Statement
(for immediate release)

January 29 2021

Statement

Issued by the families involved in the review of the Quality of Investigations into five deaths at Southern Health NHS Foundation Trust, commissioned by NHS England/Improvement (NHSE/I) in 2019, and the proposed Public Investigative Hearing to be chaired by Nigel Pascoe QC following publication of his report;

“Stage 1 Report into Southern Health Foundation Trust, February 2020”


Against the families’ expressed concerns, Stage 2 of the Pascoe Investigation commissioned by Ruth May, Chief Nursing Officer on behalf of NHSE/I has been reduced to an analysis of how current Trust policy and procedure addresses areas of weakness identified in a flawed thematic review of five historic cases. It is to operate by getting the bereaved families to respond with witness statements restricted to comments on the Trust’s current policy and procedures.

For the families, this exercise has never been about whether the Trust has adequate policy and procedure. It has always been about the lack of discipline of Trust staff in adhering to published policy and procedure and a lack of governance within the Trust in openly acknowledging and accepting where this has been evidenced to be the case, with often tragic consequences. The inability of the Trust to follow its own procedure has already been proven in the Coroner’s court in at least one of the cases considered in the Stage 1 report, but is not to be considered further in the proposed hearing.

As such this proposed hearing, with Terms of Reference the families have repeatedly advised are unacceptable, does not meet their agreed overall aims either in the Stage 1 Report or in what is proposed for Stage 2. With a panel heavy with NHS management, responsible for overseeing a culture where this lack of governance has been permitted to prevail, is destined to fall far short of what the families have consistently been working to achieve for many years - honest and transparent investigations that facilitate quality improvement in patient safety and safeguarding.

True witness to whether the Trust has indeed mended its ways lies not with the five families who have brought about this hearing but with the current and most recent users of the service and their family and carer networks. It is clear from media reports of recent tragedies that problems still persist similar to those identified by the five families and has continuously been the case for over five years since publication of the Mazars Report in December 2015.

The proposed hearing makes very limited provision to hear witness statements from these people and the process proposed makes it highly likely that most people will have considerable difficulty in being able to access the hearing and actively participate in it. This is unacceptable and clearly shows the ongoing refusal of those in control to acknowledge the reality of the problems faced by the public they serve and their unwillingness to make reasonable adjustments to accommodate them.

All five families are unanimous in the desire for lessons to be learned from their experience, both in terms of the failings that led to their loved one’s death and the manner in which they have been treated since. This in essence is about being both believed and respected and having the truth of what actually happened to our loved ones formally acknowledged.
Statement
(for immediate release)

January 29 2021

A toxic culture is a recognised issue within the NHS, particularly towards complainants and whistle-blowers. A curious, open and honest culture would be reflected in fewer questions remaining unanswered as to what actually happened to a Service User or Patient. Where questions are unanswered a culture far removed from our experience would welcome the opportunity to respond openly and honestly. For the majority of families this will be closure. Only when this full, frank and honest evidenced narrative of each case is established can lessons truly be identified and by acknowledgement and acceptance lead to much needed change.

The manner in which this hearing has been set up falls far short of expectation and will not achieve the documented aims of the families who brought it about. Our efforts over the years have led us down many avenues and introduced us to a revolving door of NHS and government agency personnel. We have “engaged”; we have “participated” and we have “co-produced”. We have invested heavily of our time and emotional energy. Sadly, and as evidenced by the manner in which we have been treated during the course of the past two years, and specifically the manner in which the Stage 1 Report was published, we have lost all trust in those charged with both commissioning and delivering this hearing.

Sadly, all efforts to have our voices heard, acknowledged and accepted have met with a belligerent dissonance by those in senior management positions, both within the Trust and the wider national NHS management, in facing up to the truth and we have been openly misled, misrepresented, gaslighted and bullied.

We must remain true to our cause and in honour of our lost loved ones refuse, through our participation, to legitimise the charade that this hearing has become.

Ian and Jane Hartley, parents of Edward Hartley
Angie Mote and Kim Vella, daughters of Marion Munns
Maureen Rickman, sister of Jo Deering
Diane Small, mother of Robert Small
Richard West, father of David West

Ends