex Sites:

    a. there were 233 absconding incidents for the period 2006-2023;
    b. there were 72 repeat absconding incidents;
    c. No abscondings resulted in the death of a patient;
    d. The number of absconding incidents classified as a near miss (see above) is 6;
    e. with respect to the electronic data, only Chelmsford has absconding incidents recorded as "serious" and where the patient experienced significant injury or harm of which there were four within the relevant period. We have not been able presently to confirm what level of investigation followed these incidents.
    f. we have located two TIRs where there has been a follow up to the 24-hour report (or similar);
    g. we have not located any incident records where a substantive report (such as an RCA or equivalent) has been prepared in relation to abscond incidents for NHS patients in Essex services.

29. Whilst the data searches to date have not identified any relevant incidents for our Essex inpatient facilities based on this Rule 9(5) request in the relevant period, and therefore I have not included any specific learning or changes in practice arising from abscond incidents in the Essex sites, that does not mean that Essex services will not have altered and improved awareness around abscond risks over the 24 years being discussed. As a group, we use information from abscond incidents (as with any incidents) to inform the overall safety and approach we take across the services we run, ensuring group-wide learning and continuous improvement via the above governance framework and system.

30. By way of example in relation to learning and improvements around abscond risks specifically, as a result of a fatal incident involving an inpatient taking their own life after absconding from one of our (non-Essex) sites, we initiated a programme of increasing fence heights in all adult acute mental health services across the group (including Chelmsford) to 3.2m as part of the action and learning. This was despite there being no national requirements or guidelines from the DHSC or

any other body as to the standard for fence heights in such facilities. We also put in place specific risk assessments for outside spaces across all our acute mental health services and ensured the learning from that incident was widely disseminated across equivalent services, including Essex services. I understand that the outside spaces risk assessment has been shared with and rolled-out across some NHS organisations.

31. I understand that lessons learned and how they are communicated will be dealt with more fully in the response which is being prepared to the Rule 9(8) Request received by Priory but please note the summary of key points at paragraphs 32 – 37 below.

32. We created a new role in 2022 through the appointment of a Patient Safety and Experience lead: the role includes ensuring lessons learned are collected centrally and shared across the division via varying means of communication and also arranging patient safety forums.

33. We have improved the functionality of the Priory Intranet system for all colleagues so they have ease of access to all Policies and Standard Operating Procedures and other communications including a weekly summary from the group CEO and other Executive members of the Priory Management team around group learning.

34. There are a number of other channels or forums which we use to share learning across the organisation:

    a) Policy changes are disseminated to all staff via internal emailing system
    b) 7 minute Lunch and Learn safety briefings for staff
    c) Alert and cascade system for messages to be disseminated to all staff
    d) Hospital and Regional Newsletters
    e) Regional Hospital newsletters
    f) Shared learning events both face to face and over Teams
    g) Weekly Hospital HD huddles
    h) 2 x weekly Hospital reports to MD highlighting incidents of concern for review
    i) Weekly escalation summary of sites sent to CEO

35. Priory also has a robust clinical governance framework in place at all sites to support 2-way learning via local hospital Clinical Governance meetings, regional Clinical Governance meetings and Divisional Clinical Governance meetings.

36. As part of the clinical governance policy all sites are subject to completing quality walk-rounds of their services (both in and out of hours). This provides assurances on matters such as observations being completed correctly as one of the standard checks that is required.

37. Sites also have a weekly Hospital Director "huddle" with the Managing Director each Friday afternoon where immediate lessons for learning are shared amongst the region. For the Essex sites this would be the East of England of which I am the Managing Director.

38. With regard to training, please see the information provided in the template exhibit GS/05 and please note the below general comments at paragraphs 39 – 44.

39. All nursing and HCA staff receive mandatory training in the identification, assessment and management of patients and their risk profiles which includes absconding risk. This training is completed on induction and also via e-learn.

40. In addition, all staff receive supernumerary days on the wards before being allowed to be included in the staffing complement for each shift. This includes orientation to the ward which includes awareness of the physical environment of care, including areas where a risk of absconding may require specific management (such as around exits).

41. Patients who are known to be at risk of absconding or present with other significant risks will often be placed on enhanced observation monitoring: all nursing staff are required to undergo observation and engagement training and a competency assessment before they are able to complete observations on a patient

42. All sites complete local security training as part of their site induction plan which is relevant to their service line. At Suttons Manor which is a low secure service, there will be a strong emphasis on the three components of security (procedural, physical and relational security) and training will include secure key management, perimeter checks, door security and use of the relational explorer tool. Training is also required for those staff who are nominated as a security lead (ie the person responsible for completing allocated checks relating to the physical environment). At sites such as Chelmsford and Elm Park the training remains focused on the same three components but with a change of emphasis as these Hospitals are not secure services.

43. As part of local induction, all staff are subject to local procedures and policies in relation to section 17 (leave procedures, GS/06) and also the management of absconds (GS/07) including escalation, search policies and completion of relevant reports.

44. All agency staff are required to complete an 'agency' induction checklist (GS/08 – 09) which covers local security procedures, environmental awareness, observation competency, location of emergency equipment, garden and courtyard access arrangements and current risk of patients on the ward for the shift they are working.

45. As requested by the Inquiry, please see below at paragraphs 46 to 49 some general remarks on the incidence of absconding depending on the nature of the service and the patient cohort.

46. Suttons Manor is a low secure setting and as many patients will have transferred from prison or been diverted to Hospital from court, appropriate perimeter fencing of not less than 4.2m is required to impede absconding. In addition, there is a strong emphasis on relational, procedural and other aspects of physical security (including the requirement for a staffed reception area with an air lock and all doors must be locked with staff holding authorised 'secure' keys). As such, the incidence of absconding (as defined in paragraph 15) is low and generally pertains to those situations where a patient returns late from leave (where typically they return voluntarily or are located and returned with assistance from the local police). We only have manual records of eight abscondings between 2007 – 2013 and there are no absconding incidents recorded on Datix, e-compliance or IRIS.

47. Chelmsford is not a secure hospital and specific security features such as perimeter fencing and air locks are not mandated in terms of building or unit design. There is still a focus on the three aspects of relational, physical and procedural security but the emphasis is different given the nature and conditions of the patients and the need for the patient to be supported in a therapeutic setting with less security features.

48. The incidence of absconding is higher in CAMHS and adult acute wards (as compared to Suttons Manor) as patients are in a position to leave the grounds unobserved to access the local community. For example, a patient may take grounds leave having been risk assessed for a smoking break (and could have taken many breaks previously without incident) but may decide on a particular occasion to leave the grounds. As referenced above, though there are no mandated national guidelines or requirements on the height of security fencing for acute wards, Priory has installed 3.2m fencing around the courtyard/garden of the adult acute ward at Chelmsford in order to deter absconding. There is lower absconding risk in relation to Eating Disorder patients at Chelmsford as they typically have physical issues which restrict their ability to abscond.

49. Elm Park is a neuro-rehabilitation service and many patients have physical or mental health conditions which restrict their ability to leave the site of their own volition and as such the incidence of abscondings is low. Between 2006 and 2013 there were 12 recorded incidents of absconding.

50. Please find attached at GS/10 a list of policies and related documents with relevant dates. These are updated on a 3-year cycle or more frequently if required by changes in practice or national guidance. Key changes are included on the document list where a ratification form is available (a process implemented in 2012).

51. I believe that the facts stated in this statement are true. I understand that proceedings for Contempt of Court may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief in its truth.

Name: Gary Stobbs

Signature:

[I/S]

Date: 21 March 2025