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ACTUALITY IN HOSPITAL

SAM: We are now approaching Suffolk Ward, which is one of acute psychiatric wards that we've got here. To enter we have got this intercom system, so we press [BEEP]. Can we get in please?

O'HALLORAN: So the importance of these double doors is that they're normally locked, right?

SAM: Yes, normally locked, yes.

O'HALLORAN: And security is quite important on the ward?

SAM: Very much so.

O'HALLORAN: An in-patient psychiatric ward. The people who are treated here are suffering from acute mental illness. But mental health charities and senior nurses warn that staff are often so overstretched they have little time to care for the patients. And mistakes can sometimes happen.

ACTUALITY ON PSYCHIATRIC WARD

O'HALLORAN: And do your patients ever manage to get out of here, those who are detained and should be kept here? Do they ever manage to get through?

SAM: They do and at times they do succeed in getting through. It happened three days ago where a patient's relative pressed the buzzer and this patient just ran out of the ward.

O'HALLORAN: Did you get that patient back?

SAM: The patient's still in the community.

O'HALLORAN: That ward seemed bright and well-run and the patients expressed confidence in the staff. But elsewhere conditions are said to be grim and care sub-standard in some units. File on 4 investigates events at three psychiatric hospitals which suggest that understaffing or lack of training - or both - could be endangering staff and even costing the lives of patients.

SIGNATURE TUNE

ACTUALITY AT LEISURE CENTRE

O'HALLORAN: At the end of a busy day, a game of five a side football or squash here at the St Mary's Leisure Centre in Southampton, is the perfect way to unwind. And so it was in the past for 29 year old Matthew McDonald. When the centre's future was under threat early last year, he went on a protest march and campaigned – successfully – with others against its closure. It was one of a number of causes that Matthew McDonald joined on behalf of others. But he did so against the background of a much bigger battle in his own life, against the demons and delusions of schizophrenia, an illness which was having a shattering effect on his own hopes and ambitions.

MCDONALD: Well, he was a very diligent, determined young man, very clever. He went to university, played the piano, played chess, just got on with life.

O'HALLORAN: But five years ago that life was turned upside down by serious mental illness, says his Matthew's mother, Di McDonald. His career in accountancy stalled and over the next four years he needed medication and in-patient psychiatric treatment. His delusions convinced him that he and his family would be killed by a parallel network of beings he called the Matrix. To escape the fear and torment he saw only one way out.

MCDONALD: Matthew attempted suicide in February 2004 and went into hospital as a result of that. He went into the Department of Psychiatry at the Royal South Hants Hospital in Southampton, but eventually he was fully discharged on the 10th of May and that seems to have been a strange episode because we, his parents, were away and weren't consulted. And the care in the community was not working well enough to give Matthew the support he needed out of hospital.

O'HALLORAN: She says in the next few days Matthew wounded himself in the neck with a knife in an apparent suicide attempt. He went back to the Department of Psychiatry and pleaded to be re-admitted. But because he'd been discharged rather than let out on leave, that took a further 24 hours. Di McDonald believes that even when he was back on the ward, only one of the staff realised what a high suicide risk he was.

MCDONALD: Matthew did get a great deal of support from a psychologist, a trainee psychologist who he saw for an hour on a one to one basis. And she did at one point on the 25th of May express extreme anxiety about Matthew's condition, and she wrote that in his hospital notes on the ward, but nobody seemed to take any notice of it.

O'HALLORAN: Extreme anxiety in what terms?

MCDONALD: That he was at a very high level risk of suicide. I think that they didn't take it seriously enough because they didn't get close - in psychological terms - to his distress. They didn't talk to him about how he tried to stab himself, they didn't talk to him about where was the knife.

O'HALLORAN: What happened in the end?

MCDONALD: In the end, Matthew killed himself. He killed himself in the same way as he tried to before, which was to stab himself to cut his carotid artery in his neck.

O'HALLORAN: The staff found Matthew lying in a pool of blood in a shower room. The weapon he used was a Swiss Army knife he'd taken onto the ward. It later emerged that the hospital was short of about thirty psychiatric nurses last summer. Whatever impact that had on care, Di McDonald says not enough checks were made on Matthew, given his history. And no effort was made to see what had happened to the knife he had used in the earlier suicide attempt.

MCDONALD: The shocking thing to us is that he wasn't searched or asked about it, we think that would be an obvious and reasonable thing to do since that's how he came to be in the hospital because of trying to kill himself in that way.

O'HALLORAN: Is it fair to say, though, that staff might not search someone simply in order not to distress them and in order to respect them as individuals?

MCDONALD: As a general rule that may be the case, but in Matthew's case he was at high risk, and it was their duty and responsibility and Matthew's greater human right was to life.

O'HALLORAN: The Department of Psychiatry is run by the Hampshire Partnership Trust. Its Chief Executive, Martin Barkley, says the whole issue of searching patients is a delicate one.

BARKLEY: Whilst we have a search policy for patients, that search policy is only activated when we have evidence to suspect that whatever they've brought with them is going to be of harm to others or themselves.

O'HALLORAN: Why are there not routine searches of people who are known to be suicide risks though?

BARKLEY: It is all about the level, the exact level of risk that people are placed on or assessed as posing. There is also the delicate issue of human rights and gaining the trust and confidence of patients without being intrusive or mistrusting.

O'HALLORAN: You see, Matthew's mother, Di McDonald, says she understands about patients' rights, but isn't the right of a seriously mentally ill and suicidal person, their right to life greater?

BARKLEY: Of course it is. I mean, we have a duty of care to all of our patients, and if we had suspected that Matthew had a knife on his person or indeed any other means of harming himself, we would have instituted a search.

O'HALLORAN: Do you know whether the notes of the trainee psychologist assessing him as a serious suicide risk, whether that information was effectively transmitted to the other staff on the ward?

BARKLEY: It was.

O'HALLORAN: Everyone knew he was a serious suicide risk and yet he was never searched?

BARKLEY: He was not searched because we had no knowledge that he had a knife on him or other means of harming himself.

O'HALLORAN: We've since learned the Trust is considering the use of metal detectors in the future. Sadly that wasn't the only death last year of a patient at Southampton's Department of Psychiatry, where security was called into question. Mary Conduct, who was 47, fell into a severe depression the year before last, when one of her daughters died suddenly at the age of 21. She was treated at the Department of Psychiatry in late 2003. Although her family felt she wasn't getting better, her sister, Diane Lyons, says she was soon under pressure to leave the hospital.

LYONS: I could see she wasn't really improving much, but they kept saying that she needed to come home all the time and they couldn't keep her there indefinitely. We didn't want her to stay there indefinitely. We just wanted my sister to get better and live a normal life again.

O'HALLORAN: Mary Conduct was discharged and went home but within weeks, in January last year, she was very ill again. One day she went to a bridge over the River Itchen, apparently bent on suicide, but she was talked down by a passer-by. Police, family members and doctors agreed she should be sectioned – detained for her own safety in hospital under the Mental Health Act.

LYONS: She was detained in the police station in Southampton. Me and my niece went down there. She was sectioned later on that night.

O'HALLORAN: What actually happened? Where did she go from the police station?

LYONS: She went straight to the Department of Psychiatry in Southampton.

O'HALLORAN: And stayed in there the weekend?

LYONS: Yes.

O'HALLORAN: But Mary Conduct was allowed to go and spend time in a day care area in the same complex, called the Canberra Unit, where psychiatric out-patients visited, signing in and out as and when they wished. Because of staff shortages, gaps were being filled by agency people. And, once there, Mary was able to pose as an out-patient.

LYONS: On the Tuesday she told the ward staff she was going down to lunch and then going to the Canberra unit.

O'HALLORAN: That's the day care unit?

LYON: The day care unit. And then she would be back up. But it wasn't checked that she'd signed in that morning to go there. And it should have been checked that she had been signed in. But she just signed her own name out and walked out. The receptionist on the door was an agency person, his first day in the unit, who, we've been told, had had back-up behind him, but obviously not the right back-up to stop people leaving the unit.

ACTUALITY AT RIVERSIDE

O'HALLORAN: After being allowed to just walk out of the Department of Psychiatry within three days of having been detained there for her own safety, Mary Conduct made her way here to the River Itchen and the high concrete bridge which crosses it and the boatyards which line its banks. This time there was no one to intervene. Later, a bus driver crossing the bridge saw a pair of shoes and raised the alarm. Police later found Mary Conduct's body in the river. She had drowned.

LYONS: My niece phoned me, said the police had been and they'd pulled Mary's body out of the river.

O'HALLORAN: What were your thoughts?

LYONS: I've lost my sister. When the police phoned the hospital and said Mary jumped off the bridge, they didn't know she was missing.

O'HALLORAN: A further two suicides by patients brought the total at the unit to four last year. The Hampshire Partnership Trust owned up to a series of mistakes and errors. Its Chief Executive, Martin Barkley, says the Trust is doing all it can to learn the lessons. And he concedes the escape of Mary Conduct exposed a serious gap in security.

BARKLEY: This is the first time that a patient had got out of the Department of Psychiatry using this methodology and as a consequence of this we have changed our procedures. We are confident that that cannot happen again.

O'HALLORAN: But isn't it right that the reason Mary Conduct got out was that there was a new receptionist, agency staff I believe, who didn't know anything about her and was on their first day at work?

BARKLEY: It is true that there was an agency member of staff on reception, but this was not the fault of any individual whatsoever. This was a systemic issue where we didn't have a robust enough system in place. We now have a robust system in place, where the reception staff know the names and identities of patients that are not allowed to leave the building.

O'HALLORAN: So it wasn't the receptionist's fault, it was the management's fault?

BARKLEY: It was a system fault.

O'HALLORAN: And who's responsible for the system?

BARKLEY: Well, ultimately I am.

O'HALLORAN: The management of the Trust?

BARKLEY: Yes.

O'HALLORAN: So in a sense, you and other parts of management in the Trust failed at that time?

BARKLEY: As I say this was not about the failure, there was no individual failed in this. What we didn't have was a robust enough system. We thought we had a robust system in place, but this was proven not to be the case by the way that Mary Conduct left the Department of Psychiatry.

O'HALLORAN: Conditions at the Department of Psychiatry have long been causing concern at the Southampton branch of the mental health charity MIND. Director Richard Barritt has seen things for himself there within the last year.

BARRITT: On one occasion I visited and went to one of the wards to meet a patient at his request, and he showed me round. And the immediate reception area smelt of urine and burnt paper, and as we moved on through, there was broken furniture around. He took me through to the cubicle where he was expected to sleep and where he'd been for the preceding week, and next to him was a chap who was, this was in the middle of the afternoon, lying on his bed asleep, smelt of alcohol, his clothes and belongings were strewn around. It looked really more like a doss house than a hospital - and this was somewhere where this patient had gone to get better. And people who use our services in MIND have been saying for years that when they're in the Department of Psychiatry, they don't see enough of the staff and the limited contact they do have is very welcome. There just isn't enough of it.

O'HALLORAN: Do they know why it is that the staff don't have much contact with them?

BARRITT: Well one of the issues is certainly staffing levels and we know that about halfway through last year they were seriously understaffed. And they're still very dependent on agency staff, and they're also very dependent on going abroad and recruiting staff from places like South Africa.

O'HALLORAN: Martin Barkley of the Hampshire Partnership Trust says half a million pounds has been spent in four years improving the environment on the wards. But he concedes that problems still exist over recruiting staff.

BARKLEY: The situation on the vacancies, I think, is twelve qualified staff vacancies.

O'HALLORAN: So you're short of a dozen trained nurses. That's quite a big problem, isn't it?

BARKLEY: It is, and the Department of Psychiatry and sadly it's not the only psychiatric hospital where we have significant shortage of staff.

O'HALLORAN: Why do you think this place that you are running there is so unattractive to staff?

BARKLEY: I think the particular issues at the Department of Psychiatry are that that it isn't a modern, purpose-built psychiatric unit and when staff, trained staff have a choice of hospitals to work in, they will often choose to work in an environment that is physically more pleasant and that certainly is a factor.

O'HALLORAN: But it's fair to say, isn't it, that across the NHS, much excellent work is done in old buildings or buildings that were not built for purpose?

BARKLEY: I agree, and I am not using the fact that the Department of Psychiatry is an old building as an excuse. We are trying to improve the number of permanent staff working in the Department of Psychiatry. We are introducing more training and staff development.

O'HALLORAN: Nationally, figures suggest that vacancies in psychiatric nursing are around 4.5%, getting on for double the figure for general nurses. And for psychiatrists, vacancies are much worse, 11%. The Sainsbury Centre for Mental Health says that in the two years ending in 2004, new money for mental health was well below increases in the rest of the health service. Their Chief Executive, Angela Greatley, says that was despite mental health being named as one of the top three clinical priorities in the NHS Plan for this decade.

GREATLEY: Mental Health has not kept pace with the rest of spending on the NHS and Social Services. In the NHS generally in the year that we looked up to 2003/4, we found that the NHS as a whole got in real terms about 5%, that's after taking into account inflation, pay awards and so forth.

O'HALLORAN: So it got a spending increase, money it could actually spend in the NHS as a whole, of 5%?

GREATLEY: That's right. But for mental health the same figure was 1.6%.

O'HALLORAN: Okay, given that mental health is in theory a top government priority, by what annual amount would real terms spending in mental health need to increase over say the next ten years?

GREATLEY: It would need to increase by 8.8% every year in real terms between 2000 and 2010 if it were to achieve the government's own aspirations for what mental healthcare should be. It's not going anywhere near that. It's certainly not going to achieve the requirements of the NHS plan, which was to make mental health a priority.

O'HALLORAN: And what is the impact of that on the sharp end of mental health – that is the in-patient psychiatric wards?

GREATLEY: Some acute in-patient wards have acquired a bad reputation, others will have few permanent staff, and therefore the thing can become a spiralling down of the quality of the staff in some difficult units.

O'HALLORAN: The Department of Health turned down our request to interview a minister. But it said real spending increases in earlier years had been much higher for mental health. During the three years from 1999, it got a total of 19% extra. And last December a further £30 million had been put into psychiatric intensive care. However we found that, in in-patient care, concern about low staffing levels and lack of training are widespread. They certainly featured in the background to a disturbing death, which took place at a psychiatric unit in South Wales.

ACTUALITY IN SWANSEA

O'HALLORAN: I'm in the grounds of Cefn Coed Hospital. It's a complex of two storey, red brick 1930s buildings surrounded by grass and trees on an attractive hillside above Swansea. It was here that a young man called Kurt Howard was often cared for during a long mental illness which lasted from his late teens to the age of 32. His last visit here, in 2002, was to end tragically and to reveal to NHS Trust officials a number of serious failings.

YORK: When we returned from the hospital, we believed that Kurt had suffered some form of heart attack. At the same time, the mortuary assistants were concerned at the extent of bruising on Kurt's body and particularly a huge bruise under his eye.

O'HALLORAN: Bob York says that when his stepson Kurt died suddenly in a Cefn Coed psychiatric ward at the age of 32, he was at first shocked, and then increasingly perturbed as he learned more about events in the hours leading up to that death. Kurt Howard had been a lively and likeable teenager, but he'd succumbed to serious mental illness before he was twenty. During the next dozen years he was in and out of hospital suffering psychotic delusions. In June 2002, after police detained him in Swansea, it was agreed he should return as a voluntary in-patient to Cefn Coed. Within days he was sectioned, as his mental state went downhill.

YORK: His condition and his behaviour deteriorated. Over that following nine days I believe that Kurt was actually physically restrained on eight occasions.

O'HALLORAN: And why was he being restrained, as far as you understand it?

YORK: It may have been because of his behaviour and agitation, but I mean it's pretty clear that his mental state was deteriorating all the while. Other than the restraint and being given anti-psychotic medication, I'm not sure that he actually saw a doctor again during the following week.

O'HALLORAN: Bob York says one Saturday morning around 7.30, Kurt Howard got into an scuffle with staff after being refused a cigarette. After punching one of them, he was held down for about twenty minutes. He was finally subdued, but more trouble broke out an hour later, and several staff struggled to calm him down for a second time.

YORK: Certainly Kurt was restrained from around 8.30, if not before, for at least 55 minutes, and that is a physical restraint. We believe it started off on his bed, but then he rolled off his bed onto the floor and remained in that position throughout the restraint. I mean, it's very clear from the subsequent police investigation that he'd been held in a supine position - that's face down – which, you know, we know is a highly dangerous position for people to be restrained in for any length of time.

O'HALLORAN: And how is that known?

YORK: A report last year established that, in the view of the experts involved, any restraint in a face-down position was highly dangerous and should not exceed three minutes. And Kurt, as we know, was restrained for at least 55 minutes, if not longer. But whatever happened, at 9.26 they all say that Kurt went limp. He was pronounced dead at around 9.45.

O'HALLORAN: That evening Bob York, at home in Dorset, was told that Kurt had died of a heart attack. Thirty-six hours later, still stunned by the news, he set off for Cefn Coed Hospital. There, he says, staff told him about the first twenty minute period of restraint, but not the second, much longer one. He learned only three days later that Kurt had died while under restraint and that police were investigating.

YORK: I was shocked and very very angry, I mean, we went to the hospital specifically to try and find out what had happened. And although they referred to the restraint first thing in the morning, there was absolutely no indication whatsoever that he'd actually died under restraint. I mean, if we'd known that, I would have phoned the police immediately. Kurt died on the Saturday morning, the post mortem didn't take place, I think, until the Tuesday. And I think it was something like 86 hours after Kurt's death, and it was certainly 86 hours before the police arrived to commence their investigation. And obviously a lot of the anatomical and forensic evidence which may have existed had been lost at that stage.

O'HALLORAN: We've obtained a copy of an internal inquiry into the death carried out by the Swansea NHS Trust. It says that in the final restraint incident, three support workers, who are not qualified nurses, and one staff psychiatric nurse had taken part. The report came to a series of troubling conclusions.

READER IN STUDIO: The level of training in the management of aggression and violence that the staff nurse had undertaken was inadequate to manage this situation. The training records were inadequate. These shortfalls are significant and of concern. Responsibilities for this situation lay with both the individual and the unit management team.

O'HALLORAN: The inquiry team panel were also unhappy over how the ward was staffed.

READER IN STUDIO: The panel was concerned to discover that it was normal practice to have one qualified member of nursing staff only on this ward. Violent incidents do occur on a regular basis in this area. One qualified nurse with three support workers was insufficient.

O'HALLORAN: The panel also said the care plan drawn up for Kurt Howard was unsatisfactory and did not meet the standard of care expected. We asked Swansea NHS Trust for an interview, but they refused, saying the inquest was yet to take place, and the death was also the subject of an NHS complaint process. But they listed a number of improvements at Cefn Coed, including new medical staff, better care plans, and training in restraint techniques. But they are still short of trained psychiatric nurses. Welsh Assembly member for South West Wales, Dr Dai Lloyd, of Plaid Cymru, himself a family doctor, says he's troubled by the staffing levels revealed in the inquiry.
The internal investigation by the NHS Trust suggested that it was quite routine on Kurt Howard's ward for there to be only one psychiatric trained nurse and the others would be nursing assistants.

LLOYD: From the outside that does appear a staggeringly low level. But I'm aware of, from my medical experience here in Swansea, because of the staff shortages, that that situation is not unusual. I sincerely hope it's changed in recent months and years, but frankly, at the end of the day, we still have a mental health system here in Wales, which is suffering from chronic shortages of staff, both medical and nursing.

O'HALLORAN: Even today the Swansea NHS Trust tells us that there are eleven vacancies in the vital area of nursing at that unit, and they are not going to be filled, we learn, until the summer or possibly the autumn even of this year.

LLOYD: That is a very worrying scenario, because underpinning all improvements in clinical care are your staff. We need as a nation in Wales two thousand nurses to fill current vacancies, that's across all specialties. And

LLOYD cont: bearing in mind that mental health again is that sort of Cinderella subject, that really is going to be a severe challenge to fill these vacancies here in mental health.

O'HALLORAN: Where there are staff shortages and lack of training, NHS staff can also be put in extra danger when trying to deal with highly disturbed patients. There are about fifty thousand incidents of violence or aggression in mental health trusts every year. Ann Leedham-Smith of the Royal College of Nursing, says much more must be done to protect those working on the wards.

LEEDHAM-SMITH: In 2003, the Department of Health produced figures showing that there was 116,000 incidences of violence within the workplace. 43% of those violent incidences took place in mental health and community trusts.

O'HALLORAN: Are there cases where nurses have been seriously injured here?

LEEDHAM-SMITH: Yes. There are many cases where nurses either have sustained head injuries, broken bones, but also the stress of being attacked. Believe me, if you see a patient coming for you, it's a very frightening experience, and you need all the skills you've got to help the patient to calm down. The government needs to recognise this and needs to put money into training, not only of mental health nurses but community nurses as well.

O'HALLORAN: Do you think this increasing violence, as you see it, is a symptom of some more fundamental malaise in the psychiatric services in the NHS?

LEEDHAM-SMITH: The pressure on health professionals has grown, because there's been an increase in the number of people with registered psychiatric disorders, also because we haven't got enough staff. I think that it's quite clear that patients become very frustrated because they feel that they're not getting the care that they should do, and the frustration leads to violent behaviour.

O'HALLORAN: One hot day last summer, a psychiatric nurse in the Midlands found order on her ward descending into chaos as staff were unable to subdue a highly disturbed patient. Repeated alarms were sounded, summoning other hospital staff, but the trouble continued.

NURSE: We had a patient who was very violent. We had about seven alarms going off that morning, with the same patient having to be restrained. He went from trying to hit staff, to pulling off the radiator, to trying to damage the windows, you know, he was just violent, trying to destroy all the property in his room.

O'HALLORAN: That nurse, who asked not to be named, was working at Birmingham's Queen Elizabeth Psychiatric Hospital last June. She had qualified as a psychiatric nurse only weeks earlier. She recalls that the man had been violent for some days. On the day in question a colleague of hers was injured trying to restrain him and went to Accident and Emergency. Now they were one nurse down, and she agreed to work beyond her shift, becoming the senior nurse on the ward.

NURSE: He continued to be distressed and violent, and we had two members of staff looking after him. He was just lashing out at them. They were finding it difficult to really contain him. Alarms was going off all the time.

O'HALLORAN: The alarms were going, but no staff were arriving at that point from other units?

NURSE: No, not quick enough. It all happened very very quickly. I was very concerned because I wasn't trained for restraint. I had just started working a few weeks in, so I wasn't very experienced also.

O'HALLORAN: Now there is a ten day restraint course that I've heard about. Are you saying you had never done that course?

NURSE: No I've never done it. So I went into his bedroom, my two colleagues were struggling with him. He was fighting, kicking. We tried to get him to the floor, which we did, and he continued to kick. I was trying to keep his legs still, so that we could turn him over, he had to get medication, and that's when I got injured.

O'HALLORAN: Her hand was put in plaster and she was off work for four months. The Birmingham and Solihull Mental Health Trust, which runs the hospital, says for legal reasons it can't answer her allegations. But deputy chief executive Mark Cooke did agree to discuss some of the issues raised.
How many of your qualified psychiatric nurses are likely to find themselves in charge of wards when they've had no training at all in restraint techniques? And particularly not the ten day course, which I understand a number of nursing assistants and others do?

COOKE: Our course, which is called the MAPA course, which is the Management of Actual or Potential Aggression, is something which we have as a mandatory requirement of this organisation, so we ensure that every member of staff has to go through that process.

O'HALLORAN: And are you saying every member of your staff has done that course?

COOKE: No, I'm saying it's mandatory training for the organisation and we are ensuring that every member of staff will have had that training.

O'HALLORAN: So it's quite possible that some nurses are put in charge of wards without having done that training, now?

COOKE: That's not a logical conclusion of what I've just said.

O'HALLORAN: It seems to be a very possible conclusion from what you've just said and from what I have heard from the RCN and others.

COOKE: Well, what we undertake to do is ensure that every member of staff undertakes the MAPA training, which is a ten day intensive course …

O'HALLORAN: But when?

COOKE: As soon as possible after they're appointed. And by and large, we ensure that every member of staff has that training, certainly within the first few weeks, if not the first few months, of being employed.

O'HALLORAN: So despite the Trust policy, it appears that new nurses can work for weeks - or even months - on such wards with no practical training to deal with violent patients. The injured nurse says she'd warned more senior staff in writing before the incident that the ward was short of experienced staff. And she thought too much responsibility had been thrust onto her too soon.

NURSE: I was very concerned that I would have been left in charge of the unit without the skills and the experience to deal with such a situation if it did get out of hand. And I wrote to my senior nurses.

O'HALLORAN: What did you want the management to do?

NURSE: I was asking really just to have some support as a newly qualified nurse to have some support from senior staff and more experienced staff. And what I got was a phone call back from my manager saying basically that's what you're employed to do.

O'HALLORAN: You're employed to be in charge?

NURSE: Yes.

O'HALLORAN: Did you mention the promise that had been made, that you would have support?

NURSE: Yes I did.

O'HALLORAN: And what was the response on that?

NURSE: He didn't really respond. He just basically said that he couldn't spare staff to give me support, and that's what I am employed to do.

O'HALLORAN: Birmingham and Solihull Mental Health Trust insists that it always ensures there are enough staff to provide safety. Deputy Chief Executive Mark Cooke says one unit has recently been temporarily closed due to lack of nurses but he insists there isn't a general staff shortage.

O'HALLORAN cont: How normal do you think it is, would you say, for someone who has recently just qualified as a psychiatric nurse to find themselves in charge of a ward with possibly quite difficult and violent patients on it?

COOKE: Again, if you're relating this to the specific incidents of the case, I can't comment on it. What I can say is that we ensure that if people are put in charge of ward areas, they are suitably qualified and experienced in that field.

O'HALLORAN: And how much experience as a psychiatric nurse do you need – as a qualified psychiatric nurse – before you think you can take on that responsibility?

COOKE: Well, that's a very difficult question to answer specifically, because experience in terms of timescale is not really relevant. It's the competency of the individual, and all our staff are assessed in terms of their competency before they're put in charge of a ward environment.

O'HALLORAN: Is it possible that a very few weeks of experience could be considered enough to be in charge of a ward, as a qualified psychiatric nurse?

COOKE: Well, as I say, if you are referring to the specifics of this case, I can't comment on that. But what I can say is that we only appoint ward managers on the basis of their competency.

O'HALLORAN: Again, we would have liked to question a government minister, but none was available. New figures today show a slight decrease in attacks on NHS staff, but the Department of Health told us the level is wholly unacceptable and it's developing training for staff in how to prevent such violence. However, pressure groups and many patients and staff still insist there's a gulf between the government's pledges on mental health and improvements on the ground. On the psychiatric wards, their fears are reinforced by the lack of staff in many units.
Those shortages cause not just discomfort and neglect. They can, at their worst, result in injuries and even deaths.

SIGNATURE TUNE