Gosport Families Slapped In Face By PHSO

By Eileen Chubb © January 24th 2019

Professor Liam Donaldson, who in 2003 as Chief Medical Officer at the Department of Health ordered a review into deaths at Gosport Memorial Hospital has been discovered only this week to have been advising the Parliamentary and Health service Ombudsman .(PHSO)

The review ordered by Sir Liam into Gosport in 2003 was damning but was not made public for 10 years when it was published in 2013 after the families continued to fight for justice and overcome the barriers to obtain the truth.

On Monday 22nd January 2019 I attended the Public Administration and Constitutional Affairs select committee hearing. I went after being alerted that the PHSO was going to give evidence. I was alerted by the campaign group PHSOthefacts. which has done brilliant work in exposing the failures of the Ombudsman's investigations or lack of them. More on the PHSO later in this report.

I was sat next to Ann Reeves' whose mother Elsie Devine was killed at Gosport and when the PHSO stated that Sir Liam Donaldson was advising them, I saw first hand the shock on Mrs Reeves face and spoke to her after the hearing.

She told me that that ***" It was a slap in the face for the Gosport families, to learn that the PHSO had made the decision to engage and seek advice from Sir Liam Donaldson, Sir Liam was heavily involved in preventing justice for the Gosport victims by the following actions,***
Withholding the Baker report from the families for over 10 years whilst sharing this report with Dr Jane Barton, the GMC and other agencies,

Sir Liam sat in and contributed at meetings at the GMC with Dr Barton and with her brother, Professor Christopher Bulstrode, who was a member of the GMC council 2001- 2010."

I can completely empathise with Mrs Reeves, her family and the other Gosport families have had to fight tooth and nail to get the truth exposed at great personal and emotional cost to themselves, they have been obstructed every step of the way and Sir Liam Donaldson has been one of those at the very heart of the cover-up and obstruction.

When the next Gosport happens, then the route to redress for the victims would be the very PHSO Ombudsman being advised by Sir Liam Donaldson. Indeed Gosport is not the extent of Donaldson failure to act

Quote from Christine England Whistle blower, Hammersmith NHS
"***Liam Donaldson was informed of the Hammersmith radiology whistle-blowing case and the invisible harm done to patients without their knowledge, he failed to respond or take action. Donaldson is just one of many in powerful positions who choose to help wrong doers at the expense of all those harmed. Am I surprised about his actions re the Gosport deaths? Not at all and is he fit to advise the PHSO? Absolutely not. What is needed is a public inquiry into all historic whistle-blowing cases to expose who (i.e. those such as Donaldson) knew what and when, and how they failed, including many cases in which the PHSO has been involved. Also the pattern to note is that the Cameron report into Hammersmith Radiology has been kept secret for almost two decades by the Department of Health."***

I have always campaigned for a system that would hold to account **both** the perpetrators and those who aided and abetted such perpetrators. I was very disappointed with the BBC Panorama on Gosport, because half an hour did not do the story justice, mostly because chasing Dr Jane Barton down the road was a pointless exercise without doing the same to the dozens of individuals such as Sir Liam Donaldson, police, judges and **all** of those who are equally guilty for covering up all the deaths at Gosport. The law Misconduct in Public Office could and should be used for these offences.
See our report [should we Abolish Accountability?]

When we have to rely on the tenacity of individuals and groups such as the Gosport, Midstaffs and Hillsborough families to uncover the injustice, corruption and indifference of our public institutions, to expose individuals who are respected and honoured by the establishment for their part in aiding and abetting the wrong doing, that we have to rely on victim's families and whistle-blowers sacrificing decades of their lives fighting the cover-ups is not beyond wrong, it's a canker infecting our institutions and judicial systems and we **all** pay the price.

Sir Liam Donaldson said ***"To err is human, to cover-up is unforgivable and to fail to learn is inexcusable"*** These are the words of an individual who is absolutely assured of protection, that no one will hold him to account and a level of complacency that is ingrained from the presumption that people in his

position have never been touched by any consequences for their actions. Esteemed experts, Government advisors, other organisations, all those who play a crucial role in obstructing the truth and maintaining the façade. The result? A continual conveyor belt of human suffering, grief, avoidable and criminal loss of life, and injustice.

The PHSO and Regulators

Another observation from attending the Public Administration and Constitutional Affairs Committee or PACAC, I have seen many regulators grilled by many select committees and if you have seen one you have seen them all. Some of the committee members genuinely do their best to obtain a single fact of worth from such regulators who all respond identically with a plethora of waffling nonsense about strategies and systems and how things have all improved each and **every** time they are called to give evidence about their most recent failures. A whole host of Jeremy Paxmans could be deployed but would soon be pulling their hair out in frustration.
If you ever want to see why nothing is ever done about anything that **really** matters watch a regulator or ombudsman accounting for their actions, it's a real eye- opener. Failing that watch a CQC board meeting.

I did obtain one of the documents that was referred to by the above committee, but you would as a member of the public have to go and obtain such a document to find out the whole truth, as very little of it was referred to, neither was the implications for the public raising concerns with the PHSO.

The case relates to a complaint against two doctors upheld by the Ombudsman*, Howarth and Miller v PHSO:*

61 "***It is also of note that in this case the final report of the Ombudsman contained not one trace of the extensive expert opinions provided to the ombudsman on behalf of the doctors nor of the important challenges to the advices of the ombudsman's clinical advisers in respect of good practice, the timing of symptoms and causation. It is as if the Ombudsman had never received these opinions. They were rejected without explanation"***

In summary the doctors were not given full information on exactly what was complained about. Whatever the full facts are, a family who has waited a considerable time for justice has been failed by the Ombudsmans'

investigation. What are the implications for current and future members of the public raising concerns?

The judgement clearly lays out how the principles of fairness are expected to be applied by an Ombudsma.

39 ***"The principles of fairness are not to be applied by rote identically in every situation. What fairness demands is dependent on the context of the decision, and this is to be taken into account in all its aspects. An essential factor of the context is the statute that creates the discretion, as regards both its language and the shape of the legal and administrative system within which the decision is taken"***

"***41 "The courts have emphasised the wide discretion the Ombudsman has over investigative procedures"***

Email to PACAC chair from Ombudsman PHSO dated 15th February 2018

"I am writing to inform you we have disappointingly lost a Court of Appeal hearing, the judgment was handed down at 10am this morning, Thursday 15th February the full judgment is attached.

The ruling applies to a case we completed four years ago and relates to our approach to alternative legal remedy (ALR) the standard we use in cases that involve clinical advice and the proposal to investigate stage.

We have long been planning for this potential outcome and have been considering the possible implications and solutions, since the completion of this case, we have significantly improved our processes and policies and many of the issues raised in the ruling have already been addressed, or are in the process of being addressed. We are pleased that the court confirmed the breadth of the Ombudsman's discretion in determining our approach to casework.

Nevertheless, we are urgently considering some policy issues in particular the standard we apply in a case that involves clinical advice. Importantly, the court has not ruled that we must adopt a specific test which retains the important freedom we have currently to choose a test that best meets our

needs. But it has disapproved aspects of the way that we apply a current standard and these need to be resolved .

We are carefully considering the ruling and whether there is merit appealing. We have 28 days to appeal but our aim is to reach a provisional view in the next 2 weeks during this time to ensure we are compliant with the ruling we will not issue any draft or final decisions on NHS cases that involve clinical advice, All other cases will of course continue as usual.
I will update you once we have made a decision with regards to a potential appeals process and next steps"

Considering all the previous failures of the Ombudsman, this case raises the following questions for me, which were not asked by the select committee and which ask now.

One: How many other cases are likely to have been affected by the fundamental shortfalls highlighted by this case?

Two: What steps should now be taken as result of this judgement to review all those cases?

Three: How are current and future cases going to be affected by this judgement given that the Ombudsman has by their own admission altered their processes and policy in light of this judgement, in spite of the judgement highlighting that each case should be assessed individually anyway?

Four: Given the serious nature of the failings highlighted in the judgement, is it not time we accepted the PHSO is unfit as an organisation and remedy for the public?

Five: Could this case also have the consequence of impacting on public safety whereby an appellant who should have been sanctioned but is not because of the PHSO altering its procedures?

There are those who would argue that we need **more** regulators to regulate the regulators- where does this end?. WBUK argue that for whistle-blower protection we need a bounty hunting US system with yet another ombudsman

type of regulator, office of the whistle-blower, this would be funny if it were not so tragic.

Please read our report on whistle-blowing There is no ME in Whistle-blower for our work and all our evidence that supports Ednas Law

Edna's Law is the **only** law that would protect you in hospital, but **also** ensure you did not need hospital treatment as a result of an avoidable train crash, being hit by a dangerous bus driver, an environmental hazard, neglect or abuse in care homes, eating or drinking contaminated food or drink, being killed working in construction, suffer a miscarriage of justice…. the list is endless.

Eileen Chubb