IN THE MATTER OF THE LAMPARD INQUIRY

STATEMENT OF GARY STOBBS IN RESPONSE TO THE RULE 9 (4) 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(4)' dated 28 January 2025. The focus of the Rule (4) request is, in summary, data regarding harm arising from ligature incidents arising over a 24-year period at the mental health facilities owned by Priory (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. 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 (i) 8 ligature incidents at Suttons Manor for the period May 2007 to January 2012 and (ii) 71 ligature incidents for Oaktree Manor for the period July 2006 to June 2014. Searches of hard copy archives are ongoing and if any relevant documents come to light we will of course update the Inquiry.

8. Our review of the located IR1s established that none of the ligature incidents required offsite medical attention, the attendance of paramedics or physical medical attention from doctors on site. The local actions taken by site are in respect of the well-being of the patient and are in line with relevant clinical practice at the time including de-escalation, increased observations, allowing time to ventilate feelings and removal of risk items. There is no indication that a substantive investigation report (such as an RCA or equivalent) was required or prepared.

9. 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 2012 to August 2019 when they moved to the Datix system.

10. 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 in between 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".

11. 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”).

12. The categorisation of “near miss” and “no harm” is 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.

13. Ligature 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 either discussed at site as part of Ward Rounds (ICRs) with the Clinical Team (for lower risk incidents) or referred upwards via the 24-hour notification system referenced below (for higher risk incidents).

14. As such, there are a significant number of ligature incidents where a substantive investigation (such as an RCA or equivalent) has not been carried out as the incidents generate immediate local actions and learning with respect to a specific patient or ward (for example the removal of a risk item and sharing knowledge with staff on shift at the handover).

15. With regards to actions following a ligature incident, the immediate safety of the patient will always be priority. Medical attention will always be sought following any injury to a patient. As standard practice there will be a clinical review of any incident and both the keeping safe care plan(s) and risk assessment will be updated to reflect any changes in risk presentation. Incidents will be discussed in morning “flash” meetings with both Hospital SMT and MDT members present and actions required for completion will be documented and assigned for follow up.

16. Depending on the seriousness of the incident, in addition to a Datix entry, a 24-hour report is also 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.

17. This form has had various iterations during this time 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.

18. Following this, a further 72-hour fact finding report (providing more detailed information about the incident) should be prepared 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 Director of Quality and a decision is made at a regional level as to whether a TIR is required, or if a substantive investigation is needed.

19. TIRs are due for final review within 14 days of this being requested 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.

20. 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**.**

21. 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 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 Hospital Director at the relevant site with oversight from the regional Managing Director.

22. In respect of the data requested by the Inquiry to be inputted into the template provided, this is exhibited at GS/1. But please note the following additional comments below.

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

a. we have found one ligature incident resulting in death (which has previously been reported for the purposes of Rule 9 (1) and recorded on the LoD spreadsheet). This was a former patient at Chelmsford who came by his death at home in November 2015 following discharge in September 2015. An internal review of the patient's care was carried out.

b. we have located 651 ligature incidents on our electronic incident reporting systems which have been reported as a near miss or no harm (as explained above). In respect of our paper-based records, as explained above at paragraph 8, there are 79 ligature incidents recorded but the level of harm is not graded. These have been reviewed and based on the narrative contained in the summary of the incident, have been categorised as low harm.

c. in relation to the ligature incidents which fall within the intermediate categories (i.e. between death on the one hand and no harm/near miss on the other), based on the information contained in our electronic incident reporting systems the data sets are as follows:

    i. *Chelmsford*: the site recorded 966 minor harm incidents, 86 moderate harm incidents, and 8 serious/severe harm incidents.
    ii. *Oaktree Manor*: the site recorded 116 incidents as low harm and 9 as moderate harm.

d. as recorded in the template in column H, we have currently located ten incidents where a 24-hour report, SBAR or internal incident report was generated. The type of report is indicated in column I.

e. there are no incidents that resulted in an inquiry or investigation by an external agency (but please note as follows below at paragraphs 25 to 28 in respect of the general position of external agencies and the notification and review of ligature incidents).

24. In relation to the attached template where repeat attempts of ligatures have been documented, in most cases, these attempts have resulted in no or low harm. With the patient population this refers to at Chelmsford (Eating Disorder, CAMHs and adult acute), behaviours of low level self-harm are not uncommon and attempts typically involve pieces of clothing being tied loosely, where staff have intervened in a timely manner and no medical attention has been required. In

these circumstances, the clinical team would review the patient's care plans and risk assessments and consider if items of clothing or property should be removed and if the patient requires an increased level of nursing observations.

25. As with all health care services, scrutiny and oversight of all serious incidents would be subject to CQC (formerly Health Care Commission) monitoring following internal escalation by sites (who are obliged to report it to CQC via a standard template under Regulation 18(2), Care Quality Commission (Registration) Regulations 2009). This notification may result in the CQC asking for further information about the incident or attending the site to carry out a wider inspection. It should also be noted that all relevant sites in Essex throughout the relevant period have been subject to ongoing announced and unannounced inspections from the Care Quality Commission (or Health Care Commission) as the regulatory body.

26. NHS Commissioning bodies such as NHSE, ICBs, Local Authorities and CCGs are also notified of such incidents in accordance with Priory incident management policies and in line with contractual reporting requirements in relevant framework agreements or pursuant to statutory obligations.

27. For NHSE-funded patients in secure services (Suttons Manor) and specialised commissioning placements (Chelmsford CAMHs and Eating Disorder wards) a serious incident reporting tool is required to be completed for any incidents that meet the required threshold. This is currently known as StEIS (Strategic Executive Information System) and was previously known as an NHSE 60-day episode reporting. In addition, as NHSE commissioned sites, Chelmsford and Suttons Manor have also been and remain subject to quarterly performance / contractual reviews on an ongoing basis where management and review of serious incidents is a fixed item on the agenda. This would include a review of all incidents for the previous quarter including ligatures.

28. Any incidents that result in patient harm or potential harm may also be raised with local external Local Authority safeguarding teams as per safeguarding policies. Where appropriate, internal investigations are completed as requested by LA safeguarding teams where this is deemed necessary.

29. As a general point, learning from lessons is an integral process of Priory as an organisation committed to continuous improvement. There is particular focus on learning from ligature incidents by all providers in the mental health sector. During the relevant period, ligature risk management at the Essex sites developed as learning was disseminated from a number of sources

including; developments in national guidance, stakeholder feedback and learning lessons from incidents at other sites which was disseminated across all Priory hospitals. 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.

30. The updates in procedure, policy and tools can be seen through the documents listed below at paragraph 43.

31. In relation to the Priory Group's annual programme of audit and annual risk assessment audits, CQC guidance on ligature points originally circulated in 2015 was updated in 2022 to draw attention to the fact that the risk of low lying ligature points also needs to be considered and audit data collated by Priory does not delineate between "high level" and "low level" ligature points. However, the data does record the number of high risk ligature points based on a scoring system – this will be used to populate the template.

32. Our initial searches show that we have audits for Chelmsford, Suttons Manor and Elm Park for 2017 – 2023 and our ligature audit process requires audits to be completed for every area of a Hospital both internal (such as bedrooms, en suite bathrooms, kitchens etc) and external areas where patients have access. A manual review of each individual audit template and an analysis of each audit is required in order to complete the template provided by the Inquiry. We are grateful to the Inquiry for the additional time allowed to complete this substantive exercise.

33. With regards to Oaktree Manor, it is currently not possible to confirm the amount of "high level" ligature points or how many ligature points were identified prior to its closure in 2019 due to a lack of available information but we will make further enquiries in this regard.

34. As already stated above, audit methodology has been subject to ongoing review and development since at least 2014 (based on available records).

35. Long-serving staff have advised audits were previously completed on paper records. These audits were placed onto action plan templates using a RAG rating system of Low, Moderate and High. At the time of submission, searches are continuing to establish if any historic paper audits for the relevant period can be located.

36. In today's current practice, ligature audits are undertaken as part of the organisation's annual audit process where they are completed electronically and uploaded to both site and central data

systems. This allows for both local and divisional governance processes to be able to review and support with any actions that are needed for completion. Actions required from these audits are then added to SIPs.

37. With regards to training, it has proven difficult to complete the attached template GS/1 in the required format. Searches of hard copy and electronic drives are ongoing and we will update the Inquiry if further relevant data is found. Training specific to ligature management is covered in ILS for qualified nursing and medical staff which is completed annually.

38. All nursing staff receive mandatory training in the management of suicide and self-harm as part of their induction at all sites. Prevention of suicide webinars are available and accessible to all staff at any time on the Priory intranet.

39. 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 ligature heat maps and where ligature cutters are stored.

40. Since March 2023, all staff who are required to undertake ligature audits are required to complete webinar training hosted by either an Associate Director of Quality and/or Quality Improvement Lead to ensure they are competent to complete the role. Audits are always completed by 2 staff members: one senior clinician and one senior non-clinician as per policy.

41. Whilst in the first 12 weeks of position, nursing staff are required to complete ILS training and HCA staff BLS training. This training includes management of non-responsive persons and also familiarises staff with the use of ligature cutters. This is refreshed annually.

42. As per the Priory's Clinical Governance policy, all sites are required to complete training drills for varying scenarios over a 12-month period. This includes medical drills and ligature scenarios.

43. As requested, listed within GS/2 are the materials or documentation used by Priory to record and/or monitor ligature data including internal policies, protocol and risk assessment tools. It is our understanding that this request does not include documentation such as training materials, internal learning communications, and patient feedback as, whilst of great importance, such documents are not used to monitor the data collated from ligature incidents. However, please do let us know if the Inquiry would prefer this to be provided.

44. 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