Case outline Tina Graham

Tina_graham@btopenworld.comTel: 01202 533253

On 8th November 2010, I was working as a senior counsellor and supervisor of counsellors for Dorset PCT.

A client had been referred into me and was known as ST. An outline of issues and a discussion with a colleague indicated he had relationship concerns, nothing out of the ordinary.

The hour-long session culminated in an extremely labile presentation of ST, who was clearly markedly disturbed. I felt at risk in the room and after the session because of the disclosures. This was a person with severe psychological issues and likely a severe personality disorder. Later those were confirmed via the newspaper reports. He had served time in HMP Grendon, where the most dangerous are treated in an attempt at rehabilitation. Again management knew this.

It was evident to me that based on ST's disclosures, it was likely that he may commit a serious offence, I had reason to believe that his girlfriend/partner was at serious and imminent risk. This was a person known to Dorset probation and after a Phoenix Bureau check by my manager, my manager discovered that ST had indeed murdered a young child some years prior, and served a long prison sentence. I was aware of a murder conviction but not that it was a child. This would have and should have triggered a potential child protection issue. My manager and head of service did not ask if he had contact with children.

STs history, along with my encounter should have triggered disclosure to the probation service and a risk assessment by appropriate experts.

My manager and the head of service decided to reassess ST. They asked no risk questions. He was graded no risk and nothing was disclosed to the probation service. Both of them were not adequately experienced nor qualified to conduct an expert forensic assessment. They made no attempt to establish whether ST had a personality disorder. They placed him with a colleague of mine whom I was to supervise in the future. My manager would not tell me who this was, I discovered this after the termination of my employment. In my opinion they placed my colleague at severe risk because the work could have opened up any of his disturbance. It is evident from the newspaper report by this time he was compliant and not truthful e.g. he was drinking and admits the relationship was volatile.

Throughout this process, I was cold shouldered by colleagues, ostracised from a meeting which included discussion about this scenario, left to work in an unsafe building. I was signed off sick from work on 11th November 2010. My handover colleague had failed to give me the risk assessment where it evidences he had destroyed his partners communication equipment. Phone and computer. This was a man ready to potentially seriously hurt someone. As well as my own clinical supervision I sought expert forensic supervision which I paid for at the instruction of my clinical supervisor. Both experienced professionals agreed that the work place dynamics were strange and dangerous.

The building had no reception area, no slam locks no security of any kind, I had concerns that ST would regret his disclosures to me, and possibly return. None of us had any panic alarms. There was no policy in place in case a client attacked one of us.

I fully disclosed my concerns to my manager and as I was aware of a cover up and strange dynamics at work I recorded the conversation. Emails etc. and response to my concerns were dismissed, I was told that he had been rehabilitated. These were all attempts to shut me down. I felt powerless and isolated.

This was the IAPT service running from Dorchester, now known as steps to well-being. This is a step three service for mild to moderate anxiety and depression. The service specification does not include working with aggressive, forensic patients.

At the time of seeing ST, I was in the early stages of a second pregnancy, having miscarried a year before. I lost the baby in early December 2010. I was throughout this in a state of extreme anxiety/stress as I anticipated a serious crime being committed (possibly a murder) and my concerns were being brushed over. None of this made any sense to me. I was offered no explanation. As an experienced member of the team this was highly inappropriate, I was and had been supervising counsellors since 1999, 11 years with a master's degree in supervision yet I was unable to discern between a person who was stable or one who was totally unstable…? I saw his instability and his capability in that hour, I was witness to a terrifying encounter.

Human resources tried to steer me towards speaking with the head of service Peter Thorne, but as he was part of this decision-making, I felt that that was inappropriate. Human resources refused to give me the line management route for me to address my concerns. I made the decision to whistleblow as soon as I was able to following

my miscarriage, and attempting to challenge the decision making of my manager and the head of service.

I whistle blew to the CEO, Paul Sly in early January 2011 after challenging the decision making. Dorset PCT dragged their heels and responded after 4 phone calls. They started the investigation in March 2011 so it as clear that there was no intention to take my concerns seriously. I was off sick and due to my contract received no sick pay just SSP. I asked them to assist me as I was in a bad way with my pain condition in full flare due to the stress and the miscarriage, the trust refused.

I was contacted by the head of human resources, Charles Summers and encouraged to go through with an investigation. I disclosed all the information to the investigator Will Smith, which was very distressing as I had to relive the whole hour with ST, which was terrifying. Mr Smith is now the head of homicides, NHS England, when I contacted NHS England with my deep concerns about his investigatory abilities they said his references were fine. The management who referenced Mr Smith were all part of this.

The investigation did not in any way address the issues I had raised, there was no investigation into the decision-making, the lack of contact with Dorset Probation (which I came to realise many years later after contact with Dorset Probation), **there was no mention of the fact the service was running without any risk policy/protocol/procedure, in the event of a client's being a danger to themselves or others.** I discovered this after my employment tribunal in late 2013/2014.

In fact, some of the concerns I have, include;

• Professional undermining

• Deceitful practices

• Lack of compliance with FOI by Dorset healthcare. Outstanding requests for risk policy ignored

• Failure to disclose documentation to the courts

• The deaths of members of the public accessing an NHS service and not having appropriate investigations into matters

• Coroner rule 43 (Coroner flagged up concerns ref no of deaths)

• Lack of risk protocol/policy/procedures at the time (no standardised instruction in dealing with danger to self or others)

• Failure to appropriately information share with the probation service allowing Probation to risk assess ST which may have prevented the crime

• Bullying

• Failing to conduct an inappropriate investigation. Mr Smith failed to transcribe a single interview as he said he would. These interviews were transcribed for my employment tribunal because colleagues were slanderous and this aided the judge in smearing my character. My interview was NOT transcribed for court. I was painted as a moaner who went on for hours by their barrister – Mr Smith was the one who kept me there for hours and I was extremely distraught. I had not been diagnosed with PTSD by then but it was very clear that I was very traumatised by matters. I have the recording.

• Investigator fails to mention a lack of risk policy which is either evidence of negligence and/or collusion with management

• Investigator failed to follow up with probation

• Investigator failed to scrutinise the risk assessment

• Investigator failed to interview the head of service who was part of grading ST – no risk

• Missing minutes from meetings for period of my employment (minutes exist prior to and after my resignation

• Evidence of tampering with electronic record by my ex-manager and other members of staff. This is to hide the dates of creation of documentation and in another example one of the managers tampered with one of my emails to make me appear unreasonable. **An undated "risk policy was created for the court "None of my ex-colleagues had ever seen it before.**

• Failure to adhere to Service Specification (aggression issues coupled with a prior murder conviction not step 3)

• Failure to appropriately risk assess (no risk questions asked) a patient with a prior child murder conviction who was labile

• Failure to follow up on fact he committed a serious assault and is now in prison

• Failure to investigate the disabling injuries sustained by his partner

This list is not exhaustive. ST went on to commit a serious crime, he held his partner hostage for two days and she sustained serious injuries. I gave management evidence of his lying and how dangerous he was and I was to be investigated for bullying and breaking confidentiality (I spoke to my supervisor and colleagues listened at my door). They were looking at anything they could to bully me out.

The handover from a colleague was flawed and put me in a very vulnerable position. She failed to give me the risk assessment and another document which would have tuned me into the dynamics as a very experienced therapist, e.g. ST destroying partner's communication equipment and lying about what was disclosed to his GP. I expressed my concerns to my own clinical supervisor on the phone after discovering some of the content of the police check…colleagues listened in at the door and behaved in a deplorable way and said things in the investigation that were grossly untrue.

http://www.dorsetecho.co.uk/news/9624435.Child_killer_from_Maiden_Newton_jailed_for_brutal_attack_on_partner/

The employment tribunal I attended was perverted by Dorset healthcare. I was painted as a difficult employee. The fact of the matter was I had PTSD following this whole scenario, it took the trust three years to diagnose this after my GP was called to the house following my resignation, thus finding me in an extremely distressed state. My employer became my healthcare provider and failed to provide appropriate assistance. I was horrified to find that a manager who was involved in all of this was also talking with another manager about my healthcare. I believe there was no intention to give me appropriate supportive therapy, which was agreed when I was first referred for help.

The crux of matters is that I whistle blew to try and prevent a serious crime. My encounter with ST was completely quashed and his management was entirely clinically inappropriate. **I believe the motive for all of this was a service running without any risk procedures for many years. The implications of this are vast because there were many suicides in the service and colleagues of mine were flagging up deep concerns about the appropriate management of vulnerable people. Extremely fragile people were being dealt with by poorly qualified clinicians. This is still the case today based upon colleagues whom I am still in touch with.**

The situation today in spite of all of these claims being supported with documentary evidence, including Dorset probation CEO Rob Menary, stating he believes I was clinically undermined, is that **not one regulator, CQC, monitor, PHSO is willing to look at this. These are matters of public interest. These are serious matters, people died and were harmed**, I had my career effectively destroyed. My PhD is in its final months after being stalled for 3+ years. I have PTSD with dreadful insomnia and sadly a pain condition which is virtually unmanageable. I was a happy, conscientious, professional who enjoyed her work, whistleblowing effectively destroyed my life as I knew it. I am still trying to rebuild my life, five years further on.

Monitor (regulator) have fallen silent after years of game playing wherein I have been bounced from one regulator to the other, their last email stipulated that the team involved would be responding to me in August. There has been no communication in spite of follow up emails. Now they are taking the stance just like PHSO, this is a whistleblowing case therefore it does not need investigating? This is a case with serious clinical issues at its heart. The ET were duped by managers all involved in concealing some dangerous facts. The service had no risk guidelines. It is inconceivable that this service was ever up and running without those guidelines.

This was a whistleblowing case and the courts (whistleblowing cases can be referred to external regulation if a specific box is checked on the employment tribunal form, ET1 which I did), were meant to refer this to the regulator when it came to their attention. I tracked down the appropriate department and discovered they shredded my claim form and failed to locate the regulator. The courts never wrote to me to tell me this. After tracking down the appropriate department which was not easy, jurisdictional support have allegedly changed their policy.