INFORMATION FOR CONSIDERATION BY
THE NATIONAL ASSEMBLY FOR WALES PETITIONS COMMITTEE
AT A MEETING DUE TO BE HELD ON THE 23 SEPTEMBER 2014

INTRODUCTION

ABMU Victim Support Group is an unincorporated association set up to;-

a. Find out what happened to their loved ones, why it happened, who was accountable, and why serious mistreatment and in some cases, deaths were not prevented;

b. Support one another; and

c. Help prevent the same mistreatment occurring at Abertawe Bro Morgannwg University Health Board, ("ABMU"), through a desire to get to the bottom of what has happened so that lessons can be learned, not only to benefit ABMU but also other health boards throughout Wales.

THE PETITION

ABMU Victim Support Group request the Petitions Committee to compel the Minister for Health and Social Services, (the "Minister"), to order a full public inquiry to investigate the serious concerns raised about standards of care and complaints handling within ABMU.

Under Section 1 (1) of the Inquiries Act 2005 the Minister, has the power to establish an inquiry:

> *(1) A Minister may cause an inquiry to be held under this Act in relation to a case where it appears to him that-*
>
> *(a) Particular events have caused, or are capable of causing, public concern, or*
>
> *(b) There is a public concern that particular events may have occurred.*

In *R v. Secretary of State for Health ex p. Wagstaff [2000] WHC 34*, before deciding that the Secretary of State's decision not to hold a public inquiry was irrational, the Divisional Court analysed a number of factors which could be regarded as persuasively in favour of opening a public inquiry:

"(1) the fact that when a major disaster occurs, involving the loss of many lives, it has often been considered appropriate to hold a full public inquiry, and the case for such an inquiry would seem to be enhanced where –

(a) there is doubt as to how many and which deaths are properly attributable to the known cause of many other deaths:

(b) the fact that deaths occurred over a long period without detection is suggestive of a breakdown in those checks and controls which should operate to prevent such a tragedy:

(c) as a result there is likely to be a widespread loss of confidence in a critical part of the National Health Service which needs to be addressed.

(2) There are positive known advantages to be gained from taking evidence in public, namely –

(a) witnesses are less likely to exaggerate or attempt to pass on responsibility:

(b) information becomes available as a result of others reading or hearing what witnesses have said:

(c) there is a perception of open dealing which helps to restore confidence:

(d) there is no significant risk of leaks leading to distorted reporting.

(3) The particular circumstances of this case militated in favour of opening up the Inquiry because -

(a) by April 2000 it was clear that was what the families wanted, and that the Secretary of State had been mistaken to think otherwise. As he chose to rely on what he had believed to be their state of mind he should have consulted them before reaching his decision of 27th January 2000, and he should therefore have given them a proper opportunity to deal with his new reasons for maintaining his position if he was not to accede to the written submissions of their solicitor:

(b) the wide and unamended terms of reference gave those relatives and friends of persons not named in the indictment good

reason to believe that the Inquiry would investigate how and why their relatives died:

(c) even if Parliament was not misled, what had been said and what had not been said in the House of Commons on 1st February 2000 had for obvious reasons given rise to misunderstanding:

(d) there was no obvious body of opinion in favour of evidence being received behind closed doors:

(e) given an inquisitorial procedure and firm chairmanship, there was no reason why the Inquiry should take longer if evidence were taken in public, nor was their any tangible reason to conclude that any significant evidence would be lost.

(4) Where, as here, an Inquiry purports to be a public inquiry, as opposed to an internal domestic inquiry, there is now in law what really amounts to a presumption that it will proceed in public unless there are persuasive reasons for taking some other course. Although Article 10 of the European Convention is not yet incorporated into English law it does no more than give expression to existing law as to the right to receive and impart information.

(5) If the Inquiry has been conducted in public, then the report which it produces and the recommendations which it makes will command greater public confidence. Since all members of the community, especially the elderly and vulnerable, have been accustomed to place great trust in their GPs, such restoration of confidence is a matter of high public importance."

There are parallels between the case being presented to the Petitions Committee and *R v. Secretary of State for Health ex p. Wagstaff [2000] WHC 34,* as such it would seem appropriate and reasonable to apply the same factors.

FACTUAL BACKGROUND

Mr Gareth Williams is the founder of ABMU Victim Support Group.

Mr Williams' mother, Lilian Maud Williams ("Lilian"), died on the 17 November 2012 at the Princess of Wales Hospital, Bridgend. The treatment leading up to her death and the circumstances surrounding her death are yet to be fully investigated.

Lilian's family have raised concerns about the care provided to her in a period that began in the Autumn of 2010. The Williams family have vividly described the systemic neglect of vulnerable patients at the hospital, including Lilian; and incidents including the inappropriate use of sedative medication; the failure to help patients with toileting or feeding; the withdrawal of food and nutrition for long periods, often days on end, pending inefficiently arranged speech and language therapist assessments; the falsifying of records to indicate that basic nursing care had been provided; the failure to ensure that medications were given or taken; and the inappropriate use of the end of life pathway by designating patients with life threatening conditions that they did not in fact have. Such concerns are reiterated by other members of ABMU Victim Support Group and those that have come forward to the group.

In June 2013 Mr Williams was attended by CID officers at his home and informed that Lilian was one of 39 patients whose medical observations had been falsified by a member of nursing staff who had been allegedly falsifying blood sugar readings.

As of September 2014 a total of 15 nurses, (14 from the Princess of Wales Hospital, Bridgend and one from the Morriston Hospital, Swansea) had been suspended as

part of the same investigation. Five of those nurses have been charged with the wilful neglect of nine patients under the Mental Capacity Act 2005. One of those nurses has pleaded guilty to wilful neglect in relation to nine patients. The others are yet to enter pleas.

In November 2013 the Minister ordered a 'deep dive' review seeking to answer four questions;-

d. how professional nursing standards are protected and delivered consistently and to determine how ABMU responded to lapses in delivery of these standards;
e. the culture of care, particularly focusing on the care of older patients in the medical wards;
f. responding to complaints, particularly looking at how complaints were handled by ABMU and how professionals were held to account for lapses in care through investigation of complaints (including protection of vulnerable adults investigations); and
g. the administration and recording of medicines, particularly looking at how medicines are administered to patients who are cognitively impaired or have other challenges is taking medicines orally.

The review was undertaken between December 2013 and April 2014 and was led by Professor June Andrews. The Trusted to Care Report, (the "Report"), was published on the 6 May 2014.

The Report states:

> *"The Review Team visited the hospitals on a number of occasions over a four month period and spoke to a range of people including staff, managers, patients, volunteers, external voluntary and statutory organisations, non-executive board members, local elected representatives, staff representatives, health department officials, police officers and relatives. It visited people in their homes, observed clinical areas during the day and night-time, and attended clinical and management meetings"*

The review identified a number of issues in the care provided at ABMU hospitals. These are summarised at page 2 of the Report as being;-

a. Variable or poor professional behaviour and practice in the care of frail older people;
b. Deficiencies in elements of a culture of care based on proper respect and involvement of patients and relatives;
c. Unacceptable limitations in essential 24/7 services leading to unnecessary delay to treatment and care;
d. Lack of suitably qualified, educated and motivated staff particularly at night;
e. Adversarial and slow complaints management;
f. Disconnection between front-line staff and managers and confusion over leadership responsibilities and accountabilities;
g. Problems with organisational strategies on quality and patient safety, capacity development and workforce planning.

The Report goes on to say:

> *"The sense the Review Team developed was that some staff in certain wards felt ill equipped to meet the needs of patients with dementia and other frail older people and were unclear of what to do about it. This was not true of all wards or even shifts, with the variation depending on specific circumstances. There was a sense*

of hopelessness and 'learned helplessness' and the resulting variation in care seems to result from the lack of immediate advice and support from senior clinical leaders when needed, the apparent failure to act or provide feed-back on reports of problems and incidents, the absence of basic knowledge and know-how and a fundamental lack of clarity from the managers about what was expected of staff".

The language of the Report becomes more evocative as it continues:

"My first impression was of a chaotic atmosphere. Staff appeared stressed and not in control. They told me that they were six senior staff down, with one suspended and one on sick leave. The agency staff nurse had not appeared. There were patients calling out, one stuck in bed with bed rails and one lady said to me "I am in Hell". There were more beds in the bays than was planned for. The consultant only visits a couple of times a week, and the out-of-hours cover was described by the nurses as "hit or miss". Staff were not confident about caring for confused people. Newly qualified staff weren't being supervised and junior doctors came and went

with very little interaction with the nurses. The noise and clutter was over stimulating, with TVs on but not being watched, and an atmosphere where there were too many people – doctors, cleaners, nurses, all in the patient space at once. (Review Team member)"

Patient accounts are also listed within the Report, which mirror those expressed independently by members of ABMU Victim Support Group:

"We couldn't look to the nurses to care for mum. They had no power. They couldn't get a doctor when we needed one. They couldn't get medicines over the weekend, or a swallowing test. My mum had no medication or food or water for days. (Daughter)" and: "Nurses have to wait until another staff member has finished with the trolley before they can give out their medicines – so some patients never get their medicine on time. The chaotic atmosphere increases the risk of drug errors. Patients that probably have dementia were being prescribed antipsychotics without a proper risk assessment. The inappropriate use of sedation for "aggression" was observed. Nurses are administering medicine who don't know the procedure or policy about mental capacity and one said she did

not know what to do if a patient without capacity refused medication. (Review Team member)"

The Report goes on to say:

"The Health Minister made it clear to the Review Team that he was concerned about historic complaints that medicines were not properly administered to frail older people in these hospitals. It had been alleged to him that in the past unwell older patients in ABMU had been found with medicine pots containing prescribed pills that had just been left near them on a locker or table. These confused or immobile patients were unable to take their pills without supervision or assistance and so did not get their medication at the right time, if at all. Abandoned pills had been pointed out at various times by relatives, other patients and visitors, and other staff members. The danger of this practice is that a different confused patient may be harmed by accidentally taking the medicine. The medicine could get lost, or dropped on the floor, or into the bedclothes. If the patient's condition gets worse because they missed a dose, the prescribing doctor may assume that the

initial dosage has been too small and make a decision to increase or change the prescribed medicine which could cause an overdose or other harm".

This makes reference to historical events and an understanding by the government that the problems identified were also historic.

The Review Team note their dismay at the extent to which doctors, pharmacists nurses and managers tolerate: *"hazardous, prohibited and unjustifiable practice"* in relation to drugs and medications.

It was evident that despite the recommendations made by the Review Team that no action was taken by staff at the ABMU in response:

"The Review Team offered practical advice and support to staff, but three months into the Review a ward visit resulted in the Team again witnessing this completely unacceptable and dangerous practice".

There is further clear evidence that historical steps to improve standards through advice have not been successful:

> *"This toleration of lack of care acted for the Review Team as a diagnostic measure of the culture of care in ABMU. It demonstrated to us that there is a disconnection between members of the health care team, an overwhelming sense of powerlessness and a failure of individuals to demonstrate personal professional responsibility. The debilitating public campaign against the hospitals must have had a negative effect on ABMU staff morale and made it more difficult to recruit and retain staff and support staff to make improvements. However given that the public concern has focussed on medicines being left with elderly frail patients it is incredible that existing staff in the whole system would not by the time of this Report have worked together to make sure that it never, ever happens again in ABMU hospitals… The Review recommendations for dealing with this issue at the bedside are practical and could be implemented at once. The records indicate that when this poor practice has been pointed out in the past general education is provided and nurses are warned that it must not happen. That*

clearly has not worked. As a temporary measure we propose that all medicine pots are signed for and disposed of after dosage, so that nurses better understand that witnessing the swallowing of medicine is part of the procedure and it is easy to identify any nurse who left medicine out. Medicines must not be given out by inexperienced nurses without supervision. Nurses must be given a formal procedure to follow when the patient refuses or fails to take the medicine in the time the nurse has to spend with that patient".

Where the Review Team did engage in a 'look back' exercise they identified a significant history of other cases where neglect of the elderly and frail was reported:

"During the Review and in particular during the "Look Back" process the Review Team interviewed and received written submissions from people who had complaints about both the Princess of Wales and Neath Port Talbot hospitals.6 Most of the complaints were about the Princess of Wales Hospital and the Review Team concentrated on those complaints relating to older, frail patients. Those complaining were upset in large part about the way that

their complaint had been handled. It is clear that complaints management was slower and more cumbersome than anyone would expect. People waited for months in some cases for an acknowledgement and some lost the will to pursue the problem long before the system responded to them. Not least there was evidence of one POVA investigation process that appears to have handled wrongly by ABMU staff giving misleading and confusing messages about whether it was actually happening. Delay, prevarication and misinformation seemed to lead in the end to either the aggrieved person giving up or to them becoming so angry that they became litigious or vexatious"

The investigation was limited to two hospitals within the ABMU Health Board, the Review Team commented at paragraph 2.10 of the Report:

"It is not obvious how other Welsh hospitals might stand up to a similar process of scrutiny and that must be addressed by the Department of Health and Social Care in the wake of this Report".

Although the report is at pains to distance the problems within the ABMU from those identified by Sir Robert Francis QC in the Mid Staffordshire Inquiry it is impossible not to draw comparisons with the following features of that Trust, identified within the executive summary to the Francis Report:

> *"A culture focused on doing the system's business – not that of the patients;*
>
> *An institutional culture which ascribed more weight to positive information about the service than to information capable of implying cause for concern;*
>
> *Standards and methods of measuring compliance which did not focus on the effect of a service on patients;*
>
> *Too great a degree of tolerance of poor standards and of risk to patients;*
>
> *A failure of communication between the many agencies to share their knowledge of concerns;*
>
> *Assumptions that monitoring, performance management or intervention was the responsibility of someone else;*

A failure to tackle challenges to the building up of a positive culture, in nursing in particular but also within the medical profession;

A failure to appreciate until recently the risk of disruptive loss of corporate memory and focus resulting from repeated, multi-level reorganisation."

Various recommendations were made in the Andrews Report regarding changing practice in the future. The recommendations were directed towards the ABMU in the whole, although four recommendations were made to and addressed by the Welsh Government.

Following publication of the Report Mr Williams' Solicitor wrote to the Minister on the 14 May 2014 setting out concerns about the breadth and quality of the Report and asking that he use his discretion under Section 1(1) of the Inquiries Act to order a public inquiry. In particular:

a. The primary focus of the review was not on the historical issues or patient experiences at the hospitals significantly prior to December 2013. It did not engage in any detailed review of the matters that had led to members of

nursing staff being suspended prior to December 2013 or for that matter investigate the broader reasons why ABMU had reached the position identified on review.

b. The review did not examine mortality rates or the likely contribution of the issues that they identified to the apparently increased mortality rates at ABMU.

c. The investigation did not examine why it had taken until 2013 to identify problems within the trust, that is to say why necessary safeguarding mechanisms were not in place or were ineffective in highlighting these issues sooner.

d. The investigation was carried out behind closed doors. There were no open hearings; witnesses were not questioned in public and interested parties were not provided with facility to make representations to the investigation.

e. The Report makes reference to three nurses being suspended whereas by the time that the Report was published it was evident that many more had been suspended and a number were facing criminal charges. The Report

made no effort to investigate the circumstances of those cases or examine whether patients had been put at risk or harmed as a consequence of the issues surrounding those cases.

f. The review was not able to examine whether similar issues existed in other hospitals across the Welsh Health Authority.

g. The review did not examine the extent to which budget restrictions, management and spending had led to poor delivery within the hospitals.

h. The review made only a superficial assessment of the management at the hospitals. It did not engage in any proper exploration of whether management targets had contributed to poor care.

i. The review did not look into historic allegations relating to the alleged euthanasia of patients across ABMU.

LEGAL FRAMEWORK

The relevant provisions of the ECHR are as follows;-

a. Article 2 - everyone's right to life shall be protected by law;

b. Article 3 - no one shall be subjected to torture or to inhuman or degrading treatment or punishment; and

c. Article 8 - everyone has the right to respect for his private and family life, his home and his correspondence.

The appalling standards of care received by Lilian and others give rise to breaches of the positive substantive duties under Articles 2, 3 and 8 ECHR. This is in respect of:

a. The systemic Article 2 duty to ensure that hospitals adopt systems of work which will protect the lives of patients and to employ competent staff who are trained to a high professional standard. A failure to perform these general obligations will result in a violation of Article 2 -

Savage v. South Essex Partnership NHS Foundation Trust [2008] UKHL 74. Similar principles apply in respect of Articles 3 and 8. The Articles 2, 3 and 8 investigative obligation therefore applies in respect of the systemic failures which led to an excess mortality rate at ABMU hospitals.

b. Breaches of the operational duty to protect patients in cases where an appalling standard of care has been received. *Rabone v. Pennine Care NHS Foundation Trust* [2012] UKSC 2. The language of the Supreme Court in the *Rabone* case makes clear that whilst the court were considering the case of Melanie Rabone there are broader categories of voluntary hospital patients for whom the operational duty may be engaged, beyond merely psychiatric patients. In the present cases, it is crucial to consider that a great number of the victims were elderly, cognitively impaired and exceptionally vulnerable.

c. Gross negligence in a medical context – which may constitute a breach of Article 2 ECHR – *R (Takoushis) v HM Coroner for Inner London North* [2006] 1 WLR 461.

There is an obligation upon the State to comply with its investigative duties under Articles 2, 3 and 8 in respect of the causes of deaths resulting from patient neglect and inhumane and degrading treatment that has occurred and continues to occur at ABMU hospitals. In order for the procedural, investigative duties under Article 2, 3 and 8 to be engaged such breaches need only be 'arguable.' It is, of course, a low threshold.

WHY IS THE PETITION BEING MADE?

It is submitted that a decision not to order a public inquiry is unlawful in that it is a violation of the investigative obligations under Articles 2, 3 and 8 of the European Convention on Human Rights, ("ECHR") and / or it is irrational and / or it is unreasonable for the following reasons:

a. In order for the procedural duty to be discharged, the investigation into the alleged breaches must as a minimum, inter alia (*R (Amin) v Secretary of State for the Home Department* [2004] 1 AC 653):

   (i) Be independent.

   (ii) Be effective.

   (iii) Be reasonably prompt.

(iv) Involve a sufficient element of public scrutiny.

(v) Involve the next of kin and families of the victims to a sufficient extent.

<u>Independence</u>

b. The Welsh Government commissioned investigation led by Professor June Andrews, ('the Investigation'), necessarily involved close interaction with the hospitals under scrutiny, and with the Welsh Government and was undertaken without proper input from the victims or their families. There is very little, if any, information about what evidence was gathered. An investigation commissioned by the Government into which only the Government and the Health Boards under investigation have any proper input cannot provide the necessary appearance of independence. In any event, the lack of any public scrutiny in the Investigation: its remit, its methods and the information and instructions that are provided to it inevitably influences the extent to which it appears independent in the minds of the public.

<u>Effectiveness</u>

c. There has, to date, been no effective investigation of patient deaths. Many if not all of the deaths have fallen outside of the jurisdiction of the Coroner because they were certified by doctors at the hospitals as being brought about by natural causes. Where inquests have been held, they have not addressed wider systemic issues and would not in any case discharge the investigative duty.

d. Considering the very serious and widespread evidence of inhumane and degrading treatment found at ABMU hospitals, the findings of the Report are extremely flawed and offer nothing to heighten public confidence. The Report cannot be considered to constitute an effective investigation, for the following reasons:

   (i) The Report admits that poor professional practice evident in the past is still happening today. This is the same poor professional practice complained of by patients and relatives at every level. Their complaints have clearly not resulted in change.

   (ii) The review was not enough to prevent poor professional practice in

relation to the administration of medication. Direct, on the spot, recommendations made by the review team were ignored. Key aspects of an Article 2 compliant investigation are to ensure that lessons are learned that may save the lives of others; and to safeguard the lives of the public, and to reduce the risk of future breaches (*Amin*, para.31). It is clear that the Report is not capable of discharging these duties.

(iii) The Report advocates that it is acceptable to set a standard of care based upon financial constraints.

(iv) The Report makes many a sweeping statement that it cannot possible justify, e.g. there was no evidence of criminal activity, there were no cases of euthanasia, ABMU is not another 'Mid Staffs'.

(v) The review team were not made aware as to the scale of the concerns at ABMU. They were only made aware of three nurses having been arrested when in fact it is now common knowledge that there are fifteen nurses suspended and most were suspended prior to the commencement of the review. The Report is therefore not capable of

ensuring that the full facts of the appalling standards of care are brought to light; nor of ensuring that culpable and discreditable conduct is exposed and brought to public notice, and those responsible identified and brought to account – both are key aspects of the investigative duty. Fundamentally, the Report was not capable of identifying properly and rectifying the dangerous practices and procedures.

(vi) The investigation should be broad enough to permit the investigating authorities to take into consideration not only the actions of the employees involved but also the surrounding circumstances including such matters as the planning, management and control of the operations in question (*R (Ali Zaki Mousa) v Secretary of State for Defence (No.2)* [2013] EWHC 1412, paras 148-149). The Report confirms the existence of "unacceptable" standards of care but does not properly analyse the cause and surrounding circumstances, and nor was it possible to do so within the limited remit set:

- The review was restricted to examining the practice at only two out of the thirteen hospitals under the control of ABMU. The

Report admits that it is not obvious how other Welsh hospitals might stand up to a similar process of scrutiny (paragraph 2.10 of the Report).

- The review was conducted between December 2013 and April 2014, an extremely limited timeframe.
- The review team only investigated whether the current level of care was acceptable, i.e. the review was forward looking and did not investigate the historical issues that might have contributed to this appalling statement of affairs. In the circumstances it cannot therefore have amounted to an investigation of the matters complained of by patients at the hospital prior to December 2013. Those patients have not been provided with any Article 2 or 3 compliant investigation.

e. Where the investigation concerns systemic failures, an effective investigation should be capable of ascertaining;-

(i) Any shortcomings in the system *(Oneryildiz v Turkey* (2005) 41 EHRR 20, para.94;

(ii) Defects in the instructions and training of the employees involved, and the planning, management and control of the actions under consideration, including the supervision of staff (*Al-Skeini v UK* (2011) 53 EHRR 18, para.174; *R (Wright) v Secretary of State for the Home Department* [2002] HRLR 1.);

(iii) The relevant legal or regulatory framework in place (*Kakoulli v Turkey* (2007) 45 EHRR 12, para.106; *Oneryildiz*, above, para 94); and

(iv) Individual failings that sound system is expected to detect and remedy before harm is done (*Middleton v HM Coroner for West Somerset* [2004] 2 AC 182).

It is plain that the Report is not thorough or wide enough in its scope to discharge these duties.

f. Finally, a crucial aspect of the effectiveness of an Article 2, 3 and 8 compliant investigation is that reasonable steps should be taken to ensure that evidence which is reasonably available should be secured – *R (Rowley) v DPP* [2003] EWHC 693 (Admin) para.55; *Al Skeini v UK* (2011) 53 EHRR 18,

para.166. As stated below, the evidence reviewed for the Report has not been disclosed to the families of the victims, and the assurances given in the Report as to the scope of the evidence surveyed are vague (e.g. para.2.7). Given the scope of the issues involved, a full forensic inquiry into the documentary evidence is required in order to satisfy Articles 2, 3 and 8. Oral evidence should be heard, and there should be a mechanism for oral evidence to be tested. The interspersing of apparent quotations regarding standards of care throughout the Report, is clearly insufficient to discharge the burden to ensure that the proper, relevant evidence is received by the investigation.

Public Scrutiny

g. The Report has not allowed for a sufficient element of public scrutiny to discharge the investigative duty. The degree of public scrutiny required by the Convention depends on the circumstances of the case. However, in a situation of the seriousness and scope of the present, a 40 page report, limited in its scope, with no evidence heard in public, and no disclosure of the evidence on which it was based, cannot be considered adequate to discharge this duty.

The Effective Participation of the Families

h. In all cases where the procedural duty under Article 2 and/or 3 and/or 8 is engaged the families of the deceased/victims must be able to participate effectively in the investigation *(R (Humberstone) v Legal Services Commission* [2011] 1 WLR 1460, paras 75-77). This requires more than merely informing the next of kin of the progress of the investigation, and includes their active involvement in it (*Anusca v Moldova* App No 24034/07, 18 May 2010, para 44).

i. As regards the participation of the families in the preparation of the Report, upon asking Professor June Andrews to meet with Mr Williams, his Solicitor received an e-mail from Professor Andrews on the 10 January 2014 that stated:

> *"…at this stage, the review is not looking at previous events, but rather auditing the current position. Although I am looking forward to meeting with Mr Williams it is important that this meeting is*

uncoupled from the review that I have been asked to undertake. I have been asked initially to look at the current position. I will do that initially without reference to what has happened in the past…"

On the 24 February 2014 the following statement was issued on the website of ABMU:

"Professor June Andrews … today asked people who have made complaints about the Princess of Wales or Neath Port Talbot Hospitals in the past three years to come forward and share their experiences with the Review team … Now the Review Team … wish to look more closely at the way complaints have been handled in the recent past.

Professor Andrews comments:

"We want to hear directly from patients and families who made any complaint about the Princess of Wales or Neath Port Talbot Hospitals (ABMU Health Board) between December 2010 and December 2013.

"We want to get a clearer picture about what complaints were made, from local people themselves, and to understand the levels

of satisfaction with what happened as a result, particularly about the care of older people.

"We are using a short, simple-to-use questionnaire to gather some information. Then we hope to talk to a number of those who respond about their experiences …"

Participation of bereaved families was extremely limited and focused only on the way complaints were handled and not the nature of the complaint. Such level of participation does not discharge the States procedural duty under Article 2 and/or 3 and/or 8 for there to be effective participation of the families of the deceased/victims in the investigation.

A full public hearing, in the form of an Inquiry under the 2005 Act, with the families being legally represented, disclosure to them of the relevant evidence, and a right to ask questions of witnesses, will properly discharge the State's investigative duty.

Any decision not to hold a public inquiry, is irrational, and/or unreasonable under domestic public law principles for the following reasons:

a. There is a need to identify personal responsibility but also to understand the systemic problems that have led to good staff trying to do their best but being unable to do so – whether it is due to staffing resources, financial constraints, lack of management and direction, lack of scrutiny internally and externally, targets, a culture of acceptance of poor care, or a combination of all those factors. Fundamentally, the present Report is not adequate to enable lessons to be learned and similar deaths prevented in the future.

b. Poor care has been independently identified, yet up until recent media pressure, no whistleblowers have come forward. There must also be an examination of the possible reasons for this reluctance. Poor care would have been evident to staff working on ABMU wards.

c. There is a need to determine exactly why things appear to have gone so wrong at ABMU and why poor care has not been properly detected or acted upon for so many years despite patients and relatives raising concerns.

d. Only through a public inquiry can the relevant facts be determined, key

themes identified and important lessons for the future learnt about the appalling standards of care found at ABMU hospitals, in a way that will ensure public participation and engagement.

EVIDENCE OF BREACHES OF ARTICLES 2, 3 AND 8

There is sufficient evidence, from a variety of sources, including members of ABMU Victim Support Group, but also the Trusted to Care report itself, as well as public sources of information, to establish that arguable breaches of Articles 2 and/or 3 and/or 8 have occurred on a systematic level, over a period of years, in hospitals run by the ABMU, and particularly in respect of the care provided to elderly, vulnerable patients.

Article 3 ECHR

The following practices, whether taken individually or in the round, constitute arguable breaches of the basic, negative duty under Article 3:

The systematic neglect of patients.

Assigning elderly patients nil by mouth without justification and with prolonged delays before patients are seen by SALT teams.

Failure to assist with taking prescribed medications.

Falsification of medication charts.

Falsification of blood sugar readings

Deprivation of prescribed medication.

Failure to provide essential care – e.g. fitting of a venflon and feeding tubes without prolonged delays.

Inappropriate sedation of patients carried out by nurses without the direction of a doctor.

Patients being allowed to remain in soiled clothing and bedclothes for persistent lengths of time.

A chaotic atmosphere inappropriate for the care of patients.

Failure to assist with eating and drinking.

Deprivation of nutrition and hydration.

Failure to assist with toileting needs

Failure to assist with hygiene needs including the removal of false teeth overnight.

Failure to assist with the removal of an artificial limb overnight

Failure to perform basic medical observations

Inappropriate use of end of life care pathway

The taking place of the above breaches over a persistent period of time, and in circumstances where the Health Board were clearly aware of the allegations,

constitutes a breach of the operative substantive duty to prevent breaches of Article 3.

The following constitute arguable breaches of the positive duty to establish an adequate system to prevent breaches of Article 3:

Inadequate complaints systems.

Inadequate use of the POVA system by a failure to notify other agencies regarding a POVA investigation in accordance with the ABMU's statutory duties

Failure to engage/invoke the POVA procedures

Inadequate provision of trained nurses.

Inadequate staffing e.g. failure to provide an adequate level of clinical care/monitoring, especially over a weekend

Failure of management to act upon alerts made

The following is evidence of the above breaches:

a. The witness evidence of members of ABMU Victims Support Group

b. The full POVA report in the Williams case

c. Rebecca Jones pleading guilty on 07.08.14 to charges of wilful neglect of 9 patients at the Princess of Wales Hospital between April 2012 and February 2013.

d. The charging of four other nurses from the Princess of Wales Hospital with wilful neglect in respect of treatment of several patients.

e. The suspension of 15 nurses from the ABMU in May 2014 in relation to an investigation regarding the falsification of blood tests.

f. Ongoing NMC investigations.

g. The AQuA report dated the 12 May 2014 headed "Abertawe Bro Morgannwg University Health Board Mortality Review". Of note, the report found that there were issues regarding levels of clinical staff and cover. Also, leadership, accountability and governance arrangements appeared unclear at times. The example used was where infection rates were high but there was a reluctance to challenge the behaviors that enabled poor practice to continue. In addition, the report found that there were issues with end of life care in that there were a limited number of consultant led ward rounds and this could negatively impact on the assessment of patients at the end of their lives.

h. The Report of Keith Evans dated June 2014 relating to the Welsh complaints handling system. The report criticises the implementation of the Putting Things Right Scheme.

i. A Dignified Revolution's, ("ADR") published response to the Trusted to Care

Report. Of note, ADR have, since their formation in 2008, continually raised the following issues to those in a position to influence change:

(i) Poor nurse leadership

(ii) Disregard for hydration and nutritional needs

(iii) A fundamental lack of respect for the care needs of vulnerable people

(iv) Patients being told to 'go to the toilet' where they lay

(v) Poor infection control

(vi) Poor record keeping

(vii) Concerns about the fundamentals of care audit

(viii) Serious problems around the administration and recording of medications

(ix) Inappropriately immobilising patients

(x) Absence of positive culture of care

(xi) Lack of awareness of responsibilities towards POVA, the nurses' code, mental capacity, etc.

(xii) Poor handling of complaints

(xiii) Inappropriate medical and nursing education leaving staff ill prepared for the care of all older people including those with dementia and confusional states

(xiv) Lack of public involvement

j. The following, inter alia, from the Trusted to Care Report:

3.8 – *"It was reported to the Review Team that older patients were kept nil by mouth for longer than we would have expected. Reports from families of missed medicines that had been recorded as having been taken by the frail elderly patient were not unusual. We were shocked to be told of numbers of older patients who had been instructed to "go to the toilet" where they lay. Although some of these allegations remain unsubstantiated the Review Team found the accounts given by relatives and staff sufficiently credible to support our conclusions."*

3.20 – *"… Medical and nursing staff in the Princess of Wales Hospital appeared not to know about ameliorating the common problems in care of frail older patients, including management of continence, delirium, mobility,*

nutrition, dementia, hygiene, and fear."

3.27 – *"The Review Team observed medical ward layouts with bays where extra beds were placed against the wall in bays, and the chaotic atmosphere made it difficult to concentrate and think.* ***Vulnerable elderly patients will remain at risk if the bed numbers are not reduced in some of these areas and other changes made. "***

3.28 – *"Clinical staff, in both hospitals, seem unaware of serious problems with administration and recording of medicines."* Further, a member of the Review Team notes that *"patients with dementia were being prescribed anti-psychotics without a proper risk assessment. The inappropriate use of sedation for "aggression" was observed."*

3.29 – Incapable patients not being assisted with taking medication. A lack of risk assessments being carried out regarding self-medication.

3.31 – The Review Team noted that *"Doctors, Pharmacists, Nurses and Managers in ABMU knowingly tolerated this practice."*

3.32 – Three months into the Review the Review Team again witnessed this practice despite having warned against it previously.

3.38-39 – The Management structures regarding nursing in ABMU and the lack of leadership added to the problems (evidence in respect of the systemic claims).

3.40 – The uncertainty regarding whether the newly appointed nurse director will be able to take these issues forward.

3.45 – The Review Team were also concerned that lapses in care were largely blamed on poor "*nursing*" standards alone, as opposed to management standards or other clinical standards that are shared responsibilities with other members of the team (evidence in respect of the systemic claims).

3.52 – Patients requiring support were immobilized and left to soil themselves in their beds.

3.52 – The Review Team raises the issue of lack of responsiveness of staff levels to the specific needs of patients at a given time (evidence in respect of

the systemic claims).

3.53 – concludes that *"lapses in standards have not been picked up by the Board early enough, and the response has been limited in its effectiveness."*

3.61 – in terms of the effectiveness of any investigation and the involvement of families – *"The Review Team met families who appeared to have received little support and information from the hospital, the Community Health Council, the Ombudsman or the Older People's Commissioner about how to pursue complaints and we signposted them to that help."*

3.79 – The paragraph states that *"Current assurance processes cannot be said to be fit for purpose."* It also states that *"both hospitals also appear to be operating a sedation policy which is not acceptable, with sedation being used to enable staff to cope with the pressures of caring for patients overnight."* It also recognises that *"older patients have been deprived of water and food without protection from some staff of all professional backgrounds"* and that *"medicines were not reaching patients as prescribed."* The paragraph also provides the example of a patient being asked to urinate in bed due to staff shortage.

3.80 – In terms of the effectiveness of an investigation: the Report suggests that the *"volume of undigested data at Board and sub-Board level means Board members are denied the ability to understand and act on symptomatic complaints. The focus appears to be too much on managing down the numbers of the complaints rather than learning the lessons."*

The following paragraphs raise significant issues in terms of the causes of the lack of care provided by ABMU being financial, including an over-emphasis on targets.:

3.93 – *"The Review Team does have a concern that the Board over a number of years appears to have been driven mainly by a model of short-term financial planning required by the operational and planning framework processes in place across the NHS in Wales. The question should be asked about whether such a relentless focus on financial delivery year-on-year prompted by the national*

system is distracting NHS Boards from a proper focus on quality and patient safety."

3.94 – *"The Review Team feel that, however admirable and necessary this might have been at the time, the issues which the Review and this Report are addressing now may well reflect an overemphasis on short-term financial targets at the expense of quality and patient safety."*

3.95 *"It is not too great a stretch to see current muddled management structures, lack of clinical cohesion and failures to have sufficiently skilled and oriented staff working in front-line settings, as being directly traceable to an overemphasis on short-term operational and financial delivery at the expense of the underlying core purpose of providing best possible care and treatment to local people."*

Article 2 ECHR

The following practices constitute arguable breaches of the basic, negative duty under Article 2:

The systematic and repeated neglect of patients affecting their ability to recover.

Inappropriate use of the end of life care pathway.

The failure to prevent the real and immediate risk to the lives of vulnerable patients subject to the above treatment constitutes a breach of the operative substantive duty to prevent breaches of Article 2. Further, the treatment amounts to gross negligence, which is also capable of breaching the substantive duty.

The following constitute arguable breaches of the positive duty to establish an adequate system to prevent breaches of Article 2:

Inadequate complaints systems

Inadequate use of the POVA system.

Failure to engage/invoke the POVA procedures

Inadequate provision of trained nurses.

Inadequate staffing e.g. failure to provide an adequate level of clinical

care/monitoring, especially over a weekend

Failure of management to act upon alerts made

The following is evidence of the above breaches in addition to the evidence listed above.

a. Paragraph 3.18 of the Trusted to Care Report comments:

   The Review Team is still concerned about how death is described in terms of "withdrawal of care", in a relatively unsophisticated way in ABMU. It seemed that it was often not explained well that a patient was dying, what dying looks like or how death happens. In particular ABMU doctors need more education about how to manage and talk about death and dying in hospital.

b. The report of Professor Palmer regarding mortality rates dated the 25 June 2014 is clear evidence that the current system for review of mortality rates is not a meaningful measure of hospital quality. Whilst it is accepted that a high mortality rate does not necessarily indicate a

poor standard of care, it has to be an alert that something may be wrong at the very least, as was the case in Mid Staffordshire. However, if the necessary checks and balances are not fit for purpose then there is no adequate system in place for raising alerts that could prevent breaches of Article 2. Professor Palmer notes that the key challenge is to accurately and quickly identify the minority of all deaths which were as a result of poor care/treatment in order to learn what went wrong so that future care can be improved. The system currently in place and that has been in place throughout the relevant period is not adequate to identify deaths which were as a result of poor care/treatment so that breaches of Article 2 can be prevented.

c. The Report of Professor Palmer recognises that there is poor clinical engagement at ABMU in case note reviews which is the main barrier to providing assurance that all in hospital deaths can provide learning.

Article 8 ECHR

As an alternative that, regarding the alleged breaches of Article 3 ECHR, if they

should not meet the requirement threshold for inhuman or degrading treatment, then they nonetheless constitute breaches of Article 8 – still necessitating an investigation.

Approved but not signed by
Mr Gareth Williams on behalf of ABMU Victim Support Group