I refer to Agenda item 8, CQC reports, especially 8(b).

“A truly deplorable and unacceptable saga” – I quote Nigel Pascoe QC in his recent report on Southern Health, which I trust you read before this meeting.

Mr Pascoe concluded:

“The long and complex process of the review of this Final Report has brought home to me just how wide the gulf still is between the family members and the Trust.... The reality is that deep distrust remains. It is no part of this Report to assess the degree of reputational damage that this Trust has sustained by their actions and failures towards these families. But I retain the hope that an independent limited Public Investigation at least has the potential to change the narrative of a very troubled story.”

Mr Pascoe proposed a two-stage Public Inquiry – stage one into a patient’s death and stage two into the Trust’s current conduct.

Mr Pascoe exposes fatal flaws in the CQC report, which you are considering later. Worst of all is (I quote the CQC):

"The leadership team had engaged proactively with a number of families who had previously not received the appropriate level of care, consideration and investigation into their loved one’s deaths or poor experience of care (under a previous leadership regime).

"Each family worked with a senior member of the trust's leadership team.... In late 2018, the trust sought the assistance of NHS Improvement to help address the outstanding concerns of five families...."

Alastair Campbell would be proud! It is (at best) a half-truth or (at worst) a terminological inexactitude and (more worryingly) the CQC knows it.

The Trust, “Sought assistance” from NHSI only at the families’ behest. Yet, another meeting in December 2018 was a conspiracy between the Trust, NHS England and the CQC to silence families, not help them.

A bereaved father reports:

“Understanding the barriers to progress to be wider health system issues we [his wife, another bereaved father and a supporter] were instrumental in establishing a meeting between Dr Broughton and Ms Hunt of the Trust, Dr Lelliott [CQC] and Professor Kendall of NHSE in December 2018.”
"The stated purpose of the meeting was to explore what these barriers were and attempt to find ways around them. In effect we were committing to continuing to work with the board in our own time and at our expense in order to gain assurance that lessons were being learned and real improvements in service made.

"Sadly, the meeting did not go to plan. We were treated with utter contempt by Professor Kendall and Dr Lelliott and essentially told to go away and mind our own business. Ms Hunt did appeal to us to act as critical friends of the Trust, an offer I personally accepted on the spot, only to be rudely rejected by Dr Broughton. That is where my direct engagement with the Trust ceased."

The father submitted evidence to the recent CQC inspection, including a reminder of this. Yet the CQC still had the impertinence to publish a wholly misleading statement. I have a full report about this farce: it is available on request.

It shows an upside-down management structure: the CEO over-rides decisions of the Chair! The Chair cannot control her CEO. This does not characterise a well-led regime.

Members can reach their own conclusions about the probity of the Chair and CEO – both would have seen a draft of the CQC report yet failed to amend it for clarity – there is more evidence to follow.

The Trust’s Family Liaison Officer is said to support all bereaved families. I have advised a bereaved father for two years. Neither of us has heard from her.

Bereaved families and others are sick of Dr Broughton preening himself in the media with his 'not me guv' approach, whilst continuing to offend bereaved families.

For example, following a bereaved mother’s protest, the Portsmouth News amended its website article on the Pascoe Report to add to the mother’s quote:

"Dr Broughton had a real opportunity to resolve our cases but for whatever reason chose another route. His distancing himself from the Trust’s failures to investigate is offensive.”

Rhetorically, how can Members take the CQC Report seriously, when, simultaneously, an eminent QC recommends a limited Public Inquiry into the Trust’s current conduct?
How can a Trust be well-led and how can culture be improved when, after an investigation, its Chair has to send written apologies to a mentally unwell patient and his advisor for intimidatory conduct at a meeting held in public, causing the patient to flee the room? And the apology was insincere.

Also, the Chair, no doubt in reprisal, later made spiteful, offensive and completely unfounded allegations against the advisor to try to prevent him assisting complainants. Cllr Harrison can attest to the work done by this advisor.

In assessing the CQC report, Members should take note of the November 2019 Report of the Joint Parliamentary Committee on Human Rights. The JCHR heavily criticised CQC inspections and concluded (amongst other things):

“\textit{A regulator which gets it wrong is worse than no regulator at all.}”

Members should also note Health Service Journal articles on the CQC – including comments added by NHS clinicians and others. There is almost unanimous agreement that the CQC is not fit for purpose. My deputation supports this view.

How can a Trust be well-led and caring when it fails to report the alleged rape of an inpatient to the police; allows cleaners to contaminate the scene of death before the police finish their work; and withholds key evidence from the Coroner?

And later another Inquest revealed near-identical failings (save for the alleged rape) – same unit, same Consultant etc – i.e. no learning from the first death.

Eminent QC, Mr Tom Kark wrote to me of public inquiries:

“\textit{As you say these things are expensive and as I said in my report much of the learning about what goes wrong in the system is already there if only recommendations from previous reports and inquiries were followed.}”

Mr Kark talks of systemic NHS problems. In Southern Health’s case, there has been little (or no) perceptible learning from multiple expensive reports and inquiries into its own conduct and repeated failings exposed at Inquests and in the Criminal Courts. Now, taxpayers must foot the cost of a Public Inquiry.

I strongly urge Members not to take anything the CQC or Southern Health Directors say or write at face value without checking the facts, such as with a member of the Forum for Justice, Accountability and Equality at Southern Health. Cllr Harrison can access their co-ordinator.
It is deeply concerning that Members are asked to note only the CQC report’s findings and the improved rating of, ‘Good’. Yet Members are not asked to note the findings of a truly independent report by an eminent QC. How many Members have even read it? I submit that it is not in the public interest for Members to deliberately give a rose-tinted view of Southern Health.

To end on a positive note, I would like to thank Cllr Harrison – the only Member who has been seen to take a serious interest in the Trust’s failings, acting in the public interest – even attending a Forum meeting.

Thank you, David: thank you everyone for listening. I hope, from now, Members will be part of the solution, not part of the problem.

Geoff Hill
3rd March 2020
There must be a serious question mark against Southern Health’s genuine will to act against serious misconduct within its own ranks.

Its handling of complaints leaves much to be desired. The question mark in my mind arises from one particular case - a detainee in police custody.

The facts are as follows:

This lady was violently and unlawfully manhandled out of a public meeting before it started in Ashburton Hall by a Police Community Support Officer. She suffered painful injuries from his assault.

It seems that some of the public officials who organised the meeting (which was to do with the police) did not want her there because she had raised embarrassing questions they did not wish to answer.

The lady was then hustled off to custody without caution or lawful arrest, and held in solitary confinement for 22 hours in a police cell.

In the course of her custody the Lady was attended by a Psychiatric Nurse brought in by custody officers with an evident view to getting her sectioned.

This man failed in any way to identify himself or his role. She was left to assume he was a doctor, which she had requested, to look at her injuries. Had she known what he actually was, she would not have spoken to him, any more than she was prepared to speak to the police officers holding her.

He questioned her for about ten minutes, failing to ask about any physical injuries. Instead he tried to get her to say that her husband “abused” her.

Only some months later did she discover that this man had written a psychiatric “assessment” of her. This had been placed in the hands of the police from whom she obtained it, and who had no shadow of a right to hold such a document.

It gave an entirely false account of what she had said in her interview with the Nurse, covering topics never discussed. It was designed to imply that the lady was mentally deranged, attributing all sorts of bizarre utterances to her that she had never made.

She would no doubt have been incarcerated in a mental ward if she had not been assessed honestly the next morning by a Hampshire County Council Approved Mental Health Practitioners team. This found her fully compos mentis.
Frustrated in their attempt to have the Lady sectioned, Hampshire police instead brought a prosecution against her for “assaulting” the PCSO - the truth stood on its head. This relied on false witness statements and perjury.

Throughout, the Psychiatric Nurse concerned violated every principle of the Nursing and Midwifery Council Code of Conduct. He never put the interest of his client or patient first. He served the agenda of the Police.

He must have known that the requirements of PACE Code C were being violated. If police even suspect that a detainee may be mentally ill, they must provide an appropriate adult. He could see there was no-one present.

His attempt to blacken the Lady’s husband as an “abuser” would “justify” the police excluding him from the role: he was the obvious choice. Had he been allowed to fill the role, her detention might have been greatly shortened.

The Nurse also took no action to obtain a doctor for the Lady.

By his own later testimony, he was content to go off duty at 8.00 in the evening leaving her in a squalid, unhygienic cell, entirely on her own, until the morning when the Council AMHP team turned up. He showed no concern for her whatever at any time.

Later complaints to Southern Health have been brushed off. The Nurse concerned has been allowed to respond to questions from the Lady with evasive, irrational and mendacious nonsense.

He remains in place to this day. Both the events and the complaints date from 2016.

The present Director of Nursing at the Trust has responded that she is “sorry if this leaves you with unanswered questions”.

Should we be satisfied with this? If we are, and if this sort of thing continues, what sort of a Service are we going to end up with?

The one man who has really helped victims of Southern Health shortcomings has been Mr Geoff Hill. It is very telling that the Trust now seeks to blackball him. They now say that they will no longer communicate with him when he is “seeking to support, assist, advocate for, or otherwise represent third parties who wish to come forward with a concern, complaint or other grievance against the Trust”.

This shows neither openness nor a genuine will to get to grips with the thorny problems.

Teresa Morse
We feel the need to bring to the attention of Hampshire county council and all other organisations at this meeting the grave concerns we have surrounding the safeguarding of vulnerable adults in the community. We feel the issues we raise need to be dealt with immediately to prevent harm occurring to vulnerable adults or the wider community in future.

We have tried to raise these concerns with relevant individuals/ agencies/ organisations with little acknowledgement or understanding that there is a problem with the safeguarding system currently in place. The grievances we have about the current safeguarding of vulnerable adults in the community are as follows:

- The failure to adequately safeguard vulnerable adults from abuse which under the care act is a criminal offence.

- The failure of HCC to acknowledge potential abuse cases and take appropriate action where necessary.

- The failure of HCC to involve the potential victim of abuse and there carer or family when ascertaining whether abuse has occurred before coming to their conclusion.

- Agencies / organisations collaborating in such a way that it results in safeguarding vulnerable adults not occurring when there is valid reason for it. The rationale that agencies/ organisations do not have the resources to meet their obligations and responsibilities is being used as a defence it is not. This itself could be viewed as abuse.

- That individuals or organisations use the safeguarding of vulnerable adults process / system inappropriately to make malicious claims against individuals who are helping or assisting a vulnerable adult.

- That there is no independent regulator scrutinizing the safeguarding of adults only self-regulation or self-auditing which is potentially putting people at risk.

We are willing to work with any individual or organisation to change and improve the system as in its current state we feel it does not adequately protect the most vulnerable in our society. Our aim is that all vulnerable adults in Hampshire are afforded the protection from abuse. Thank you for your time.

Russell Stevens
Sarah Stevens