

An independent investigation
into the conduct of David Britten
at the Peter Dally clinic

**A report
for NHS London**

July 2008

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INVESTIGATIONS – REVIEWS – INQUIRIES

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Authors:
Alison McKenna
Tariq Hussain

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Verita
77 Shaftesbury Avenue
London W1D 5DU

Telephone **020 7494 5670**
Fax **020 7734 9325**

E-mail enquiries@verita.net
Website www.verita.net

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1. Introduction

Background

1.1 This report is about the conduct, management and supervision of David Britten.¹ It follows an independent investigation commissioned in June 2006 by North West London Strategic Health Authority (since subsumed into the London-wide strategic health authority, NHS London). The investigation was commissioned in accordance with guidance published by the Department of Health in HSG (94)27² in circumstances “*where the SHA determines that an adverse event warrants independent investigation, for example if there is concern that an event may represent significant systemic service failure...*”.

1.2 David Britten was employed as a nurse in the eating disorders service at the Gordon Hospital from 1980. He transferred as clinic manager to the Peter Dally clinic, a specialist eating disorders service, when it opened in October 1996. In March 2002 David Britten was dismissed on grounds of professional misconduct³. A number of former patients approached the trust (and us) after his dismissal and during this investigation, stating that David Britten had sexual relationships with them while they were in his care.

1.3 In the course of this investigation we have received more than 3,000 pages of evidence⁴ and interviewed 31 witnesses including former patients and their families, former colleagues of David Britten, his line managers and senior managers in the trust at the relevant time. We know of 23 women with whom David Britten had some sort of unprofessional contact over 20 years, ranging from inappropriate remarks to full sexual relationships. Some of them have given us evidence or been in contact with us.

1.4 We conducted our first interview on 14 November 2006 and our last interview on 2 April 2008. In 2007 the Central & North West London NHS Foundation Trust (CNWL NHS Foundation Trust) which was responsible for the eating disorders service by then, wrote to 135 former eating disorder service

¹ There is a David Britten who is a counsellor and psychotherapist at the York clinic for complementary medicine. We would like to stress that he is not the David Britten this report refers to and has no links to this investigation. Refer to BACP Tel: 01485 883300

² *The discharge of mentally disordered people and their continuing care in the community* (updated paragraphs 33-36 issued in June 2005).

³ He had in fact resigned claiming constructive dismissal before the disciplinary hearing which led to his “dismissal”.

⁴ See appendix H.

patients. Several more women came forward with complaints that we have considered as part of this investigation. However, there may be more women who have been abused by David Britten whom we do not know about, given the scale of his abuse of patients. The trust has established a dedicated support service for former patients affected by these events because the publication of this report may result in other women coming forward.⁵

1.5 This investigation has focused on management's response to the issues raised by David Britten's behaviour, in accordance with its terms of reference.

1.6 This is not an investigation under the Inquiries Act 2005 and we did not therefore have power to compel any witness to give evidence to us. We are grateful to all the witnesses who took the time to help us. We are particularly grateful to the women David Britten abused, for whom we recognise that giving evidence was difficult. We have included or referred to at least part of each woman's story in this report.

1.7 We would also like to record our thanks for the valuable assistance given to us by the charities 'beat'⁶ and WITNESS.

1.8 We have also been greatly assisted by the former Central and North West London Mental Health NHS Trust (CNWL) and the CNWL NHS Foundation Trust which now runs the Vincent Square clinic. We recognise it inherited a difficult situation. The Peter Dally clinic was closed down by the CNWL trust in May 2001 and a new eating disorder service, the Vincent Square clinic, was opened in April 2002.

1.9 We have tried to trace David Britten. The CNWL NHS Foundation Trust gave us a private investigator's report which identified addresses he had used. We wrote to them and received a reply from a relative of David Britten's, who told us he had no contact with him but understood he was living in the Philippines. In contrast to this information, a CNWL NHS Foundation Trust employee reported seeing David Britten in London during the summer of 2007. We also received information that he may have been living in France. We have tried unsuccessfully to contact David Britten and conclude that he does not wish to speak to us. We produce this report without the benefit of his input.

⁵ See appendix F.

⁶ This is the working name of the Eating Disorders Association. For contact details of both charities see appendix F.

1.10 We have considered what effect the lack of input from David Britten may have had on the ability of the investigation to meet its terms of reference. We conclude that we have received enough evidence to be confident about our findings, conclusions and recommendations, although interviewing David Britten might have provided extra information not available elsewhere. In reaching this view we take into account first the quality and quantity of the evidence provided to us by witnesses with direct experience of David Britten; second, the comprehensive nature of the documentation the trust gave us, compiled from records made during his employment; and third, the availability of the official transcript of the Nursing and Midwifery Council hearing. We have considered the fact that we had no power to compel David Britten to give evidence and also that he was unlikely to meet us voluntarily, given that he did not attend the trust disciplinary hearing or the Nursing and Midwifery Council hearing into his conduct, even though he was given notice of them.

1.11 It is important to recognise that while some managers and colleagues had concerns about David Britten's conduct with patients, no one had specific knowledge or proof of his sexual abuse of them until he had left his employment. We conclude, however, that there were many indicators of his poor practice and boundary violations⁷ which could have been responded to differently when they occurred. It should also be borne in mind that this investigation is about the deliberately abusive conduct of a skilled and practiced manipulator who consistently deceived colleagues, patients and management alike. We recognise that it is difficult to have systems to deal with a situation like this. However, when the unthinkable happens, it is instructive to look at what the perpetrator did to see if such a situation could be prevented in the future. We have attempted therefore to identify the components of his "grooming" of patients in addition to other indicators of unprofessional practice.

1.12 David Britten's abuse has clearly affected the women we mention in our report, but we also recognise that it has affected a considerable number of professionals who did nothing wrong but whose reputations have been tarnished by association because they worked in the clinic. This is particularly so in the case of Dr Peter Dally, after whom the clinic was named. A short biography is included in appendix G in recognition of Dr Peter Dally's work. Following the closure of the

⁷ See appendices D & E which deal with boundary violations.

Peter Dally clinic in May 2001 a new inpatient eating disorder service was started in April 2002 and the new service has been renamed the Vincent Square clinic.

Method used by the investigation panel

1.13 The terms of reference did not task us to conduct a new investigation of complaints made by patients but rather, in light of those complaints, to take an overview of why “...*managerial systems, policies and practices within the current and predecessor trusts...allowed Britten to act as he did for so long*”. As a consequence we have focused this investigation on:

- How did it happen?
- Why was it not detected until BKCW trust⁸ started to investigate concerns at the clinic?
- Are services safe now?

1.14 We have not tried to prove or disprove the evidence we received from former patients but have concluded that in most cases it exceeded the civil standard of proof. In some cases it would exceed the criminal standard of proof, namely, beyond reasonable doubt. We come to this view because of the similarities in evidence from women who did not know each other, combined with recognition of the courage which was required for these vulnerable women to tell us their stories. We also take into account the supporting evidence from staff and the contemporaneous documents the trust supplied.

1.15 We have not in general found it necessary to test evidence from witnesses although there were one or two instances where we had to take steps to establish the reliability of evidence in order to reach conclusions and make recommendations. This was the case when a conflict emerged between different witnesses’ accounts of the same incidents.

1.16 We reviewed all the statements taken during the three previous internal investigations and the documentation presented at the trust disciplinary hearing. This documentation included a comprehensive copy of file notes, letters and other documents related to the eating disorders services between 1998 to 2001 (with

⁸ Brent, Kensington, Chelsea and Westminster NHS Trust.

some information going back as far as 1982). The solicitor representing a number of patients also provided us with psychiatric reports and statements prepared on behalf of all but one of the women who made civil claims against the trust.

1.17 In this report we anonymise patients and staff. We set out in section four our reasons for doing so.

2. Terms of reference

The terms of reference set for us by the strategic health authority were:

2.1 To summarise and document the chronology of concerns or complaints concerning the practice and conduct of David Britten during his tenure as clinic manager of the Peter Dally clinic.

2.2 To review, as far as is possible in the light of organisational and personnel changes, the managerial systems, policies and practices within the current and predecessor trusts that allowed David Britten to act as he did for so long. (A key process in carrying out this particular term of reference will be to review the previous internal inquiry reports).

2.3 To assess and draw conclusions about the effectiveness of the governance/management arrangements now in place to deter any similar future misconduct. For example, what policies and procedures are in place to cover the following:

- the use of treatments involving touch
- the guidance given to staff about patient/staff boundaries
- the measures in place to ensure patients know what are acceptable and unacceptable professional practices
- whistle-blowing.

2.4 To make recommendations informed by this case as to improvements, if any, to the policies and procedures now in place in the trust. A principal focus of this recommendation is how clients in general and those receiving treatment for eating disorders in particular are supported and encouraged to report abusive behavior. (The views of service users groups and other experts will be sought to ensure comparison against best practice).

2.5 To provide a full report and recommendations on these matters to the strategic health authority.

3. Executive summary and recommendations

3.1 North West London Strategic Health Authority commissioned this investigation in June 2006. Responsibility for the investigation has now passed to NHS London, the London-wide strategic health authority. The investigation was commissioned as a result of the disclosure by a number of women that they had sexual relationships with a nurse called David Britten while they were his patients at the eating disorders service which is now part of Central and North West London NHS Foundation Trust⁹.

3.2 David Britten was first employed as a specialist nurse in the eating disorders service at Gordon Hospital in 1980. When the Peter Dally clinic (a specialist eating disorders unit relocated from the Gordon Hospital into new physically separated premises) opened in 1996, he was employed as the first clinic manager and remained in that post until he was removed pending redeployment in March 2001. He resigned in December 2001 and was dismissed in March 2002. David Britten had operational management responsibility for the clinic and was also responsible for the clinical supervision of the clinic's nursing staff. He personally undertook some counselling of patients and worked with the consultant psychiatrist to assess potential patients for admission to the clinic. The clinic received a high number of extra-contractual referrals (ECRs)¹⁰ and developed a reputation for working with patients who had been treated unsuccessfully elsewhere. Since the events in this report the National Institute for Clinical Excellence (NICE) has issued good practice guidelines for eating disorder services.

3.3 David Britten abused his position of trust by conducting numerous sexual relationships with patients in his care over 20 years, many of them simultaneously.

⁹ Eating disorders services were initially located in the Gordon Hospital and managed by the Riverside Health Authority (1980-1991). The services were then managed by the Riverside Mental Health Trust (1991-1999). The services then transferred in 1996 to the newly opened Peter Dally clinic. The Riverside Mental Health Trust along with a number of other trusts merged and the services came under the management of the Brent Kensington, Chelsea and Westminster NHS Trust (1999-2002). Following further trust reconfigurations BKCW trust merged and the service was placed within the Central and North West London Mental Health NHS Trust (2002-2007). Since April 2002 it has been known as the Vincent Square clinic, and is located within what is now Central and North West London NHS Foundation Trust.

¹⁰ See appendix B.

Riverside Mental Health Trust conducted an inquiry in 1998 into possible boundary violations towards patients but its investigation found the allegations not proven.

3.4 The BKCW trust also commissioned an inquiry into the Peter Dally clinic in August 2000 soon after becoming responsible for it as there were concerns that multi-disciplinary working between various professional groups had broken down. The BKCW trust had no knowledge of the earlier inquiry in 1998 conducted by Riverside Mental Health Trust until shortly after it set up its own inquiry. As a consequence of the inquiry findings David Britten was removed from the clinic pending redeployment and then became subject to a disciplinary investigation and hearing. In May 2001 the BKCW trust closed the Peter Dally clinic. It was only after David Britten had been dismissed for other reasons in 2002 that other patients began to come forward and disclose the extent of his sexual contact with them. We are aware of 23 women with whom he had an unprofessional relationship involving boundary violations of various kinds. He may have abused other women who have not yet come forward and the CNWL NHS Foundation Trust has established support services in recognition of this possibility.¹¹

3.5 In March 2002 David Britten was dismissed and the BKCW trust made a formal referral to his professional regulator the United Kingdom Central Council for Nursing Midwifery & Health Visiting which was succeeded in that year by the Nursing and Midwifery Council (NMC).¹² Later that year the CNWL trust (successor trust to the BKCW) passed to the NMC evidence about David Britten's sexual contact with patients. The NMC did not suspend David Britten from the nursing register until March 2004 and then removed him from it after a hearing in July 2004 which he did not attend.

3.6 The CNWL trust also referred David Britten to the Metropolitan police in 2002. The CID conducted an investigation but on advice from the Crown Prosecution Service (CPS) brought no prosecution at that time. The police have conducted a fresh investigation on the basis of new evidence obtained by this investigation and new complaints but have concluded that there is insufficient information to proceed further. The police will undertake a fresh investigation if any fresh complaints are made or previous complainants produce new evidence or if those previously unwilling to proceed change their mind.

¹¹ See appendix F.

¹² The NMC was established by statute in 2002 and replaced the United Kingdom Central Council for Nursing Midwifery & Health Visiting.

3.7 The CNWL trust reached financial settlements totalling £405,000 with 14 former patients in relation to David Britten's abusive conduct. One further claim is pending.

3.8 Our terms of reference required us to summarise and document the concerns and complaints about David Britten during his tenure in the eating disorders service and to review the managerial systems, policies and practices that allowed him to act as he did for so long. We have considered the evidence, made findings and reached conclusions about the effectiveness of the management arrangements then in place. We have also considered whether the revised arrangements since David Britten's dismissal provide a robust means of protecting patient safety.

3.9 We have also considered whether the three internal investigations, carried out by predecessor trusts in 1998, 2000 and 2001 should have uncovered the extent of his abuse. We have reflected on the interaction between the various public bodies involved in these events and considered whether their approach could have been more coherent in the interests of patient safety.

3.10 We make recommendations to the trust and NHS London in respect of:

- issuing guidelines for internal NHS inquiries
- wider dissemination of guidance on patient/professional boundaries for vulnerable patients as part of risk-management systems
- implementing systems for the retention of institutional knowledge about proven and unproven allegations of a sexual nature when NHS services are re-configured.

3.11 We also make recommendations to NHS London about the level of co-operation needed by public sector bodies for investigations like this to ensure patient safety issues are addressed coherently. We also identify a loophole in the vetting and barring system and recommend that professional regulatory bodies be required to make referrals to the Protection of Vulnerable Adults scheme (POVA)¹³. We recommend that our conclusions and recommendations be shared with the

¹³ See appendix B. Recommendation 9 of this report identifies forthcoming legal changes that are expected to close this loophole.

Council for Health Care Regulatory Excellence (CHRE), the National Institute for Health and Clinical Excellence (NICE) and the Healthcare Commission.

3.12 David Britten's abuse and unprofessional behaviour is similar to the abuse investigated in the Kerr/Haslam inquiry¹⁴. The common features include abuse over a number of years, grooming of patients for sexual purposes, use of unorthodox treatments, the unwillingness of professionals working with the abuser to confront them, and the failure of managers to investigate properly. We therefore include a brief summary of the CHRE's report in appendix E and have cross-referenced our recommendations with those of the CHRE¹⁵.

Recommendations

We make the following recommendations.

Internal trust investigations

R1 We recommend that the trust ensure that its policies and guidance on the conduct of internal investigations into complaints by patients include the following:

- the procedures to be adopted
- the burden and standard of proof to be applied
- the need for vulnerable witnesses to be supported in such situations. This will be particularly relevant to eating disorder services
- the selection and training of chairs for such investigations
- referral to other agencies.

Eating disorder services

R2 We recommend that the trust consider the guidance produced by the CHRE¹⁶ on patient/professional boundaries and the need to adopt appropriate risk

¹⁴ Kerr/Haslam inquiry, July 2005, CM 6640-1

¹⁵ Commissioned by the DH as a result of a number of abuse inquiries

¹⁶ The Department of Health response to the Shipman inquiry's fifth report and to the recommendation of the Ayling, Neale and Kerr/Haslam inquiries deals with the need to develop guidance on patient/professional boundaries (chapters six and seven of the Department of Health's response to the inquiries is included as appendix D). As part of its response the Department of Health commissioned the Council for Healthcare Regulatory

management procedures in the management of services dealing with vulnerable patients such as those with eating disorders.

R3 We recommend that NHS London ensure that trusts put procedures in place to ensure that whenever there is a reorganisation there is always a comprehensive handover of information to incoming management. This should highlight concerns about patient safety issues. The continuing work arising from the Bichard inquiry¹⁷ and the management of police records of unproven complaints of a sexual nature may be helpful in this regard.

R4 We recommend that the trust invite a panel of external experts in eating disorders to evaluate its eating disorder services against the policies and procedures contained in the document presented to us and set out in appendix C.

R5 We recommend that NHS London send this report to the CHRE, Healthcare Commission and to NICE¹⁸ for consideration in its next review of guidelines for the treatment of eating disorders.

R6 We recommend that in the light of this report eating disorder services be identified in the trust risk register and as a consequence complaints received from this service be reviewed closely by the trust board.

R7 We recommend that the trust ensure clinical supervision of staff is in place and working effectively.

In addition to the recommendations above which relate directly to our terms of reference, we would like to comment on a number of additional matters relevant

Excellence to produce such guidance. This was published in January 2008 and is referred to in appendix E.

¹⁷ The Bichard inquiry, established to consider information management issues in the wake of the Soham murders, made a number of recommendations regarding the retention of police records about persons who had not been convicted of any offence. The inquiry specifically considered cases where investigations of sexual offences were either discontinued or not proceeded with because of lack of corroboration but where there was a public interest in retaining the records, subject to a pre-set review period. Ref: Bichard inquiry report - <http://www.bichardinquiry.org.uk/report/>

¹⁸ See glossary, appendix B

to our investigation. We believe it is appropriate to highlight these issues as they relate to patient safety.

Multi-agency working

R8 We were concerned at the lack of cooperation we received from the Nursing and Midwifery Council during this investigation. We suggest that NHS London considers asking the Department of Health to discuss with regulatory bodies how they might cooperate with inquiries and investigations commissioned by public bodies in the public interest. We recommend that the NMC should explain to the CHRE and the CNWL NHS Foundation Trust why it did not stop David Britten practising as a nurse until two years after it became aware of his alleged conduct.

R9 We believe there is a loophole in the regulatory framework for promoting patient safety. NHS bodies will soon be able to refer individuals directly to the POVA¹⁹ register, but there is no similar power for regulatory bodies to do so. If a health professional's registration is revoked in circumstances such as David Britten's, where they have already been dismissed by the NHS, there is no system for their name to be entered on the POVA register. Consequently, unless their NHS employer has previously referred them, they would not be identified as a risk if they applied for work in an unregistered role dealing with vulnerable clients. (Since drafting this recommendation we have been advised that the Department of Health is bringing forward legislative changes which will close this loophole and these changes are due to come into force by the autumn of 2008.)

¹⁹ See glossary, appendix B.

4. Note on anonymity

4.1 The patients who gave evidence asked not to be named and we agreed. We refer to each by a consistent letter of the alphabet throughout the report.

4.2 We refer to staff by their job title at the relevant time, rather than their names, except for David Britten, whose name is already in the public domain since the NMC hearing and press reports. This is because the purpose of this investigation was *“To review, as far as is possible in the light of organisational and personnel changes, the managerial systems, policies and practices within the current and predecessor trusts that allowed David Britten to act as he did for so long.”*

4.3 We make clear in the report where our assessment of the managerial, clinical and governance arrangements leads us to criticise the conduct of individuals. However, we do not believe that identifying those individuals by name serves any purpose in view of the time passed since the events concerned. Furthermore, naming individuals could attract attention to them rather than to the need for effective managerial, clinical and governance systems to protect vulnerable patients in eating disorder and other services.

4.4 We asked ourselves whether the actions of any individual (other than David Britten) should be referred to the appropriate professional or regulatory bodies. We conclude that they should not.

5. Brief chronology

5.1 We set out below a brief chronology of events. We highlight in grey the events that should have triggered robust intervention by trust management.

Date	Action
1980 - 1991	Eating disorders services at the Gordon Hospital were managed by the Riverside Health Authority.
1991-1999	Eating disorder services at the Gordon Hospital managed by the Riverside Mental Health Trust.
October 1996	Peter Dally clinic opens.
July 1998	Complaints from two patients about David Britten touching them inappropriately.
August 1998	First investigation commissioned.
August 1998	Conditions imposed on David Britten in lieu of suspension during investigation.
September 1998	Complaint that David Britten breached the conditions imposed.
October 1998	First investigation concludes, no action regarding breach of conditions.
December 1998	Addendum to first investigation's report at David Britten's request.
1 April 1999	Following the merger of a number of trusts the service became the responsibility of the Brent, Kensington, Chelsea and Westminster Mental Health NHS Trust.
Early 1999	Complaints that David Britten is contacting patients outside of work and has not returned to supervision.

February 1999	Service director rules that David Britten is not required to attend supervision “ <i>because he is not conducting individual patient therapy</i> ”.
August 1999	Patient complains to doctor in therapy session that she has seen David Britten in a restaurant with a fellow patient. Does not wish to make a formal complaint. Doctor informs service director and consultant. This is not reported to chief executive.
September 1999	Operational policy adopted at Peter Dally clinic.
February 2000	Final draft of policy on physical contact (response to first investigation).
March 2000	David Britten referred to occupational health service but refused to discuss his medical condition.
May 2000	Supervision group at Peter Dally clinic closed by psychological therapy services.
May 2000	David Britten denies he is undertaking individual patient therapy.
May 2000	Psychological therapies complain to service director of “dangerous practice” at Peter Dally clinic.
July 2000	Psychological therapies confirm that they wish their complaint to be formally investigated.
August 2000	Second investigation commissioned.
December 2000	Interim report to chief executive which he reports to trust board.
March 2001	David Britten notified of trust intention to redeploy him and put on garden leave.
March 2001	Patient complaint to chief executive about David Britten.

April 2001	Following approaches by the chief executive, some staff were prepared to complain about David Britten.
April 2001	Following contact from the chief executive second patient complains to trust about David Britten.
April 2001	Chief executive receives 43 letters of support for David Britten from patients, their families and MPs.
May 2001	Disciplinary investigation commissioned. David Britten suspended from duty.
May 2001	Peter Dally clinic closed.
December 2001	David Britten resigns claiming constructive dismissal.
January 2002	Trust reaches first financial settlement with patient abused by David Britten.
February 2002	Disciplinary investigation concludes.
March 2002	Complaints from three further patients about David Britten.
March 2002	Internal disciplinary hearing.
March 2002	David Britten dismissed for gross misconduct.
March 2002	Trust makes complaint to Nursing and Midwifery Council and police about David Britten.
April 2002	The new Vincent Square clinic inpatient eating disorder service opens a year after the closure of the Peter Dally clinic.
April 2002	Brent, Kensington, Chelsea and Westminster Mental Health NHS Trust becomes Central and North West London Mental Health NHS Trust. The management team responsible for the Peter Dally clinic did not change and had been constant since 1999.

2002 - 2003	Extensive correspondence from the chief executive to the CPS requesting prosecution under section 128 of the 1959 Mental Health Act. The CPS decides not to prosecute David Britten, but refuses to disclose its reasons.
March 2004	Britten suspended from nursing register by NMC.
June 2004	Complaint to trust from two more former patients about David Britten.
July 2004	NMC hearing. David Britten removed from nursing register in his absence.
2006 - 2007	More complaints about David Britten. This investigation commissioned.
May 2007	Central and North West London Mental Health NHS Trust becomes Central and North West London NHS Foundation Trust.

6. Clients' stories

6.1 These stories have been compiled from various sources including:

- statements prepared as part of patient claims for civil damages
- evidence presented at the Nursing and Midwifery Council (NMC) hearing
- transcripts of evidence given to this investigation
- information passed to us during our investigation.

6.2 We use quotes in this section to give the best sense of the experience of the women and their families. In the analysis section that follows we quote selectively to illustrate certain points.

6.3 Not all patients made civil claims, presented evidence to the NMC, or gave evidence to this investigation. We tried to hear from anyone who wanted to speak to us. We carried out interviews with former patients and we received written submissions and heard about individuals from other sources such as family, solicitors and former staff.

6.4 We have sought to include something of each person's story in this section, even if it is a short reference, because we believe that hearing the stories of the women who were abused is an important part of the investigation. As a consequence some stories are quite detailed, others less so. Each patient is referred to throughout the report by the same capital letter.

Patient A (born 1975)

6.5 Patient A was abused while she was an inpatient and day patient at the Peter Dally clinic between 1996 and 1998.

6.6 She was diagnosed in early 1994 with '*borderline anorexia nervosa*' which later became bulimia nervosa.

6.7 She began outpatient treatment (aged 21) following treatment at another London hospital (which included an alcohol detox) and then in early 1996 was

admitted as an inpatient at the newly opened Peter Dally clinic. She remained as an inpatient until early 1997.

6.8 She started one-to-one therapy sessions with David Britten shortly after admission. He would ask intimate questions and she said *“He would always be very tactile during our meetings and asked me to sit on his lap so that he could cuddle me. He would often lock his office door.”*

6.9 The relationship rapidly became a full sexual one, including oral sex and occurred during therapy sessions in David Britten’s office, her bedroom and on a visit to her home when her parents were away.

6.10 Patient A’s relationship with David Britten deteriorated towards the end of her inpatient stay. She began drinking again and self-harming by cutting her arms and was placed on close observations due to concerns about possible suicide attempts.

6.11 After her discharge as an inpatient she continued to have outpatient appointments and to see David Britten for therapy. These sessions continued to involve sitting on his lap, cuddling, kissing and David Britten stroking her hair.

6.12 Her general condition deteriorated with high levels of drinking alcohol and self-harm, as a result she attended the clinic as a day patient but over the year she improved enough to attend the clinic only periodically.

6.13 In November 1998 she was admitted to a London hospital A&E as a result of cutting her hand badly while drunk. She was admitted for observation and referred to the substance misuse team. The admitting registrar recorded in her notes, *‘attachment behaviour re; psychotherapist overstepping the boundary.’*

6.14 She did not see David Britten again after her discharge as a day patient. In early 2002 she met a former patient by chance and found out that David Britten had been suspended and was being investigated for having inappropriate relationships with a number of patients at the same time as her. This revelation had a serious effect on her health.

Patient B (born 1979)

6.15 Patient B was abused while she was an inpatient at the Peter Dally clinic between 1998 and 1999.

6.16 When patient B was about 15 she was diagnosed with anorexia nervosa. By the age of 19 her weight had dropped to below five stone and she was admitted to the Peter Dally clinic in late 1998 under section 3 of the Mental Health Act. The section was removed a few weeks later when she agreed to stay as a voluntary patient.

6.17 On admission she was assigned separate staff as her key worker nurse and therapist, however both these roles were eventually taken on by David Britten. After she had been in the clinic about eight or nine months David Britten took her to a restaurant in Kensington for dinner. At the end of the meal he drove her to Victoria station to walk back to the clinic alone because he did not want them to be seen together.

6.18 Following this meal he began making advances during therapy sessions in his office by asking her to sit on his knee, kissing her, sexual touching and eventually after a number of sessions asking her to perform oral sex on him. Patient B said that during these sessions he would burn candles in the room and always locked the door.

6.19 In mid-1999 she was discharged from inpatient treatment. Before her discharge the clinic helped re-house her in the local area. David Britten persuaded her not to return home and, she said, sabotaged her relationship with her father. At this time she believed that she and David Britten would be together permanently and was therefore pleased to be offered a flat in Pimlico.

6.20 Patient B was discharged from inpatient care to the clinic's day programme in mid-1999 and her relationship with David Britten continued. He would visit her at her flat in Pimlico and would let himself in with his own keys. The relationship now included full sexual intercourse.

6.21 David Britten reinforced her belief that their relationship was special and that they were going to leave the area and live together. The relationship

continued to late 2001 and included holidays together. After David Britten was suspended he continued to contact her by email and telephone until as late as March 2004.

6.22 In the report prepared for her civil claim the psychiatrist describes her prognosis as '*no better than very guarded*' and that her '*disorder has also become chronic, following this abuse.*'

Patient C (born 1977)

6.23 Patient C was abused while she was an inpatient at the Peter Dally clinic on her second admission in late 1998 (aged 21) until early 2001, by which time she had become an outpatient.

6.24 Patient C suffered from anorexia from the age of 16. When her weight had dropped to a life-threatening level she was admitted as an emergency to the Peter Dally clinic in late 1997. She gained weight again and discharged herself a few months later in early 1998.

6.25 During this first admission she would see David Britten once or twice a week. Her relationship with him during this admission was non-sexual but she was made to feel special and that he was the only person she should confide and speak to. This was achieved by confiding in her that his mother had died on Christmas Day when he was 12 and that he had lymphoma cancer and was going to die. She described her relationship with him as '*He made me able to live*'.

6.26 Her weight gain was not maintained and she was readmitted as an inpatient in late 1998. On her readmission David Britten began stroking her cheeks and kissing her on the forehead and moved on to more intimate sexual touching and then to oral sex. This took place in his office and her bedroom in the clinic. By February 1999 the sexual relationship had developed and they had full sexual intercourse in her bedroom in the clinic. Their sexual relationship continued until she was discharged as an inpatient in late 2000.

6.27 David Britten would reinforce her sense of being special during her inpatient treatment by telling her that he would fight her corner in clinical team meetings discussing her care. He would also change her menu prepared by the dietician if

she was not happy with it. He reinforced the belief that she was in a special relationship with him by these and similar means. She said that *'my whole world revolved around him and I felt I couldn't exist without him.'* He also marginalised any involvement that her family had and suggested that they were a hindrance to her recovery.

6.28 She was treated as an outpatient from late 2000 until early 2001. The sexual relationship continued during this time. When she came to the clinic they would engage in heavy petting and oral sex in his office. David Britten continued to telephone her after his suspension until May 2002.

6.29 In the report prepared for her civil claim the psychiatrist says *'I think what is clear, is that the abuse in treatment has markedly exacerbated her difficulties and made long-term prognosis and prospects for treatment, worse'*. The reports also say that David Britten's abuse has caused her to suffer from post-traumatic stress disorder in addition to prolonging treatment for her anorexia and to an increase in the frequency of relapse.

Patient D (born 1972)

6.30 Patient D appears to have developed anorexia nervosa in the autumn of 1995. Her illness was severe and potentially life-threatening as it combined low body weight with abnormalities in her blood. Her admission to the Peter Dally clinic was her first experience of treatment for anorexia.

6.31 Patient D was abused while she received care as an inpatient, day patient and outpatient at the Peter Dally clinic from her first admission in the middle of 1996 (aged 24) until early 2002.

6.32 She said David Britten told her shortly after her admission in 1996 that he did therapy with only a few of the patients and offered her one-to-one sessions with him. This was conditional on her putting on weight. In these early meetings he gained her trust by telling her that:

- his mother had died on Christmas Day
- his father was an alcoholic
- he had a disabled brother

- he had lost his fiancée in a car crash
- he was suffering from Hodgkinson's disease
- he had also suffered from anorexia and therefore knew how to relate to patients better than anyone else in the clinic.

6.33 Patient D says the personal disclosures he had made caused her to hide her lack of progress with her eating disorder because she focused on his problems, not her own. For example, she would hide weights in her clothing when she was weighed.

6.34 He told her he had a number of qualifications, including in psychotherapy. He undermined her trust in other team members by describing them as incompetent. *“For example I would do my menus with (the dietician) and then he would overrule her.”* He also damaged her close relationship with her mother by claiming her mother wanted to keep her sick.

6.35 She described how the relationship grew as the meetings with David Britten continued and she felt that she trusted him spiritually and intellectually. She gave him a poem which she had written describing her feelings towards him. When she gave it to him he said he felt the same way and gave her a hug and a kiss on the lips.

6.36 The relationship intensified when they were in her bedroom at the clinic in late 1996. He questioned her about previous boyfriends, the degree of intimacy she had with them and how she felt about it. He told her that the conversation would be their secret. At the end of this intimate conversation he hugged her and placed his hand under her pyjama top on her naked back. He unlocked the door when leaving. She did not realise he had locked it. Patient D's therapy sessions with David Britten became more tactile after this. They started by her sitting near him, then sitting on him, kissing and other intimate physical contact and then oral sex.

6.37 Patient D was discharged as an inpatient in the middle of 1997 and became a day patient. Before this she applied for and received housing locally. She gave him a key to her flat because he had told her he needed a key in case anything happened to her outside the clinic. He would take her to restaurants for meals and introduced her to alcohol.

6.38 They were now having full sexual intercourse and this level of intimacy continued even when she transferred from day patient to outpatient.

6.39 When patient D heard about the first investigation she told David Britten that if it was true she would not let it lie as she thought she was having a special relationship with him. He told her that the patient was lying because she had a drug and alcohol problem.

6.40 During the 1998 investigation David Britten rang patient D and asked her to give evidence to the panel in his favour. She gave evidence but had misgivings as she wanted to be open with the panel. She said that *“As much as I was dependent on David Britten, I also hated him! Because I knew I was still sick and I was not able to tell anyone I was sick”*.

6.41 Patient D described how guidelines were set for David Britten after the investigation, which he soon ignored. He started to lock the door again and to have individual meetings with four or five different patients. He started to meet patients outside the clinic so that people would not know about it.

6.42 In 2000 David Britten was taking weeks away from the clinic but he continued to telephone patient D at her flat during the day and night mostly talking about his sexual needs. Patient D was still not well and in 2001 took an overdose.

6.43 After David Britten’s suspension in May 2001 she suspected that he was involved with other patients and she arranged to meet another patient from the clinic. When the other patient disclosed her relationship with him they realised that he might have been having multiple relationships with clinic patients. The other patient then arranged to meet David Britten in a bar. Patient D joined them and both patients challenged him.

6.44 It is clear from the psychiatric reports that the abuse patient D experienced has caused her to suffer from an adjustment disorder, to abuse alcohol and to prolong the course of her anorexia. The abuse also contributed to extreme interpersonal problems, with a disabling inability to form trusting relationships.

Patient E (born 1981)

6.45 In mid-1995 patient E was admitted to an eating disorder unit in the Home Counties for a month as her weight had dropped from 56kg to 30kg in a short time.

6.46 In mid-1998 she was admitted to the Peter Dally clinic (aged 17). She was diagnosed with anorexia nervosa; her weight had dropped again to a dangerously low 30kg. Patient E was abused while she was an inpatient and outpatient at the Peter Dally clinic from 1998 to 2002.

6.47 Patient E said that within three months of her admission David Britten told her he had cancer and invited her to sit on him and began to kiss and cuddle her. They would meet every other day either in his office or her bedroom. She said he made her feel that she was in a special relationship with him. She said their relationship became stronger later in 1998 and that he had totally '*won me over*'. They often went out for meals at patient E's expense.

6.48 In early 1999 David Britten became her key nurse and they would regularly meet in his office behind locked doors with the curtains drawn and lights out. On one occasion she said he shaved her legs with an electric razor he had made her buy. She told us she remembered him kissing her in the presence of the deputy manager with whom he shared an office. She said that the consultant psychiatrist of the unit and the nurses knew he locked the door when seeing patients.

6.49 From mid-1999 to October 2002 patient E was treated as a day patient and sometimes as an outpatient. David Britten told her parents not to visit and gradually made her feel that she did not need her parents, only him. Patient E's mother provided evidence of how David Britten tried to damage the relationship she and husband had with her daughter. She used to attend family therapy sessions and said "*It felt like it was patient E's family against David Britten and patient E.*"

6.50 The clinic found her a place in a hostel five minutes from the clinic, before she was discharged as an inpatient. A resident at the hostel sexually assaulted her and was later charged and convicted. David Britten encouraged her to return to the hostel, though she was reluctant to do so. He encouraged her to buy and model underwear for him at the hostel on the first occasion when full sexual intercourse took place.

6.51 In early 2000 the clinic helped her get a flat in St John's Wood. David Britten visited regularly and often stayed overnight. He often phoned her late at night and made suggestive remarks.

6.52 Patient E said that while attending the Peter Dally clinic as a day patient or outpatient '*David Britten was seeing me maybe 2-3 times per day, either at the clinic, in the hostel or in my flat and every session involved some sort of sexual activity/kissing and touching*'.

6.53 After David Britten's suspension and resignation in 2001, their sexual relationship continued until early 2002 and he continued to contact her until the middle of the year. She also discovered that early in the year he was having intimate relationships with other patients. This created a deep sense of loss and a feeling of being used and fooled.

6.54 The psychiatrist who examined her in 2005 believed she would need lengthy psychotherapy relating to this relationship and the associated underlying difficulties.

Patient F (born 1971)

6.55 Patient F had a number of admissions to psychiatric hospitals for eating disorders and depression before her admission to the eating disorders unit of the Gordon Hospital in 1991. She was first diagnosed with anorexia nervosa in 1987 and on that occasion tried to take her own life. She had been sexually abused between the ages of six and 16 and was bullied at school. She was working as a nursery nurse before her admission.

6.56 She was admitted to the eating disorders unit of the Gordon Hospital as an inpatient in mid-1991 (aged 20) with a diagnosis of anorexia and bulimia.

6.57 Patient F said that David Britten used to see some patients on a one-to-one basis and he told her this was a privilege she could earn by putting on weight. She said there was a great deal of competition among the patients to see him. She then started seeing him on a one-to-one basis.

6.58 David Britten began to hold her close and repeatedly kiss the top of her head fairly shortly after her one-to-one sessions started. He would lock his door and she said staff knew it was locked as they would knock and wait for him to unlock it. She said it was not long before she became hooked on him and despaired when someone else was in her 'slot'.

6.59 She received treatment as an outpatient on a weekly basis between late-1991 and the middle of 1994 following her discharge as an inpatient. Her meetings with David Britten progressed to his touching intimate parts of her body through her clothing. He would also take her out for drinks and meals locally. She was still quite ill and self-harming and she took an overdose in early 1993.

6.60 In late 1993 she took another overdose and was readmitted as an inpatient for treatment of her anorexia nervosa. Her meetings with David Britten again had no therapy content during this admission and consisted of sexual intimacy, although short of full sexual intercourse.

6.61 She attended the Gordon Hospital three times a week for small group meetings following discharge as an inpatient, and after a multi-disciplinary meeting she was referred for '*psychotherapy with a view to commencing this with our ward manager Mr David Britten*', which began in early 1995. David Britten told her he had qualifications in psychotherapy.

6.62 She found part-time work but continued her appointments with David Britten and her small group meetings. The meetings with David Britten became more intimate, progressing to oral sex and heavy sexualised petting. Patient F told him she was falling in love with him and he said he was feeling the same way. She often took time off work to go to appointments and he frequently cancelled their meetings, which caused her distress and suffering and left her feeling rejected and abandoned.

6.63 She was discharged from the clinic in mid-1996 (by which time the eating disorder service had transferred to the new Peter Dally clinic) but continued to see David Britten. They continued to have intimate sexual relations. Patient F said she was unsure whether full sexual intercourse took place.

6.64 In the summer of 2001 David Britten telephoned patient F to tell her he had been suspended and staff at the clinic were conspiring to oust him from his position. He asked her to write a letter of support - which she did not do. She was also worried that a colleague in her social services department who visited the Peter Dally clinic might read her clinical notes. So she phoned David Britten who reassured her that when he had been suspended he had asked his deputy to remove her notes and she had taken them home and stored them in her loft. Patient F telephoned the deputy who told her that her notes were “safe”.

6.65 Patient F last met David Britten in mid-2002 when she met him to collect her notes and go out for meal. She went to the NMC hearing in July 2004 and was shocked to hear the evidence against him. She collapsed at home on the last day of the hearing and was taken to hospital where she received five days of inpatient treatment. She discharged herself but was readmitted for three weeks in August. She continued to suffer from depression and made a number of suicide attempts.

6.66 The psychiatrist who assessed her as part of her civil claim said ‘...*that this relationship has...markedly re-enforced difficulties in terms of trust and self-esteem and has delayed the progress of therapy.*’ And goes on, ‘...*I think on the balance of probabilities, this abuse is likely to have a very adverse affect upon her gaining further therapy and moving on with her life.*’

Patient G (born 1977)

6.67 Patient G was diagnosed with an eating disorder when she was about 14. She had her first hospital admission when she was 15 and had her second in 1996 (aged 19) when she was admitted to the Peter Dally clinic for almost a year. She then became a day patient for about a year, then an outpatient for about a year, and reverted to being a day patient for about eight months.

6.68 Patient G was abused while she was an outpatient and day patient at the Peter Dally clinic from 1997 to 1999.

6.69 Shortly after she became an outpatient David Britten asked her if she wanted an appointment with him, as he was a trained therapist. He told her he had trained at a college or university in London. She then started seeing him weekly for ‘therapy sessions’. He told her his father had been an alcoholic and that his mother

had died when he was young. He also told her that his fiancée had died in a fire in a car crash while they were on their way to ask her parents for permission to get married. He told her other personal stories which made her believe that their relationship was special.

6.70 After a few months of ‘therapy sessions’ she began to have romantic feelings towards him and she told him of her feelings in one of these sessions. He told her that it would be nice to meet outside the clinic and he kissed her. This was just before the Christmas break and when he returned to work they met again in his office and kissed and hugged.

6.71 Towards the end of January David Britten invited patient G to meet him at various hotels and restaurants. Even though she was taking anti-depressants they would drink alcohol. At the end of March 1997 he took her on a four-day trip to Somerset where he had rented a cottage. They slept together but did not have full sexual intercourse.

6.72 Patient G said that in April 1997 David Britten’s deputy was on a month’s leave. The relationship became more intimate and they had full sexual intercourse in his office. In September she became a day patient and rented a flat nearby in Pimlico where they met every couple of weeks. Sometimes they had full sexual intercourse.

6.73 In late 1998 patient G became an outpatient and she did not see David Britten as often. She became depressed as a result and in 1999 was again admitted as a day patient and was able to see him more regularly.

6.74 Patient G was interviewed during the first investigation of David Britten and denied any impropriety. She said this was because she was intimately involved with him and wanted to defend him. When he was suspended in relation to the second investigation she was one of the key patients who tried to orchestrate support from families, patients and MPs to have the investigation stopped and have David Britten reinstated. David Britten was constantly in contact with her during this period, despite being told to not contact patients and staff. Mobile phone records produced to the NMC confirm this.

6.75 Towards the end of February 2002, after David Britten had been removed from his post, another of the patients told her that she had been having a relationship with David Britten for a number of years. Patient G was devastated by this news and so was the other patient. They decided to confront Britten and arranged to meet him at a local pub. He admitted that he was seeing both of them and said it was because he could not decide whom he loved. After this she made a statement to the trust about the nature of her relationship with David Britten.

Patient H (born 1968)

6.76 Patient H was never a patient at the Peter Dally clinic but received treatment at the Gordon Hospital.

6.77 Patient H's first contact with the Gordon Hospital was in early 1992 (aged 24) where she was initially seen for assessment by the specialist eating disorders consultant psychiatrist. She put on weight at first but stopped between July and October that year. She was always seen as an outpatient.

6.78 Patient H was referred to David Britten for therapy early in her time at the Gordon Hospital. He formed an unprofessional relationship with her soon after which quickly led to sexual activity. Their sexual relationship lasted a number of years but then continued with occasional contact until 2005.

6.79 David Britten helped patient H get a local authority flat by writing to the local authority saying that her life was at risk because she was in a vulnerable position at home.

6.80 She said the relationship started when he invited her to join him on a day trip to Somerset to visit the grave of a patient who had died from anorexia nervosa. She said:

"I thought this was incredible that this man wanted to take me away for the day, and I was very excited and got all dressed up."

6.81 They would meet at her flat but they also once had full sexual intercourse in his office in the Gordon Hospital. We asked whether the door of his office was locked. She said:

“Oh yes. I don’t remember a time when he didn’t lock the door...I’m sure staff were very aware of it because often they would knock on the door and turn the handle and see it was locked.”

6.82 The following quote comes from a report prepared by a medical expert and sums up how the relationship developed:

“Mr Britten embarked on a process akin to ‘grooming’ in which he appears to have persuaded patient H that he enjoyed a unique relationship with her, to the extent of being ‘soul mates’. He implied that he only had the power to treat her, and that other members of the treating team were inadequate. He would provide sporadic and intermittently intense emotional support, and then withdraw that support from patient H in order to play upon her sense of insecurity in their relationship. In her mind, he established a notion that her anorexia was linked to issues of physical intimacy, and that therefore cuddling her or stroking her hair had therapeutic benefit.”

“...it should be borne in mind that at that stage her physical state would have rendered her physiology to resemble that of a prepubescent girl rather than a mature adult.”

6.83 The psychiatric report sums up the continuing consequences of her relationship with Britten as:

“Even after the end of their relationship, Mr Britten continued to be the dominant force in her life. She believed him to have been her only ‘serious relationship’ and she has had no other lasting sexual relations. In particular, discrete episodes of depression, which have varied from a mild to a moderate severity, appear to have arisen solely as a result of insecurity in that relationship, and on occasions had resulted in significant episodes of deliberate self-harm and potentially fatal overdosing on tablets.”

Patient I

6.84 Patient I first came into contact with the service in 1983 when she was admitted as an inpatient to the Gordon Hospital. She was discharged to outpatient status and then readmitted in 1985.

6.85 Patient I met David Britten during her first inpatient admission and said her relationship with him then, and as an outpatient, was as a friend. During the second admission in 1985 David Britten suggested that they take their relationship onto another level, which they did. This relationship became a full intimate relationship and they would see each other on average two or three times a month.

Patient J

6.86 Patient J was an inpatient at the Peter Dally clinic and was suspicious of David Britten. She realised that he was possibly breaching patient/professional boundaries. Patient J told us she believed that what David Britten was doing in respect of clinical practice was equal to, if not worse than, having sex with patients.

6.87 She said that David Britten pushed her to a degree that she took an overdose of tablets and removed support from her by telling the staff she was acting as a “*drama queen*”. She was also concerned about the ‘body image therapy’ that she had with David Britten and about his locking the door of his office when she had sessions with him.

6.88 In one of her sessions David Britten touched her inappropriately by putting his hand on her and kept it there for a while, so she rebuffed him, soon after he ended his sessions with her. She was also aware of rumours that other patients were having sex with him in his office but she said she did not really believe them.

6.89 After rebuffing David Britten she had a taxi booked to get her back to the unit on Christmas Day. When it did not arrive she was told that David Britten had cancelled it and consequently she had to walk back in the dark from the King’s Cross area to the unit. She told us she was “*crying my eyes out, frightened*”.

6.90 When a number of patients set up a campaign to have David Britten reinstated after his suspension, patient J contacted and was interviewed by the chief executive and director of nursing. She told them that she had concerns about him, but also had fears about her safety.

Patient K

6.91 Patient K was referred to the Gordon Hospital in 1989 (aged 22) and treated as an outpatient until 1991. During that time she was seen only by David Britten, who she understood to be a clinical therapist. She then became an inpatient in 1992 and was then transferred to a day patient.

6.92 David Britten would stroke her leg or her arm during her sessions with him. During one of them he kissed her. He bought her clothes to wear for a meal on Valentine's Day but then did not turn up. This led to deterioration in her illness.

6.93 While being treated as a day patient she had a conversation with another patient of the unit who was confused and upset because she had just had sex with David Britten in his office. She challenged David Britten about this and he told her that she would not be believed. As a result David Britten arranged for her to be discharged and banned from entering the hospital.

Patient L

6.94 Patient L was an inpatient in 1998. She returned from a social engagement where she had been drinking and saw David Britten in his office. She complained that David Britten placed her head in his lap facing his groin and stroked her face and hair.

6.95 This complaint, along with a complaint from patient M, formed the basis of the first investigation into David Britten's conduct. She resolved to make her complaint when David Britten and his deputy interviewed her, tried to dissuade her from complaining and offered her extra support.

Patient M

6.96 Patient M was a patient in 1998 at the Peter Dally clinic. In one of her sessions with David Britten (when they were looking at photographs of her that her

mother had supplied at the request of David Britten) she was concerned that he had made inappropriate remarks about her body. The remarks were “*clearly defined bust*”, “*nice legs*” and “*quite narrow hips*”. He also asked whether she was menstruating and whether she was a virgin. She was also concerned that he had stroked her cheek.

6.97 Patient M knew that another patient had made a complaint so she spoke to her consultant who advised her that she needed to decide whether she also wanted to make a complaint. She was approached by David Britten’s deputy, like patient L, and encouraged to have a meeting with her and David Britten in which she was also offered extra support.

6.98 Patient M was more determined to make a complaint because of her concerns about that meeting. Patient M and patient L’s complaints triggered the first investigation into David Britten’s professional practice. This patient is now dead.

Patient N

6.99 Patient N was referred to the Gordon Hospital in October 1986 and became an inpatient in January 1987. David Britten began individual therapy sessions with her in the second week. She did not reach her weight gain goal and was discharged as an inpatient to outpatients and David Britten became her therapist.

6.100 The outpatient sessions took place at first in his office at the hospital, later in his car, coffee shops or parks, and later still at her home or on outings. David Britten expressed his feelings for her during this time and she expressed strong feelings of love for him. He told her he could not commit to a long-term relationship due to his non-Hodgkinson’s lymphoma. They continued their relationship for another year and then maintained contact via phone and mail and would meet up every month or so. The relationship grew into a full sexual relationship.

6.101 They continued their relationship and she told us David Britten arranged for her to work at the new Peter Dally clinic on Friday and Saturday nights. Trust records confirm she worked there for about 18 months. She told us she often had sex with David Britten in his office during working hours.

Patient P

6.102 She was admitted to the Peter Dally clinic in 1997 for a year, and was then a day patient for six months followed by time as an outpatient. She was not involved in a sexual relationship with David Britten but she told us that he:

- asked inappropriate intimate questions
- tried to encourage her to sit uncomfortably close to him
- locked his office door during sessions with him
- tried to arrange to meet her outside the clinic
- would hug her closely.

6.103 She also describes a group of girls that always seemed to be knocking on David Britten's door to see him at all times during the day. Notes were pushed under the door during her meetings from girls desperate to see him.

6.104 In patient P's letter to us she told us that David Britten was *"very good at manipulating our thoughts and played on all our emotions and feelings and as much as I was striving for independence during my stay, he did have a strange sort of hold on me, that I am unable to explain"*.

Patient V

6.105 Patient V was referred to the eating disorder unit at the Gordon Hospital in 1993. The consultant assessed her but as there was a waiting list they could not help her and her mother was told to go home and feed her otherwise she was going to die. David Britten called her the next day and said he had arranged for her to be admitted immediately. She told us that it was clear when she was admitted that he was *"running the whole show"*. She told us she had therapy with David Britten and that he used to touch her a lot by putting his hand on her knee, and tried to put her hands between his legs. She said the door was locked and notes from other clients were often pushed under the door.

6.106 Patient V discharged herself from inpatient care in July 1993 but was given outpatient appointments twice a week to meet David Britten. These were usually at about 6pm and he would give her a lift home. During these times he tried to kiss her and suggested that they go into the back of his car for a cuddle.

Other patients

6.107 The CNWL NHS Foundation Trust wrote to former patients of the Peter Dally clinic inviting them to contact the trust if they had concerns about their care. Twelve former patients contacted the trust and six of those complained of possible inappropriate behaviour by David Britten. The behaviour was consistent with that discussed above. We have also heard about a family who read their deceased daughter's diary and discovered numerous references to David Britten suggesting a relationship, but we have had no contact with them.

Pregnancies

6.108 Some patients' sexual relationships led to pregnancies and in some cases the pregnancies were not accidental but a deliberate choice between David Britten and the patient. The attempts to get pregnant led to one client attending the Peter Dally clinic at times when she was most fertile to have full sexual intercourse in David Britten's office.

7. Analysis of clients' stories: the grooming process

7.1 We conclude that David Britten had a consistent way of operating, repeating a series of lies and behaviours to many patients over a period of 20 of years. He was able to conduct numerous abusive relationships simultaneously using this tried and tested approach, without detection by his managers and colleagues. We have analysed the women's stories to identify the common features of this 'grooming' of his patients. These were:

- choosing vulnerable patients
- making patients feel special
- speaking about his personal history and problems
- making his patients emotionally dependent on him
- separating clients from their families
- undermining patients' trust in colleagues
- encouraging dependence after discharge.

7.2 We consider these behaviours in more detail later. A number of witnesses have likened his behaviour to that of a predatory paedophile, systematically 'grooming' his victims; this professional view was also taken by one of the psychiatrists who provided expert evidence in the civil claims brought by some women. David Britten evoked strong feelings of attachment and dependence among the vulnerable patients he abused, as can be seen from their stories. Many of those he abused went on to campaign on his behalf when management intervened. Patients who complained about David Britten were mistreated by him (see patient J's story), and isolated by the other patients (patients L and M).

7.3 It is also instructive to consider whether David Britten manipulated his colleagues and how he did it. Colleagues did not suspect the extent of his abuse even though many were concerned about his practice. Colleagues who did challenge David Britten were variously bullied, victimised, threatened with legal proceedings and often driven out of the service by him. One (then junior) doctor who had passed information to management about David Britten told us "*he stood in the door and pointed his finger, saying he was going to ruin my career and make*

trouble". David Britten's threats of legal proceedings were taken so seriously by some colleagues that one senior member of staff inserted a self-styled legal 'disclaimer' into his correspondence with management about David Britten.

7.4 David Britten evoked strong feelings in colleagues. Witnesses who mistrusted him as a colleague described him as "*devious*", "*manipulative*", "*disturbed*", "*arrogant*", "*a svengali*" and "*secretive*". On the other hand, he evoked strong feelings of loyalty and support from those colleagues and patients whom he apparently did not regard as a threat. More than one witness told us he seemed to 'groom' colleagues as well as patients. The deputy manager at Peter Dally clinic told us she was:

"...very concerned that I also had been groomed by David. Not in a sexual way but in a way in which he took advantage of my inexperience, lack of confidence and respect for him to ensure that he maintained complete control in the workplace".

7.5 David Britten's deputy serves as an example of his grooming of colleagues. She initially told us that she had had no further contact with him after she left the clinic in 2002. She told us later that she had had contact with him until 2003, albeit intermittently. She said she had misled us out of embarrassment and humiliation at having had contact with someone who had breached her trust and the trust of patients and the clinic. She was also found by the trust to have misled an internal investigation about her contact with him out of work. It may be that the "grooming process" left her with a residual feeling of loyalty to David Britten until we told her of the full extent of his activities. The consultant psychotherapist told us:

"...yes he groomed the staff as well...you get drawn into something you are not quite happy about...then you can be manipulated by that. I saw him do that to all the staff and his managers as well".

7.6 We now consider in more detail the identifiable components of the grooming process.

Choosing vulnerable patients

7.7 David Britten specialised in nursing patients with eating disorders for many years and knew this client group well. We think he used his specialist knowledge in a number of respects. For example, we were initially incredulous as to how David Britten could conceal so many simultaneous sexual relationships with patients living near each other at the clinic but who did not speak to each other about him.

7.8 To illustrate this point the following table identifies the years when David Britten was having a non-professional relationship with particular patients, but does not cover the whole period they were receiving treatment. They were not necessarily all inpatients at the time as he continued to see patients when they were day patients and outpatients and continued relationships with former patients. The table does not cover all the patients we know about, but deals with those patients for whom we have the strongest evidence of abuse.²⁰

7.9 The table shows that in 1998 and 1999 David Britten was engaged in simultaneous abuse of eight and seven patients respectively. While this table covers the experience of 11 patients, we are aware of unprofessional or abusive behaviour he conducted over 20 years and which involved at least 23 women. We recognise that this table represents serious abuse which has affected individuals deeply causing emotional pain and long-term harm. Despite the danger of reducing the abuse to cold statistics we have included this table because it graphically illustrates the scale of concurrent abusive relationships in which David Britten was involved.

²⁰ For example, we know of a number of patients who used the trust helpline but they have not chosen to contact us so we have limited information about their stories.

Years of abuse table

Patient	85	87	88-90	91	92	93	94	95	96	97	98	99	00	01	02	03	04	05
A									■	■	■							
B											■	■						
C											■	■	■	■				
D									■	■	■	■	■	■				
E											■	■	■	■	■			
F				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
G										■	■	■						
H				■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
I	■	■	■	■	■	■	■	■	■									
N		■	■	■	■	■	■	■	■									
K				■	■													
V						■												

7.10 During our meeting with the chief executive of the charity ‘beat’ we discussed how these intelligent young women could each believe they were in an exclusive relationship with David Britten and not recognise that he was also involved with other clients. The chief executive helped us understand how eating disorders affect the thinking processes of sufferers because the starved brain operates differently from the nourished brain. The women’s general alertness to what others may assume were obvious signals would have been greatly reduced. The chief executive told us:

“Young women with anorexia nervosa can demonstrate a very compliant and eager to please disposition. There is a marked avoidance of conflict in all domains except in refusal to eat.”

“In addition to personality traits and behaviours, anorexia nervosa affects brain function - leading to some cognitive impairment, particularly in relation to emotional state and rational thought.”

7.11 The Peter Dally clinic received many referrals from NHS trusts and other agencies outside its own catchment area and frequently received patients who were extremely vulnerable and had been difficult to treat elsewhere. David Britten promoted himself and the clinic as a leading service in this field, attracting such referrals. David Britten seems to have singled out certain types of patient for grooming treatment.

7.12 We interviewed a consultant psychiatrist who worked at the Peter Dally clinic when he was a junior doctor. He told us:

“...you had two classes of patients. For the patients who were not his favourites...they would have to be weighed and have blood tests...if they were his favourite patients then they would say David says...I do not have to be weighed. This made me uncomfortable because...there would be unquantified patients on the unit”.

7.13 We asked him if David Britten selected patients as favourites based on physical appearance. He told us:

“...younger [patients] possibly...there were two kinds that seemed to be his favourites...the most ill and the ones with emotionally unstable personality traits, with alcohol and/or drugs problems”.

7.14 This shows the extreme emotional and physical vulnerability of these young women at the time David Britten selected them for grooming.

Making patients feel special

7.15 David Britten would tell a chosen patient he could undertake therapy with only a small number of clients but he would be willing to see her if she wanted. This inevitably made the patient feel special. He would often increase this feeling by acting alone to change clinical decisions about that patient, such as decisions made by the dietician or about leave or bed rest.

Patient A said:

‘Although I was receiving antabuse medication to help me with my drinking, David Britten took me off this medication telling me that I deserved to have a good time over Christmas.’

Patient B said:

“Even after only being in the clinic for ten days as a vulnerable mental health patient, [David Britten] said that it was no longer necessary for my bedroom door to remain open, which was usual procedure as I was on ‘level two observations’.”

7.16 Patient F described how David Britten promised to allow her out of the unit during her first admission if she ate something, even though she had been forbidden from leaving by her psychiatrist. She also said he used to see some patients on a one-to-one basis and he told her it was a privilege which she could earn by putting on weight. She said there was a great deal of competition among the patients to see him. The consultant psychiatrist who had spent time in the Peter Dally clinic as a junior doctor described how:

“...you would have a line of patients sitting there, cuddling their teddy bears ...one would go in and, after an hour, another would go in. Then there would be a big fight...it was my turn! No, it was my turn!”

Speaking about his personal history and problems

7.17 One of David Britten’s most consistent techniques was to tell patients stories about his personal problems. His approach would have stood out as ‘personal’ while other staff observed professional boundaries. He told many patients similar stories. The following examples illustrate this aspect of his behaviour.

7.18 David Britten told patient A, who had alcohol problems, that his father had alcohol problems. He told patient B (during a meal he had taken her for in a restaurant) that he had cancer. She said: *‘I was shocked to hear this news as I had become very dependent upon him.’* He told patient C that his mother had died on Christmas Day when he was 12 and that he had lymphoma cancer and was going to die. And he told patient D:

- his mother had died on Christmas Day
- his father was an alcoholic
- he had a disabled brother
- he had lost his fiancée in a car crash
- he was suffering from Hodgkinson’s disease
- he had also suffered from anorexia and therefore knew how to relate to patients better than anyone else in the clinic.

Making his patients emotionally dependent on him

7.19 We think David Britten was good at understanding how to make sure those he abused were kept emotionally dependent on him. Patients told us they felt that they were in love with him and that he reciprocated. At times he would manipulate this by withholding personal time, which would make the patients desperate to meet him. The psychiatrist's comments quoted in relation to patient H are instructive:

“He would provide sporadic and intermittently intense emotional support and then withdraw that support from patient H in order to play upon her sense of insecurity in their relationship.”

7.20 Patient B said:

‘During our meetings, he would talk about spiritual things using clever words, making me feel important, and whenever I talked to him about what was troubling me at that time, he always seemed to understand what I was saying, using soothing, pleasant responses to make me feel safe...I soon began to trust him and I felt myself becoming very dependent on him.’

7.21 Patient A said:

‘He made me feel very special, but then he would change. For example, he would be loving and affectionate with me one day and then he would become cold and ignore me the next.’

7.22 Patient D described how the relationship grew and she felt that she trusted him spiritually and intellectually. She gave him a poem which she had written to describe her feelings towards him. When she gave it to him he said he felt the same way and gave her a hug and a kiss on the lips.

7.23 Patient G told us:

‘The way I saw it, this was genuine. It sounds so ridiculous, but it was the “star-crossed lovers” sort of thing. It was all, we shouldn’t be doing it, but neither of us can help the way we feel and it’s real and it’s genuine. It was everything to me. I went into that clinic with nothing, with barely a desire to live, and regularly quite the opposite desire. I didn’t have any hope in

anything, I didn't have a big desire to get better, I was very depressed, so when this happened, this was the only thing that could make me want to breathe in and out, so I was going to guard that with everything. And I knew that he would be in trouble, and this was nothing that anybody else could understand, as far as I thought.'

Separating clients from their family

7.24 David Britten sought to separate patients from their parents. He would tell the patient that many of their problems stemmed from their relationship with their parents and if they wanted to get better they would need to distance themselves. This enabled David Britten to act without fear that his behaviour would be shared with parents.

7.25 For example patient A states:

'I remember David Britten stopped my father from visiting me. When I look back I now realise he was trying to sabotage my relationship with my father because David Britten knew that we had a close relationship which was important to me. Therefore I became even more dependent on David Britten.'

7.26 Patient C states:

'Whilst at the Peter Dally clinic, David Britten influenced me into thinking that my family were a hindrance to my recovery, and that only he could help and motivate me. At the family sessions that my parents attended, their input was not really taken notice of by David Britten, and so they soon became 'excluded' from any involvement in my treatment plan.'

7.27 Patient B's father's statement, made in the course of civil proceedings, comments:

"There were a number of times when [patient B] would come home...to visit her family, but on a number of occasions her visits were cut short because she would receive a telephone call and then tell me she had to return to London... [patient B] has since told me that it was David Britten who would ring her and ask her to return to London. I don't know whether this was

because he wanted to see her or whether it was to keep her away from her family...As a family we were left feeling empty and saddened at the fact that, as time progressed, she had ostracised and detached herself from us”.

7.28 Patient E’s statement in the civil proceedings said:

“He told my parents not to come and visit me and as time went on I started to feel I no longer needed them, as I had David Britten. He encouraged me to keep secrets from them and told me they were keeping me ‘unwell’.”

7.29 David Britten conducted “*family therapy*” sessions with patient E and her parents. Her mother’s statement in the civil proceedings stated:

“During the family therapy sessions David Britten’s approach was to be a conduit between [patient E] and her family. It felt like it was [patient E’s] family against David Britten and [patient E]. I felt very intimidated and uncomfortable in David Britten’s presence.”

Undermining patients’ trust in colleagues

7.30 David Britten encouraged splitting²¹ between staff and patients. He told some patients that colleagues were incompetent, or “*out to get him*”. We have heard of instances of his overriding colleagues’ clinical decisions and there were resignations during his tenure where trust records show that this was stated as the reason. One nurse told us she had written to the trust’s personnel department expressing her concerns, but she had been told her letter had disappeared.

7.31 In evidence to the NMC patient D described how David Britten said other staff were incompetent and did not have her best interests at heart. She said he always seemed to override their decisions about her care.

Encouraging dependence after discharge

7.32 David Britten continued to see some patients after they had been discharged. Some have told us they visited him at the clinic and would have sex in

²¹ Splitting here refers to the creation of division between groups and loyalty to different managers/clinical teams (see glossary, appendix B).

his office long after they had stopped being outpatients. Several women have told us that he was in telephone contact with them for many years after their treatment ended. One patient told us David Britten gave her a job at the clinic after discharge so they could see each other there, which we have confirmed from personnel records.

7.33 David Britten was involved in arrangements for obtaining local authority housing in accommodation near the clinic for a number of the patients he was in a relationship with. In one instance he wrote a letter to the local authority predicting that the patient would die if housing was not made available for her. This was not always in the best interests of the patient as it separated them from their families and sometimes meant accommodation in hostels. It enabled David Britten to continue his relationship with the clients when they were discharged, or receiving care as an outpatient or a day patient. He held spare keys to their flats at his office. David Britten asked some patients' families to declare them homeless when they were welcome to return home. We were concerned that David Britten may have fraudulently obtained accommodation, and we have informed the local housing authority. We were informed that the chief executive of CNWL trust also wrote to Westminster Housing about his concerns regarding this matter.

Effect on patients

7.34 The effect of David Britten's abuse on patients cannot be over-estimated. All these women have continued to suffer as a result of the abuse, some to a severe degree. They have suffered not only because of delays to their treatment, but they have also experienced difficulties in forming new relationships with men, trusting new therapists and holding down jobs and careers. David Britten's abuse of the women left them without appropriate professional help and vulnerable. The psychiatric reports on the women prepared in connection with their civil claims confirm the trauma they suffered.

7.35 David Britten's behaviour also had an effect on the patients he did not choose as his favourites. We interviewed a former member of the nursing staff who told us "*one patient said to me 'how come I'm not attractive like the rest of them? How come David doesn't see me? What's wrong with me?'*"

7.36 Patient H said:

‘...I feel that ever since I’ve known him, which is since I was 18 or 19, regardless of the time that we had apart, my whole life has been based solely around being concerned about him, worrying about him. I didn’t take jobs and things like that because I wouldn’t have been able to cope because I would be worrying about him. All of my limited treatment that I had, the private therapy that I had to pay for, was spent with me talking about him. That really angers me, and I feel now, at least hopefully at some point in the near future, I can start to make some headway and try to make life a little better. I don’t think I will ever get well, but I think I can most certainly make life a little more bearable and move on. I am glad that I found out’

7.37 The following quotes are from patient E:

‘It was my first relationship I had ever had with the opposite sex and so it was all very new to me and I simply never questioned it. David Britten was both my protector and my boyfriend.’

‘When I first went to the clinic, I was an extremely vulnerable and dangerously ill 16-year-old girl. I had no experience of life and I was desperate for help.’

‘Allowing David Britten to continue working unsupervised and unchecked despite having knowledge of his inappropriate behaviour has had devastating consequences on me and other women.’

‘He was the one person that made me feel very good and I have never experienced anything like it before or since. He completely overwhelmed me for all the wrong reasons - for his own sexual gratification. I do not think I will ever let another man close to me ever again as my trust in others has been utterly destroyed.’

Comment

David Britten must have been aware of the effect an eating disorder has on a client. It seems likely that he was able to take advantage of their compliance and possible cognitive impairment in order to abuse them. These features of

cognitive impairment indicate a high degree of vulnerability in this patient group and suggest that eating disorders services should be highly vigilant about observing boundaries in patient/clinician relationships.

As noted elsewhere, David Britten seemed able to override the clinical decisions of colleagues with relative impunity. Several clinicians have told us about the tendency of this client group to split staff and it is clear that there needs to be a high degree of clinical cohesion in services working with these patients. David Britten must have been aware of these features as an eating disorders specialist, and it seems likely that he was able to exploit them in order to groom and abuse patients.

The rumours about David Britten's health are a good example of the way he manipulated colleagues and patients alike. We do not know whether he ever had cancer, but he disclosed this information to a large number of people, while asking each to "guard his secret". Some of the patients believed for years that he would have married them if it were not for his cancer. Some members of staff have suggested that some of his colleagues and superiors in the Riverside Mental Health Trust hesitated to tackle his poor practice because they thought he was dying. Ill health in staff should obviously be treated sensitively, but it should never be allowed to put at risk the effective running of a service.

Since the events in this report NICE²² has produced guidance on treatment of eating disorders that makes clear that family involvement is desirable. The lack of a clear operational policy on family involvement at the time let David Britten separate clients from their families and made clients even more dependent on him.

David Britten had a sophisticated way of grooming vulnerable patients. In addition to the factors set out above, he relied on certain key ingredients in the clinic environment. These were:

- his ability to have private contact with patients, unobserved by colleagues and unrecorded in patient notes*

²² National Institute for Health and Clinical Excellence, eating disorders, NICE guidelines, 28 January 2004

- *his ability to tell patients that he was able to see them for counselling, despite being unqualified for this task*
- *his repeated boundary violations, unchecked within the clinical team*
- *his ability to avoid clinical supervision*
- *his ability to override the decisions of colleagues and management*
- *the failure of the first internal investigation to uncover the full extent of his conduct or to follow up recommendations*

We comment on these factors elsewhere in this report.

8. The internal investigations

8.1 The allegations and concerns about David Britten led to three internal investigations by successive trusts. Riverside Mental Health Trust set up the first in 1998, which examined complaints from two patients. Brent, Kensington, Chelsea and Westminster Mental Health NHS Trust, set up the second inquiry in 2000, to examine the breakdown of management and clinical relationships (at the time of setting up this inquiry the chief executive had not been informed that a previous inquiry had taken place). The same trust set up the third investigation that was not an inquiry but a disciplinary investigation of David Britten's conduct. This led to a formal disciplinary hearing at which he was dismissed (although he had already resigned). None of these investigations revealed the full extent of David Britten's abusive conduct towards his clients, which emerged later.

8.2 The current trust, Central and North West London NHS Foundation Trust, is a successor to the former trusts and did not commission any of the earlier investigations. It has cooperated fully with our investigation. A key part of this investigation has been to consider whether the failure to uncover David Britten's multiple abusive relationships was because the earlier investigations were flawed, whether the women were simply unwilling to say what was happening to them, or whether it was a combination of the two factors. We asked the solicitor representing a number of the patients to make representations to us on this issue and her comments are reflected later.

The first investigation

8.3 In July 1998 patient L, then an inpatient at the Peter Dally clinic, complained to a junior doctor that David Britten had touched her inappropriately by stroking her face and hair and allowing her to curl up on his lap, speaking to her in a way she found intrusive. She complained that they had been alone in a ground floor office during daylight with the curtains drawn and the lights off. Patient L was supported by patient M who also complained that while conducting 'therapy', David Britten had made distressing and embarrassing remarks about her appearance and stroked her face. The doctor reported the complaint to the on-call consultant who advised him to report it to the Peter Dally clinic consultant psychiatrist (the consultant psychiatrist responsible for the medical care of the clinic), which he did. The papers from the original investigation say that when he reported this to the consultant psychiatrist she "*...was shocked, although unsurprised*". The consultant psychiatrist told us:

“I can remember saying to the (SHO) ‘Well, I am not surprised because I know he does touch patients and I have told him not to’, but I thought it was just this sort of therapeutic touch. This was my fear that this would happen. I then went to see the patients and I talked to them. I can’t remember the sequence of events but they very clearly said they did want to complain, so then they did complain and we gave the letters to the (service director). That is what I remember. That is how I remember it.”

8.4 The service director swiftly commissioned an investigation into this allegation and appointed the chief psychologist²³ for the trust to conduct it. The service director provided the chief psychologist with some background information and terms of reference. We interviewed the chief psychologist, who told us he felt with hindsight that he had not been given enough information at the beginning of the investigation to be effective. He had received no guidance about good practice in conducting an investigation of this type. For example, he had no guidance about the burden or standard of proof to be applied. He had never undertaken an investigation of this sort and other witnesses have told us they had thought it was an inappropriate task for him due to his lack of experience in this area.

8.5 The service director told us she had thought it important to have a psychologist conducting the investigation in view of concerns about David Britten raised by the clinical leaders/managers of the psychological therapy department at South Westminster. They had begun to articulate concerns about David Britten’s attitude and his approach to his work. In particular they were concerned about his:

- undertaking clinical work for which he was not trained
- not attending clinical supervision sessions
- using unsafe and unsound clinical approaches to clients that *“...are both seductive and exploitative of the psychopathology of these patients.”*

8.6 The service director told us she thought she had tried too hard to understand the psychological aspects of the dispute surrounding David Britten, rather than investigating the facts. The chief psychologist was unclear in his

²³ It was the chief psychologist of the Riverside Mental Health Trust who conducted the first investigation.

interview with us whether this had been a formal disciplinary investigation under the trust's human resources policy or a free-standing investigation of the facts. The papers reveal some confusion at the time about the status of his work.

8.7 The chief psychologist carried out a number of interviews with the two complainants and interviewed several members of staff. The interviews took place at the clinic while David Britten still worked there. Staff and patients knew that the investigation was in progress. Several members of staff told us they had seen David Britten and his deputy holding one-to-one meetings with patients before their formal interviews. A patient petition against the investigation was prepared and sent to the trust. Some of the patients we interviewed said they felt uncomfortable at the clinic at this time, with witness interviews being conducted in their midst. This may have affected the investigator's ability to obtain full evidence, and we know from the clients' stories that some of them did not reveal the extent of their relationships with David Britten when interviewed. Records show that other patients isolated the complainants (patients L and M) at this time, causing them distress. These events also disrupted clinical relationships. One nurse told us that a patient told her *"I don't want you to be my key nurse if you continue to see [patient L] and support [patient L] through this inquiry"*.

8.8 David Britten was interviewed and said the patient had flung herself at him and that her head rested on his right and left hip. He denied that he flinched when someone opened the door and then closed it. He said in his first interview that the lights were off and the curtains closed, but when he negotiated an addendum to the report (see below), he said the lights were off because it was sunny and that the curtains were not drawn.

8.9 A number of patients were interviewed in 1998 and reported variously that David Britten had touched their toes, hugged them, stroked their arms, kissed their heads and held their hands. Nevertheless, the same patients found David Britten to be caring and understanding. The investigation report recorded that staff were aware that David Britten hugged patients but that they believed his use of touch was acceptable and non-sexual. David Britten's deputy told us that *"I did see David touching clients on a few occasions but it never came across as being inappropriate or sexual"*. She has specifically denied to us seeing David Britten kiss patient E as patient E alleges (see paragraph 6.48).

8.10 The consultant psychiatrist told us she had been aware that David Britten used touch in his therapy and that he had shown her a book supporting this approach. She told us she had told David Britten that she did not support this approach, she thought it was misconceived and also left one open to accusations of abuse. The consultant psychiatrist clearly disapproved of David Britten's touching but she did not ban it and allowed a policy on its use to be discussed after the first investigation (see paragraph below). She told us:

"I always said to DB not to touch; I always said that to him, 'Do not touch the patients, even if it is holding a hand, giving them a hug'. I have always said that to DB because at that point I felt very, very strongly that you do not touch patients."

8.11 The service director told us she had considered whether David Britten should be suspended from work pending the outcome of the investigation. She told us that she drafted a suspension letter but never sent it to David Britten because the trust's solicitor had told her she did not have a case for suspension. She told us:

"If you have a consultant psychiatrist who is working day by day very closely with someone, saying this practice is sound, and you have an inquiry which doesn't come up with conclusive evidence...it is quite hard to suspend."

8.12 The service director ultimately decided not to suspend but instead to impose certain conditions on David Britten. These were:

- that he did not attempt to speak to the complainants
- that he attended team meetings and discussed his work with others
- that he attended regular supervision
- that under no circumstances should he touch any of the patients at the clinic.

8.13 The chief psychologist noted in his conclusions that David Britten had breached the conditions during the investigation process by meeting one of the complainants. The chief psychologist recommended that the service director should address this, but no action seems to have been taken by the service director other than to note that the meeting had taken place.

8.14 In October 1998 the chief psychologist concluded his investigation and provided his report to the service director. He concluded that the allegations made by patients L and M had not been substantiated and that no action should be taken against David Britten. He expressed concerns about the clinic in general terms in his conclusions. These observations were clearly meant to refer to David Britten (as he confirmed in our interview) but he concluded:

“...the investigation has highlighted...issues within the unit which are of serious concern and need to be urgently addressed.”

He told us he viewed his role as only to establish whether the patients' complaints were proven, so he did not feel he could comment on other things or directly criticise David Britten.

8.15 The service director told us that the trust's solicitor reviewed the evidence with her before the conclusions were reached. The report made nine recommendations:

- the use of touch in individual therapy should cease
- guidelines should be developed on the physical comforting of patients
- all staff and patients should be informed of the guidelines
- procedures should be developed on the process for patients to receive psychotherapy
- individual work should be integrated with the multi-disciplinary team work
- staff must be trained for psychotherapeutic work
- individual therapy should be supervised
- written records should be kept of individual sessions
- incidents of physical contact between staff and patients should be recorded in the notes.

8.16 In November 1998 the chief psychologist wrote a letter to patients L and M informing them of his conclusions. Patient L wrote to the service director of Riverside Mental Health Trust describing the report as a “*whitewash*”. She subsequently brought legal proceedings against CNWL as the successor trust.

Liability was quickly agreed and her case was settled with an award of compensation.²⁴

8.17 In December 1998 the service director, the chief psychologist, David Britten and his union representative met to discuss the report. David Britten made a number of comments and asked for them to be appended to the report. The chief psychologist and service director agreed to this. The chief psychologist said he did not think the appendix affected the conclusions of his report.

8.18 The chief psychologist told us that, in retrospect, he thought he could have told the service director that there were problems with David Britten which should be looked at independently of his investigation. He told us that he now thought he had not been given appropriate powers or scope to be hard-hitting enough. He thought that only a more extensive investigation could have uncovered the extent of David Britten's conduct at that time.

8.19 The chief psychologist accepted in his interview with us that the boundary violation alleged by patient L (the subject of the original complaint) could have been an indication of David Britten's sexualised behaviour towards his patients. However, he said he lacked evidence to take further action at the time because it had been difficult for him to judge whether David Britten was well meaning but naïve and misguided or whether something more sinister was happening. He said his approach had been to try to set out clearly the policies and procedures that should apply in future so that David Britten could be stopped or controlled if trust management had further concerns.

8.20 The chief psychologist told us he did not know what had happened to his report. He had had no further dealings with the service director about this matter or any other professional dealings with the Peter Dally clinic. The service director told us she had reported the findings of the inquiry to the then chief executive of the trust, but she did not know if the matter had been reported to the trust board. The author of the second investigation report and the incoming chief executive of the trust following the merger in 1999 told us that neither the service director nor the outgoing chief executive told them about the first investigation. They said they thought they should have been told about the problems at the Peter Dally clinic as part of the handover.

²⁴ We have not been able to trace patient L for the purposes of this investigation as she is believed to have left the country. The second patient, M, is dead.

8.21 The service director told us she asked the area senior nurse firstly to implement the first investigation report's recommendations and to look at restoring effective multi-disciplinary working; secondly, to draw up an operational policy at the clinic. A consultant from the Tavistock clinic was engaged to work with the multi-disciplinary team in an attempt to restore good working relationships in the clinic. We have seen the resulting operational policy, dated September 1999.

8.22 We have also seen a note dated 21 February 2000 which is titled "*final draft*" of Peter Dally clinic policy regarding physical contact between staff and patients. The note states:

The absolute rules...

3. Spontaneous physical contact between female patients and male staff...should never be initiated by the member of staff (p2)

4. Physical contact as therapy should never be initiated by male staff with female patients

5. Any therapy which involves physical contact between staff and patients can only take place once it has been specifically agreed by the executive management group

8.23 We have seen no evidence that this draft was ever adopted and issued as a formal trust policy or as an addendum to the operational policy.

8.24 We know from the patients' stories that David Britten continued to see patients alone and to touch them after the first investigation report in breach of the recommendations from the first inquiry.

Comments

Interviews with staff and patients revealed a serious problem with David Britten's boundaries with patients.

- It is unacceptable that it took 16 months to finalise a policy on touch considering that inappropriate touch was a central allegation of the first investigation and one of its recommendations was the formulation of a policy about it.*
- It was inappropriate for David Britten to be given the task of drafting the policy for his line manager, the area senior nurse.*

- *David Britten should have been suspended from duty in 1998 following the receipt of the complaint from patient L until the first investigation was completed.*
- *The consultant psychiatrist should have taken more strenuous steps to ensure the cessation of inappropriate clinical practice following the publication of the first inquiry report because the protection of patients is a fundamental duty of clinical staff but an even greater responsibility of a consultant in sole clinical charge of a unit.*
- *We agree with the many witnesses who said the first investigation was seriously flawed. An early opportunity to detect David Britten's abusive practices was missed. We now know that by 1998 David Britten was involved in multiple sexual relationships with patients, which all started with the type of boundary violations complained about in this investigation.*

We summarise below the flaws in the first investigation.

- *Poorly selected and briefed chair: the service director chose the chief psychologist to conduct the investigation because she recognised that clinical issues were involved. However, in appointing a skilled clinician, she also put in place an inexperienced investigation chair. The chair made some fundamental errors.*
- *He did not take into account the civil standard of proof in evaluating evidence.*
- *He did not take into account the difficulties faced by patients making complaints, particularly those receiving services from mental health professionals.*
- *He allowed an addendum to be made to his report that diluted its impact, following representations by David Britten.*
- *He did not consider the impact that conducting interviews on the unit would have on the patient community and on the quality of evidence provided.*

- *He did not try to find out if his recommendations had been implemented or what happened to the report.*

Failure to suspend David Britten

The service director told us she had drafted a suspension letter but did not send it to David Britten because of legal advice. We take the view that her role as service director was to evaluate the legal advice received and to decide, taking into account patient safety issues, whether to suspend David Britten. Suspension is a neutral act in NHS services and is there to protect the service and the employee. We suspect that her normal instincts as a manager may have been affected by David Britten's repeated threats of legal action so that she gave disproportionate weight to legal advice in the face of what we believe were strong arguments in favour of suspension. The service director told us that she also relied heavily on the advice of the consultant psychiatrist. We comment elsewhere on the interaction between the consultant psychiatrist and David Britten.

We were also concerned that no action was taken against David Britten for his breach of the conditions imposed on him in lieu of suspension at the beginning of the investigation. This was clearly the responsibility of the service director.

The service director told us that she had sought advice from the trust's solicitor on several occasions. First, to decide whether to suspend David Britten pending the outcome of the first investigation and second, the trust's solicitor reviewed the evidence before the conclusions were reached. We were surprised to hear of this second involvement. The conclusions should have been those of the chair and of those who heard the evidence. It seems to us inappropriate to use the solicitor in a way that made him/her an invisible member of the panel, although it would have been appropriate to seek his/her advice about the action to be taken in implementing the recommendations or about any proposed disciplinary action by the trust as David Britten's employer.

The service director was inexperienced in these matters and told us she took a "social model approach" in trying to resolve disputes. She apparently failed to understand that certain types of complaint and disputes must be responded to with formal disciplinary procedures based not only on sound employment law but also the primary need to protect patients from abuse.

These matters should have been resolved by seeking advice from her head of human resources or chief executive, supplemented by legal advice when necessary. We are concerned that threats of legal action from David Britten and animosity between professionals in the merged trust generated a defensive response by the service director. We would have expected to see an approach that put patient safety considerations at the heart of resolving a situation where a service was in crisis.

Failure to implement the recommendations

There was a 16-month delay after the final recommendations of the first investigation before the policy on touch was approved as part of the clinic's operational policy. This was unacceptable, especially as David Britten had flouted the interim ban with impunity.

It was the service director's responsibility to ensure the recommendations were implemented fully and within a reasonable time. This was a serious failure on her part.

Although the consultant psychiatrist had been interviewed in relation to the first investigation, she had not been involved in agreeing a response to the report. She was key to the report's implementation because she was responsible for clinical practice at the clinic (especially in relation to the use of touch) and she should have asked to be more involved.

Addendum to report

The service director and the first investigation chair should not have agreed to David Britten's request to add an addendum to the report. We believe it diluted its impact (see for example, paragraph 8.8). The decision to accept it gave the impression that they were retreating from David Britten's threats of legal action and we think David Britten thought this left him free to continue his abuse of patients. The chair of the inquiry has told us that he does not accept that the addendum diluted the report's impact as the changes were minor and that "there were no changes to or dilution of the final conclusions or recommendations of the report." We accept the changes were of a relatively minor nature but the process of negotiation in our

opinion continued to reinforce David Britten's sense of importance and authority.

Handover to new trust management

The new chief executive of the BKCW trust was not given any information about the first investigation at handover. Institutional retention of knowledge about David Britten's activities was (in this and in other respects) poor.

The consultant psychiatrist

The consultant psychiatrist told us that she had not seen the whole of the first report and that she "wasn't really that involved in it." We believe it is unacceptable for the consultant psychiatrist, who was the only consultant in the unit and (as set out in the clinic operational policy) was jointly responsible for its management, not to have insisted on seeing the report so as to agree with the service director what action to take to ensure safe practice in the clinic for which she was jointly responsible.

The second investigation

8.25 David Britten's colleagues continued to express concerns about his practice after the first investigation. The consultant psychotherapist at the Gordon Hospital wrote to the service director on the 19 January 1999:

"This is formally to let you know that despite your letters to David Britten in the Autumn, most recently the 4 December, and mine to him of the 13 November 1998 (see enclosed), he has not returned to our regular meeting for the discussion of supervision of individual work at the Peter Dally clinic, nor has he discussed his own supervisory requirements and arrangements with me, as the responsible consultant psychotherapist to the clinic....I have therefore to inform you that I cannot take responsibility for the practice of any member of staff who is not prepared to have his or her work discussed in an ordinary way with reference to clinical supervision provided within the clinic."

8.26 A protracted and acrimonious correspondence followed between the psychotherapist and the head of psychological therapies, on the one hand, and the service director and David Britten on the other. The psychological therapies staff were concerned about David Britten's practice and as a result the head of psychological therapies wrote to the area senior nurse in May 2000, giving notice that he was closing the supervision group at Peter Dally clinic. The letter was copied to a wide range of recipients including the consultant psychiatrist. He said:

"individual unsupervised therapy of particularly vulnerable patients by persons unqualified to undertake that specific specialist task [is] still continuing in the unit after at least 18 months of our protestation about this".

8.27 This letter did not refer explicitly to David Britten but it was copied to him by the locality manager, to whom David Britten replied that the author:

"...also mentions that he has 'good cause' to believe that specific pieces of individual unsupervised therapy are being conducted in the clinic. This is not the case and has not been so since we established the basic principles for the operational policy."

8.28 The head of psychological therapies had sent the letter to the service director in May 2000. The service director responded by asking him if he wished to make a formal complaint. He said he did and in August 2000 the service director commissioned a second investigation of David Britten's conduct. The service director told us that she had taken legal advice in between receiving the complaint in May and commissioning the investigation in August and that was the reason for the delay. We have not seen this advice. The chief executive told us that the service director was *"unnerved by fronting up to David Britten...David Britten could seriously unnerve people."*

8.29 This second investigation was set up after discussion with the new chief executive and the director of nursing practice (who was to chair the new investigation). The service director failed to tell the new chief executive and the director of nursing practice during that discussion that there had been an earlier investigation into David Britten's conduct.

8.30 The director of nursing practice was joined on the panel by the chief psychologist from BKCW²⁵ and a representative from the human resources (HR) department. The director of nursing practice told us he had later discovered that the HR manager appointed to the panel (at the service director's request) had been personally involved in the earlier investigation. He said that if he had known this he would not have agreed to have her on the panel because it could be seen to have compromised the impartiality of the investigation. He told us he suspected her of leaking information to the service director throughout the process. We have seen no evidence of this.

8.31 The investigation panel was asked to find out whether dangerous practice was taking place at the clinic that put patients at risk; whether there was a breach of the operational policy of the clinic, either by individuals or groups of staff; and whether standards of practice were declining.

8.32 The investigation chair carried out a large number of interviews between August and December 2000.

8.33 The director of nursing practice told us that by December 2000 he was so concerned at what he had found he decided to give the chief executive an interim report. He told us:

"...there had been a breakdown of effective multi-disciplinary working at the clinic; the operational policy (drawn up in the wake of the first inquiry) was not being complied with; staff in the psychological therapies service had withdrawn their services from the clinic without the agreement of trust management; the clinic manager's role lacked definition, especially in relation to contact with clients; new therapies raising ethical issues (the use of touch) had been included in the operational policy without first contacting the local ethics committee."

8.34 By this time the director of nursing practice had concluded that David Britten was seeing patients individually for therapy. David Britten continued to deny this to trust management, saying he saw patients for management purposes only. The interim report concluded:

²⁵ This chief psychologist should be distinguished from the chief psychologist of Riverside Mental Health Trust who chaired the first investigation and will be referred to in this report as chief psychologist from BKCW

“there should be no problem within a reasonably run service in finding out whether a particular individual was seeing patients and what they were doing with them. The fact that there was uncertainty about whether patients were being seen for therapeutic purposes by a particular individual is, in itself, an indictment of the insular and closed culture which was allowed to develop with the Eating Disorders Service and the failure of successive management to put in place arrangements for the proper scrutiny of an NHS service treating a vulnerable and complex client group.”

8.35 In our interview the director of nursing practice was critical of the service director’s actions in establishing the second investigation. He told us he had been sent an incomplete bundle of correspondence to review. He had found out about the first investigation only because witnesses mentioned it in their interviews. He told us he had found it odd that he had not been told about the earlier investigation and had raised this directly with the chief executive. The director of nursing practice told us he concluded that the service director was *“not part of the solution but part of the problem”* and that was why he decided to treat her as a witness in the investigation and to report directly to the chief executive. He told us he had explained to the chief executive that he was concerned about senior management in Westminster and that the chief executive was deliberately being kept *“out of the loop”*. The chief executive informed the director of nursing practice that he would personally let the trust board know of these concerns as soon as possible.

8.36 The director of nursing practice told us that he felt the service director had obstructed his investigation and that he felt he would have to resign his commission if the service director did not stop interfering. He thought she was acting in this way for reasons of self-preservation, because she had made mistakes that she did not wish to be scrutinised. He described the service director’s style critically as *“management by memo”*. He was concerned about the volume of correspondence arising from disputes at the Peter Dally clinic and did not think correspondence was the appropriate way to manage the situation. He was also critical of the agreement to include the addendum in the earlier report (at David Britten’s request) and said it diluted its impact.

8.37 The chief executive told us that when he received the report from the second investigation he thought there had been some *“serious management*

failings. Had people like [the area senior nurse] and [the service director] done their jobs properly, this could have been unearthed.”

Comments

There was poor institutional knowledge of the historical problems with David Britten and the clinic, and the managers of the new BKCW trust had not been given information related to the previous inquiry or difficulties in respect of the problems in the clinic.

The service director had personal knowledge she appears not to have passed on to the new trust managers.

There was contamination as a result of the inclusion of a panel member from the first investigation. This could have compromised the findings if challenged by David Britten. Team working had broken down and services were being withdrawn from the clinic as a result. The service director’s decision to take legal advice before setting up the second investigation was disproportionate, causing unacceptable delay in taking decisive action about the withdrawal of services.

The disciplinary investigation

8.38 David Britten was formally notified of the trust’s intention to redeploy him in March 2001 after the trust board and chief executive had considered the interim report. He was placed on special leave while this was arranged. Once again, this quickly became public knowledge and some of the clinic patients launched a reinstatement campaign, supported by their families and some staff. Some patients told us David Britten had encouraged this behind the scenes.

8.39 At this time patient J, a former patient of David Britten’s, made unsolicited contact with the trust’s chief executive. She said she wanted to offer him her own view of David Britten, in contrast to the campaign of the other patients. She said David Britten had touched her inappropriately in a therapy session, she had rebuffed him, and afterwards he had victimised her during her stay at the clinic.

8.40 The chief executive sought evidence from former members of staff, seven of whom were prepared to give evidence to assist in the trust inquiry.

Meanwhile, the pro-David Britten lobby had been active and later that month the chief executive received 43 letters of support for him from patients, their families and an MP. They demanded his reinstatement in emotive terms, even suggesting that patients would die if he were removed from the clinic. Six staff members at the Peter Dally clinic then threatened to resign unless David Britten was reinstated.

8.41 The chief executive then took his own informal soundings by speaking to former patients and staff. In April 2001 he met the consultant psychiatrist at the Peter Dally clinic to discuss his concerns. She confirmed that patient J, who had contacted him in March, had previously made the same allegation to her. She told him she had taken no action at the patient's request but had reported the matter to the medical director of her employing trust at the time. The medical director (who had since retired) attended the meeting with the chief executive and confirmed the advice he had given (see paragraph 10.39).

8.42 Later that month the chief executive received a letter from solicitors acting for patient L, the original complainant in the first investigation. The letter said she intended to sue the trust for David Britten's conduct leading to the first investigation.

8.43 In the face of considerable pressure from patients, families, staff, MPs and others supporting David Britten, the trust board on the advice of the chief executive closed the Peter Dally clinic in May 2001. The closure resulted in considerable financial loss for the trust and required sensitive and concerted organisational effort to ensure the safe assessment and relocation of patients, some of whom were seriously ill. A new inpatient eating disorder service opened as the Vincent Square clinic in April 2002.

8.44 In May 2001 the chief executive commissioned a formal disciplinary investigation and David Britten was suspended. He was instructed in writing not to contact patients or staff at the clinic while suspended.²⁶ David Britten tendered his resignation in December 2001, before the conclusion of the investigation.

²⁶ Subsequently, mobile telephone records produced to the Nursing and Midwifery Council showed that Britten *did* continue to contact patients at the clinic until at least the end of that year.

8.45 The disciplinary investigation was thorough; the advice of a barrister was sought; it reviewed the evidence collected in both earlier investigations and produced new witnesses.

8.46 David Britten's disciplinary hearing was held in March 2002. He was charged with the following 12 allegations:

1. He had behaved unprofessionally to a patient.
2. He failed to comply with complaint procedures.
3. He failed to make proper records of complaints in patient records.
4. He met patients individually for therapy contrary to management instructions.
5. He showed favouritism to patients and did not cooperate with key workers and other professionals.
6. He conducted meetings with patients behind closed doors and held keys to patients' private flats.
7. He intimidated staff and patients in order to obstruct complaints about himself.
8. He instructed staff not to record serious and untoward incidents.
9. He harassed a former member of staff by touching her inappropriately.
10. He failed to arrange for supervision of junior staff.
11. He created a culture of dependency amongst patients.
12. He breached his terms of suspension by contacting staff and patients.

8.47 David Britten was invited to attend the hearing, even though he had resigned, but did not do so. The panel decided to proceed with the formal hearing. All allegations except 2, 3, 9 and 11 were upheld and he was found guilty of gross misconduct, summarily dismissed and immediately reported to the UKCC²⁷ (now the Nursing and Midwifery Council).

8.48 In January 2002 the trust reached a financial settlement with patient L, the complainant in the first investigation, after receiving a formal claim supported by witness statements and psychiatric reports. In March 2002 the trust received complaints from three more women who had been patients at the Peter Dally clinic, alleging abuse by David Britten. The extent of David Britten's sexual contact with patients became clear for the first time. The trust took statements

²⁷ United Kingdom Central Council for Nursing, Midwifery and Health Visiting.

from two patients, made formal complaints to police of offences under s.128 of the Mental Health Act 1959 (see appendix B) and added this information to their referral to the NMC.

8.49 Many other women have contacted us since the start of this investigation: former patients at the clinic who had sexual relationships with David Britten or with whom he had tried to have an inappropriate relationship. Their evidence was clearly not considered in any of the earlier investigations.

Overview of the three investigations by patients' solicitor

8.50 We showed the solicitor acting for a number of the patients in this matter the papers from the internal investigations and the disciplinary investigation. She met us and gave her critique of the internal processes on behalf of her clients. Her views are summarised below.

Management failures

- David Britten should have been suspended and removed from the ward while the first investigation was conducted.
- There should have been clear guidance about how to deal with competing allegations and stories, especially when a patient needs to be protected. The conclusions of the first investigation were extraordinary. Lawyers should have been involved to advise on the standard and burden of proof.
- There appears to have been a systemic failure by the service and also some negligence by David Britten's managers. He was not followed up or managed appropriately after the first investigation. The consultant's and deputy manager's role should be looked at. David Britten would have tried to get round any system in place, so individuals needed to tackle him. The service and certain key individuals failed the clients.
- The second investigation contained a great deal of management language and did not really address the core issues.
- The Riverside Mental Health Trust missed a number of opportunities to intervene. The trust needs to consider how it uses information given by clients and colleagues. The allegations that prompted the first investigation uncovered some wider issues but these were not really

followed up. The withdrawal of psychological services should have been seen as a “*flag being run up*”.

- Once the trust realised that there had been several sexual relationships, it should have contacted other patients. There may be other women who have not yet been contacted. The support services offered to her clients could have been better.

General

- Management should have picked up, and acted on the lack of patient notes and the lack of attendance at supervision sessions.
- David Britten also seems to have been able to introduce unorthodox practices into the clinic with no control.
- David Britten was extraordinarily manipulative. The situation was akin to hero worship in some quarters. Management should recognise the propensity for this in eating disorder services and guard against it. There are specific issues concerning patients’ safety for this client group.

Comments

We were impressed by the approach of the chief executive and of those who carried out the second investigation and the disciplinary (third) investigation. The second and third investigations were robust and responded appropriately to the seriousness of the issues.

We noted that considerable pressure was placed on the chief executive by a group of patients who sought David Britten’s reinstatement from special leave. We commend his forthright response in not yielding to that pressure, and in temporarily closing the Peter Dally clinic at considerable financial cost to the trust.

The chief executive responded appropriately when reports of sexual abuse were brought to his attention, by setting up support mechanisms for individual patients, though these arrangements helped some patients more than others. The chief executive acknowledged the trust’s liability in these matters and met with victims and/or their families and supporters and made

it clear that the trust accepted responsibility and wished to settle their claims. The chief executive was then involved with the NHS Litigation Authority and the claimants to reach a financial settlement.

Professionals to whom allegations about colleagues are made are in a difficult position. We are aware of a report by the charity WITNESS that compares the requirements of the different codes of practice for different professional groups in this regard. We also note the response by the Department of Health (DH) to the findings of the Shipman inquiry's fifth report, and to the recommendation of the Ayling, Neale and Kerr/Haslam inquiry reports. The DH's response was to commission guidance on patient/professional boundaries and this includes consideration of ways for professionals to express concern about colleagues without having to make formal complaints or break patient confidentiality. The guidance was published on 10 January 2008. A summary of the report is attached at appendix E. We welcome the commissioning of this work and believe the implementation of the guidance will result in improvements to patient safety in this difficult area.

9. Operational management

9.1 Our investigation has identified a number of problems with the operational management of the clinic. These include the failure of management to resolve long-running staff disputes; poor line-management of David Britten (including the poor management of his annual leave and sick record); the failure to implement and monitor the recommendations of the first investigation and the failure to deal with David Britten's breach of the conditions imposed in lieu of suspension; poor client record-keeping and management; and the failure to recognise that David Britten was operating outside his area of competence. We consider these areas of concern below.

Disputes between staff

9.2 It is clear from the papers the trust gave us and from the witness evidence we heard that staff regularly expressed concern about David Britten's practices from the early 1990s onwards. He had clearly developed an unorthodox approach to treatment, including the use of touch in therapy, which was of concern to many colleagues. Two former members of staff told us they had heard rumours about David Britten, even before they worked at the Peter Dally clinic, of "*patients sitting on his knee*".

9.3 There appears to have been little intervention by the then Riverside Trust management, and the unresolved issues developed into a long-running dispute between David Britten and other staff, including the clinic's consultant psychotherapist²⁸. This particular disagreement resulted in David Britten refusing to attend the supervision sessions held by the consultant psychotherapist. He also encouraged other nursing staff to leave the supervision group. The consultant psychotherapist told us that David Britten fomented the situation, "*paralysed*" the service with his conduct, and made threats of litigation against fellow members of staff. An interview with one of the junior doctors and our review of the documentation confirmed the threats of litigation. For example, David Britten wrote in a letter to the service director dated 1 December 1998:

"I have sought legal counsel on the matter and have been advised that their letter constitutes a defamation of character and is a direct attack on my professional standing."

²⁸ The consultant psychotherapist's full title is "consultant psychiatrist in psychotherapy"; for the purposes of this report we have termed her consultant psychotherapist.

9.4 By the end of 1997 matters had come to a head, and the consultant psychotherapist made a written complaint to the service director. The service director met her, David Britten's line manager and the head of psychological services. In response to that meeting the consultant psychotherapist wrote to the service director again and said that despite some progress she still supported the idea of psychological services' suspending practice at the clinic. In December 1998 the service director wrote to David Britten (as part of the follow-up to the first investigation) and instructed him to have no therapeutic contact with patients unless he returned to supervision. She accepted that he would need to have limited one-to-one contact with patients at the Peter Dally clinic for management purposes. It is clear from numerous sources that David Britten continued to see patients as before.

9.5 In March 1999 the consultant psychotherapist and the head of psychological services for the trust informed the service director that the provision of psychological therapies to the Peter Dally clinic would have to be suspended because they thought David Britten's conduct was undermining them. The consultant psychotherapist wrote:

"Clinicians are so persistently put into positions where their work is seriously compromised, both ethically and professionally, that the situation has become untenable."

Later in her letter she said:

"...all our attempts to try to address this have been ineffective in producing change."

9.6 A consultant from the Tavistock clinic who was skilled at working with services in trauma was brought in to try to resolve the difficulties between the staff groups as part of the service director's response to the first investigation report. The consultant psychotherapist told us this was consistent with the "social care model" which the service director used. She said she felt this model allowed David Britten to "get away with" his conduct, by tackling the system rather than tackling him personally. There was also considerable discussion after the first investigation between the service director and David Britten about new management objectives. A new set was produced after a meeting between David Britten, the service director and the area senior nurse. The areas covered were:

- improved multi-disciplinary working
- improved recruitment and retention
- improved use of the nurse bank
- the re-opening of closed beds
- implementation of the operational policy
- the need to work within the trust's standing financial instructions.

9.7 One objective of particular note arises from the first inquiry. It is quoted here in part:

“To develop in consultation with others a protocol about the touch of patients by staff: this is to be agreed with [the unit consultant, the principal psychologist and the area senior nurse] and subsequently implemented.”

9.8 David Britten responded to these objectives with a long letter trying to justify the way he ran the clinic and stating why he felt the objectives were a criticism of his management.

9.9 There is evidence on the trust files that in June 1999 a doctor who was concerned about the Peter Dally clinic complained to the service director that he had not been offered an exit interview despite requesting one at which he could discuss his concerns with her. The service director told us she was unaware of this at the time.

9.10 David Britten's deputy brought a formal grievance against the head of the psychological therapy service alleging bullying conduct in a meeting on the 11 May 1999. Interviews took place with David Britten's deputy and the head of psychological therapies. We have not seen a record of the outcome.

9.11 The service director told us that David Britten was always “defended” by the consultant psychiatrist in these disputes, although the consultant psychiatrist denies this. She said the consultant psychiatrist had reassured her that the dispute concerned differences of clinical perspective and approach between David Britten and the consultant psychotherapist and that patients were not at risk as the consultant psychotherapist alleged.

9.12 Another person perceived by witnesses to be a key “defender” of David Britten was his deputy manager. The manager who took over the clinic after David Britten left told us that the deputy manager was closely involved with David Britten’s patients on a therapeutic level, and supported them in their distress at his departure. She also described the deputy manager as a ringleader of those who supported David Britten. We interviewed the deputy manager who told us:

“despite sharing a room with David, I never once saw anything that caused me concern or led me to believe that he was making a client feel uncomfortable or working outside his remit or the guidelines he had impressed upon me...I never once found the door locked when David was seeing clients in the office although out of respect I would often try to stay out of the office. When patients dropped in I never heard or saw anything inappropriate. I believe he realised that if he acted appropriately around me and impressed upon me his professionalism the person deputising and working closest to him...would not be able to support any allegations of wrong doing. In doing this I think he used me to protect himself if ever complaints were made. I did not whistle-blow because I could not see anything suspect and had no concern about clients’ safety...when I left I thought that David was innocent and was being forced out of the trust.”

9.13 The service director told us that she had found it increasingly difficult to discuss David Britten or the Peter Dally clinic with the new chief executive, who was now her own line manager after the merger into the BKCW trust in 1999. She said there were differences between their approaches, a lack of trust between them, and “the whole thing broke down”. In contrast the chief executive told us in his evidence that the service director was defensive in respect of her services and was reluctant to discuss things openly with him. The area senior nurse also told us she felt she could not discuss David Britten with her line manager at the time (April 2000), which forced her to seek advice from academic colleagues outside the trust. In interview with us she said:

“One of the issues that concerned me at the time in terms of reporting was that new trust, new organisation, new chief executive, my role was changing at that point again, so my job description was being rewritten at that point, and I was also trying to build a new relationship with a new line manager. Therefore, when I went back to talk to [the locality manager]

about my concerns, I did not feel that they were really being heard, which I found quite difficult obviously.”

“This was one of the reasons why I talked to the leader of my learning set at the King’s Fund.”

9.14 The consultant psychotherapist told us she had discussed David Britten many times in her supervision and with fellow consultants. In the end she decided to withdraw services from the clinic to “*cause a stink*”. She told us she was reprimanded in her appraisal for doing so.

Line management of David Britten

9.15 The following line management arrangements were in place for David Britten.

- The service director operationally managed David Britten before and during the first investigation.
- From August 1998 the area senior nurse clinically managed him, to provide clinical nursing supervision. Operational management remained with the service director.
- From April 1999 operational management was transferred from the service director to the area senior nurse, so she became responsible for both clinical and operational management of David Britten.

9.16 In 1999 when the operational policy was adopted for the Peter Dally clinic, the role of the clinic manager was described as:

“...to jointly manage the clinic and its work with the consultant psychiatrist; to take overall responsibility for the management and supervision of nursing staff”.

9.17 Neither one of David Britten’s line managers, nor the consultant psychiatrist, were based full time at the clinic. This clearly hampered their ability to observe how the clinic operated and David Britten exploited the difficulty. The chief executive told us:

“...we had it out, me [the service director], [the area senior nurse]...You aren’t in touch with what is going on and so forth”

9.18 He described his memory of how the area senior nurse had given evidence to the NMC:

“...her total inability to understand how to go about dealing with these issues came across appallingly. The chairman of the panel would ask her things such as ‘why didn’t you meet him regularly’ and she said ‘well he always forgot his diary’ and ‘why didn’t you walk around the unit?’ ‘well the geography was hard to find your way around’. All the women and their families sitting behind me...she should never have been in the job”.

The area senior nurse told us that her evidence at the NMC hearings as quoted by the chief executive is selective and portrays her unfairly. She told us her evidence was also influenced by her not receiving any briefing on the process, by the hostile questioning she was subjected to and by her state of health at the time.

9.19 In September 1999 the service director had received a written complaint from the consultant psychotherapist which referred to David Britten breaching an agreement to cease *“unsound practices”* some two years before. Our investigation has found no evidence of such an agreement, although a number of witnesses have referred to its existence. It seems to have been inadequately recorded, or perhaps lost with the subsequent change of consultant psychiatrists and NHS mergers. The consultant psychotherapist told us she thought the mergers of trusts allowed David Britten to *“make use of dynamics”* and *“keep his empire together”*. We have concluded elsewhere that successive line managers did not know enough about past events and agreements to monitor his practice effectively.

9.20 In January 1999 following the first investigation the consultant psychotherapist complained to the service director that David Britten had still not returned to the supervision group. A protracted correspondence between the service director and the consultant psychotherapist followed, regarding the correct supervision arrangements for nursing staff at Peter Dally clinic. In particular, the service director said that David Britten did not have to attend the supervision group as he was not conducting individual patient therapy. This response was fundamentally misconceived.

9.21 It appears from the above that the service director had accepted David Britten's word that he was not conducting individual patient therapy. There does not seem to have been any independent investigation of this point and David Britten's managers did not know enough about what happened in the clinic to be able to contradict him. One witness memorably described the relationship between the service director and David Britten as '*management by memo*', although the service director told us that she regularly met David Britten and the consultant psychiatrist at the clinic. The service director conceded that "*half the time David wouldn't turn up*". The chief executive of the merged trust (CNWL) told us that he had inherited a situation in 1999 in which David Britten's managers had not been sufficiently "*hands on*" in their role for the Peter Dally clinic. He told us that on one occasion he had been struck by the fact that the area senior nurse had told him she could not remember the ward managers' names at the Gordon Hospital. When he asked her why, she had said she tended to email them rather than speak to them. The chief executive had walked round the hospital with her and noted that staff did not seem to know her. The area senior nurse told us that the chief executive had misunderstood her on that occasion and that his poor opinion of her had negatively influenced their subsequent working relationship.

9.22 Some former members of staff told us they never saw the service director or the area senior nurse at the clinic. The chief executive stressed to us the importance of managers "*walking the job*". We asked the service director if she was fairly detached because she managed a range of services and she told us:

"Oh yes, because the size of the service was such...My role was managerial and I was managing the whole of south Westminster, so I was not involved on a day-to-day basis with running the clinic."

9.23 The area senior nurse told us she had also found it difficult to pin David Britten down when she took over line managing him. He would often not turn up to their meetings. She said she tried to make regular arrangements to meet him, either at her office in the Gordon Hospital or in his office at the clinic. She recalled remonstrating with him on one occasion for not telling her that he had already booked leave at a time when he had agreed to attend an important meeting with her.

9.24 In May 2000 the area senior nurse went to the Peter Dally clinic to meet the consultant psychiatrist. She found a queue of female patients sitting on the stairs outside David Britten's office waiting to see him. Several other witnesses have described these "queues" to us; they seem to have been a regular feature at the clinic. However, the area senior nurse told us she was surprised that he was seeing patients alone in his office on a systematic basis and that she had been disturbed by the patients' conversation. It may be significant that she was in the clinic that day unannounced due to a diary mix-up. She described some of the conversation she heard which had sexual overtones:

"The most disturbing part was a conversation about making him coffee, so they were arguing about how he liked his coffee and who made him the best coffee, and then somebody said, 'because I want to have some connection with him, when I make him coffee what I do is I put the spoon in the cup and lick it and then put it back in the cup so that there is something from me that goes to him', by which time the conversation was really disturbing I guess. I went back and talked to my manager about it."

9.25 She spoke to her manager who told her to speak to David Britten, which she did. David Britten explained the patients' conversation as:

"...I can't help it if patients develop crushes on male staff. That is something that commonly happens in this sort of service, rather like children at school developing crushes on their teacher."

The area senior nurse told us that she did not accept David Britten's explanation and sought further advice.

9.26 We asked the service director why she had not considered re-deploying David Britten in view of the difficulties he caused the service. She told us he was unqualified to work in another setting because he was a senior nurse specialist in eating disorders (H grade)²⁹. Furthermore, he would have fought re-deployment with the backing of his union and the patients. The trust could not afford to put him in a supernumerary position elsewhere, so she had tried to keep him at the clinic and manage the difficulties. The chair of the second investigation told us that if he had been faced with the allegations made in the first investigation he would have gone straight into a full and proper disciplinary investigation.

²⁹ See glossary, appendix B.

9.27 The service director told us she relied on the consultant psychiatrist to tell her if there was a problem at the clinic because she herself was off-site and had no clinical involvement. However, she said that the consultant psychiatrist had responded to her concerns by saying “*I will not betray David*”. We put this to the consultant psychiatrist in our second interview with her and she emphatically denied having said it.

9.28 The area senior nurse told us she had asked David Britten to make clear to others his counselling qualification. He told her he had paid for training privately so it was not the trust’s concern. In fact, the consultant psychotherapist had supported his request for training back in 1994, but told us she never found out what happened about it. We understand that the trust did not agree to fund the training. At the NMC hearing David Britten was found not guilty of acting outside his area of competence in relation to counselling, but this was only because:

“...there is no evidence [that] the relevant activities undertaken by the respondent [Britten] with these patients could properly be called psychotherapeutic work.”

9.29 The evidence we have received shows that not only did he represent himself as a therapist, but that consultants in the Gordon Hospital and the Peter Dally clinic directly referred patients to him for counselling.

David Britten’s sickness and leave record

9.30 Several witnesses have told us that David Britten had unpredictable working patterns. He would either not take his annual leave, or he would take it but come into the clinic while he was supposed to be away. He would appear in the clinic, sometimes at night, when colleagues were not expecting him to be there. The service director told us she thought he was using his annual leave to have medical treatment, thus limiting the amount of sick leave he claimed, and it would have been “*counterproductive*” to reprimand him for this because she wanted him to be more open about his illness and accept more help. We examined his personnel file which had no information about this.

9.31 In February 2000 David Britten took sick leave for three weeks, triggering a referral to the trust’s occupational health service adviser. In April 2000 the occupational health service doctor reported to the service director that David

Britten had refused to discuss his medical condition and would only confirm that he was fit for work. The service director told us that she discussed this with the human resources department and she was advised “...that as he appeared to be coping with his workload that no further action should be taken.”

9.32 There had been rumours at the clinic for some time that David Britten was suffering from some form of cancer, possibly terminal. He had confided in a number of colleagues who each thought they were in possession of a secret. David Britten had been seen in the clinic with a cannula (a medical tube suggesting chemotherapy) in his hand, although a number of witnesses mentioned that he did not lose his hair. The service director told us that the consultant psychiatrist had confided in her “*tearfully*”, that David Britten would not be around in five years. The service director told us that she understood this to be a request by the consultant psychiatrist for the service director not to deal with David Britten’s shortcomings. The service director said the consultant psychiatrist had also told her in confidence that David Britten was gay, and not therefore a threat to the female patients. We put these reported statements directly to the consultant psychiatrist in a second interview and she strongly denied that she had told the service director that David Britten had cancer or was gay, saying it was “*rubbish*”. In subsequent correspondence the service director told us that she did not think that the disclosure by the consultant psychiatrist was intended to get them to “...ignore his shortcomings, but given that she had confidence in his competence the repeated investigations were uncalled for and detrimental to his health.”

Financial management of the clinic

9.33 The service director told us that the Peter Dally clinic was keeping adult services afloat financially in the 1990s because of its ability to attract funding through extra contractual referrals (ECRs)³⁰. Many witnesses held this view and they described the clinic as a “*golden egg*”. The consultant psychotherapist described the clinic as “*a casualty of the internal market*” because its success was measured on its financial performance rather than its clinical outcome: more money was made available if patients failed to gain weight and stayed in the clinic than if they recovered and left. The consultant psychiatrist was the only witness who strongly disagreed with this analysis. She pointed out that this client group was difficult to treat, often requiring lengthy stays at the clinic.

³⁰ See appendix B.

9.34 ECRs also meant that inpatients were often a long way from home and family, more dependent on David Britten and vulnerable to exploitation. As noted elsewhere, the NICE guidelines now place greater emphasis on involvement of the family in the treatment of eating disorders, and NHS reforms have limited the use of ECRs.

Management of client information

9.35 Our investigation has uncovered an issue about safe-keeping of patient records at the Peter Dally clinic. Patient F's solicitor told us her client brought her original records when she came to see her.

9.36 Patient F told us:

"I was worried about the safekeeping of my clinical notes when I learned that David Britten had been suspended. He used to hold my clinical notes in his office drawer...when he was suspended he said that he had asked (his deputy) to remove them. He later told me that she took them home to store in her loft. I remember telephoning (her) and she told me that my notes were safe. I had never met her before but I knew that they shared an office as I had spoken to her on a number of occasions when I was trying to reach him. I did have a few conversations with her, particularly when I expressed my concern to her about him dying of cancer but she reassured me that he was fine. I recall that there was one conversation we had where it was very apparent that she knew we were close...sometime later around early to mid 2002 I recall meeting up with David Britten so that he could return my notes to me."

9.37 In our interview with the deputy manager she said she had never met this client. She thought they may have spoken on the phone. She told us:

"I have absolutely no recollection of handing David any medical records or any specifically relating to this patient. I am very concerned and do not understand why this lady has mentioned my name and suggested that I gave these notes to David. I do not understand why David would have asked me for the notes and I do not know why she would have asked for the notes. This is not something I believe I would have done...I suppose only David has the answer to how he got the records, but I would like to make it clear that I am not comfortable with this allegation and wish to formally refute it."

The clinic environment and administration

9.38 Many witnesses described the clinic and its administration during David Britten's tenure. The physical environment clearly lent itself to secrecy and the blurring of boundaries. Patients and staff have described David Britten burning candles in his office, sitting on patients' beds upstairs and closing doors that had no viewing panels. We spoke to the manager appointed by the BKCW trust who went into the Peter Dally clinic after David Britten left. She described how she found a number of knives in David Britten's office. She was told they had been confiscated from patients but they were not locked away. She also found syringes in a carrier bag in the office together with used swabs. She found letters in his desk drawer that had not been placed on the relevant patient file. She said records, such as rotas, were missing. She also told us there had been a difficulty between the Peter Dally clinic and the pharmacy service over the clinic's requests for laxatives, sedatives and anti-psychotic medication. In one instance the pharmacy had refused to supply David Britten with medication he had requested, although management did not seem to know about this. She commented on the lack of viewing panels in the clinic doors and the confusion about who had keys to different doors and cabinets. She made changes to the clinic before it reopened. In particular, a review of ligature points resulted in works to place boarding over exposed pipes in bedrooms and bathrooms. The controversial version of body image therapy that David Britten introduced to the clinic was ended.

9.39 She told us that the clinic had been mismanaged on a number of levels. There was confusion about the status of several ECRs in relation to which payments had not been made. The computer system was poor; there was an absence of clinical data about length of patient stays and outcomes. She described the administration systems as chaotic. There were no proper personnel files for staff; there were no leave cards; no system for time off in lieu; the trust's sickness policy was not being followed; no appraisals were being carried out. She told us she would have expected management above David Britten to have picked up these issues.

Comments

David Britten's counselling qualifications

It is clear from the patients' evidence that David Britten was purporting to conduct counselling/therapy and we have received evidence that patients were referred to him for that purpose. Considering the concerns that were

raised by the first investigation it would have been appropriate for his managers to find out whether he was qualified to conduct this work.

David Britten's sickness

The service director referred him to the occupational health service and both she and the HR department then accepted that he refused to discuss his health with the occupational health doctor and did not seek further action or advice.

Management of complaints

As this report shows, there were a number of complaints, concerns, disputes or investigations relating to David Britten over the years. These seem to have been considered case by case, with little cross-analysis. Institutional knowledge of the problems that David Britten presented seems to have been lost when mergers took place, personnel or line management arrangements changed, or when investigations concluded. Management follow-up was often poor, with David Britten breaching instructions without sanction. This allowed staff disputes to develop.

Managing David Britten

David Britten was a skilful manipulator of management and colleagues. That said, he was sometimes permitted to operate outside the boundaries of a normal employer/employee relationship. He failed to follow normal procedures for sick leave, management supervision sessions and proper recording of his work.

Various witnesses said management had "backed off" dealing with these issues because of David Britten's alleged ill health, confrontational approach, rumoured homosexuality or the risks to the financial success of the clinic. None of these was an acceptable excuse for tolerating his behaviour.

David Britten's line managers, prior to the BKCW trust taking over responsibility, failed to ensure he operated in an acceptable manner.

Management of client information

Removing clients' notes from a NHS service without permission is a serious breach of confidentiality and could amount to professional misconduct. Patient F had her notes when she first went to her solicitor. There is a clear dispute between the client's view of what happened and that of the deputy manager. Although the deputy manager does indicate she may have spoken to the client on the phone (which is consistent with what the client told us), she denies having removed the notes from the clinic. This is a conflict of evidence which this investigation cannot resolve so long after the events.

The clinic environment and administration

When the new manager was appointed following the dismissal of David Britten she found evidence that a large number of basic administrative and operational procedures had not been followed. Her evidence confirmed much of the information we received from others and indicated that David Britten had run the clinic almost totally independent of the trust operating procedures. Neither management nor clinical supervision effectively addressed this approach to his role as clinic manager.

10. Safe clinical practice

10.1 Our investigation has identified problems with safe clinical practice at the Peter Dally clinic during David Britten's tenure. These include:

- The introduction and practice of approaches such as a novel form of body image therapy.
- The failure to ensure the use of touch within clinical practice was stopped.
- The failure of David Britten to attend supervision.
- David Britten seeing patients behind closed or locked doors.
- David Britten's persistent failure to make clinical notes of his interaction with patients.
- David Britten overriding colleagues' decisions.

10.2 A number of witnesses told us that in the early 1990s David Britten had been "*warned off*" his use of physical contact in one-to-one counselling. We were told an agreement was reached that this approach was not advisable with this client group and it would cease, but we found no evidence that the agreement was put in writing or communicated to trust management.

10.3 We interviewed the consultant psychiatrist who had been responsible for the eating disorder service at the Gordon Hospital before the service's move to the new Peter Dally clinic. He told us there was no written agreement concerning touch, but said David Britten had verbally agreed to "*...attend supervision*" and not to "*undermine the work of other therapists*". We asked the consultant in post before him to speak to us but he declined.

10.4 The consultant psychotherapist at the Peter Dally clinic told us she thought the practice of physical contact had ceased after that agreement, and she became aware only many years later that David Britten continued to practise in this way.

David Britten and individual therapy

10.5 It appears to have been common knowledge within the service that David Britten saw patients individually for ‘therapy’. Witnesses described queues of female patients outside his room. Some patients’ clinical notes indicate formal referrals to David Britten “*for therapy*”. Patient K, who was abused by David Britten when she was being treated at the eating disorder unit at the Gordon Hospital, said she was directly referred to David Britten for counselling and treatment and never saw any other therapists.

10.6 Evidence from the area senior nurse showed that she knew David Britten was seeing patients for one-to-one therapy while she was his manager. She said in her evidence to the trust that:

“[Britten] had said at times he would be unable to make a particular time for supervision as he was doing therapy with a patient and that appointment could not be changed. [She] said she did not know who his appointment was with as he had therapy supervision with someone else.”

10.7 As stated elsewhere in this report, we have seen evidence that David Britten applied to pursue formal training in cognitive analytic psychotherapy in February 1994. Records show the trust refused to pay for this training. David Britten later claimed that he had undertaken the training at his own expense, but there was no evidence of this.

10.8 In June and July 2000 the psychological services staff continued to complain to the service director that David Britten was seeing patients for individual therapy sessions and that he was not receiving supervision. They complained that this was putting patients at risk. The service director responded by asking David Britten to agree to make notes of his interaction with all patients, so that she could review the purpose of these one-to-one sessions. David Britten told her he relied on fellow staff members to make up notes of his contact with patients, but he would check that they definitely did this. It is difficult to see how this could have been plausible given that he was speaking about one-to-one sessions.

10.9 We asked the consultant psychiatrist whether the responsibility for making patient notes was a clinical, as opposed to an operational role and also, whether she, as the clinical medical lead, had responsibility to ensure that clinical notes were made and if not to report to the appropriate managers that they were not being kept. She said this was a difficult question. She could not explain how David Britten had managed to continue for so long without making patient notes. She told us that nursing notes were kept separate from medical notes. In terms of her own practice she told us:

“No. I didn’t really get involved in the clinical notes - that was more the junior doctor. I know that’s what happened towards the end of his time at the clinic, that they criticised him for not making notes, but it tended to be the junior doctors who tended to write in the notes.”

She was then asked:

“Would it normally be that clinical notes are made by clinicians and therefore, for example, if we take another speciality, a doctor doing a ward round in a medical ward or a surgical ward would expect to see that the notes have been maintained not only by their junior doctors but by the nurses who have been caring for somebody as well?”

And answered:

“Yes”

10.10 In May 1999 a family therapist at the Peter Dally clinic wrote to the consultant psychiatrist resigning from her position, saying:

“...my work has been undermined, and I am unhappy about a situation in which members of staff are able to undertake therapeutic work for which they are not trained, and do not have adequate supervision.”

10.11 In late July 2000 the head of the psychological therapy service wrote to the service director:

“The senior management team has been aware for a considerable time of the difficulties maintaining standards in the psychological therapies on this unit; I know you yourself were formally following up what could be described as risky practice...on the unit.”

10.12 There is no evidence in the documentation to show what reply she received or who she was referring to, but the content of her complaint is consistent with other professional staff complaining about David Britten's "*therapeutic practices*".

10.13 David Britten admitted to the service director at that time that he *was* having some clinical contact with patients, but only in order to "*assist colleagues*" due to staff shortages. The records show that he again agreed to make sure that notes were taken of these interactions. This suggests that the notes he had previously agreed to ensure were made had not appeared, although this is not recorded in the correspondence. He also agreed to make file notes when he had individual contact with patients for "*managerial reasons*".

10.14 David Britten then announced at a staff meeting in July 2000 that he would stop all client contact within four weeks. At this meeting, he appeared to acknowledge for the first time that he had been seeing inpatients *and* outpatients for therapy on a one-to-one basis. Neither the service director nor the area senior nurse appeared to have known that he was seeing outpatients *at all* before this announcement, which demonstrated their lack of knowledge of the day-to-day life of the clinic. The service director took David Britten to task for making the announcement having agreed with her not to because it was inflammatory in view of the staff shortages.

10.15 The consultant psychotherapist told us she was concerned about David Britten's ability to observe proper patient boundaries. David Britten had advocated the use of touch, in discussions concerning the operational policy, citing professional literature, although she told us it was definitely not advisable for this patient group. She had also expressed concern at David Britten's unwillingness to engage with supervision from 1999 onwards. She had complained to the service director that David Britten had not returned to the supervision group after its reinstatement, and that he breached an agreement to do so after the first investigation.

10.16 The consultant psychiatrist's evidence to the first investigation suggests that she knew David Britten was conducting therapy without supervision. She told us that she had tried to facilitate supervision of David Britten from the consultant psychotherapist but had not been successful.

10.17 In August 1999 patient L complained about her treatment at the Peter Dally clinic during a meeting with the consultant psychotherapist. This patient was the original complainant in the first investigation. She also said she had seen David Britten in a restaurant with a fellow patient. The patient said she did not want the consultant psychotherapist to take any action in relation to this complaint. The consultant psychotherapist informed both the consultant psychiatrist at the clinic and the service director, by letter, of what the patient had said. She was concerned about confidentiality issues and sought advice about her own position from the British Medical Association (BMA). The consultant psychiatrist told us that she had confronted David Britten who gave her the explanation that it was a chance meeting, which she had accepted. The consultant psychotherapist cannot remember receiving any reply to her letter from either recipient and we have found no record of one.

10.18 The consultant psychotherapist told us she thought the consultant psychiatrist:

“...was like someone paralysed in the headlights. She really did not know what to do. He had managed to convince her that she would not be able to cope at the clinic without him. She felt completely caught between him and me and could not be on either side.”

10.19 The consultant psychiatrist told us she had asked for another consultant to be appointed as she worked part-time and there was no cover on her days off. She commented that she *“was not in a position to monitor closely DB’s work, nor was it my role to do so. His line manager had the opportunity and responsibility for this role”*.

The use of touch

10.20 In October 1999 David Britten brought to a staff meeting at the Peter Dally clinic a draft policy advocating the therapeutic use of touch. He agreed to provide the supporting literature on which it was based so his colleagues could consider the benefit of this approach. In response to a question from us the consultant psychiatrist said:

“No, I was always against the idea of it. I always said to David - he would always justify it, just say ‘I just put a hand out’ but I would say ‘David, it can be misinterpreted, you are laying yourself wide open’ - not knowing

that all this was going on, but saying 'As a man you mustn't do that'. Even as a woman you shouldn't do it.'

10.21 A policy for the therapeutic use of touch was prepared as part of an operational policy for the Peter Dally clinic following the first investigation, in spite of the consultant psychiatrist's view about it. David Britten was asked by the area senior nurse to produce the first draft of this policy, even though he had just been the subject of an investigation related to inappropriate touching. In January 2000 David Britten produced a draft of his policy on the therapeutic use of physical contact and in February 2000 the management advisory group for the Peter Dally clinic agreed the final policy document.

Locked doors

10.22 Numerous witnesses have told us that David Britten held one-to-one meetings with patients in his office behind a locked door with no viewing panel. Many witnesses have told us David Britten locked the door from the inside. Witnesses have told us that that David Britten would burn candles in the office. We now know from former patients what took place in 'therapy sessions' in these circumstances, while the normal life of the clinic took place outside. Patient I also told us that during her relationship with David Britten from 1983 to 2000 she visited him in his office and had sex with him there, despite having no clinical involvement with the clinic at that time. The fact that they were prepared to take this risk suggests that there was a high tolerance at that time of David Britten's office door being shut (and probably locked) while he was inside with visitors.

10.23 The consultant psychiatrist told us that before the first investigation she knew that David Britten locked the door when he was seeing patients, but she was not concerned because she trusted him and thought it was to ensure privacy, as otherwise people walked in all the time. She told us she thought he had stopped locking the door after the first investigation in 1998. She was clearly badly informed about events in the clinic, despite sharing responsibility for its management with David Britten. Other clinic staff told us they always conducted one-to-one sessions with patients in a meeting room with a viewing panel, although they were aware that even after 1998 David Britten saw patients in his office behind a closed and/or locked door. The consultant psychiatrist and the deputy manager both told us they did not know the door was locked, even though many other staff and patients have told us that it was.

10.24 The consultant psychotherapist told us that she thought David Britten had “groomed” the consultant psychiatrist, the service director and the area senior nurse, as he had the patients, so that they did not confront him directly.

Clinical audit

10.25 Clinical audit was not a common practice in the NHS in the early days of the clinic. However, in August 2000 records show that the service director discussed with David Britten the results of a survey into clinical outcomes at Peter Dally clinic. We have been unable to obtain a copy of this, but we know that some patients spent years as inpatients at the clinic while involved in relationships with David Britten. The consultant psychiatrist said this was a difficult client group, for whom long-term intervention was often necessary and the outcomes reflected this. She denied strongly the suggestion that any patients had stayed with the clinic longer than necessary for non-clinical reasons.

Serious untoward incidents

10.26 The chief executive told us that when he took over in April 1999 (after the merger into the BKCW trust) he asked the service director why he never received reports of serious untoward incidents (SUIs) from the Peter Dally clinic. He told us that in his experience, services for patients with eating disorders were notorious for incidents of self-harm, overdoses etc. He said the service director told him it was because the service was well run, but he remained concerned. Other witnesses said David Britten did not complete SUI reports and actively discouraged others from doing so. Patient stories in section six of this report show that there were serious incidents of self-harm at the clinic. The new manager of the clinic after David Britten’s departure told us she found only one SUI report on file. One nurse told us that staff were instructed to telephone or bleep David Britten if any problems occurred at the clinic, even when he was on leave. He told staff not to call the duty doctor but to let him deal with problems.

Overriding colleagues’ clinical judgment

10.27 A number of witnesses told us that David Britten tended to override colleagues’ decisions without consulting them. For example, he would grant leave to patients who were supposed to be on bed rest, or alter the dietician’s menu for particular patients. Patient stories in section six confirm this. We were told that this information often emerged in ward rounds when the consultant psychiatrist would suggest a particular course of treatment but the patient would

say that “David had told [me] [I] did not have to do that”. The consultant psychiatrist told us:

“A typical thing that would happen would be that, say, for example, somebody would be having a pudding at lunch, the dietician would have arranged all that with the patient, and then the patient would go to David and say ‘I don’t want a pudding with lunch’, and he would say ‘all right, you don’t have to have the pudding at lunch’. The dietician would come to me, furious: ‘David has changed my diets’. The dietician and I would then go to David and we would end up having a huge row, saying you don’t do this, you mustn’t do this, etc., and he would say ‘well, she was going to leave, so we’ve done this’.”

Patient notes

10.28 David Britten did not keep notes of his interaction with patients, even though management told him at various times that he must. The consultant psychiatrist told us she was not responsible for the nurses’ record keeping. Nevertheless the consultant psychiatrist was jointly responsible for the overall clinical management of the clinic with David Britten which included the effective taking and use of reliable clinical records.

Unorthodox treatments

10.29 David Britten had also introduced ‘body image therapy’³¹ to the clinic. This was an unorthodox version of such therapy involving patients wearing revealing clothing (such as a swimming costume or a leotard) for his comment and approval. One patient went shopping for underwear with him, with the subsequent modelling of it leading to full sexual intercourse with him for the first time. Some unorthodox ‘body image therapy’ was also carried out by the physiotherapist, who also apparently wore her own swimming costume in the session as a point of comparison for the patient.

10.30 The consultant psychotherapist told us that she had experience of psychiatrists elsewhere who experienced boundary difficulties with patients. She thought David Britten needed training and supervision on this issue. She believed he thought he could cure patients using forms of therapy that she knew were

³¹ See glossary, appendix B.

ineffective. She said that she discussed David Britten with psychiatrist colleagues, and some of them thought she was not being hard enough on him.

The consultant

10.31 We interviewed the consultant psychiatrist twice during this investigation. This was because other witnesses made critical comments about her practice at the clinic after our first interview with her. We met to put these points to her and to clarify some other matters. The consultant psychiatrist told us she worked only three days a week, had a full outpatient list, and was consequently busy. She also said she had asked trust management for more support but did not receive it.

10.32 The critical comments we received from other witnesses centred mainly on the view that even though people were concerned about David Britten's practice, they could do nothing about it because the consultant psychiatrist would always defend him to management. The consultant psychiatrist denied this.

10.33 The consultant psychotherapist spoke to us about the role of the clinic consultant psychiatrist and told us that

"...when she (the consultant psychiatrist) discovered what had been going on, it was absolutely terrible, because she realised she had let it go on and she had not stopped it. That has to be a failure, but that is the damage this man has done."

In subsequent correspondence the consultant psychotherapist told us that she and the consultant psychiatrist took their concerns to their medical director, who told them it was not their business. She said to us that *"Our failure was therefore a collective one..."*

10.34 The area senior nurse told us:

"I did not pick up any specific concerns or any sense of concern from [the consultant psychiatrist]"

10.35 The service director told us:

“...what you had at Peter Dally clinic was a very strong partnership. The clinic was run on the basis of the relationship between the consultant psychiatrist and the nurse manager, the clinic manager. They were the pivotal point, managing the intake to the clinic and managing the process and it was a very powerful working relationship. I can remember talking to [the consultant psychiatrist] and her saying to me - I’m not trying to put words in her mouth but my sense was that she was saying, ‘I will not betray David, I will not say things about him.’ She had confidence in him, she believed that he wouldn’t harm a patient. I think if she had known she would have spoken about it, but she was very clear.”

10.36 As stated above, the service director said the consultant psychiatrist had told her that David Britten was not a risk to patients because he was dying and was gay. The consultant psychiatrist strongly denied that she had said this.

10.37 The first investigation (in 1998, conducted by Riverside Mental Health Trust) recorded the following evidence from the consultant psychiatrist:

“The consultant for the clinic was interviewed and in her evidence she states that she was aware that David used touch in therapy and he had shown her a book supporting this approach. She had indicated to David that she did not support this approach as it was misconceived and left one open to accusations of abuse. She was also aware that he was not receiving supervision for his clinical work and was not regularly attending team meetings”.

10.38 The consultant psychotherapist told us it was recognised in the research literature that first boundary violations were minor but soon escalated. She felt that David Britten was like a paedophile, targeting a group of adult women who were in a pre-pubertal state. She felt he would have subverted any procedures put in place because he was not someone on the “slippery slope” but a determined, predatory character.

10.39 The chief executive told us he was concerned that although the consultant psychiatrist had known about David Britten’s boundary blurring, she did nothing. She had told him that she had reported her concerns about David Britten being seen in a restaurant with a patient to the medical director of the Riverside Mental

Health Trust at the time, who had advised her to take no action. The medical director (who had retired in 1999) confirmed this to the chief executive in 2002.

10.40 Witnesses said the consultant psychiatrist had known David Britten for years. She told us they worked together for nine months when she was a junior registrar, and had also later worked together for 14 months when she was a senior registrar. They then had no contact for nine years, before there was a renewal of their working relationship when she came as a locum and then as a consultant to the Peter Dally clinic.

10.41 The consultant psychiatrist had recently been promoted to consultant when she joined the Peter Dally clinic, and this was her first post in eating disorders. She told us:

“[Britten] was helpful and willing to take on tasks and problems; he was helpful in a crisis. I remember him being particularly helpful with a patient who collapsed and nearly died - a very low weight patient. He was very skilful and helpful in dealing with this and made a significant contribution to saving her life. He was good at managing very sick, low weight patients; he was helpful when patients needed to be sectioned under the Mental Health Act. He had enthusiastic support from certain key nurses; he had the confidence and often enthusiastic support of the patients and, significantly, of many relatives. He seemed to historically have the enthusiastic support and admiration of senior and other managers in the clinic...He had good organisational skills; he was able to delegate effectively; he had a sound knowledge of anorexia and experience of dealing with difficult patients, and he had experience of dealing successfully with problems presented by relatives.”

Comments

The operation of the Peter Dally clinic was clinically unsafe during David Britten’s tenure. David Britten consistently undermined or ignored clinically appropriate systems, such as supervision groups, management meetings, clinical notes, ward rounds and procedures for reporting serious untoward incidents. He also overrode colleagues’ decisions. He did all this, apparently, without repercussions for his own position in the clinical team.

David Britten's clinical practice

David Britten was frequently seeing patients on his own, as is clear from the evidence of the patients, the service director, the consultant psychiatrist, other members of staff, and from the earlier complaints by the psychological therapies services.

The arrangements the service director agreed, that other nursing staff would record the meetings he had with patients, were clearly inappropriate. The consultant psychiatrist's evidence to us that she knew he changed patients' treatment plans without consultation and without recording it in the notes, showed insufficient regard to well established basic safe clinical practice. The failure to require this of David Britten illustrates how operational managers and senior clinical staff failed to make him account for his unprofessional behaviour.

David Britten skilfully undermined safe clinical and operational systems, but senior clinical staff, particularly the consultant psychiatrist, also failed to be alert to the possible effects of David Britten's actions and the consequent risk to patients.

Former colleagues of David Britten told us they did not realise the scale of David Britten's actions because they were involved in a limited aspect of his work only and did not see the bigger picture. We recognise this difficulty, but we believe there were sufficient single indicators that should have prompted the consultant psychiatrist and/or the area senior nurse and/or the service director either to stop him seeing patients alone, or to instigate his removal from the clinic. Some of the factors that should have led to such strong and decisive action were:

- *consistent failure to attend clinical and managerial supervision*
- *continuing to see clients for therapy when he had been instructed not to*
- *failure to keep records of meetings with clients*
- *seeing clients behind closed or locked doors*
- *overriding colleagues decisions on treatment.*

We recognise that the consultant psychotherapist and the head of psychology made considerable efforts to bring their concerns about David Britten to the attention of the management and the consultant psychiatrist. Other less influential staff also raised concerns but left themselves open to negative responses from David Britten and others that usually resulted in their leaving the unit. Arrangements to learn from their departures (such as exit interviews) were clearly inconsistent, and there was no way of them expressing their concerns apart from making a formal complaint.

It was a serious breach of good clinical practice that David Britten was permitted to represent himself as a therapist when unqualified. His line managers should have been aware of his qualifications. If they had been checked when concerns were raised about his seeing patients alone, his therapy sessions could have been stopped and his role could have been redefined. Even if he had been qualified, his failure to attend clinical supervision should not have been tolerated.

No senior clinician or manager was apparently prepared to write a memo or position statement that clearly said that touch was not allowed as part of the therapeutic work of the Peter Dally clinic. There would obviously need to be some exceptions to such a statement, such as accidents, but it should not have taken long to agree a memo or position statement and to discuss it with all staff to make sure it was followed. Furthermore, when the management advisory group finally agreed the policy on touch they did not refer it to the local ethical committee for consideration.

In any service where male staff hold one-to-one meetings with female patients good practice should be clearly set out, including meeting in a room with a viewing panel. Patients and staff meeting behind locked doors should not have been tolerated in any circumstances.

It was clearly well known that a novel form of body image therapy had been introduced at the Peter Dally clinic. The ability to introduce novel therapies without formal approval is of concern because it shows the service was not being properly managed in accordance with trust procedures.

Proper attention to boundaries was lacking in the clinic. Issues regarding boundary violations are well understood within psychiatry and the health

service, but senior clinical and managerial staff were not alert to the risks in this case and apparently tolerated blurring of the usual boundaries between David Britten and his patients.³²

We have no evidence that colleagues knew what David Britten was doing with patients but, as we say above, there were enough clues to alert his colleagues to the possibility that patients were being put at risk. In particular the consultant psychiatrist knew that David Britten:

- saw patients on his own either in a locked room, or behind a closed door, with no viewing panel*
- advocated touch as part of treatment*
- changed patient treatment decisions made in clinical meetings, without reference to other colleagues*
- did not attend clinical supervision, despite complaints from senior professional colleagues*
- did not record his interaction with patients in clinical notes.*

The consultant psychiatrist of any unit plays an important role, taking clinical responsibility for the patients in their care, and setting standards of practice and operating procedures for some aspects of the unit. Her failure to take effective action may have been partly attributable to her previous working relationship with David Britten and to her working pattern and workload, which required her to depend on David Britten to run the unit in the absence of other consultant-level cover. It was also due to her inexperience as a consultant and her reliance on his apparent expertise in eating disorders (as perceived by her and others).

Even taking into account David Britten's ability at deception and skilful concealment of his abuse over many years, together with the undoubted pressures the consultant psychiatrist faced in her role, we take the view that if she had paid more attention to her lead role in ensuring safe practice it would have been possible to take effective action against David Britten

³² We are aware that the charity WITNESS provides training for professionals in setting appropriate boundaries.

earlier. A more robust response by senior managers would have been likely if she had made it clear that David Britten's practice was unacceptable, and that he had ignored her requests to change. It is possible that abuse of some clients could have been avoided or stopped earlier if this had happened. On the contrary, most other professionals and many clients have told us that she supported David Britten, which made it more difficult for management to intervene.

11. The safety net: interaction with other agencies

11.1 Our investigation has highlighted a number of concerns about the trust's relationship with other agencies. The Central and North West London Mental Health NHS Trust did take appropriate action in dismissing David Britten, but the response of other agencies had an impact on its ability to protect the public from him. We have considered whether there is an effective safety net to protect vulnerable patients, and ensure that staff who have abused patients cannot continue to do so in another care setting. We have considered the trust's interaction with the Nursing and Midwifery Council (NMC), police and the Crown Prosecution Service (CPS) and protection of vulnerable adults scheme (POVA) to see if, in the light of these events, recommendations can be made to ensure patient safety and prevent future misconduct.

Nursing and Midwifery Council

11.2 In March 2002 the trust sent to the UKCC (now the NMC) the conclusions of its internal disciplinary hearing at which David Britten was dismissed. The complaint to the NMC included David Britten's managerial failings and was followed up, later that year, by complaints about sexual abuse from three patients when this was disclosed to the trust.

11.3 The NMC did not suspend David Britten until March 2004 (following correspondence from the trust chief executive) despite having received allegations of sexual abuse in 2002.

11.4 In July 2004 the NMC professional conduct committee held a formal hearing in David Britten's absence. David Britten had been notified of the proceedings but did not attend. He faced eight charges:

- Exceeding professional/patient boundaries with four patients.
- Engaging in sexual activity with three patients.
- Failing to record in patients' records that he had telephone contact with them.
- Conducting one-to-one meetings with patients in locked rooms.

- Failing to work in a collaborative and cooperative manner with other health care professionals.
- Consistently failing to attend multi-disciplinary team meetings.
- Acting outside his area of competence.

11.5 The NMC found him guilty of all but two charges³³ and found that his actions amounted to gross professional misconduct. David Britten was struck off the nursing register in July 2004.

11.6 We interviewed the NMC interim director (fitness to practice) and the department manager (hearings) and asked them why the NMC did not use its power of interim suspension for two years after the referral by the trust. They said that the transition from the UKCC to NMC in 2002, and a move to new hearing rules from August 2004, had created operational difficulties. They said the NMC's approach to a case like David Britten's would have been to wait for the outcome of any police investigation before arranging a hearing. However, new guidance issued since David Britten's referral has emphasised the need for the committee to consider whether there is a danger to the public. If so, the NMC should exercise its powers of interim suspension pending a full hearing.

11.7 We asked the NMC why David Britten was not suspended pending a full hearing, given that powers of interim suspension were available between 2002 and 2004. We were told that the NMC did not have access to UKCC's case records, including those for David Britten, so our question could not be answered. We asked if a search for David Britten's file could be carried out, but we were told we would not be allowed to see it anyway because it was confidential. We pointed out that this was at odds with the approach of the other public sector bodies we had interviewed in this investigation. However, our interviewees were insistent that this was the case. They agreed to answer some questions about any records they had but would not show them to us. They understood that it was difficult for us to formulate our questions without being able to see the papers.

³³ The two charges he was found not guilty of related to undertaking psychotherapeutic work outside the sphere of his competence with two clients.

11.8 We were told that if David Britten's case were to be referred to the NMC today, it would be considered in light of standard advice to any committee considering interim suspension. We have been given a copy of this advice, which includes the condition that the nurse must disclose to any employer or potential employer the fact of their suspension.

Crown Prosecution Service

11.9 We interviewed the director and the former assistant chief crown prosecutor of London south sector CPS about the decision not to prosecute David Britten after his conduct was made known to the police in 2002.

11.10 Both these witnesses had reviewed the CPS file in relation to David Britten and were willing to disclose to us (i) documents created by witnesses, subject to their consent and (ii) any file contents not subject to legal professional privilege. They were also willing to discuss the sequence of events and the reasons for the CPS's decision in David Britten's case.

11.11 David Britten was investigated by the CID in relation to offences under section 128 of the Mental Health Act 1959³⁴. The CPS decided not to recommend prosecution in light of the evidence submitted to it. There were a number of reasons for this. First, statements made by the two complainants to the trust in advance of the police investigation contained material differences to the statements they later made to the police. These included crucial details relevant to the offence alleged, such as whether sexual intercourse took place in the hospital where the complainant was being treated, or somewhere else. We have seen one of these statements with the consent of the complainant. The CPS could not succeed in a prosecution without firm evidence about this point. Second, the trust took the statements from the two complainants in the presence of each other, so there was a risk of contamination of evidence. The CPS thought this would leave it open to challenge by David Britten's defence team at a trial (although the issue of witness contamination must be a common feature in such cases where complainants know each other). We were told the CPS left the door open for more evidence about David Britten to be submitted later, but this was apparently not communicated to the trust. As a consequence, the significant additional information amassed by the trust, by the NHS Litigation Authority and by us had not been passed to the CPS.

³⁴ See appendix B.

11.12 There was a lot of correspondence between the trust chief executive and the CPS about the decision not to prosecute David Britten. However, no explanation of that decision was given to the complainants or to the trust. This may have affected the trust's view of the merit of submitting further evidence to the CPS in any event. It is now CPS policy to explain decisions like these to the complainants in sexual offence cases. This is an integral part of the Home Office "*Code of Practice for Victims of Crime*"³⁵. The CPS has confirmed it would be willing to explain its earlier decision to the complainants now if they wish.

11.13 The CPS also said that if any of the patients wanted to make a formal complaint, it was willing to review the evidence obtained during this investigation with a view to bringing a prosecution against David Britten now for offences committed while the relevant sections of the 1959 Mental Health Act were still in force. As a consequence of this offer by the CPS, three of the women involved were willing to speak to the police. They were subsequently contacted/interviewed by the police, but the police have informed us that they "*...have been unable to secure any further evidence (of the specific offence) against David Britten.*" Despite this the police have confirmed to us that any new complaints or evidence presented to them will be investigated with a view to the CPS bringing a prosecution.

*Protection of Vulnerable Adults*³⁶

11.14 The POVA register is an important way for a potential employer to discover conduct like David Britten's when there is no criminal conviction which would be revealed by a criminal records bureau (CRB) check.

11.15 In this case the CNWL trust could not have reported David Britten to POVA, because he was dismissed before this procedure began. POVA officials told us that they could not take referrals about NHS staff, unless it was for a job that required registration with the Commission for Social Care Inspection (CSCI). This was because the part of the Care Standards Act that covers the NHS has not commenced.

11.16 The NMC said they referred relevant cases to POVA, though they did not refer this one. David Britten's removal from the nursing register had been

³⁵ This code of practice was issued by the Home Secretary under section 32 of the Domestic Violence, Crime and Victims Act 2004.

³⁶ See glossary, appendix B.

publicised by the NMC in the usual way, by circulation to NHS employers and the Secretary of State. POVA officials told us there was no provision to take a referral directly from the NMC, although information could be shared on a voluntary basis. The CPS told us they would not expect to have dealings with POVA.

11.17 When we started on our investigation, any request for information to POVA by a prospective employer of David Britten's would not have revealed his dismissal and removal from the nursing register. It would therefore have been possible for him to work in a care setting (but not as a nurse) and for his employer to be unaware of the risk he presented. As a consequence of our bringing this to the attention of the CNWL Foundation Trust they have referred him to the department responsible for maintaining the POVA register to seek to have his name included.

11.18 The Safeguarding Vulnerable Groups Act comes into force in 2008 and this will extend the POVA list to include the NHS. Our understanding of these changes is that they will enable regulatory bodies such as the NMC or GMC to refer individuals found guilty of professional misconduct *after* they have ceased to work in the NHS, as was the case with David Britten, to be included on the POVA list.

Comments

We do not know whether David Britten sought or obtained work as a nurse between 2002 and 2004, but he was free to do so because he was not suspended from practice by an interim order. As a matter of public record it is important to understand why neither the NMC nor the UKCC used their powers of suspension granted for a case like this where abuse of more than one patient was alleged to have taken place over a sustained period. The NMC had power to suspend when it took over from the UKCC on 1 April 2002. Consequently we do not accept that our investigation could not be told why David Britten was not suspended given that the NMC took over the case from the UKCC and therefore had access to their records. David Britten was a danger to the public and the NMC should explain to the CHRE and the trust why it did not stop him practising as a nurse until two years after it became aware of his alleged conduct.

In its response to viewing relevant extracts of a draft of this report the chief executive of the NMC wrote us and explained that "...we have no information available to us to suggest what prompted the decision in 2004 to go for an

interim suspension, or why this was not prompted previously.” *As the NMC is a statutory regulatory body and was exercising its fitness to practice jurisdiction we find this inability to explain the delay in using its powers to suspend David Britten of concern. We are aware that there was correspondence between the chief executive of the CNWL trust and the NMC about the trust’s complaint that interim suspension had not been used. Additionally there would be minutes of the interim suspension that did eventually take place and reasons for imposing interim suspension at that stage would have been given. A failure to provide specific evidence in this case is unacceptable.*

Public confidence in patient safety depends upon on a coherent approach by the agencies involved in the detection and prosecution of abuse. The NMC has told us that “In 2003/04 the PPC considered 230 interim suspensions (this is a combination of newly-issued and three monthly reviews)”. Nevertheless in this case the ‘safety net’ failed because of the NMC’s delay. This meant that David Britten continued to pose a threat to public safety in this period.

The NMC’s failure to give us access to the UKCC and their records about David Britten is unwarranted. This investigation was given access to sensitive personal information from other sources and we believe that witnesses should have been asked permission for their statements to be disclosed (as the CPS agreed to do). We conclude that the NMC failed to take account of public safety issues when it denied us access to relevant information in this investigation.

We conclude that the CPS’s explanation of why a prosecution was not pursued in 2002 is understandable. It is unfortunate that the reasons were not explained to the trust or the women at the time but we welcome their offer to explain their reasons to the patients and the trust now. We also welcome their offer to consider whether a prosecution could still be pursued.

We welcome the changes that will allow regulatory bodies to make referrals to the POVA list.

12. How safe are services now?

12.1 In this section we look at the safety of the current eating disorders service based in the Vincent Square clinic. We are not specialists in eating disorders so we cannot compare it to other eating disorder services. Other organisations, like the Healthcare Commission, have that responsibility.

12.2 Eating disorder services are specialist services. They are few and often isolated from other NHS mental health services. They usually deal with young women who have major emotional difficulties. These factors combine to make it difficult to identify abuse in these services and protect patients from it. The context of these services must be taken into account when assessing whether services are safe.

12.3 We asked the trust for information about how the current service is run and changes they have made since the dismissal of David Britten. The trust gave us a document prepared by the clinic consultant psychiatrist of the unit (appendix C). We met with her and the trust chief executive to discuss the document.

12.4 We used the following questions to guide our review of the current service.

1. Are patients made fully aware of the boundaries of professional practice and how they can be encouraged to be open about any concerns they have about their treatment?
2. Are there clear pathways for patients to raise their concerns?
3. How can staff who have concerns about a colleague's professional practice (whatever their position) be encouraged to raise that with a manager or supervisor?
4. Is there a team approach to care or is the service dominated by an individual or professional group?
5. Are senior managers aware of the quality of service being delivered and how do they monitor the service?
6. Is the service operating as part of a wider mental health directorate and do staff from the service participate in wider trust activities?

12.5 These questions link back to the failures we identify which allowed David Britten to abuse patients for so many years. We have thought about the consequences of David Britten’s grooming methods because many of the patients tried to conceal their involvement with him. Therefore any systems and processes put in place need to have different but interrelated warning systems that are likely to reveal abuse when a patient and a professional collude to conceal it.

12.6 The trust statement mentioned in paragraph 12.3 sets out how the trust has changed and is changing the systems, policies and procedures at the Vincent Square clinic. In this section we quote extracts from that statement that answer our questions (the full text of the document is in appendix C), but believe that the whole document should be reviewed to put these selective quotes into context. We have also added comments where we believe changes may still be necessary.

Q1 Are patients made fully aware of the boundaries of professional practice and how they can be encouraged to be open about any concerns they have about their treatment?

12.7 The following quotes relate to this question:

User and Carer Empowerment section

“Service users, their families and friends are helped to actively participate in care planning meetings in outpatient, day patient and inpatient settings.”

“Staff are encouraged to discuss boundary issues with patients as part of their clinical care.”

“Copies of the NICE guidance for the treatment of eating disorders are available and accessible to patients using the service.”

“Information sheets are provided for patients describing what to expect of therapy (e.g. Cognitive Behaviour Therapy, Cognitive Analytic Therapy) or inpatient and day patient care within the service.”

Comment

Many of the patients in this investigation thought they were in love with David Britten and that he was in love with them. It is important that people close to a patient can express concerns without harming their relationship with them. The measures included in the quotes above will create a more open and transparent culture.

Q 2 Are there clear pathways for patients to raise their concerns?

12.8 The following quotes deal with this question:

User and Carer Empowerment section

“Service users and staff are encouraged to report complaints, harassment or abuse to the service management team. Service users may be helped in the process by key workers, the patient advisory and liaison service (PALs) or any other member of the team.”

“An anonymous complaints and comments box is being installed in the reception area to allow any patient or carer to raise concerns without the need for face to face interaction.”

“Families and carers of service users have the opportunity to give feedback and share concerns at the fortnightly carers group.”

Team Ethos section

“The Eating Disorders Clinical Governance Group is chaired by the Director of Operations and reports to the central Trust Clinical Governance Committee. Participation of senior staff is mandatory and external scrutiny is encouraged - there is a carer and clinical audit representative on the steering group.”

“The group ensures that systems are in place for collecting, collating and reviewing satisfaction questionnaire results, complaints, untoward incidents, staff turnover and exit interviews, audit results, national policies, feedback from visiting external agencies (e.g. MHA commission) and other key issues.”

“A culture of ‘appropriate blame’ encourages openness in reporting of concerns, complaints and mistakes, and a response that ensures patient safety and staff development.”

Trust section

“The chief executive reviews and signs formal responses to complaints”.

Comments

One element in this investigation was that patients did not know how to raise concerns and were left to raise them only with their doctors. Clear pathways for patients to raise concerns are a central feature of NHS complaint systems and patient advisory and liaison service staff (PALs) now support them and it is good to see that these systems are available in the NHS and this service.

The chief executive and the trust board should regularly review the number and type of complaints as a central part of the good governance of a trust, so that any hotspots can be identified. It is clear from the quotes below that complaints will be scrutinised by the trust governance committee, but it is important that the high-risk nature of eating disorder services is identified in the trust risk register. Furthermore, we believe that the factors set out in the paragraph below dealing with complaints should always be borne in mind. We are also informed by the trust that it was commended by the HealthCare Commission in April 2008 for its complaint-handling after a nationwide survey they conducted. The trust also told us it has a “learning from complaints group” which meets regularly to review complaints and their findings and that the lessons are fed into an organisational learning group. This is to be commended.

Q3 How can staff who have concerns about a colleague’s professional practice (whatever their position) be encouraged to raise that with a manager or supervisor?

12.9 The following quotes indicate that the trust recognises the need for more robust and effective supervision.

Team Ethos section

“Managerial and clinical supervision are provided according to Trust policy. Thus all staff, including the consultant psychiatrist and consultant psychologist, participate in regular clinical supervision of their work with patients. We are in the process of further developing the supervision structure in order to improve documentary evidence of supervision.”

“Staff are helped to better understand boundary issues and the factors that increase the risk of boundary violations through individual supervision (clinical, professional, line management) and through work in group settings, including a facilitated staff group and psychotherapy supervision groups.”

Trust section

“The trust has a ‘Whistleblowing - how to raise concerns’ policy which has been in place in its current form since 2005. It gives very clear guidance on the process and procedure for raising concerns formally as well as mechanisms for seeking senior informal advice.”

Comment

Most employees find it difficult to raise concerns about colleagues because of their anxiety that they will not be believed or may be the subject of discrimination by managers or other colleagues. In compliance with the Public Disclosure Act all NHS trusts and many other public bodies have whistleblowing policies. These policies are useful but they do not of themselves create a culture of openness. In isolated or specialist services like eating disorder services regular supervision also provides opportunities to raise concerns at an early stage, perhaps before serious boundary violations have occurred. It is important therefore that the trust rigorously ensure supervision is in place and working effectively.

Q4 Is there a team approach to care rather than the service being dominated by an individual or professional group?

12.10 The following quotes show that the trust recognises that team working is essential:

Team Ethos section

“To ensure that no single individual dominates the culture of the organisation, there is now a management team consisting of the service manager and the three senior clinicians (the consultant psychiatrist, consultant psychologist and modern matron).”

“Care planning and the rationale for treatment is shared between the multidisciplinary team (MDT), patients and their families/carers.”

“Members of the MDT share responsibility for care and the outcomes of care, reducing the risk of competition, rivalry and lone working.”

“All staff record their clinical contact in the same shared set of MDT notes - there are no separate notes kept by any individual or discipline.”

“Staff are encouraged to attend the weekly facilitated staff group, which provides an opportunity for team members to share the emotional and interpersonal experience of working as a team to provide care for patients.”

Comment

One of the clear features of this investigation was David Britten’s dominant position in managing the Peter Dally clinic. He worked alongside a consultant psychiatrist but she was only part-time and had a busy clinical workload. His two line managers were also inexperienced. As a result David Britten was able to run the clinic without close scrutiny and to conceal his abuse of patients for a long time. The Peter Dally clinic did not have a team approach to the delivery of care at any time when it was operating in its own building. As a result the team working identified in the quotes above are welcomed as effective team work is critical to providing a safe service.

Q5 Are senior managers aware of the quality of service being delivered and how do they monitor the service?

12.11 The following quotes are relevant to this question as they show a greater involvement by senior managers in the running of the clinic than existed during David Britten’s employment.

Management section

“Accountability to the Trust has been strengthened and the Director of Operations personally oversees the management of the Clinic.”

Trust section

“The Trust has implemented an Organisational Learning Group, which reports to the central clinical governance committee and examines the lessons learnt from complaints.”

“A routine user satisfaction survey is conducted by the trust.”

User and carer empowerment section

“A carer representative from B-Eat is a member of the local Clinical Governance group. A user representative is also being sought.”

Service model section

“The service aims to comply with NICE guidance for the treatment of eating disorders, and has arranged to have an external audit of such compliance (the first in the country, conducted by the national user representative body, B-Eat).”

Comments

One of the features that made it difficult to detect the abuse for so long was the location of the Peter Dally clinic in a building separate from the Gordon Hospital. This was compounded by the failure of David Britten’s line managers to visit the clinic sufficiently. We received evidence that the trust senior managers did not realise that they were not receiving serious untoward incident reports. The quotes above identify a number of areas that will help senior managers to be more aware of the quality of service being delivered.

The trust also says in its document that it is opening services to wider scrutiny by asking non-statutory agencies and organisations to review the quality of services. This scrutiny is important because it creates a more open culture that is more likely to identify boundary violations at an early stage.

All the improvements listed above are welcome and contribute to the overall safety agenda but one of the most important arrangements is for line managers and senior managers to visit services regularly. This is needed because the specialist nature of eating disorder services can be used as an excuse to allow practices and systems to develop which would not be tolerated in other mental health services. This danger is greater when a service is physically separate from other clinical services.

Q6 Is the service operating as part of a wider mental health directorate and do staff from the service participate in wider trust activities?

12.12 A danger for specialist services is that they can deliberately or unconsciously operate independently of other trust services. This isolation means that clinic staff do not benefit from the experience of colleagues from other services helping them to evaluate their practice. David Britten managed to ensure that the Peter Dally clinic was only minimally involved in trust-wide activities. The trust document has addressed this problem and tries to make sure the clinic is more open to staff from other services and that it plays its part in trust activities. The following quotes illustrate the improvements being made to address the isolation of the service.

Team Ethos section

“The eating disorder service participates in the Trust wide program of audit in addition to local clinical audit.”

“Connections outside the service have improved considerably to enhance openness and transparency.

- a. Students and junior doctors regularly rotate through the service.*
- b. Involvement of CMHTs, other professionals and carers within the clinic is very much encouraged.*
- c. The service has welcomed visits from other services and the Mental Health Act Commission (MHAC). At the last MHAC visit (12th January 2007) staff were found to be very motivated and involved in patient care.*

- d. *Consultation from others for second opinions is sought when necessary or requested by patients or their carers.”*

Comments

We have reviewed the report prepared by the trust and discussed it with the author and chief executive and visited the Vincent Square clinic. We believe that the policies, procedures and change in ethos of the unit set out in appendix C provide a significantly improved and safer service. Our discussions with the trust and its cooperation with this investigation assure us that the changes are likely to continue. We expect the trust to consider carefully the findings of this report and to supplement their operational changes with actions arising from our recommendations.

The seriousness and scale of abuse that occurred in the Riverside Mental Health Trust is such that the CNWL NHS Foundation Trust should invite a panel of external experts in eating disorders to evaluate how well the proposed changes set out in the trust document have been implemented. This recommendation is in addition to the trust’s invitation to ‘beat’ to conduct an external audit of their services which will provide a valuable user perspective and is commended as it shows the trust’s commitment to openness to external scrutiny.

We are encouraged that following discussions on drafts of this report the trust chief executive has informed us that they have commissioned a team of expert reviewers to begin a review of their eating disorder services in July 2008. They have also commissioned “WITNESS” to undertake boundary training in the trust.

The trust has reviewed the recommendations of the CHRE report “Clear Boundaries” referred to earlier and published on 10 January 2008. This guidance provides helpful advice in improving the safety of the service as well as its quality and clinical effectiveness. As a result of the trust’s review it has put in place a new policy based on the guidance produced by the CHRE.

Note on the emotional consequences of an eating disorder³⁷

Eating disorders are a serious psychiatric condition which primarily affect young women between the ages of 14-25.

Anorexia nervosa is an eating disorder characterised by a range of personality traits and behaviours. These include perfectionism and a need for control combined with very low self esteem.

Young women with anorexia nervosa can demonstrate a very compliant and eager-to-please disposition. There is a marked avoidance of conflict in all domains except in refusal to eat.

Ambivalence about the need for treatment can be very strong, even in people severely affected by the condition, and acceptance of the 'ill role' can be low. Most people, given a diagnosis of a serious, potentially life-threatening condition and admitted to a specialist hospital, would accept that they are 'ill'. This is not the case with anorexia nervosa.

The desperate fear of gaining weight can provoke behaviours which appear manipulative, such as playing clinical staff or family members off against each other - usually to avoid adhering to treatment goals that involve increasing calorie consumption. This is referred to as 'splitting' by treatment teams, and requires a great deal of vigilance to prevent it occurring.

In addition to personality traits and behaviours, anorexia nervosa affects brain function - leading to some cognitive impairment, particularly in relation to emotional state and rational thought.

Full and effective brain function requires a sustained level of nutrition, both in adequate quantity and in the nutrients which allow hormones to both be secreted and absorbed. Fats are particularly important in hormonal function, and are most likely to be severely restricted by someone affected with anorexia nervosa.

³⁷ This note was prepared by 'beat' (the working name of the Eating Disorders Association).

The brain responds to a starved state by reducing those functions which are not critical to maintain life, and these can include the capacity for abstract and rational thought. There is also a dulling of emotional state, as the hormone which regulates adrenaline requires fat to be transmitted.

This impaired brain function can produce a sense of calm. The person affected often describes feeling 'safe' by which they may mean they no longer experience the turmoil of the emotional state that may have prompted the eating disorder to develop. It is this dangerous combination of feeling safe in a physical state that is life threatening that can make the treatment of anorexia nervosa so challenging and complex.

Glossary

Splitting

Splitting in this report refers to the creation of division between groups and seeking to create loyalty to different managers/clinical teams.

H Grade

This is a senior clinical nursing grade usually given only to those holding specialist qualifications and working in a specialist area. This grade is the equivalent of a middle management grade and senior to a ward manager.

Extra- contractual referral

Extra-contractual referrals (ECRs) relates to trusts funding other trusts on a patient by patient basis for specialist services such as eating disorders, drug rehabilitation services and services for people with personality disorders.

Protection of Vulnerable Adults³⁸

The Protection of Vulnerable Adults - POVA - scheme acts as a workforce ban on those professionals who have harmed vulnerable adults in their care. It adds an extra layer of protection to the pre-employment processes, including criminal records bureau checks, which already take place and is designed to stop known abusers from entering the care workforce.

Criminal records bureau (CRB)

An executive agency of the Home Office which vets applications for people who want to work with children and vulnerable people.

Mental Health Act 1959

Section 128 sexual intercourse with patients

- (1) Without prejudice to section seven of the Sexual Offences Act 1956, it shall be an offence, subject to the exception mentioned in this section,—
- (a) for a man who is an officer on the staff of or is otherwise employed in, or is one of the managers of, a hospital to have unlawful sexual intercourse

³⁸ Part 7 of the Care Standards Act 2000

with a woman who is for the time being receiving treatment for mental disorder in that hospital or home, or to have such intercourse on the premises of which the hospital or home forms part with a woman who is for the time being receiving such treatment there as an out-patient;

This section was not repealed by the Mental Health Act 1983 but has now been repealed by the Sexual Offences Act 2003.

CNWL NHS FOUNDATION TRUST
RESPONSE TO DAVID BRITTEN INDEPENDENT INQUIRY PANEL

ENSURING A SAFE ENVIRONMENT FOR PATIENTS
VINCENT SQUARE CLINIC

October 2007

Maintaining appropriate boundaries between staff and patients is critical to the safety and effectiveness of any clinical service. Success depends upon education and empowerment of users and carers and an organisational culture in which responsibility for the task is clearly shared between individual professionals and the organisation.

User and Carer Empowerment

The Vincent Square Eating Disorders Clinic aims to treat service users with dignity and respect whilst assisting them in improving the quality of their lives and providing an opportunity to recover from their eating disorder. We believe that for care to be effective and safe, people with eating disorders must be empowered to be contributors to the quality of provision at Vincent Square and to be active collaborators in their own care. Effective communication between staff and service users is also essential.

- Service users can communicate both positive and negative aspects of their experience of care through our satisfaction questionnaire, which is currently being updated.
- Service users and staff are encouraged to report complaints, harassment or abuse to the service management team. Service users may be helped in the process by key workers, the patient advisory and liaison service (PALs) or any other member of the team.
- An anonymous complaints and comments box is being installed in the reception area to allow any patient or carer to raise concerns without the need for face to face interaction.
- Inpatients and day patients also feedback and contribute to the day to day running of the unit through community and business meetings.
- A robust system of user representation within the group of in and day patients is currently being implemented.
- Families and carers of service users have the opportunity to give feedback and share concerns at the fortnightly carers group.
- A carer representative from B-Eat is a member of the local Clinical Governance group. A user representative is also being sought.
- One of our service users sits on the Trust Board of Governors.
- Further strategies to empower users and carers and facilitating their involvement are in progress, including involvement in staff recruitment and induction.

- Assessment summaries are routinely written to the service user, rather than the referring professional (who receives a copy). All subsequent letters are either written to, or copied to service users.
- Service users, their families and friends are helped to actively participate in care planning meetings in outpatient, day patient and inpatient settings.
- Copies of the NICE guidance for the treatment of eating disorders are available and accessible to patients using the service.
- Information sheets are provided for patients describing what to expect of therapy (eg Cognitive Behaviour Therapy, Cognitive Analytic Therapy) or inpatient and day patient care within the service.
- Staff are encouraged to discuss boundary issues with patients as part of their clinical care.
- Patients are no longer encouraged to spend time at the clinic outside their specific treatment appointments or care plans.

B-Eat will undertake an audit of the service that will pay particular attention to the views of service users and carers, in addition to assessing level of compatibility with the NICE guidelines (see below).

The Service

The clinic re-opened with a new management structure, service model, and team ethos. Each has been developed specifically to ensure delivery of a safe and effective service.

Service Model

- The service aims to provide timely access to evidence-based treatments where available, and to care consistent with best practice guidelines where the evidence base is lacking.
- The supervision and management of psychological therapies has been brought back within the service.
- No treatments involving touch are recommended by the key clinical guidelines for the treatment of eating disorders (e.g., NICE, American Psychiatric Association). Therefore, none is offered by the service.
- Very occasionally, physiotherapy is provided for the treatment of associated physical health problems in debilitated patients (e.g., for treatment of neck/back problems or pressure point management), but only under medical guidance. Practice is expected to the standards of the Chartered Society of Physiotherapy.
- Male staff are accompanied by chaperones at all times when physical examinations are conducted.
- Body Image therapy is offered only in a group setting and participants remain fully clothed throughout.
- The service aims to comply with NICE guidance for the treatment of eating disorders, and has arranged to have an external audit of such compliance (the first in the country, conducted by the national user representative body, B-Eat).

Team Ethos

There is evidence to suggest that eating disorder services may be prone to a culture of abuse. We believe that an awareness of the risk and a team ethos of sharing, openness and supervision is necessary to ensure safe practice and the maintenance of appropriate boundaries. This ethos specifically targets problems identified within the previous service that may have contributed to institutional abuse. For example:

2. Care planning and the rationale for treatment is shared between the multidisciplinary team (MDT), patients and their families/carers.
3. Members of the MDT share responsibility for care and the outcomes of care, reducing the risk of competition, rivalry and lone working.
4. All staff record their clinical contact in the same shared set of MDT notes – there are no separate notes kept by any individual or discipline.
5. Staff are encouraged to attend the weekly facilitated staff group, which provides an opportunity for team members to share the emotional and interpersonal experience of working as a team to provide care for patients.
6. All doors are now fitted with observation windows.
7. A culture of ‘appropriate blame’, encourages openness in reporting of concerns, complaints and mistakes, and a response that ensures patient safety and staff development.
8. The service welcomes the opportunity that complaints provide to review and develop the service and better meet the needs of patients and carers.
 - a. Strong leadership within the service ensures that problems are addressed according to Trust policy in a timely and appropriate manner, to safeguard patient safety and quality of care.
9. The eating disorder service participates in the Trust wide program of audit in addition to local clinical audit.
10. The Eating Disorders Clinical Governance Group is chaired by the Director of Operations and reports to the central Trust Clinical Governance Committee. Participation of senior staff is mandatory and external scrutiny is encouraged – there is a carer and clinical audit representative on the steering group.
 - a. The group ensures that systems are in place for collecting, collating and reviewing satisfaction questionnaire results, complaints, untoward incidents, staff turnover and exit interviews, audit results, national policies, feedback from visiting external agencies (eg MHA commission) and other key issues.
 - b. The group scrutinises clinical protocols and provides approval only when the relevant evidence base / practice guidelines have been appropriately utilised.
11. Connections outside the service have been considerably improved to enhance openness and transparency.
 - a. Students and junior doctors regularly rotate through the service.
 - b. Involvement of CMHTs, other professionals and carers within the clinic is very much encouraged.
 - c. The service has welcomed visits from other services and the Mental Health Act Commission (MHAC). At the last MHAC visit (12th January 2007) staff were found to be very motivated and involved in patient care.

- d. Consultation from others for second opinions is sought when necessary or requested by patients or their carers.
12. Our work is open to peer review through presentation of aspects of our work at local, national and international meetings.
13. Managerial and clinical supervision are provided according to Trust policy. Thus all staff, including the consultant psychiatrist and consultant psychologist, participate in regular clinical supervision of their work with patients. We are in the process of further developing the supervision structure in order to improve documentary evidence of supervision.
14. Staff are helped to better understand boundary issues and the factors that increase the risk of boundary violations through individual supervision (clinical, professional, line management) and through work in group settings, including a facilitated staff group and psychotherapy supervision groups.
15. Appraisal is routine and conducted according to trust policy. The process ensures that the professional development needs of staff of all disciplines are regularly reviewed and personal development plans developed and pursued.
16. Continuing professional development is mandatory and the clinic has a strong record of supporting team members in pursuing further academic and clinical qualifications.
 - a. Internal training events take place within the clinic and all staff also attend Trust wide training with staff from other specialities.
 - b. The service actively encourages staff to participate in external therapy training, conference attendance, special interest group membership and professional networking to ensure the service maintains a highly trained and motivated staff as well as an outward looking culture.
 - c. In addition to central trust resources, a local training fund has been established to ensure staff have the opportunity and funding to receive externally validated training.

Management Structure

- To ensure that no single individual dominates the culture of the organisation, there is now a management team consisting of the service manager and the three senior clinicians (the consultant psychiatrist, consultant psychologist and modern matron).
- To help foster a culture of effective multidisciplinary, patient-centred working, staff groupings are focused around roles and responsibilities, rather than professional disciplines.
- Accountability to the Trust has been strengthened and the Director of Operations personally oversees the management of the Clinic.

Staffing

- Staff recruitment is conducted according to trust policy and procedures to ensure appointments are appropriate and safe.
- Interviews are multidisciplinary and external members are recruited to interview panels for all key appointments.

- All staff attend the trust induction program. Induction to the Eating Disorder Service is also provided locally by line managers. All bank and agency staff are also given mandatory local induction.
- All staff are expected to adhere to professional standards as set out through trust policy and professional bodies including nursing and medical
- Staff leaving the Trust have exit interviews and all concerns or difficulties are feedback to the management team.

The Trust

- The Trust has robust policies in place to ensure all staff are recruited, managed, supervised and appraised appropriately.
- The trust has a “Whistleblowing – how to raise concerns” policy which has been in place in its current form since 2005. It gives very clear guidance on the process and procedure for raising concerns formally as well as mechanisms for seeking senior informal advice.
- The Trust has implemented an Organisational Learning Group, which reports to the central clinical governance committee, and examines the lessons learnt from complaints.
- The Chief Executive reviews and signs formal responses to complaints.
- A routine user satisfaction survey is conducted by the trust.

National Safety Agenda

In order to prevent further incidents of institutional abuse of service users, it is important that not just our service, but all services benefit from the lessons learnt following the disclosure of serious and persistent institutional abuse at the Peter Dally Clinic. Whilst an understanding of an individual abuser can be important and helpful, the key to prevention lies in understanding the structure and culture of an organisation that may allow professional abuse to thrive. We have worked to develop an understanding of:

1. the interpersonal dynamics and behaviours that may arise in teams working with patients with eating disorders
2. how those dynamics and behaviours contribute to a context in which abuse may occur
3. the structures and staff ethos necessary to prevent boundary violations and abuse.

This work has been presented at an international conference and is being prepared for publication.

Developing greater awareness amongst service users of acceptable and unacceptable professional practice and, importantly, how to access help when exposed to unacceptable behaviour is the other cornerstone of prevention. We are keen to contribute to this task on a national as well as local level.

Copy of chapters six and seven of Safeguarding Patients - the government's response to the recommendations of the Shipman inquiry's fifth report and to the recommendation of the Ayling, Neale and Kerr/Haslam inquiries

Chapter 6 Boundary Transgressions

6.1 Both the Kerr/Haslam and Ayling inquiries concerned allegations of sexual assault on female patients over prolonged periods of time. There were significant differences in the circumstances:

- Kerr and Haslam were consultant psychiatrists and the assaults were on especially vulnerable patients suffering from mental illness who were likely to be particularly reluctant to come forward with complaints;
- in Ayling's case, the issue was over the apparently inappropriate use of intimate examinations.

But in each case there was a similar pattern of a reluctance on the part of the NHS authorities to take seriously the complaints and concerns that were raised or to entertain the possibility that a health professional could be abusing the trust of vulnerable patients in such a way. We appreciate the courage and persistence of those involved, in particular the victims of Kerr and Haslam, for bringing their experience into the public domain and for ensuring that effective action was, in the end, taken. Patients deserve better protection in the future.

6.2 Since then, the work of organisations such as Witness⁷⁴ has shown that sexual or other abuse of patients by health professionals is, regrettably, more frequent than previously supposed. Very broad-brush estimates in other countries suggest that the prevalence could be as high as 6-7% of health professionals⁷⁵. In some cases, abuse can initially manifest or be disguised as a minor infringement of the proper "boundaries" of trust which should exist between professional and patient, and then progress imperceptibly to more serious abuse. For this reason, it is now common to treat abuse as an extreme form of "boundary transgression".

6.3 Determining policy and ethical principles in this area therefore needs to start with a careful definition of what should be the proper boundaries between professional and patient. In doing so, a difficult balance needs to be struck – allowing professionals to show patients empathy, respect, support and reassurance, but ensuring that this remains within the proper boundaries of the relation between professional and patient and does not risk an inappropriate and possibly damaging emotional attachment on either side.

Guidance on boundary transgressions and sexualised behaviour

Development of guidance

Ayling Inquiry para 2.30: The DH [should] convene an expert group under the auspices of the Chief Medical Officer to develop guidance and best practice for the NHS on this subject. The group should include the NHS Confederation, the RCOG, the RCGP (and other Colleges as appropriate, such as the Royal College of Psychiatrists), NCAS, CHRE, GMC and representatives of undergraduate and postgraduate medical education. The group should take advice from experience of dealing with sexualised behaviour elsewhere in the public sector such as educational services and from health care systems in other countries such as Canada.

Kerr/Haslam Inquiry p27: The Secretary of State, within 12 months of the publication of this Report, should convene an expert group to develop guidance and best practice for the NHS on boundary setting, boundary transgression, sexualised behaviour, and all forms of abuse of patients, in the mental health services.

p28: The terms of reference of the expert group should not be restricted to sexualised behaviour between psychiatrists (or other mental healthcare professionals) and current patients, but should also address former patients.

p26: All Trusts should develop, within their Code of Behaviour, guidance to reduce the likelihood of sexualised behaviour, that is incorporated into the contracts of employment of those staff, or contracts of engagement for all other persons providing mental health services within the NHS.

p27: The NHS should convene an expert group to consider what boundaries need to be set between patients and mental health staff who have been in long-term therapeutic relationships, and how those boundaries are to be respected in terms of guidelines for the behaviour of health service professionals, and the provision of safeguards for patients.

p27: Detailed, and readily accessible, guidance should be developed for medical professionals. The guidance should be framed in terms which address conduct which will not be tolerated and which is likely to lead to disciplinary action. Such guidance, if not provided at a professional regulatory level, should be supplemented by the NHS at an employment level.

p27: Policies should be developed that enable health workers to feel able to disclose feelings of sexual attraction at the earliest stage possible without the automatic risk of disciplinary proceedings. Colleagues must also feel able to discuss openly and report concerns about the development of attraction/overly familiar relationships with patients. These policies should include all grade levels, including consultant.

6.4 The Government has invited CHRE to lead a project involving all relevant stakeholders – including voluntary organisations, healthcare and professional regulatory bodies, NHS and professional organisations – to develop a comprehensive suite of guidance in this area.

The CHRE project will, among other things:

- produce detailed guidance for health professionals agreed by all the health professions regulators on boundary violations, including definitions of abuse and a discussion of risk behaviours in relation to their clinical context. This will build on and harmonise guidance already issued by individual regulators⁷⁶. Guidance will set out agreed principles to define the proper boundaries which should be observed between professionals and patients and covering issues such as social and financial relationships, growing emotional attachment, and the period of time which must elapse after the end of a therapeutic relationship (if ever) before these precautions can be relaxed;

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- develop guidance for members of the professional regulators' fitness to practice panels on the appropriate sanctions for different degrees of boundary violations;
 - develop information for patients to raise their awareness of professional boundary issues, with particular attention to the special needs of vulnerable groups;
 - building on the previous three publications, develop guidance for NHS and other healthcare employers on how to prevent, detect and investigate boundary violations, and how to respond effectively to patients' complaints in this area;
 - develop educational standards on boundary issues for adoption into pre-registration training and continuous professional development for all health professionals; and
 - review current research to determine the profile of perpetrators and possible predictors of abuse.

CHRE has been asked to complete this work by summer 2007.

Research on prevalence

Kerr/Haslam Inquiry p28: There should be detailed research carried out and published by the Department of Health to show the prevalence of sexual assaults, sexual contact, or other sexualised behaviour, between doctors and existing and/or former patients – particularly in the field of mental health.

p28: The Department of Health should urgently investigate and report upon the need for a coordinated method of mandatory data collection and mandatory recording, in relation to the area of abuse of patients by mental healthcare professionals.

6.5 As already noted, the CHRE project will review current research on the profile of people perpetrating boundary violations. **In the light of this review the Department of Health will consider whether to commission further comprehensive research on the prevalence of sexualised behaviour.** In the meanwhile, we will encourage the regulators to carry out a retrospective analysis of recent fitness to practise cases to determine in what proportion this has been a factor. All patient safety incidents, including abuse of patients by health professionals, should be reported to SHAs through the standing arrangements for serious untoward incidents. Once the CHRE project has completed its work **the Department of Health will consider whether the information received from these reports could be further categorised so as to allow routine analysis of this kind.**

Guidance to employers on handling allegations

Kerr/Haslam Inquiry p25: The Department of Health should develop and publish a specific policy, with practical guidance on implementation, to guide NHS managers in their handling of allegations or disclosure of sexualised behaviour. The policy should address the various issues and difficulties set out above and include examples of good practice, as well as the extended range of options for action that could be applied; where advice and assistance can readily be provided; guidance on record-making and keeping. The guidance should also include a range of preventative measures (for example, specific accessible information for patients on what they should and should not expect in consultations, and who they can speak to for confidential advice and assistance).

p32: Where possible, the NHS should give clear advice and guidance on employment protocols following allegations of abuse.

p34: Within 12 months of the publication of this Report the Department of Health should develop and publish national advice and guidance to Primary and Secondary Health Care Trusts addressing the [action to be taken by staff on the] disclosure of sexual, or other, abuse by patients or other service users, with particular emphasis on users of mental health services.

6.6 The Government accepts these recommendations and is asking CHRE to progress them as part of the project referred to in para 6.4 above.

Advocacy services

Ayling Inquiry para 2.34: We therefore recommend that accredited training should be provided for all PALS officers in this potential aspect of their work [complaints relating to sexualised behaviour], and that SHAs should require confirmation from each NHS Trust in their area of the completion of such training within the next 12 months.

Kerr/Haslam Inquiry p26: In relation to disclosures of alleged abuse, voluntary advocacy and advice services (independent of the NHS) should be supported by central public funding to offer advice and assistance to patients and former patients (particularly those who are mentally unwell, or who are otherwise vulnerable).

6.7 The Government agrees the importance of training for PALS officers in dealing with issues of alleged sexualised behaviour. The National PALS Development Group has developed a template to help SHAs establish local training needs.

6.8 Patients or their representatives who wish to raise complaints already have access to support from ICAS staff (see para 5.19 above). As a general principle, the Government believes that it is better to strengthen the competency of staff working in existing complaints advocacy services than to set up parallel arrangements for particular groups of patients.

6.9 The voluntary organisation Witness (see para 6.2 above) has already delivered training in issues relating to sexualised behaviour to mixed groups of some 60 ICAS and PALS staff, and this training has now been rolled out to many more staff nationwide. The service specification for the delivery of ICAS services now requires the provision of training in these issues.

Chaperoning policies

Ayling Inquiry para 2.58: We recommend that no family member or friend of a patient should be expected to undertake any formal chaperoning role. The presence of a chaperone during a clinical examination and treatment must be the clearly expressed choice of a patient. Chaperoning should not be undertaken by other than trained staff: the use of untrained administrative staff as chaperones in a GP surgery, for example, is not acceptable. However the patient must have the right to decline any chaperone offered if they so wish.

Para 2.59: Beyond these immediate and practical points, there is a need for each NHS Trust to determine its chaperoning policy, make this explicit to patients and resource it accordingly. This must include accredited training for the role and an identified managerial lead with responsibility for the implementation of the policy. We recognise that for primary care, developing and resourcing a chaperoning policy will have to take into account issues such as one-to-one consultations in the patient's home and the capacity of individual practices to meet the requirements of the agreed policy.

6.10 Comprehensive guidance on chaperoning for PCTs and primary care health professionals, covering these and other points, was issued by the Clinical Governance Support Team in June 2005⁷⁷. The basic principles are applicable to health professionals working in all settings, **but the Government will discuss with the health professions regulators and with NHS Employers whether specific guidance on chaperoning in secondary care settings would be helpful.**

Ayling Inquiry para 2.60: Reported breaches of the chaperoning policy should be formally investigated through each Trust's risk management and clinical governance arrangements and treated, if determined as deliberate, as a disciplinary matter.

6.11 The Government agrees and will ask CHRE to draw this recommendation to the attention of all healthcare organisations as part of the suite of guidance described at para 6.4 above.

Chapter 7

Particular Issues In Mental Health Services

7.1 The problem discussed in the previous chapter – finding the right balance between giving patients reassurance and support while respecting the proper boundaries between professional and patient – is especially acute in mental health services.

7.2 Patients with mental illness are particularly vulnerable. Compared with other patients, they may be the least likely to be able to enter into an informed discussion with health professionals on treatment options and the most uncritical of the treatments proposed. Many patients with mental illness, particularly with chronic conditions, are at risk of becoming excessively dependent on their therapist and of forming an emotional attachment (which they may believe is reciprocated). Given all this, health professionals treating mental illness need to take particular care to maintain professional boundaries and to avoid any behaviours which could be misinterpreted or which could inadvertently harm their patients.

7.3 Where issues arise, patients with mental illness may also have particular difficulty in raising concerns – and when they do pluck up courage, they may well not be taken seriously. In the Kerr/ Haslam case, it took the courage and persistence of a small number of victims over many years before the authorities took effective action. Once the issues came out in the open, a number of additional victims were encouraged to come forward who had previously kept silent either out of fear or out of a reluctance to re-open old wounds. PCTs and employers therefore need to show particular sensitivity in investigating allegations in this field.

7.4 This chapter looks at the recommendations of the Kerr/Haslam inquiry relating to the specific issues of mental health services.

Patient confidentiality

Kerr/Haslam Inquiry p26: Trusts' confidentiality policies should include a section on disclosure within therapeutic interactions in psychiatric practice and should be supported by inter-agency information-sharing policies to be used in all cases of patient abuse.

p27: The Secretary of State, within 12 months of the publication of this Report, should commission and publish guidance and issue advice and instruction (preferably in consultation with the professional regulatory bodies and healthcare Colleges) as to the meaning and limitations of patient confidentiality in mental health settings. Such guidance should be kept under regular review.

7.5 Guidance on the protection of vulnerable adults in health and social care settings makes clear the responsibility of all health and social care workers to report allegations of abuse, even if the information is disclosed in a therapeutic setting.⁷⁸ Health and social care organisations in turn are required to join in multi-agency arrangements and to take appropriate action to protect patients and the public⁷⁸, including where appropriate referring care workers who have been responsible for abuse to be included in the Protection of Vulnerable Adults (POVA) list⁷⁹.

7.6 The Government however recognises that some health professionals may be still be uncertain about the implications of patient confidentiality in relation to such allegations. **The Government therefore accepts in principle that further guidance on information sharing in mental health services would be helpful and is already working with the Royal College of Psychiatrists, the Information Commissioners and voluntary organisations to develop such guidance.** We expect to be able to publish the guidance in the spring.

Advocacy and advice

Kerr/Haslam Inquiry p30: Health and social care commission[er]s should resource independent mental health advocacy as a priority.

p31: The Department of Health should introduce permanent arrangements for the provision of independent advice for mental health patients.

7.7 Para 5.19 above has already referred to the important role which ICAS plays in advising patients who wish to raise a complaint or a concern; ICAS is specifically tasked with providing specialist advocacy support for patients least able to pursue a complaint for themselves; and the majority of ICAS advocates have now received training in the special needs of patients suffering from mental illness. In the Department's view, it would be better to reinforce the skills of ICAS advocates in helping patients with a variety of needs, rather than to superimpose a different set of arrangements just for patients with mental illness.

Supervision of consultant psychiatrists

Kerr/Haslam Inquiry p33: The Department of Health in association with NIHME [the National Institute for Mental Health in England] and the Royal College of Psychiatrists should publish guidance in relation to clinical supervision of consultant and career grade psychiatrists.

7.8 The Government does not accept that the risks associated with autonomous clinical practice are different in kind in psychiatry from those in other clinical disciplines, or that consultant psychiatrists should be subject to clinical supervision. The general safeguards described in this document and in *Trust, assurance and safety* – in particular, strengthened clinical governance, a robust system of revalidation, and closer links between local clinical management and national regulators via the proposed GMC affiliates – should be sufficient to ensure that any poor practice or deliberate abuse is rapidly identified and dealt with, in psychiatry as in other disciplines.

Intervention by regulators

Kerr/Haslam Inquiry p33: Any deviation from acceptable practice [in applying the principles of the new disciplinary framework for doctors] in mental health services should be identified by the relevant statutory regulatory body and, where appropriate, by Monitor, and a standard, fair and transparent set of rules governing conduct of all mental health NHS staff in all NHS bodies and Foundation Trusts be quickly established.

7.9 Trust boards, in mental health services as in other specialist trusts, have the primary responsibility of ensuring that good practice in relation to the new disciplinary framework for doctors is applied throughout the trust. Where the Healthcare Commission identifies any significant deviations in the course of its annual assessment of a trust, or in the course of an ad hoc investigation, we would expect it to draw this to the attention of the trust board and to Monitor or the SHA as appropriate. A prolonged failure to establish satisfactory disciplinary systems might well all the trust's registration into question, under the new regulatory framework described in *The future regulation of health and adult social care in England* (see para 2.5 above).

Education and training

Kerr/Haslam Inquiry p34: The GP curriculum should be reviewed to ensure that sufficient focus is given to the needs, treatment and care of patients experiencing mental health problems and illnesses and that all GPs should have some exposure to psychiatry.

p34: Mental health issues should be part of the NMC Foundation Year 2.

p34: The NHS should review the curriculum content – at all education and training levels – to ensure that medical practitioners are able to undertake appropriate cross-sector working (including within NHS ie primary/secondary boundary) as part of their practice.

7.10 The Department is sympathetic to these recommendations and will discuss them with the health professions regulators and with professional and educational interests. Training and continuous professional development for health professionals increasingly recognises the need to work across sectoral boundaries, especially in community settings and in caring for patients with longer term conditions. However, we will discuss with professional and educational interests what more could be done to promote this kind of cross-boundary working.

Council for Healthcare Regulatory Excellence
Clear Boundaries project

The Clear Boundaries project was set up at the request of the Department of Health and was undertaken by the Council for Healthcare Regulatory Excellence (CHRE). It was commissioned as a result of a number of high-profile inquiries that had a common feature of sexual abuse of patients by doctors. We summarise three of these below. The report of the Clear Boundaries project is available on the CHRE website but we include extracts of the report in this appendix as it has a relevance to this investigation and deals with some aspects of our terms of reference.

Clifford Ayling, Peter Green and Kerr/Haslam Inquiries

(The following information was taken from the WITNESS web site)

“Ayling

Kent GP Clifford Ayling was convicted of sexually assaulting women patients over a number of years.

Peter Green

On 10 July 2000 Peter Green, a GP from the Pinfold Gate practice in Loughborough was convicted on nine counts of indecent assault on five patients. The conviction was the culmination of concerns raised over a period of twelve years and followed three separate police investigations.

Kerr/Haslam

The inquiry reported on July 18th 2005. It is almost a thousand pages long and made 74 recommendations. It found serious failings on the part of local health authorities and concluded ‘that substantial risks remain that patients and staff who raise concerns or complaints will not be heard, and we are not persuaded that their concerns will even now, in 2005, be speedily and appropriately addressed.’”

(This section on the Kerr/Haslam inquiry is an extract from an article written in the Psychiatric Bulletin by Dr Peter Kennedy at the time of writing he was vice-president of the Royal College of Psychiatrists)

“By the time police investigations and the Inquiry were complete, a total of 67 patients had declared themselves victims of William Kerr and at least 10 of Michael Haslam. Kerr was convicted in 2000 on one count of indecent assault. He was considered too ill to face trial but was convicted on trial of the facts. Haslam was convicted on four counts of indecent assault in 2003 and was given a 3-year prison sentence.

Background

William Kerr was disciplined in the mid-1960s when a psychiatric registrar in Northern Ireland for allegedly having sexual intercourse in his car with a teenage patient whom he told needed this for her therapy. He was advised to leave the province if he wished to continue a medical career. He was able to obtain a post in York, then promotion to consultant without the disciplinary history being passed on to his new employer. There followed year-by-year (over the 1970s and 1980s) reports of repeated sexual incidents with patients. A few were alleged at the time but most not until 10-20 years later when the publicity of a police investigation gave patients courage to come forward with the knowledge that they were not alone. The alleged incidents generally occurred during domiciliary visits or out-of-hours consultations at isolated hospital sites. Patients reported that Kerr exposed himself and ‘invited’ sexual acts - often masturbation or oral sex, but in some cases full sexual intercourse. Kerr’s ability to make patients comply with his wishes left them feeling confused and with guilty feelings that inhibited complaints at the time.

Michael Haslam’s patients described more subtle grooming which led gradually to sexual intimacy that sometimes became consensual for periods of time. Grooming included prolonged interviews, over-detailed sexual inquiry, self-disclosure, social meetings, and supposedly affectionate touching and hugging. Patients were made to feel special by being recruited for ‘research’ using a Kirlian camera to detect their ‘hand auras’. Unorthodox ‘therapies’ were given which included Somlec (weak electrical application to the temples), carbon dioxide inhalation for relaxation and un-chaperoned whole body massage. All these were predominantly for younger female patients and, again, were often given out of hours in isolated hospital locations or private practice rooms.”

Extracts from the Clear Boundaries Project Reports
Published by the Council for Healthcare Regulatory Excellence
10 January 2008

The Council for Healthcare Regulatory Excellence (CHRE) published the following reports:

- Clear sexual boundaries between healthcare professionals and patients: responsibilities of healthcare professionals

- Clear sexual boundaries between healthcare professionals and patients: Guidance for fitness to practice panels

- Clear sexual boundaries between healthcare professionals and patients: A report on education and training

- Sexual Boundary Violations by health professionals - an overview of the published empirical literature

These documents provide helpful and timely advice to the healthcare professions on professional boundaries. The documents are not over long and provide practical guidance which if followed should help to heighten the awareness of health professions to difficulties that for too long have been considered a marginal problem. What can be seen from the overview of the published empirical literature is that the occurrence and impact of boundary violations is far from marginal.

The following quotes have been extracted from the report as they are linked to an aspect of this investigation.

**Clear sexual boundaries between healthcare professionals and patients:
responsibilities of healthcare professionals**

Context from the David Britten investigation

It is clear that David Britten exploited his position not only with the patients he abused but also because he was acknowledged by a number of his co-workers as a “specialist in eating disorders”. In addition a number of the abusive relationships he conducted continued when the patients were formally discharged.

Quotes

Page 3

“Acknowledging the power imbalance

An imbalance of power is often a feature in the healthcare professional/patient relationship, although this may not be explicit. Patients are often vulnerable when they require healthcare, and healthcare professionals are in a position of power because they have access to resources and knowledge that the patient needs. A power imbalance may also arise because:

- *in order to be diagnosed or treated a patient may have to share personal information*
- *a healthcare professional influences the level of intimacy and/or physical contact during the diagnostic and therapeutic process*
- *a healthcare professional knows what constitutes appropriate professional practice whereas a patient is in an unfamiliar situation and may not know what is appropriate.*

It is the responsibility of healthcare professionals to be aware of the potential for an imbalance of power and to maintain professional boundaries to protect themselves and their patients.”

“Sexual activity with former patients or their carers

Sexual relationships with any former patient, or the carer of a former patient, will often be inappropriate however long ago the professional relationship ended. This is because the sexual relationship may be influenced by the previous professional relationship, which will often have involved an imbalance of power as described above.

The possibility of a sexual relationship with a former patient may arise, for example through social contact. If a healthcare professional thinks that a relationship with a former patient might develop, he or she must seriously consider the possible future harm that could be caused and the potential impact on their own professional status. They must use their professional judgment and give careful consideration to the following:

- *when the professional relationship ended and how long it lasted*
- *the nature of the previous professional relationship and whether it involved a significant imbalance of power”*

Clear sexual boundaries between healthcare professionals and patients:

Guidance for fitness to practice panels

Context from the David Britten investigation

These quotes provide a useful perspective on how boundary violations impact on vulnerable patients and provide a profile of someone who has become a systematic abuser, which was the case with David Britten. The advice on the effect of abuse on patients’ abilities to give evidence is not only useful to Fitness to Practice panels but also those conducting trust internal investigations and independent investigations.

Quotes

Page 2

“FtP³⁹ panels need to be aware of certain critical factors when adjudicating cases involving sexual boundary breaches. These include the following:

- sexual boundary breaches commonly involve vulnerable people*
- healthcare professionals who breach sexual boundaries tend to abuse more than one patient, and use strategies such as minimisation, normalisation and denial when challenged about their behaviour*
- contrary to stereotypes, healthcare professionals who abuse patients may be personable and charismatic, highly regarded by their colleagues and held in high esteem by other patients*
- confusion about boundaries can impair clinical judgement*
- patients themselves may have a poor sense of appropriate boundaries. Setting boundaries is important for the protection of the professional as well as the safety of the patient.”*

Page 3

“The effects on patients and carers of breaches of sexual boundaries by healthcare professionals

Research literature demonstrates a widespread acknowledgment that sexual boundary transgressions are damaging to patients and carers. A number of qualitative³ studies have been carried out to explore the impact of such transgressions. These show that patients can experience considerable and long-lived harm.

The negative impact can be exacerbated by young age and a previous history of sexual abuse in the patient. The harms caused can include:

- post traumatic stress disorder and distress*
- major depressive disorder*
- suicidal tendencies and emotional distrust*

³⁹ FtP are fitness to practice panels of regulatory bodies which deal with complaints against their registrants.

- *high levels of dependency on the offending professional, confusion and dissociation*
- *failure to access health services when needed*
- *relationship problems*
- *disruption to employment and earnings*
- *use and misuse of prescription (and other) drugs and alcohol.”*

Page 4

“Research findings

Panel members should be aware of relevant research findings⁴ which show:

- *significant evidence of under-reporting of sexual boundary transgressions. The absence of further complaints does not necessarily mean the absence of offending behaviour*
- *that abusers commonly have a pattern of acting abusively. Healthcare professionals who display sexualised behaviour towards patients may also be the subject of complaints by members of staff towards whom they have acted inappropriately*
- *common tactics deployed by healthcare professionals who are accused of abuse include minimisation, normalisation, blaming the patient and rationalisation. This may take the form of justifications including: “the patient came on to me”, “she started it”, “I fell in love with the patient”, “I was going through a hard time and the patient really understood me”*
- *that most abusers are male and most victims are female, although there are reported examples of females abusing males and of same sex abuse.”*

Page 4

“How the experience of abuse can affect the ability of a witness to give evidence

For most complainants, bringing a complaint requires courage and fortitude. Panel members need to appreciate that all witnesses giving evidence will be nervous. Giving evidence in a quasi-judicial setting can be highly intimidating for any witness and requires courage and support. Patients or carers who have been abused may find giving evidence particularly difficult. Being cross-examined and

accused of lying can be especially traumatising for people who have been previously abused and have had experience of being disbelieved.

For this reason regulators must take particular care to ensure that vulnerable witnesses are adequately supported and that proceedings are conducted in a way that will elicit the best evidence possible from vulnerable witnesses. Most regulators have statutory provisions in place to facilitate the giving of evidence by vulnerable witnesses. These provisions should be made available to panel members. Some regulators are exploring the use of victim impact statements as a way of allowing complainants, who may not be able or willing to give evidence, an opportunity to be heard. These should be seen as one of a number of ways of making complainants feel that they have a meaningful role in the process. Complainants should be kept informed of what is happening in the case. Particular care should be taken in the language used to communicate with complainants who may be particularly vulnerable.

Advocates for the defence will wish to promote their client's case as strongly as possible. This may include cross-examining vulnerable witnesses in a way that they will find distressing. Panel chairs need to halt a line or style of questioning which they feel is inappropriate or improper.

When an allegation of sexual misconduct is made, it will often be a case of the patient's word against the healthcare professional's. The absence of corroboration may make it harder to establish that abuse has taken place. The Kerr-Haslam inquiry identified the difficulties that patients suffering with mental health problems can have in being believed⁵.

Research shows that people who have been seriously abused respond in a number of ways that may have a bearing on how they appear as witnesses before FtP panels. Dissociative identity disorder (DID) is a common symptom of having been sexually abused. This may result in complainants becoming frozen or withdrawn under stress, and appearing to lose concentration whilst giving evidence. Victims of abuse may also demonstrate passive compliance or learned helplessness, or blame themselves for what has happened. In short, witnesses may not present as strongly as panel members might expect, given the nature of their allegations.

Abused patients may, alternatively, present as hostile and angry with a disdain for authority and misgivings as to whether they will get a fair hearing. Panel members need to bear this in mind when evaluating a witness's demeanour and the reliability of their evidence.

Panel members need to appreciate that a complaint may not have been lodged immediately. It may be several years before the complainant came forward. This is entirely consistent with a post-traumatic shock disorder diagnosis, and may be exacerbated if the patient has previous experience of abuse. It may take many years for a patient to be able to pin-point the source of their problems, or to appreciate that what they experienced constituted abuse. This needs to be borne in mind if a professional raises in mitigation that no other complaints have been raised in the years since the alleged events.”

Contact details of support organisations

WITNESS

WITNESS is a charity exclusively concerned with breaches of trust in professional relationships. It works with organisations to improve public protection and support people whose trust has been broken. WITNESS runs a helpline, support and advocacy services, provides professional boundaries training and undertakes research and policy work.

Jonathan Coe
Chief Executive
Delta House
175-177 Borough High Street
London
SE1 1HR

Telephone: 0207 9399920
Fax: 0207 0399901
Email: info@witnessagainstabuse.org.uk
Website: www.witnessagainstabuse.org.uk

‘beat’ (working name of the Eating Disorders Association)

‘beat’ is a national charity based in the UK providing information, help and support for people affected by eating disorders and, in particular, anorexia and bulimia nervosa.

Susan Ringwood
Chief Executive
First Floor
Wensum House
103 Prince of Wales Road
Norwich
NR1 1DW

Telephone: 0870 770 3256
Fax: 01603 664915
Helpline: 0845 6341414
Email: help@b-eat.co.uk
‘beat’ youth line: 0845 6347650
Email: fyp@b-eat.co.uk
Website: www.b-eat.co.uk

Central & North West London NHS Foundation Trust

Claire Murdoch
Chief Executive
2nd Floor
Greater London House
Hampstead Road
London
NW1 7QY

Telephone: 020 3214 5761
Helpline number: 020 3214 5760

Public Concern at Work (PCaW)

Public Concern at Work is a whistleblowing charity. Established in 1993, and has led a new approach to whistleblowing that - both at home and abroad - recognises the key role it can play in anticipating and avoiding serious risks that arise in and from the workplace.

PCaW:

- offers free, confidential advice to people concerned about crime, danger or wrongdoing at work
- helps organisations to deliver and demonstrate good governance
- informs public policy
- promotes individual responsibility, organisational accountability and the public interest.

Public Concern at Work
Suite 301
16 Baldwins Gardens
London EC1N 7RJ

Telephone: 0207 404 6609
Fax: 0207 404 6576
Email: whistle@pcaw.co.uk
helpline@pcaw.co.uk

Biography - Dr Peter Dally

Dr Peter Dally, psychiatrist, born January 2, 1923 - died June 25, 2005, aged 82.

Dr Peter Dally had a distinguished career and made many major contributions to the development of psychiatric approaches to eating disorder services. He wrote or co-wrote textbooks on anorexia nervosa and a number of other psychiatric textbooks.

In 1961 he was appointed as a consultant psychiatrist at Westminster Hospital, a post he held until his retirement in 1988. He gave his name to a clinic for eating disorders when it opened in October 1996. The clinic was renamed as the Vincent Square clinic in the light of the events described in this report. Dr Dally said he understood this decision.

The Times and the Independent published obituaries when he died in 2005.

Documents submitted to or reviewed by the investigation team⁴⁰

- Correspondence with Peter Dally clinic deputy manager
- Correspondence with Harman and Harman Solicitors
- Correspondence with RadcliffesLeBrasseur
- Correspondence with North West London Strategic Health Authority
- Correspondence between CNWL trust and the Crown Prosecution Service
- Documents from the trust board meeting (Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust)
- David Britten's personal file
- Transcript from David Britten's professional conduct hearing (5 - 7 July 2004)
- Letter to David Britten regarding the outcome of the disciplinary hearing
- Report into investigation of allegations against David Britten (Riverside Mental Health Trust, 1998)
- Management inquiry into the Peter Dally clinic
- Trust disciplinary investigation report and related documents
- Independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling
- The Kerr/Haslam inquiry
- Learning from tragedy, keeping patients safe - overview of the government's action programme in response to the recommendation of the Shipman inquiry
- Committee of inquiry to investigate how the NHS handled allegations about the performance and conduct of Richard Neale
- The government's response to the recommendations of the Shipman inquiry's fifth report and to the recommendations of the Ayling, Neale and Kerr/Haslam inquiries
- Reports of Mental Health Act Commission visits to Vincent Square clinic
- Peter Dally clinic operational policy (September 1999)
- The protection of vulnerable adults - multi-agency policy and procedures (City of Westminster)

⁴⁰ This list is not exhaustive but identifies the principal documents referred to by the investigation team.

- Employees Guidance on Protection of Vulnerable Adults List, Department of Health
- Protection of Vulnerable Adult scheme in England and Wales for adult placement schemes, domiciliary care agencies and care homes
- Eating disorders - core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders (National Institute for Clinical Excellence)
- With safety in mind: mental health services and patient safety (National Patient Safety Agency)
- Clinical governance review (Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust)
- Clear boundaries project - launch of a national network (Council for Healthcare Regulatory Excellence)
- Clear sexual boundaries between health professionals and patients
- NHS psychotherapy services in England, summary of strategic policy (NHS executive)
- Policy: information for detained patients (Central and North West London Mental Health NHS Trust, 2000)
- Policy: raising concerns (Brent, Kensington & Chelsea and Westminster Mental Health NHS Trust, 2001)
- Whistleblowing - how to raise concerns policy (Central and North West London Mental Health NHS Trust, 2005)
- Anonymised record of calls taken by the CNWL helpline
- Chronology of key events
- Chronologies of various former patients
- Psychological reports
- Interview transcripts
- Details of investigation by Remington Hall
- Information from Eating Disorders Association 'beat'
- Food and Violence (Psychoanalytic Psychotherapy (2001) Vol 15 No3 225-242)
- Letters regarding David Britten's suspension
- Press articles
- Trust document "Ensuring a safe environment for patients - Vincent Square clinic, October 2007"

Investigation panel biographies

Verita is a specialist consultancy conducting investigations, reviews and inquiries in the public sector in the UK.

Alison McKenna was appointed as an associate with Verita in 2006. In June 2008 she took up appointment as the first president of the Charity Tribunal. She was called to the Bar (Middle Temple) in 1988, and since 2003 has had dual qualification as a barrister and solicitor advocate. She is a former head of the charities department at Wilsons LLP, a Salisbury based law firm. Before this she was an in-house legal adviser to the Charity Commissioners. In 2002 she was appointed to the judicial post of a president of the Mental Health Review Tribunal, and she was a member of the Mental Health Act Commission between 1995 and 2002. Her other posts include legal adviser for the Registrar of Criminal Appeals and an investigator for the Local Government Ombudsman.

Tariq Hussain is a senior consultant with Verita. He is a former nurse director with qualifications in mental health and learning disabilities nursing with a MA in philosophy and health care (Wales). Tariq has considerable experience of leading change management in the fields of learning disability and mental health. He gained extensive experience of investigations and tribunals as the director of professional conduct at the UK Central Council for Nursing, Midwifery and Health Visiting (now the Nursing and Midwifery Council), and for eight years as a non-executive director of a mental health trust with lead responsibility for complaints and co-lead for serious untoward incident investigations. He is also a panel member of the disciplinary committee of the Royal Pharmaceutical Society of Great Britain.