Journey Of Injustice

Evidence On Regulators

Volume One

By Eileen Chubb ©

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Introduction.

Having run a helpline for whistleblowers and the families of abuse victims for over two decades, we have throughout this time identified and highlighted many common themes. The most common of these themes involved failures of **Regulators**, **Ombudsmen**, **Professional bodies** and **Local Authority, Safeguarding Adults boards** to act on concerns.

Two years ago, we issued a call for evidence regarding these organisations, and we genuinely expected to receive hundreds of responses, we extended this call for evidence, which remains open due to the huge response. To date we have received **26,750** witness statements, whilst the consultation still remains open and we continue to receive evidence, this further evidence will be highlighted in the later reports and we are trying hard to digitise all the evidence for future publication but this will take time as we had never foreseen the sheer scale of the response.

We have evidence on **21 Regulators**, **82 Safeguarding Authorities** and **3 Ombudsman.**

The “ Journey of Injustice” reports will be published over **five** volumes and we are working hard to ensure the scale of the injustice and suffering involved is exposed.

Whilst we were fully aware there were real problems in the health and social care sector, we were determined to see the bigger picture in order to understand why these organisations were failing overall. We therefore called for evidence on **all** regulators.

We took this decision because we campaign for **Ednas Law,** which would protect all genuine Whistleblowers equally, we therefore need to understand the whole picture.

This evidence shows the following,

. **A shocking lack of basic investigation skills**

. Staff who have no aptitude for investigation regardless of training

. Regulatory capture

. Political Capture

. An ingrained level of insensitivity and complacency in regard to the consequences of failing to act on concerns.

. Ongoing serious harm and other wrongdoing as a result of failures to act

. Complaints and internal review processes which are completely ineffective

. All failures to act are seen in terms of minimising reputational damage should the failures become public.

. An ingrained culture of defensiveness that renders many of these organisations incapable of learning from mistakes and insensible to the injustice and distress caused by their actions.

. There is an ingrained authority bias towards these organizations and their work is often given unwarranted credence by MPs, the media, and other authorities.

. Many of these organisations only answer to parliament and whilst a select committee can occasionally ask tough questions, it is not the real scrutiny that is so badly needed.

We will be making specific, detailed, and extensive recommendations regarding all of the above throughout all **five** volumes of evidence.

Kevin Hollinrake MP former member of the APPG on Whistleblowing has referred to one failing regulator, the **FCA**, as needing to be overseen by another regulator.

In short, we need a regulator to regulate regulators, where does that end? A regulator to regulate a regulator and a regulator to regulate the regulator who regulates the regulator **STOP!**

We have enough regulators they do NOT work and will never work. We need to stop tinkering around the edges, wasting billions and take drastic action to address the real issues.

We have simply asked the public affected by these issues, what they think is wrong. We have done something no government has done so far and that is to listen to what people have told us. We are trusted by whistleblowers and the public who are being consistently failed by these regulators because we acknowledge there is a real of lack of accountability whilst other organisations shy away from confronting this.

Regulation and regulators help Governments to appear to meet their policy targets, but what is clear from the evidence is that these regulators are all too often a barrier to accountability and are increasingly being seen by the public as part of the problem.

The politics need to be removed from this issue, the public deserve to have access to a separated judicial system which includes robust investigation and real accountability, this is **not** provided by regulators or ombudsmen.

Governments reliance on regulators to reassure themselves that they have dealt with a problem and ticked off a policy objective has led to situation where billions are wasted on regulatory organisations who have no other purpose than to make politicians look effective. This has resulted in unprecedented suffering, avoidable loss of life, dangerous staff continuing to work and cause further harm, injustice, coverups, miscarriages of justice and numerous other wrongs.

We also recognise that within all these regulatory organisations there are a number of staff who go beyond the call of duty every day, often these staff will leave or be forced out after whistleblowing. Our initiative " **The Richard Turner Award"** for integrity in the investigation of abuse, aims to recognise these very staff and highlight how investigations should be carried out. Whistleblowers and families can nominate an individual who has robustly investigated wrongdoing and abuse. That individual can be,

. A Regulatory Inspector

. Safeguarding Officer

. Social Worker

. Police Officer

. Solicitor, Barrister or Judge

. Any individual whose role includes investigation skills.

Please see our website for more information on the Richard Turner Award.

Parliamentary Scrutiny

There are those who would argue that regulators answer to parliament and that's all the accountability that's needed. This amounts to relying on politicians to hold to account regulators, those same politicians who rely on them to state they have met their policy objectives.

Anyone watching a select committee ask a tough question or two will know that's as far as it goes, it's not a cross examination that gets to the truth, its merely at best a tough question that is often batted off by the regulator and never followed up. Many of these select committees approach regulators from the standpoint that regulators make them look good, so they cannot make the regulators look too bad.

Prime example when **CQC** came into force in 2009 as the UK regulator for health and social care settings. **CQC** issued a press statement alleging they had closed 100 bad homes, our work with Private Eye magazine showed this to be a blatant lie.

This scandal resulted in parliament asking **CQC** a couple of awkward questions but by no means was such dishonesty held to account. **CQC** went on to continue this tendency to mislead the public again and again with such scams as archiving histories of horrendous abuse by reregistering the old care home owner and reregistering as a new owner.

Please see Private Eye Issues in this section, articles include shocking details of human suffering as a consequence of **CQC** failings.

David Behan was the chief inspector at the previous regulator **CSCI** whose failures caused public outcry after appalling conditions were exposed in a large number of care settings.

David Behan went on to become the **CEO** of **CQC** in 2012. Followed by a catalogue of care failings including

The BUPA care homes scandal, Channel 4 dispatches.

The Times investigation into the **CQC** cover-up of a rape at a north London care home.

BBC Panorama The Old Deanery

BBC Panorama HC1

And many more similar scandals, see the Private Eye issues listed below.

David Behan went on to be knighted just after the rape cover-up story broke.

Sir David Behan Went on to a lucrative role at **HC1** and in April 2024 **Sir David Behan** was appointed chair at Kings College Hospital NHS foundation trust.

Andrea Sutcliffe CBE Joined **CQC** in October 2013 and was also responsible for the same period. She went on to be appointed **CEO** of the **NMC** in 2019.

The **NMC** after being criticized for fundamental failings to act on cases of nurses involved in sexual abuse and racial discrimination, is now being investigated after a whistleblower exposed a toxic culture leading to failed investigations.

There are many more such similar individuals at the top of regulators, the above are just examples, they call this the **Revolving Door**. It is a root cause of the rot that pervades these organisations.

Not a single individual has ever been held to account by parliament or its alleged scrutiny.

The Private Eye below issues feature our work exposing these failures.

1264 An Inspector Appals

1265 Southern Dross

1266 See No Evil

1267 Cross Examination

1272 Very Southern Cross Indeed

1274 Never Mind The Quality

1275 CQC No Evil

1276 Open And Shut Cases

1277 CQC Closing ranks

1283 Trigger Crappy

1284 No, Minister

1290 Southern Dross Update

1291 CQC Can't Quite Cope

1293 Great Scott

1298 Southern Loss

1301 Dross Houses

1307 Beating The System

1322 Asleep On The Job

1323 Going So Soon

1327 A Sore Subject

1337 New Home, Old Problem

1336 Court Napping Again

1343 Update

1352 Home Affront

1353 Northern Exposure

1342 Softening The Blow

1374 Bupa Bloopers

1377 CQC At Breaking Point

1403 Horrorgate

1402 Booting The Messenger

1405 Sleeping Watchdog

1407 Unfit For Purpose

1409 Asleep At The Switch

1411 Maximus Profitus

1412 Autumn Fall

1416 Burning Question For Bupa

1418 Candid Camera

1436 Desperate Times

1449 All at SHC

1451 Lodge Complaints

1455 Public Service, Private Killing

1473 Sleeping Watchdogs

1485 Smelling A Rat

1490 Home Truths

1494 Horrid History

1505 Sleeping Watchdog

1508 Lodge Complaints

1525 Care To Look

1526 Safety Secrets

1593 Into Harm's Way

1596 Ask The Families

Plus, also see over 400 special reports on WWW.Compassionincare.com which include comprehensive evidence on this issue.

Key Question If this charity with all its skill and experience of exposing horrendous abuse caused by the fundamental failures and dishonesty of a single regulator, even getting the issues exposed in over 50 in depth articles in the amazing Private Eye, and publishing over 400 special reports on the issue and yet, we still cannot get this regulator held to account for its failures, **what chance does a Whistleblower, or a victim's family have of getting accountability?**

Key Question Regarding whistleblowing law, the current law PIDA gives whistleblowers a list of prescribed regulators that they can report to if their employer fails to act and also allows for whistleblowers to bypass their employer and report directly to a PIDA prescribed regulator.

In the area of health and social care the UK regulator is **CQC**, yet **CQC** do not investigate individual concerns. Whistleblowers will often report to a regulator in circumstances of real risk, Why is such vital information being directed to **CQC?**

Many whistleblowers are reporting their concerns to **Safeguarding** authorities instead of **CQC**, it is worth noting that there are over five hundred thousand safeguarding adults alerts made annually, the system cannot cope. We have been told by **Safeguarding** whistleblowers that so much information in never investigated or investigated and wrongly not upheld because there is a serious lack of staff with the required investigation skills.

When lives are at risk and the **safeguarding** system is broken, then the next line of defence is **regulators, ombudsmen,** and **professional regulators.** No whistleblowing law that is regulator reliant will ever protect anyone and the witness evidence in these reports tells us why.

Our proposals for **Ednas Law** recognises the fact that any whistleblowing law that is regulator reliant is fatally flawed.

The proposed "Office for the Whistleblower" **OWB** would be just another regulator to regulate the regulators, those pushing these proposals are completely out of touch with the reality faced by the majority of Whistleblowers.

The **OWB** states it will have powers to review regulators investigations, when people are dying or there is other imminent risk the clock is ticking, it's way too late by the time the original regulator fails to act to then start to review that investigation. What whistleblowers want is the abuse or other wrongdoing stopped.

The **OWB** will be recruiting investigators from the same staff pool as other regulators, the people at the bottom will continue to fail and the people at the top are recruited from the same revolving door system. The rot goes deep and needs cutting out, we do not need another cloned version of a regulatory system that is failing every day. It's the equivalent of an airline manufacturer continuing to build planes that crash.

We have also received a large body of evidence from whistleblowers, some of which is published in volume one, this evidence is from whistleblowers from all sectors who in order to work in their particular job role rely on some form of formal approval from their industry regulator, a typical example are care home managers, who have to be approved and registered by the CQC as a fit and proper person.

This evidence clearly raises yet another fundamental flaw in the proposed **Office of the Whistleblower (OWB)**

Every whistleblower takes a huge risk in raising concerns with their employer

If the employer fails to act then the whistleblower is forced to take a bigger risk by reporting their concerns to the industry **regulator**.

If that industry **regulator** fails to act, which given the evidence submitted to us is highly likely, the proposed **OWB** expects the whistleblower to contact the **OWB** and report their industry **regulators** failure to investigate their employers failure to act.

Whistleblowers affected by this issue have given us evidence that they would <u>not</u> contact **OWB** because it would amount to whistleblowing on their industry regulators failure to act and that would put them at risk of not being approved to work <u>anywhere</u> in their job role.

Whistleblowers from regulated professions have also submitted evidence on this issue, those with concerns about professional colleagues have raised those concerns with their employer and when no action is taken have then approached their **professional body**. When that **regulator** fails to act, whistleblowers have told us they would <u>not</u> approach anyone else, as to do so would involve exposing their **Professional Bodies** failure to act and they understandably fear there would be a backlash on them as a consequence.

We also have evidence that regulated professionals and others would fear to bypass their **professional regulator** as they would also risk repercussions, they issue that the proposed **OWB** has neither the expertise nor the powers to investigate a registrant of a professional body.

Whistleblowers have also given evidence that the proposed **OWB** would in ordering any regulator to investigate or reinvestigate a Whistleblowers concerns would inevitably result in a flawed investigation which was more aimed at restoring the regulators reputation, i.e. confirming its original flawed investigation conclusions, or carrying out an investigation that was tainted with resentment from the outset. Add to these facts the lack of investigation skills highlighted in this report and consequences for the public interest and whistleblowers will clearly be calamitous.

Whistleblowers risk huge backlash from their employers and our evidence shows they often have to leave and work elsewhere, what kind of alleged whistleblowing protection would put whistleblowers at further risk of harm?

The above is just one of many fundamental failings in the proposed **OWB** and we are the only whistleblowing organisation who has raised these specific issues and we have done so at great risk to ourselves and have been targeted with a campaign of malicious allegations as a direct result, but we will continue to raise valid evidenced concerns, because what kind of whistleblowing organisation would we really be if we remained silent and supressed evidence of genuine concerns?

Unfortunately, the **OWB** has huge funding behind it from the vested interests that would gain from it being made law. This funding is channelled via the APPG on Whistleblowing secretariat Whistleblowers UK (WBUK) who is also the largest funder of this APPG.

Should the **OWB** be enacted it will lead to unprecedented suffering, risk, abuse, harm, and avoidable death.

The **OWB** is being proposed for one reason and one reason only, because it will benefit the vested interests behind the APPG on Whistleblowing and those who fund Whistleblowers UK (**WBUK)**

BBC Newsnight even recently platformed WB-UK and Mary Robinson MP promoting **OWB** and when Newsnight was asked why they said they considered these individuals must be experts because of the position they hold in parliament.

The above individuals and their agenda are ignoring the valid evidenced concerns of genuine whistleblowers, the steps they have taken to silence and smear this charity to stop challenging them is more reminiscent of Putin's Russia than the UK.

Keir Starmer has pledged to enact **OWB** so the danger to whistleblowers will still continue once the current government have gone.

About The Evidence

We thought long and hard on how to present the evidence and decided against categorising the evidence on each organisation separately for the following reasons,

. Raising concerns is a journey of injustice and loss of trust and we think it's important to see the cumulative harm that is caused when regulators and others fail to act.

.When families approach a regulatory organisation, and that organisation fails to act they will go to the next organisation and so on. These families may well be grieving the loss of someone they love and each time they are failed their grief is compounded.

. Whistleblowers may well have risked and lost their job for speaking out in the first place, they approach these external organisations because their employer failed to act. Each time regulators and others fail to act on concerns, the message is sent to those abusing, they are safe. The message is also sent to other staff witnessing abuse that regulators will not act should they report it.

. People's lives are not pie charts, we wanted people to be heard in their own words, to give them a voice so they could bear witness.

Over the last decade or so there has been a distinct shift for the worse in how abuse of vulnerable people is perceived. Those in a position of authority to act on abuse, prefer to think of abuse in terms of poor practice, lack of training. A positive spin has become the approach taken.

A culture of ingrained, absolute, deniability has taken hold. We have often heard people in authority say, "*We need to concentrate on the positive aspects of a case and what lessons can be learnt*." However, lessons are never learnt, and abuse continues

unchecked, and all too often is perpetrated by individuals who have been flagged to the authorities again and again but, were deemed only to be in need of training.

Outside of the health and social care sector the same patterns emerge, a reluctance to act and a complete inability to see any consequences that may occur as a direct result of that failure.

I am reminded of a favourite quote that was often cited by a good friend, Gavin MacFadyen, that quote sums up the approach we have taken in presenting the evidence in this report,

For all those regulators and authorities that feature in this report, for all those ministers and civil servants who want to be reassured by the existence of these regulators and authorities,

" We will not stay silent so that you can stay comfortable"

We as I have said we really struggled with how to present such a huge body of evidence and decided that this, the first volume should highlight all of the common themes identified overall and use a sample of typical witness statements that exemplify those themes, and the later volumes will continue this approach. As we have said we just never expected such a huge response and we aim to digitise all the evidence.

There has also been the issue that some whistleblowers do not want to be identified as they will have been forced to find other work and do not want their current employers to know they are whistleblowers.

Also, some families with a relative still living in a care setting fear being identified in case it puts their family member at risk of being evicted or them being seen as a "*Complainer*"

For this reason, we have allowed those people who do not wish to be identified to use a pseudonym or code name. In many instances the regulator or other authority is named but, in some cases, where identifying the regulator could identify the Whistleblower or family, we have anonymised the details.

Our primary concern is to ensure people can give us their evidence in safety and not be put at risk as a consequence

We have not separated the evidence on each regulator because people often have to go to multiply regulators and that is why this report is called, a journey of injustice, people

describe the process of trying to get accountability as a serious of fundamental failures by each regulator they come into contact with along the way.

Part One. Lack Of Investigation Skills

Out of **26,750** respondents

21,314 people cited lack of Investigation Skills, that is a staggering **79%**

Staff having no aptitude for investigation was cited in **24.019** cases, almost **90%**

There were various reasons given in the evidence as to why people thought there was a lack of investigation skills and no aptitude for investigation, citing one or more of the following factors,

Corruption

Political Capture

Industry Capture

Incompetence

Laziness

Complacency Indifference

Tick list Mentality

Contempt for victims

There were also many other significant themes identified, some examples listed below. We will continue to identify such themes in further volumes in this series of reports.

. Whistleblowers from industries or job roles that involved official approval by an industry regulator were understandably very concerned when that same regulator failed to act on their whistleblowing, because taking their concerns to another authority amounted to also reporting the regulator who failed to act.

. Whistleblowing, Nurses, Student Nurses HCAs and other health and social care staff are being discriminated against by regulators, the legal system, and media because they are not doctors and could be raising concerns about doctors.

. People being placed on End-of-Life pathways who are not terminally ill.

. Exploitation of overseas staff in social care in particular with an increase of reports from whistleblowers concerned about colleagues being used as slave labour, dangerous working conditions, and the impact on care.

The Evidence

S Cartright

“ *My mother had lived in this care home a while and at first everything was good, there were always plenty of staff on duty and when I visited there were always staff with people in the public areas, lots of activities and the care was really good. We were then told that a new company was going to take over and that everything would continue as usual. It changed drastically so quickly. Lots of the lovely staff just left or at least that’s what I was told when I asked.*

The first thing I noticed was that my mother was losing weight, when I asked about this, I was told it was just a symptom of dementia, but my mother had a good appetite, and she would eat ravenously when I brought her biscuits or a sandwich when I visited.

We were asked not to visit at mealtimes as they were a protected time, I started to visit a little after the mealtime had finished and would find my mother slumped at the dining table with uneaten food in front of her, she needed prompting and care to eat and that was not being provided.

I made a complaint to the home about this, nothing changed despite the management making many promises.

Nearly all the original staff had gone, some of them told me in confidence that the new company was awful and that they could not bear to see the neglect that was going on, some of these good staff had made reports about the home and the next minute they disappeared.

I would find my mother soaked in urine still in bed at midday waiting for care at midday or later, she would be so distressed it broke my heart.

When I gave my mother a glass of water she would snatch at the cup and gulp it down and I knew she so thirsty because of neglect. I had continued to make complaints to the home, but nothing changed. I decided to go to the ***CQC*** *and told them everything, they said they has noted my concerns for their next inspection.*

I could not believe the home was still rated good after the deterioration but when the ***CQC*** *next inspected they still rated it good, they said they had received concerns about hydration and weight loss and had looked at the records and found them to be in good order and that nutrition and hydration was robustly monitored and recorded by the home.*

I continued to find my mother laying in her body waste in her bedroom in the dark, late into the afternoon, she had no means of getting food or drink for herself and was totally reliant on staff who were clearly struggling to get people up.

I would wander the home for anything up to 30 minutes before I found a staff member coming out of a bedroom. When I asked why my mother was still in bed, I would be told they were short of staff that day, but it was something I was being told on every visit.

There was a spell of really hot weather, my mother's room was stifling, and she was constantly so thirsty when I brought her water.

My husband was very ill at this time and my income was what kept us afloat, I do not know how I kept my job, all I thought about was how thirsty my mother was likely to be and what would happen if I could not get to her to bring her water.

I went to the ***local authority safeguarding*** *team with my concerns, but before I heard back from them my mother was rushed to hospital with a suspected urinary tract Infection, she died six days later.*

My mothers cause of death was listed as dementia and there was no autopsy as she died in hospital. The safeguarding authority did not uphold my concerns and I spent

months writing letters and pointing out the evidence. The alleged investigation consisted of looking at the care homes fabricated fluid charts and care plans.

A year later the care home was rated inadequate after inspectors received numerous concerns and found people were found dehydrated, malnourished and with infected bedsores. Sometime after this I met the daughter of another resident in the town and I cried when she told be what had happened to her mother, how she was always so thirsty, how her urine smelt and was dark brown in colour, how her mother died in exactly the same awful way.

*I told her was so sorry that the dozens of concerns I raised with the home, the **CQC Safeguarding** were all but ignored. The individuals I dealt with at **CQC,** and **safeguarding** were absolutely useless, they actually told me that I had unrealistic expectations of the home and their attitude towards me was hostile. My mother died for the want of food and water in a care home, and no one thought that was an issue."*

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<u>H. Clark</u>

" *My mothers legs were infected, they really started to smell, we kept asking the nurses who told us everything was fine but the dressings on my mother's legs were either filthy and stained or were coming undone. A short while later I visit my mother who was whimpering in pain and barely conscious, there were maggots in the wounds on both legs. I rang for an ambulance on my mobile and my mother was rushed to hospital, she had gangrene, they had to amputate but she died during surgery. The home was rated good and is still rated good. The **Safeguarding** concluded her wounds were cared for by the home and there were good records of wound care and that the maggots must have hatched in the ambulance as the home had not recorded this"*

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<u>M. Coulthard</u>

" *I reported Nurses falsifying paperwork to the **NMC**, this caused serious injustice to someone's family who were trying to get to the truth of what happened to their parent. I had to wait over a year for any outcome, I was told there was no case to answer as the*

nurses denied the charge and mainly because there was no evidence as the paperwork available supported the nurses version of events, well it would, wouldn't it? There was plenty of evidence, but it was ignored. As for trying to challenge their decision, it was a joke. I am not sure if these people were deliberately obstructive or downright stupid either way, they were not capable of investigation. The ***NMC*** *were my last hope I had already been to* ***Safeguarding*** *and* ***CQC*** *who also concluded there was no evidence of falsification even though one of the nurses was not on duty the day they allegedly signed records and there was so much evidence, but evidence gets you nowhere"*

………

T Greenfield

" *I am a care home manager in the UK. I do not want to be identified so will just say that my whistleblowing related to something I was asked to do by my employer that would have put people in the care home at serious risk. I refused to do it and went to the* ***regulator*** *(One of the 4 UK Health and Social Care* ***regulators.)***

I was stunned when I later learnt this ***regulator*** *was not going to take any action at all. I left the company and went to work somewhere else.*

In order to be a care home manager anywhere I need to be approved by this ***regulator*** *as a " fit and proper person" to be a manager of a care home. I could not take my concerns anywhere else as I would effectively have been reporting the* ***regulator*** *whose approval I rely on for my livelihood.*

One thing I can say with absolute conviction is that the whole concept of the proposed ***Office of the Whistleblower*** *would put people in my position at further risk, would I report my industry* ***regulator*** *to another* ***regulator****? Never, I am a single parent family and I took a huge risk in going to the first* ***regulator.*** *How dare those who are proposing this* ***OWB*** *ask me to do more, I already did all I could and no one should be expected to do any more."*

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PHSO The Facts

"*I would like to submit some evidence to your report on behalf of PHSOtheFACTS. I hope you find it useful. Much of it has been submitted previously as evidence to the PACAC select committee. In addition, you can find many more examples of PHSO failure in Della's book entitled "What's the point of the Ombudsman" found on Amazon.*

https://www.amazon.co.uk/Whats-point-Ombudsman-Della-Reynolds/dp/1999929152

Kind regards

This evidence is divided into 5 sections.

1. Accountability

2. Decline in Complaints Investigated

3. Dissatisfied Customers

4. PHSO failures

5. A Biased PHSO Investigation

1. Accountability

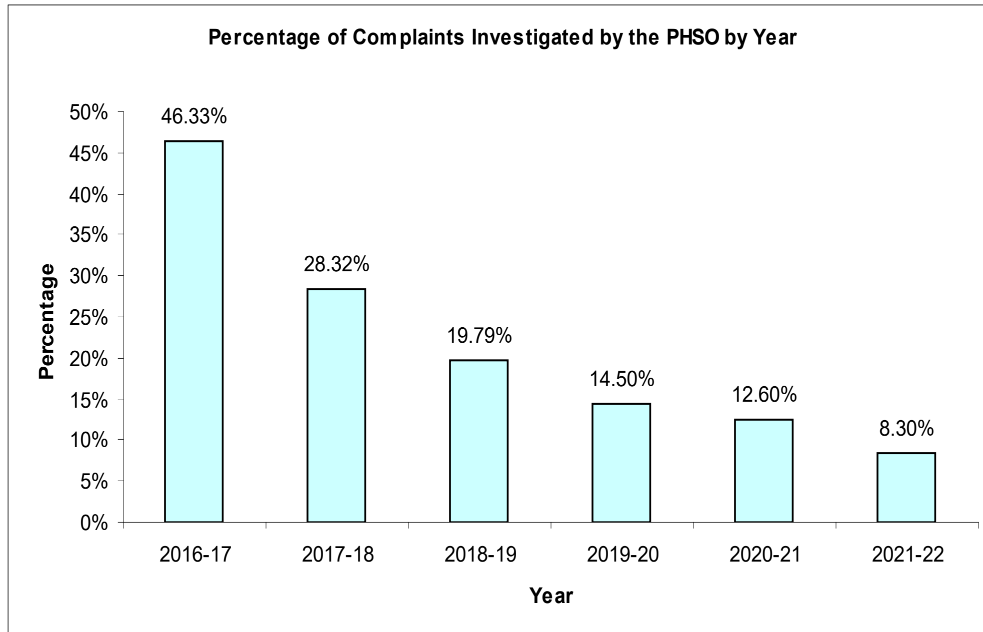
Here is a link to a blog post about government accountability through the PHSO.

https://phsothetruestory.com/2023/02/22/how-the-uk-government-holds-itself-to-account/

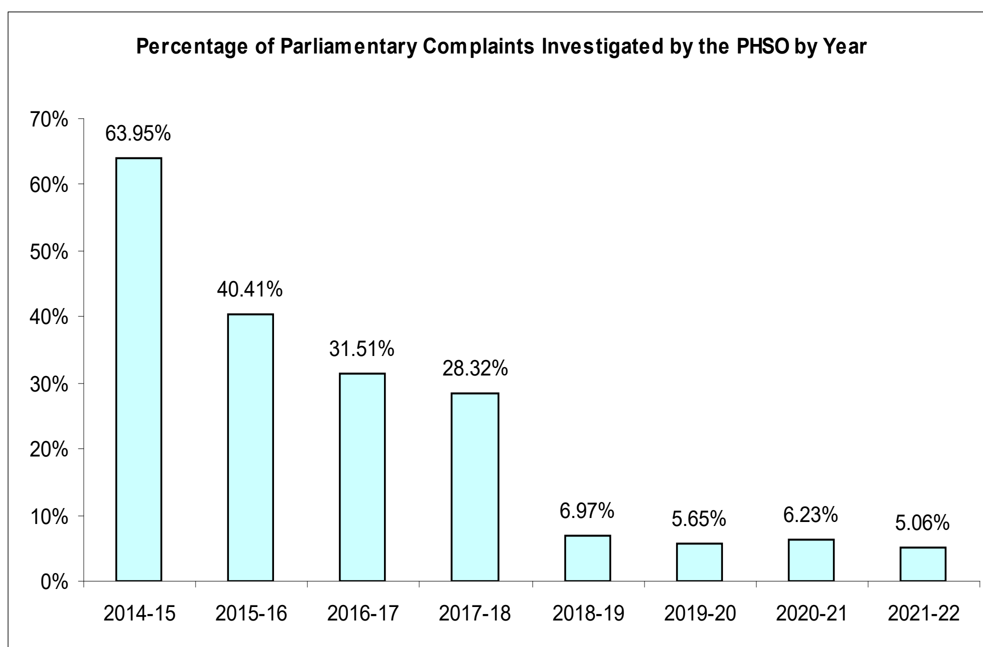
2. Decline in Complaints Investigated

Here is a graph showing the dramatic decline in the percentage of complaints investigated by the PHSO under the current Ombudsman over the last 6 years.

In 2016-17 nearly half of all complaints were investigated. By 2021-22 only 1 in 12 complaints were investigated.



For complaints about government bodies only, the situation is even worse with more than half of all complaints investigated in 2014-15 but only 1 in 20 complaints investigated in 2021-22.



All these statistics are taken from the PHSO annual reports which can be found on the PHSO website here.

https://www.ombudsman.org.uk/about-us/corporate-information/corporate-publications

3. Dissatisfied Customers

In 2015-16 the PHSO produced a feedback report showing how members of the public who had complaints investigated by the PHSO felt about the investigation. The report can be found here.

https://www.ombudsman.org.uk/sites/default/files/Complainant_feedback_survey_2015-16.pdf

It found that:

Only 35% said the decision followed an independent, fair and unbiased assessment.

Only 34% said that the final report provided evidence to support the decision.

Only 38% said the final report dealt with the most important aspects of their complaint.

The report has never been repeated so we don't know if these figures have improved or become worse, however there is no evidence that satisfaction with Ombudsman investigations has improved.

4. PHSO failures

The PHSO has produced a number of reports over the years, but they seem to have had remarkably little impact on the organisations reported on. There is also very little feedback or follow up on the reports and when there is it is usually not very positive.

DWP

In the foreword to the 2021-22 PHSO annual report the Ombudsman mentions a report produced by the PHSO in January 2022 relating to compensation payments to people who had been underpaid in regard to their ESA benefits. It should be made clear that it was the DWP who identified the error and refunded the lost money. The PHSO complaint related to compensation payments.

https://www.ombudsman.org.uk/sites/default/files/HC956_An_investigation_into_the_Department_for_Work_and_Pensions....pdf

However, according to an article by the journalist David Hencke, the DWP has ignored the recommendations for compensation made by the PHSO. He states:

“The decision also shows up the weakness of complaining about maladministration to the Parliamentary Ombudsman, Robert Behrens, in cases involving the ministry as it ignores his rulings”

https://davidhencke.com/2022/08/07/dwp-ignores-the-parliamentary-ombudsman-and-refuses-to-compensate-118000-disabled-people-hit-by-benefit-maladministration/

Maternity Care

There have been multiple failures of maternity care identified by independent reports, most recently the report into the failures at East Kent.

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1111992/reading-the-signals-maternity-and-neonatal-services-in-east-kent_the-report-of-the-independent-investigation_print-ready.pdf

Yet despite hundreds of cases of failure now being identified, the PHSO has been remarkable by its absence. It might be thought that a complaints organisation should have picked up the problems with maternity care. Yet it seems that no-one complained to the PHSO.

The PHSO did produce a report in 2013 into failures of maternity care at Furness General Hospital but it seems to have had little effect on the standards of care across the NHS.

https://www.ombudsman.org.uk/sites/default/files/Midwifery_supervision_and_regulation_Mr_M_report.pdf

Mental Health Services

In 2019 the Ombudsman produced a report into failings in the care and treatment of two young men with mental health problems at North Essex Partnership University NHS Foundation Trust.

https://www.ombudsman.org.uk/sites/default/files/page/Missed_opportunities_What_lessons_can_be_learned_from_failings_at_the_North_Essex_Partnership_University_NHS_Foundation_1.pdf

In October 2022 Channel 4 Dispatches showed a documentary about the same North Essex Partnership University NHS Foundation Trust which in their words stated that "...an NHS Trust responsible for serious failures resulting in multiple deaths still isn't keeping patients safe".

https://www.channel4.com/programmes/hospital-undercover-are-they-safe-dispatches/on-demand/72849-001

HS2

In 2015 the PHSO produced a report into a complaint against HS2 and it was followed up with a report by PACAC.

https://www.ombudsman.org.uk/publications/report-results-investigation-complaint-about-high-speed-2-ltd-hs2-ltd

https://publications.parliament.uk/pa/cm201516/cmselect/cmpubadm/793/793.pdf

However, 6 years later the very same complainant had to raise another complaint on a similar matter and another report was produced by the Ombudsman. It seems that HS2 had learnt nothing from the first report.

https://www.ombudsman.org.uk/publications/investigation-hs2-ltds-failure-communicate-family-about-acquiring-their-home

Eating Disorders

The Ombudsman published a report into eating disorders after failures of care led to death of a young patient named Averil Hart.

https://www.ombudsman.org.uk/publications/ignoring-alarms-how-nhs-eating-disorder-services-are-failing-patients

On 14 May 2019, 18 months after the Ombudsman published his report, PACAC held a follow up inquiry at which Dr. Dasha Nicholls, Chair of the Faculty of Eating Disorders at the Royal College of Psychiatrists, and Andrew Radford, Chief Executive of BEAT Eating Disorders, gave evidence.

When asked what impact the report had made, Dr Nicholls replied "As yet I would say relatively little".

Dr Radford claimed that the situation was "as bad now, if not worse than it was in 2012 when Averil died".

http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/public-administration-and-constitutional-affairs-committee/phso-report-ignoring-the-alarms-how-nhs-eating-disorders-services-are-failing-patients/oral/102194.pdf

DWP

In the Ombudsman's Casework Report of 2019, a case concerning the DWP and the new state pension can be found on pages 14 and 15.

https://www.ombudsman.org.uk/sites/default/files/Ombudsman_Casework_Report_2019.pdf

The DWP did not however properly implement the changes recommended in the report.

According to the journalist David Hencke:

"So what happened? Sweet nothing. The DWP ignored the deadline and then produced a factsheet which I know from correspondence the Ombudsman clearly felt did not fit the bill. But after one attempt to get this changed the Ombudsman dumped the issue and wimped out of getting the ministry to implement their recommendations."

https://davidhencke.com/2021/09/12/whitehalls-rip-off-ministry-the-dwp-dodges-paying-compensation-to-millions-of-pensioners-and-the-parliamentary-ombudsman-lets-it-off/

5. A Biased PHSO Investigation

An example of the poor quality of PHSO investigations and the victimisation of complainants can be found amongst the case summaries published on the PHSO website.

The case concerns a woman whose mother died at the Chelsea and Westminster Hospital. The details of the complaint can be found here:

https://decisions.ombudsman.org.uk/report/?id=d5f39b6a-34a7-eb11-9442-002248016e26

In the section entitled "Findings" we see the PHSO interrogating the complainant rather than the Trust, questioning her integrity, while accepting the statements provided by the Trust.

The complainant makes a detailed complaint about her mother's treatment.

20. Mrs A says Mrs N's nose was bleeding continually all morning and had not stopped when staff came to wash her around 9.45am. Mrs A says staff asked her to leave the bedside at this time, so she left the ward to make a telephone call. She says Mrs N's nosebleed had worsened when she returned a few minutes later. She says she could see blood collecting in her mouth, and she brought up two large clots of blood.

The PHSO disbelieves the complainant.

23. In our provisional views report, we said we thought it was unlikely Mrs N's nose had been bleeding continually all morning. We said staff would have noted this in the records and sought medical advice sooner.

The complainant explains her complaint in more detail.

24. In response to this Mrs A told us the staff would not have known it was continually bleeding. She says the nurse briefly saw them at the 8am handover, and then when she dropped off Mrs N's medication. She says staff did not attend to Mrs N again until they came to wash her at 9.45am.

The PHSO disbelieves the complainant again and question her actions.

25. In our provisional views report we said if Mrs N's nose was actively bleeding when staff came to wash her, it was unlikely Mrs A would have left the ward.

The complainant is forced to explain the complaint in more detail again.

26. In response to this Mrs A told us she only left because staff asked her to. She says this was unusual, as staff usually encouraged her to stay and comfort her mother while she was laid flat. Mrs A says she was taken aback by the nurse's request, so left without questioning it or considering the impact of lying flat with a nosebleed.

The PHSO make excuses for the behaviour of the staff and make assumptions about their behaviour, for which there is no evidence, in order to explain it away.

27. We understand why Mrs A is so concerned about her mother potentially being laid flat. However, as staff would not have been aware Mrs N's nose had been dripping constantly for several hours, we see no reason to criticise them if they briefly laid her down to change her pad and sheets.

28. Staff are likely to have seen, at most, a few drops of blood. Given they were washing her, they may have assumed the blood was dislodged from the earlier nosebleed night staff documented at 6am. If blood had been flowing from Mrs N's nose, we would expect staff to follow NICE nosebleed guidance. In this scenario we find there is insufficient evidence this was necessary.

Further on in the Findings section the PHSO refuses to believe the complainant's statements yet again. We see that the PHSO claim to respect the complainant's version of events while refusing to believe them. In many ways this sums up the fundamental failure of the PHSO, which is the refusal to believe the complainant unless they can prove their claims. Any victims of sexual assault will recognise this approach to an investigation.

34. Mrs A says staff did not take Mrs N's observations at 10am either. She says she did not see the day staff bring the observations monitoring equipment to her mother's bedside at any point. She also says she is sure they did not do this while they were washing her.

35. Whilst we respect Mrs A's recollection of events, there is no other evidence to indicate the observations at 10am or 10.15am were falsified.

It might be worth considering what type of evidence the PHSO might accept as proof that the observations were falsified. Presumably only an entry in the medical notes describing how the observations had been falsified would suffice.

The complaint now becomes truly shocking as the complainant describes how she was instructed to carry out a medical procedure on her dying mother. She was shown how to use a suction machine to suction the blood out of her dying mother's airways. I have personally seen this procedure carried out by a trained doctor and it is very distressing for both patient and relatives. It should only be carried out by trained medical staff.

49. Mrs A said the nurse asked the health care assistant to set up the suction machine and show Mrs A how to use it. She says the instruction was minimal. She says the staff told her it was like the suction machine at the dentist, and she should keep her finger over the hole and keep dipping the pipe in saline, so it did not get blocked. She says staff then left her alone for 30 minutes while she was suctioning her mother's airway.

47. The RMM guidelines explain there are some risks associated with airway suctioning. These include pain and distress, reduction in oxygen levels, slowing the heart rate, destabilising the cardiovascular system, damage to the airway, bleeding and infection. RMM guidelines say the risk of complications is higher if staff choose the wrong type of equipment, use poor technique, or too much pressure.

In this case the PHSO are forced to accept the possibility that the complainant might be telling the truth. This is not because they choose to believe her but because the Trust themselves admitted that her knowledge could only have come from instruction. There is no doubt that the PHSO would have stated there was no evidence that this had happened without the Trust's confession.

50. During the local resolution meeting the Trust acknowledged Mrs A had detailed knowledge of suctioning which could only have come from a member of staff training her.

However, the PHSO will only consider believing the complainant in the most extreme circumstances.

52. During our conversations Mrs A gave a compelling and clear explanation of how her mother deteriorated suddenly while she was suctioning her airway. Mrs A said she was worried she had accidentally done something wrong which caused her mother's deterioration and death.

53. These are strong statements from Mrs A. As she told us she is worried she may have caused her mother's death, this adds weight to the likelihood staff left her alone to suction her mother's airway. We cannot see why Mrs A would say these things if her account was not true.

Incredibly, the PHSO then consider whether it is appropriate to "delegate" a medical procedure to a member of the public!

58. On balance, it is likely staff did show Mrs A how to suction her mother's airway and then left her alone to complete this task. This is not in line with the NMC code, which says nurses should only delegate tasks to others if the task is within the other person's scope of competence. It also says the person must be properly supervised and supported when carrying out a delegated task.

Finally, we return to the point raised in section 1 of this evidence. The Ombudsman will not uphold a complaint of service failure or maladministration if the patient would have died anyway, as there is not then considered to be any injustice! In this case however the PHSO decide to identify as an injustice the complainant's feelings of guilt regarding her mother's death. In fact, the obvious "injustice" was forcing a woman to suction the blood out of her dying mother's airways.

70. Although we have seen no evidence suctioning had a clinical impact, we recognise it has caused Mrs A significant worry and distress. The timing of Mrs N's final deterioration

left Mrs A feeling as if she accidentally caused this and contributed to her death. This is an injustice to her. If staff had done suctioning rather than delegating to Mrs A, this additional worry and distress could have been avoided.

Although this case was partly upheld it clearly demonstrates why the PHSO is not fit for purpose. Their reluctance to believe the complainant is only matched by their reluctance to criticise the Trust. It is an example of the abysmal failure of the PHSO to investigate complaints seriously and impartially or to ensure the people who have behaved poorly are held properly to account.

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Ted Brown

" *My partner Noel was abused and everyone failed us, our story featured on channel 4 news and the film, Ted, and Noel.*

" After all the publicity *I went to the Care Show and went to the* ***CQC*** *stand and asked for current information on LGBT+ care homes, the person on the stand said to me " What is that? I was absolutely shocked, the person said they will have to ask someone else they eventually returned with a leaflet which was dated May 2016 and was entitled end of life care, not about living in a care home. The leaflet did not mention hate crime or abuse at all but just featured smiling people and said what you can expect in a home it had nothing to do with the reality"*

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R. R

Summary

"I am an experienced registered general nurse and registered health visitor with 35 years' experience in care of the elderly nursing, safeguarding adults and children, child

protection welfare case management, writing reports for court and case conferences in welfare proceedings, training and supervising student nurses and health visitors , expert by experience knowledge of domestic abuse and coercive controlling behaviours .

*Since 2014 I have continually challenged the poor practice of **multiple agencies** in East Surrey who have repeatedly shown an inability to protect my mother from domestic abuse – she was a vulnerable adult with advanced Alzheimer's who lacked mental capacity from at least 2014 onwards . A number of Court of Protection Orders were in place for her ; this made no difference to her safety as the Orders were disregarded by the agencies tasked with implementing them .*

All complaint processes have been a whitewash experience resulting in multiple referrals to regulators – and I became labelled as a " serial complainer " by the law firm Irwin Mitchell who tried to influence the court of protection to disregard my concerns for my mother's welfare

If my mother had a competent GP, Social worker, and other agencies since 2014 , I would not have been forced to become a " serial complainer " .

*All the **regulators I** have dealt with have shown insufficient knowledge of MCA 2005 competence , Care Act care needs assessments , recognition of Domestic abuse and violence knowledge of Stockholm Syndrome , and what good practice with victims of high-risk coercive controlling behaviours looks like .*

*I have found that the **regulators** allow poor practice to continue because they do not appear to have the rigorous approach to the assessment of practice needed and the staff, they employ do not appear to understand the subjects themselves .*

<u>Summary of my experiences of regulators</u>

***NMC** – repeatedly failed to investigate a number of nurses for MCA 2005 failings, failing to protect vulnerable adult from domestic abuse, failure to challenge negligence of others*

***NMC** tolerates a nurse amending Safeguarding minutes to remove legal advice that he chose not to follow in his position of employment by Surrey county council*

***NMC** failed to read the bundle of evidence I submitted properly showing 6 years of incompetence in domestic abuse by this nurse who also describes himself as a registered social worker which is illegal*

*The nurse lapsed his registration , **NMC** used this as further reason to do nothing*

*I challenged the **NMC** screening process, they looked at the case again, and tried to roll back on their view that amending clinical records is ok !*

*As an **NMC** registrant myself I was shocked to discover how bad a nurses conduct can be and how the **NMC** tolerates this .*

As a result, I am considering leaving the nursing profession entirely .

HCPC 2018

***HCPC** failed to investigate 9 social workers – allowed itself to be manipulated by Surrey county council who provide inaccurate misleading information which goes unchallenged .*

***HCPC** stated that I was unreliable – **HCPC** ignored domestic abuse indicators of incapacitated vulnerable adult, ignored MCA 2005 legal failings and Care Act failings*

***Social Work England** now has new SW complaints to review-*

***SWE** has refused to investigate 3 SWs based on lies provided by Surrey county council including **SCC** using an incorrect letter from **LGO** to mislead SWE*

***SWE** is happy to be misled by the local authority and prefers the views of the LA to the views of the complainant whose mother has died as a result of abuse and neglect, multiagency negligence .*

It appears that when one regulator takes a view against a complainant, confirmation bias is established, and the local authority can use this to mislead and shut down all further investigations by other regulators – it gathers momentum against the complainant

Other lives of vulnerable adults are then left at risk as there is no commitment to learning or changing the cultures of established poor practice .

LGO 2017 *partially upheld my complaint against* ***SCC*** *but totally failed to grasp the fact that SCC made serious legal mistakes by refusing to apply to the Court of Protection in 2014 for a welfare decisions*

LGO *missed " Hillingdon V Neary " mistakes by SCC*

LGO *investigator showed no understanding of dementia, incapacity and domestic abuse*

LGO *investigator wrote me a letter saying " your mother did not want your help "*

LGO *investigator sent the WRONG letter to SCC – a typo said " I have not upheld your complaint "*

This error by the ***LGO*** *has been used by* ***SCC*** *to mislead Court of Protection, SWE,* ***HCPC*** *,* ***NMC*** *since 2017 multiple times despite the* ***LGO*** *investigator asking SCC not to do this*

The wrong letter was presented to the Court of Protection in a witness statement provided by the ***Head of Adult Safeguarding***

LGO is responsible for this mistake leading to convenient use of misinformation by SCC

PHSO

PHSO *completely failed to understand my complaint that Surrey and Borders NHS trust has no grasp of the MCA 2005 – despite being a mental health trust it refuses to conduct mental capacity assessments for its patients with dementia*

PHSO *refused to accept expert witness evidence of my mum lacking mental capacity and refused to investigate the SABP NHS trust failings*

PHSO *tried to say that the evidence was not sufficiently independent - the NHS trust had refused to conduct a MCA assessment in 2015 and directed me to seek a private*

*one - the Trust then ignored it and the **PHSO** sided with the Trust views that it was not independent !*

GMC

***GMC** refused to investigate 3 doctors who left my mother at risk of domestic abuse and failed to do competent MCA assessments - GP and 2 psychiatrists*

***GMC** allows incompetent pathologist to continue to practice despite serious concerns since 2006 and new concerns coming to light in 2021*

***CQC** completely failed to investigate 2 new domiciliary home care providers for at least 2.5 years after they started trading*

Serious harm occurred to my mother during this time the agencies were not inspected

***CQC** provided a whitewash complaint to hide care agency negligence in February 2019*

***CQC** does not appear to vet the managers qualifications providing homecare*

***CQC** ignores concerns raised by families – inspectors did not respond as promised*

***CQC** inspector relies on police to identify neglect and abuse ! does not appear able to identify it herself*

***CQC** inspector walked away from investigation of the care agency using the negligent pathology report as her reason*

***CQC** appears to collude with the local authority and fails to raise concerns directly to the **LGO** asking me to do it instead*

Nothing will change when regulators collude with failing public services

OPG

Unable to investigate fraudulent claims of lasting power of attorney for health and welfare

Unable to investigate neglect and abuse – referred me back to the failing local authority !

Also referred me to the Police - who were already failing to investigate criminal behaviour and domestic abuse

***OPG** ineffective for people with 2007 Enduring Power of Attorney and no LPA in place*

ICO

***ICO** was helpful when I encountered blocks to obtaining SAR material but did not appear to carry out risk assessments or hold the agencies to account – I was too exhausted to deal with the number of cases of "smear campaign " and defamation of my character recorded in my mother's medical and care records "*

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<u>*J.* Atkins</u>

" I took all the evidence to the **PHSO,** I completed the online questionnaire first, it said the **PHSO** had the remit to investigate, I could not believe it when I was told they could not look at my case"

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<u>T. Shore</u>

" As far as I am concerned the **PHSO** is there to tone down evidence and put a positive spin on things. There is nowhere to go to get accountability "

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<u>L. Owens</u>

" *The **PHSO** answers to parliament because it's just a puppet, anything with a case that has wider implications is just swept under the carpet or dealt with so vaguely that the findings mean nothing. They do the bare minimum, and the worse injustices are downplayed to the degree that they read like nothing bad happened at all.*

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L Scott

*" The **PHSO** are a hindrance, they do not help you but put obstacles in your path."*

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P. Simpson

*" My father had a huge gash on his arm, there was no explanation as to how it happened, the wound was infected, it just never healed, and the dressings were always filthy. In the end I called the GP who called an ambulance. The wound was so infected there were maggots in it, I could not believe it could happen. My father died a week later. **Safeguarding** actually wrote in their investigation conclusions that the infection occurred in the hospital and that the home was not to blame, they ignored all the evidence."*

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K. Porter

*" I worked in this care home about 3 weeks, it was dreadful really abusive staff outnumbered the good staff and some shifts I would be working with the worst abusers, I went to the management who just looked at me and shrugged. I went to the **CQC**, I do not know why I bothered. The **CQC** did not go in but just rang the home and nothing happened. The abusive staff just carried on working and when I rang back **CQC** they said the staff had been allocated more training, what has training got to do with slapping people? I left, I won't work in care again, I feel the whole system is broken and it's got nothing to do with lack of money and everything to do with protecting abusive staff not the people on the receiving end of the abuse"*

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I Danials

" I am a care home worker and loved the job until the day I saw a vulnerable person being physically assaulted by two members of staff. The victim had dementia and could not tell anyone, they were targeted because they were gay.

These two staff had recently come to work at the home around the same time and this was my first shift working with them. I was so shocked to see this. I went straight to the

*home manager and reported them. They were suspended for about a week but then they returned and moved to another section of the home. I was appalled and asked what was going on? The manager said **safeguarding** concluded they needed to be sent on diversity training, I was so angry, I rang **safeguarding** and they confirmed this. How can physically assaulting someone be a training issue?*

*The day after phoning **safeguarding** I returned to work my shift and the manager called me into the office and said you called **Safeguarding** and I asked how she knew this and she said they had rung her and told her. I was suspended, I could not believe it was happening. One minute you're going to work and the next your world is upside down.*

*I rang the **CQC,** they told me they would make a note of it for future and they would not be doing anything further as **safeguarding** were dealing with it.*

The next thing I was called into a disciplinary and the manager actually says to me verbatim " We know you have issues with your sexuality that are affecting your mental health and that is why you made the report but we feel there has been a breakdown in trust and are dismissing you because this makes you a risk to vulnerable people" Issues with my sexuality?

*I have been openly gay since my teens, is this supposed to mean I am mad? They implied I objected to a gay resident being abused because I was Gay. I would have objected to anyone being abused and done exactly the same. I was dismissed but the abusers were just sent for training. I could not find a lawyer and gave up, but in my heart, I did not want to go to court, to suffer anymore smearing, why put myself through it? I just wanted the abuse stopped and my trust back. As far as I am concerned both **CQC** and **Safeguarding** are a disgrace"*

...

T. MacKenny

" I am a regulated professional and had worked a considerable number of years for my employer in this role and was always considered competent and to have sound judgement, until I was put in a position where I was forced to became a whistleblower.

I had serious concerns about a fellow professional, I do not want to be identified so do not want to go into detail but the concerns related to abuse of vulnerable people.

I made a formal report to my employer using their external whistleblowing arrangements and waited for action to be taken, it never occurred to me that nothing would be done at all.

I thought at first it was me and that I had not made the case clear and gathered all the evidence and presented it again, this led to hostility against me and I was treated as the problem. They asked me to move to another location as if I had done something wrong.

The stance was taken that as I objected to the abuse I should move to somewhere where I could not see the abuse.

I decided I had to look for another job as the hostility was really affecting me. I also decided that I could not walk away and not try one more time to get someone to investigate.

I was shaking with fear when I called ***Regulatory Professional Body****, I gave them a very brief overview of events and said I would like someone to take my statement and the evidence I had gathered. It was some later and I had found a new post and was about to leave and thought I would chase my* ***Regulator*** *to see if an investigation officer had been allocated. It took some time for someone to call me back and they told me the case was not being taken further because there was insufficient evidence to proceed. I could not speak I was so shocked to hear this. I rang them back and said you have not taken my statement nor had any of the evidence available, they became very cool and told me I could ask for a review, I decided to try and put in my statement and all the evidence to support my concerns, they just did not acknowledge this evidence at all and concluded their original decision was correct.*

I felt vulnerable because they were my regulator and to my eternal shame, I let it drop because there was nothing to be done and if there was another regulator I could have approached, I would not have done so because my trust was completely destroyed and I was too afraid to report my ***professional Regulator.***

What does it matter that I was right, I feel only sadness that no one acted to protect those vulnerable people when there was sufficient evidence available"

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<u>M. Hall</u>

" My experience as a whistleblower with ***CQC, Safeguarding and NMC*** *is that Whistleblowers are a pain for reporting abuse. These people just cannot be bothered to actually do anything. I felt like the attitude to me was that I should go away and stop*

inconveniencing people with evidence. It has changed me, the whole experience, I often think when I am sitting on a bus, I wonder how many people on this bus realises that there is no one there who will act if your family were abused. It's frightening that so many people are working for these authorities who do not care, they cannot be bothered to read the evidence"

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M. M

*"Regarding 2 cases with **CQC***
*1.after contacting **CQC** and my MP in 2017 with concerns that were not investigated by my employer who fired me I contacted **CQC** after speaking to my MP.*

*I spent 1.5 hrs relating multiple concerns from myself and colleagues to **CQC** who recorded them. I informed **CQC** I would provide around 70 email evidence of all concerns by email. Which I sent.*

*No feedback was provided to me as indicated by **CQC** policy as I had no wish to be anonymous.*

*Several months later my employer was given a higher rating by **CQC**, who stated my employer has robust whistleblowing policies.*

*I contacted my **CQC** rep to question what **CQC** did with my concerns and was told not to contact him direct but through the head office.*
*I pursued, asking for details regarding my concerns.my MP contacted David Behan of **CQC** on my behalf.*

*David Behan provided correspondence stating the **CQC** contacted the local authority **Safeguarding** with 3 concerns and they had been investigated appropriately. I informed my MP of this contradiction with no response.*

*I asked **CQC** for the 3 concerns stated.1 concerned an event 7 months after I was no longer employed.*
*I complained to **CQC** asking for the 70 emails of evidence and my written recordings/report to be sent to my. There was no response to this question.*

I spent several months trying to get answers to different issues. Every response seemed to spark another question. I was passed to different staff resulting in the whole complex situation starting all over again. Once again responses sparked off other questions.

*Totally frustrated I asked my MP to contact the **Ombudsman** to look into it.*

*In 2020 **CQC** agreed to an internal investigation. Then they informed me they would not be looking into the conduct of the **CQC** staff member as they were no longer employed by **CQC.***
*I protested on the basis of I reported concerns to **CQC** not a individual.*
Ater 6 months I was informed there is no record of my 70 emailed concerns or the written report of the meeting notes that were taken."

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D. Havercroft

Compassion in Care - response to call for evidence.
Regulator - Nursing and Midwifery Council (NMC)
*In September 2019 I referred five registered nurses to the **NMC** in respect of their involvement in the assessment and management of the care needs of my late mother who died aged 97 in January 2019.*
The five nurses were all involved in the NHS Continuing Healthcare process.
My referral included evidence that registered nurses were implicated in the falsification of a clinical document.
*In August 2020 I referred to the **NMC** the nurse manager and deputy manager of the nursing home where my mother died because they failed to assess my mother's end of life care needs in order to produce an agreed end of life health care plan to meet those needs.*
This failure caused my mother unnecessary physical and mental suffering in the last weeks of her life.

*In September 2020 I produced a report into the **NMC'**s handling of these referrals [1].*
*The **NMC** has not responded to my report.*

*Over a year after I referred nurses involved in the NHS Continuing Healthcare (CHC) and NHS-Funded Nursing (FNC) process and assessments, the **NMC** has failed to state its formal position as to whether it deems this activity to be "clinical care", regulated by the **NMC**.*

I conclude that:
- *The NMC does not meet the timescales set in its published Fitness to Practise Flow*

Chart and has to be repeatedly chased for updates.
*• The **NM**C downplays and trivialises the seriousness of concerns raised.*

*• The **NMC** and its clinical advisers show no evidence of understanding the National Framework for NHS Continuing Healthcare and NHS-Funded Nursing Care and the role and responsibilities of registered nurse assessors in the process.*

*• There is no quality assurance of the analyses and decision making in the **NMC's** fitness to practise screening process.*

*• The **NMC** is biased because it accepts employers' accounts of events, no matter how preposterous, in preference to the referrer's account and supporting documentary evidence.*

*• When provided with prima facie evidence that registered nurses are implicated in the falsification of a clinical document, the **NMC** takes no action.*

*• The **NMC'**s chief executive, Andrea Sutcliffe is apparently content for her registrants to participate in what the **PHSO** recently described as significant failings in care and support planning and in reviews of previously unassessed periods of care. These failings constitute an abrogation of basic rights and have led to people unnecessarily paying out large sums to cover care or going without care because of incorrect or delayed decisions. [2]*

*• The **NMC** states that "Our overarching objective as an organisation, is the protection of the public." In my opinion nothing could be further from the truth. It is a regulator that cannot be trusted to protect the public.*

Mrs Daphne Havercroft
November 2020
[1] https://adultsafeguard.files.wordpress.com/2020/09/nmc-report-september-2020-1.pdf
[2] https://www.ombudsman.org.uk/publications/continuing-healthcare-getting-it-right-firsttime"

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NHS neglect.

"In 2017 my friend was living independently at home and coping reasonably well with the help of specialist medical staff, medication, and support at home, including 4 professional home care visits per day. In July 2017 he was hospitalized for two months following a Stroke. Most of that period was spent trying to find him accommodation in a

care home as, a few days after admission, he was deemed fit by NHS staff to be discharged but not well enough to go home supported only by carers. I was concerned about him staying in this particular hospital as he had a short stay about 12 months before where I had complained about aspects of his care. This included being discharged at lunch time as being considered well enough to go home - initially dressed only in a pair of shoes and hospital issue bright orange pajamas until I insisted, he was dressed in his own clothes - but then re admitted in the evening and, an injury to his arm which no one seemed to know anything about.

In July 2017 I visited him on the morning after he was admitted, and he was still on the assessment ward. When I walked in, he looked up and recognized me saying "Here's () to the rescue. Have you come to take me home? "At that point he seemed no different to normal, and I was surprised to learn he had had a Stroke and that he was unable to go home immediately.

Over his two months stay in hospital he deteriorated and lost weight. I was visiting more or less daily save for a brief period when I was on holiday. Others were visiting too. Nothing was said to me or anyone else as far as I know that he was having difficulty with meals or that he was experiencing other difficulties probably associated with being in a communal ward and his illness.

About halfway through his stay on the ward the consultant who was responsible for his care asked to see us both. We were not told why in advance, and it turns out he wanted to discuss my friend's views about resuscitation claiming that ward staff had been asking what to do in case of a heart attack. This resulted in a DNACPR document on my friend's medical notes. I was surprised to learn the ward staff were concerned in this way is as my friend did not have a heart or lung condition and, after the consultant left, I asked my friend to give this more thought and, if he changed his mind to let me know and I would make sure it was removed. As it was events overtook us and we did not have the chance to discuss this again until later the same year when he did decide to withdraw it on the basis of the events I described below.

Although I can't produce any evidence, in time I came to suspect this concern about a possible heart attack was associated with my friend being frequently left unfed as this is what happened a few days later.

On 20th August I walked on to the ward in afternoon visiting time and found my friend to be motionless in bed resting on his right side. The right side of his face was pink and the left side white and I believe therefore he had been left unattended or unassisted in that position for some time. His eyes were half shut and his mouth open. At first glance I

thought he was dead. A member of staff was sat a few feet away from him, apparently unaware of his condition and certainly not offering him any help. When I called her to assist, she said words to the effect of he needs to sit up and helped him into a chair with assistance from another member of staff. He was limp. When I asked when he had last eaten, I was told he did not eat his breakfast and had been too grumpy to eat at lunchtime. So, no food for the best part of a day I will say. When I asked if he was grumpy due to lack of food, I received no reply. When I explained about the need to ensure adequate nutrition to facilitate recovery, I was told people can't be forced to eat and offered the opportunity to speak with the ward manager at the end of the visiting period.

My friend was not offered anything to eat by the staff during this period. He did, however, have some food of his own in his locker which I gave to him. The same member of staff who had been caught ignoring him then stepped forward offering a knife and plate and requested details of the food I had just given to him claiming she needed to record his food consumption on a handheld device she was holding. I believe it's an iPod. I took this to be the basis of the food chart I will refer to later.

I attempted to take up the chance to speak with the Ward Manager but found her to be unavailable when I went to locate her and had to ring up later. She assured me there were people with him helping him to eat. I tried to locate a consultant and was told no one was available as it's Sunday.

The day after I spoke with the consultant's secretary and then with the man himself the following day. I constantly reiterated to everyone that my friend was not refusing food but needed help. There is only one reference to these events in the notes I have been provided with by the NHS, that is the conversation with the Consultant. The incident itself is not recorded at all, there are however some notes to suggest this was not an isolated event.

Had I not walked onto the ward at that particular time and witnessed what I did then no one would have known. I supported him for the rest of his time on the ward (about 3 weeks) by taking food and drinks in more or less daily during afternoon visiting times just to make sure he was able to eat. His records show that he started to gain weight over this period although at discharge, he was still lighter than he had been at admission.

The rest of my time was spent trying to find him a nursing home placement so I could get him out of hospital before he endured any further neglect. I did, however, make a complaint and this continued on and off until 2021 and involved hospital management and various politicians. In particular, I will say the latter were particularly distinctive in

their unwillingness to become involved. I will describe those events next.

Who cares?

*This is the start of my account of my time as Power of Attorney for my friend and the experiences of inadequate and dangerous care he endured in parts of our NHS and wider care system, the inadequacy of investigation into complaints including service providers and their **regulators** and, the lack of interest and effort to make improvements by politicians who are providing these services on behalf of us all. This account starts in the second half of 2017 and continues to date which is 5 years later and counting. I have called the whole account Who Cares? because I want to explore the question whose job is it to provide and regulate safe and appropriate care for people and particularly those who are relatively disadvantaged regardless of who they are and what form the disadvantage takes and, who cares when they don't? For those who do care, what do we need to do to make sure things change for the better?*

*The following accounts are based on my recorded experiences which include meetings, conversations, and documents I have received including many which I obtained through the subject access process. The latter was often necessary to find out what was going on and, together with chance conversations, was often very useful revealing incidents which had earlier been concealed such as falls, withdrawal of medication, medication known not to be always correctly administered, cancellation of appointments, cancellation of services, decisions about and adjustments to a DNACPR documentation made in secret, a **Safeguarding** complaint made in secret, incorrect records, and institutional abuse.*

*These experiences relate to parts of our NHS and parts of the care system and their **regulators**. I say parts of as it is important to recognize that there were times when my friend did receive good quality care and attention even within parts of the same NHS Trust and by some GPs and some care staff. This leads me to conclude that the main issue then is one of Governance and Management at a senior level together with at best, complacency by **regulators** and politicians which allows poor quality and dangerous activity to continue unchallenged even when they are told about it. Given the various investigations and reports which have progressed through the years, particularly regarding parts of the NHS and its **regulators,** I don't believe I am the only one to think so.*

Is the care sector any better?

No. In my experience in the main it is not, and this applies to nursing homes and the

***regulators** including the **CQC**, **Adult Social Care and the Police**. Firstly, I will explain how my friend entered the care sector.*

For reasons I have explained earlier, I was desperate to get my friend out of that particular hospital still alive and as well as could be. He spent 2 months on ward between July and September 2017 supposedly receiving post stroke care whilst with some help located a residential home for him and at the same time, I spent the last 3 weeks of his hospital stay taking food in almost daily just to make sure he was given something to eat.

I will say the first month of hospitalization was wasted entirely trying to find him a place in a care home. When care home management were assessing him, they were refusing accommodation on the basis they could not meet his needs. Eventually I intervened and spoke to one of them. She was very helpful and explained that his needs were too complex to be met in a care home environment and he needed nursing care.

I went straight back to the NHS and informed them not to ask me to look at any more care homes but to reevaluate his situation. I don't know what happened as I was not included but, suddenly there were no more referrals to care homes but to nursing homes instead. There were two assessments by different homes and the second one offered him a place.

He and I agreed he would take it on the basis that it would get him out of hospital, and he could use it as an opportunity to settle as much as he could and try to get back to a regular routine of meals, sleep, medication, and care. I would get him some help and we would then be able to assess what his health would really be like post stroke. If possible, his preference was to go back home and reinstate the care package he was receiving there, and we kept this open as an option. In reality, as a direct consequence of the abuse he endured in the first nursing home this opportunity was taken from him forever. He left after only 3 months with a life-changing injury which meant he was never able to walk again.

He was very nervous of going into residential accommodation even for possibly a short period of time. He asked me once "They won't bash me, will they?" Although I have no evidence that he was "bashed" on the basis of what happened over and over again in Nursing homes he may as well have been.

I will describe what happened in the first nursing home next.

First Nursing home

My friend lived here for 3 months. During that period, it became obvious that he was struggling to settle in and especially the communal area was aggravating his existing anxiety. He was, however, required to use the communal area so that staff could keep him safe from the risk of falling although, as I will tell you, they failed even in this.

Soon after moving in he had an appointment with a specialist nurse who had been treating him when he lived independently at his own home. She advised additional one to one support he could receive in the privacy of his room and the nursing home staff agreed to make an application to the NHS for funding. It later came to light that they did not bother.

In the meantime, I agreed with my friend that I would try and get him some extra support thorough the voluntary sector and, if the NHS could not fund the extra one to one support, I would look to setting it up for him via a private contract between him and the provider. Either way, he needed an assessment of the current state of his health so an informed decision could be made about the type of one-to-one help which would be most beneficial to him. The nursing home were supposed to be arranging this too as well as organizing a multi-disciplinary meeting to assess his general needs. Neither of these happened either.

Soon after he arrived at the nursing home, I was informed he had been "found" uninjured on the floor of the communal living room having rolled out of his wheelchair - as witnessed by a resident not a staff member. Also, that he had been" found" wandering on the corridor outside his room. There were discussions between me and nursing staff about trying to find him a hobby by way of occupying his time and I agreed with him we would order a newspaper for him to read, and, in the meantime, he would have to keep using the communal lounge so he could be kept safe. Of course, the one-to-one support was supposed to be being organized and I was hopeful that the need for him to regularly use the communal lounge would soon come to an end. Things took a tragic turn for the worse in late December.

Early in the week before Christmas I was informed by telephone that he had been once "again" found uninjured on the floor in the communal lounge near to the bookcase where he normally sits. The nurse told me that they were playing Christmas music and he kept trying to get up and dance.

A day or so later in the same week I attended the Christmas party. Most if not all the staff were there, including the senior nurse and the manager, both of whom saw him on his feet and dancing. The manager spoke to him and remarked how well he was doing. Later he walked to the bathroom and waited outside for assistance. The senior nurse

came over and remonstrated with him for not waiting for an escort.

The staff were well aware of how mobile he could be at times, how independent of spirit he was and how vulnerable he was to falling. They were also aware of the additional risk of his intermittent mobility due to his illness and his compromised eyesight caused partly by the stroke.

Later in the same pre-Christmas week I was again informed that he had been "found" on the floor in the communal living room by the bookcase. This had happened during the routine transfer of residents between the communal lounge and the dining room at a mealtime. Nothing out of the ordinary happened that day and managing to safely move everyone from one room to another is a routine event happening twice daily which requires staff to monitor both rooms and move residents. Nothing special is needed, just enough alert staff to do it.

This time my friend sustained a serious injury but was taken to Lancaster Royal Infirmary with a broken hip and he spent the next month including Christmas, New Year and his birthday in hospital and effectively homeless. A place (in hospital albeit a different one) I would like to reiterate that was recently associated in his mind (and mine) with neglect and starvation. On one visit I made he was particularly anxious and trying to leave complaining he was in prison.

I heard nothing from the Nursing home staff at all until the 2nd of January 2018 when I received an email from a manager asking if I knew when he was to be discharged. They wanted to know this as they said they needed to reassess him. A day later I received another email from a different staff member with no narrative, just an attachment. When I opened it it was an invoice detailing unpaid bills. So, someone in the nursing home had had the time and presence of mind to look through his records to see if he owed any money. My impression at the time was that this was the start of a process designed to evict him.

*In early January 2018 I made an official **Safeguarding** complaint to the **CQC** using their online facility expecting to precipitate a competent and professional investigation to find out what had gone on and report back to me with the outcome and what they intended to do about it. It soon became clear there would not be one but there would be a move to get him moved to other accommodation assisted by the NHS. I will say more about this later but for now this.*

ASC's second attempt at a Safeguarding investigation.

*I complained officially about the conduct of the **ASC** in response to my **Safeguarding***

*complaint and, as it was not dealt with, later to the **Ombudsman**. This did eventually produce a result and the **ASC** started again. By this time 12 months had elapsed.*

*This time round a member of **ASC** did visit the nursing home and speak to some senior staff and a senior nurse. The manager who had been in post at the time of the incident had left the organization. Some documents were examined. Again, this proved to be a revelation.*

Firstly, I found out for the first time and significantly belatedly that about a month before my friend fell and broke his hip someone had conducted a falls risk assessment on him and recommended provision of hip protectors. The Nursing home had done nothing about it. Had they told me there would have been time for me to get some if needed. This would not have prevented the fall, but it could have significantly changed the outcome.

I point out that the fall had a significant and irreversible life changing impact on my friend. Having been mobile most of the time and, during his illness, made special efforts to preserve his mobility as much as possible, he never walked again. The independence he had and had fought for was taken from him and in a short space of time he was confined to a bed or a wheelchair.

He was never the same again mentally and I think this was the long-term effects of the operation/anesthetic. Although he had good and bad days, before the fall it was possible to conduct a conversation with him. He may not have recalled much of it later but in the moment, he was able to participate. The hospital considered him well enough in December 2017 to consent to the operation. This wholly avoidable incident left him unable to participate in a conversation. It became much harder to determine how much he understood about what was going on around him. His memory of nouns was noticeably diminished.

Secondly it confirmed what we already knew he should not be left unattended.

Thirdly, I found out that Nursing home staff had been discussing amongst themselves the possibility of asking him to leave. I strongly suspect this had an impact on the care he was given and, in particular I believe it is one reason they did not progress an application for the funding provision of one-to-one care. Had this been available he may not have been left alone in the way he was.

*Eventually the **ASC** "signed off" in their words their report into the **Safeguarding** complaint and referred it back to the **CQC**. By then 18 months had gone by. Far too late to do anything other than a superficial job. The time to do it would have been soon after*

the incident whilst significant members of staff were still in post and those who were on duty on the day of my friend's fall and especially those who were responsible for monitoring him but left him on his own should have been interviewed along with their supervisor.

*I will say too that I believe the person from **ASC** who did attempt to conduct the belated **Safeguarding** investigation probably did her best at that time. I expect it would have been a difficult thing for her to do to have to back track in the way she had to and particularly if she was involved in the earlier attempted brush-off. She and staff like her should not be expected to work in an environment where, for whatever reason, employees are allowed to or encouraged to act in a manner which is unlawful in terms of disability and human rights; is institutionally abusive and where such inadequate performances are tolerated and then attempted to be covered up. The **CQC** should not be accepting it either.*

*I also believe **ASC** at the time belatedly tried to flag up issues with the **CQC** and it is to their dereliction of duty I will turn to later. For now, I will describe the neglect he endured in the second nursing home.*

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<u>T. Owen</u>

"*I could not believe how hard it was to get such serious concerns addressed, the people I dealt with at **CQC, Safeguarding, PHSO,** were a nightmare, they never read the evidence, denied they had been sent emails, denied what they had been told, arrived at completely impossible conclusions and then got defensive when it was pointed out, the reason I was able tear holes in their conclusions was because I knew the evidence and just kept referring them back to the evidence, which they ignored.*

It was absolutely frustrating, I just knew they did not want to deal with it because it made the government look bad, these organizations are just there to bat concerns away and protect those who should be held to account, I was exhausted at the end and that was done deliberately, they hope you will just give up and stop saying this is so wrong, they know it's wrong but they are not here for the victims"

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T.A

One person, one situation.

IPSO *- upheld my complaint, but it was not easy and their response was not really in proportion with the matter I complained about, the outcome I achieved was lesser than the issue I reported. (Local press misrepresenting my arrest.)*
SRA *- my (daughter) was held in a solicitors' office, threatened and bribed in return for a statement used to arrest me. At least one solicitor from that firm was present and instrumental, other partners were involved. Complaint not upheld.*
ICO - *ongoing issues with trying to retrieve my data and concerns about how WBUK handles data. Significant and quality evidence provided to* ***ICO****, yet they seemed to operate with an attitude of ready dismissiveness.*
NCTL/TRA / DBS - *I was cleared BUT, both the referral and my defence evidenced serious wrongdoing by the school*
- ***The Teaching Regulatory Authority*** *was / is under no compulsion to act on information achieved like this. They stated they would have to receive a separate complaint, I could not make that complaint - as advised by my legal team - as I would be viewed as 'a vexatious complainant'.*
NMC - *failed to call me as a witness for a whistleblower quoting incorrect information, again a lot of to-ing and froing to convince them they were wrong and should have known as they had the correct information.*
PHSO *- pending*
I understand the size constraints and so offer this sketch and advise that all associated evidence - emails, legal documents etc - can be made available.

...

O. Mattews

"I worked in a nursing home for 3 years, most of the time it was ok apart from always being short of staff. The home management changed and the culture in the home changed overnight. To cut a long story short I was told by the unit manager that a particular patient was not to be fed or given fluids, I knew this elderly lady well and knew she was not terminally ill, I questioned this and was immediately reported to senior management for refusing to carry out a duty. It was not my duty to withhold food and drink from someone who was not end of life. I contacted ***CQC*** *but they did nothing, the lady died, it was an awful death and I think the unit manager was playing God, deciding who should live or die. My workplace was so hostile as a result I was signed off sick with stress and I never went back.*

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T. Littlewood

“*I worked an industry (Not health and social care) I took my concerns to my boss, that was the beginning of the end because they did not want to know and more importantly did not want anyone else to know. The issues were serious, and I could not leave it, so was forced as a last resort to go to the* ***regulator.***

After speaking to the ***regulator*** *and giving a rough summery of events, about five minutes in total for a very complicated issue, it was agreed an investigation officer would speak with me and take my statement and also the evidence I had gathered*

I waited some time and had not heard anything at all from the ***regulator,*** *I rang them and explained to the lady on the switchboard that I was waiting for an investigation to begin and for someone to take my evidence. She said someone would call me back later that day.*

About two hours later a man called me and said there had been an investigation and it was not upheld. I was just so shocked and said there must be a mistake as they did not know the details of my concerns, nor had they seen my evidence. The man just repeated the investigation had been carried out and was not upheld.

This ***regulator*** *is a complete sham, their investigation did not include any of my detailed concerns nor any of the evidence I had gathered. They do not know the meaning of the word investigation. “*

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S Pepper

*Case 2 **CQC** 2017*
*I contacted **CQC** after being terminated regarding an accusation 1 week after raising serious clinical care concerns regarding a patient at a nursing home receiving tracheostomy management*
I worked for a company who employed me to work personally with the client in readiness for them leaving the nursing home.
The nursing home disagreed with my company for their plan believing the patient should receive nursing home care until the patient died.
*I spent an hour on the phone to **CQC** explaining the concerns made by myself, colleagues, and my employers. I sent them email evidence regarding all concerns from all concerned. I also informed them I had contacted the local authority.*

I was informed by safeguarding they wouldn't investigate unless I provided a DOB for the patient, I stated this was nonsense and sent through a safeguarding referral stating I am willing to be interviewed. The rep asked me to get the name of the safeguarding lead when they contacted me. They never bothered.
*After hearing nothing **CQC** stated they are not involved unless invited, a section 42 investigation took place. I received a call stating they had found issues but would not reveal them*
***CQC** stated they had received the report, and the rep was no longer in their position.*
*The **CQC** rep informed me they would have expected the employers to of contacted me with those concerns and asked me to contact him if I needed too.*
I had found it strange that an investigation had been concluded when I was in the process of appealing my termination on whistleblowing grounds and its conclusions regarding concerns had not been concluded.

*I sent the **CQC** rep emails of contradictions being displayed by my employers regarding clinical care and non-investigation of them. I received no reply.*
My MP was informed by safeguarding and council CEO no issues were found which contradicted the evidence I was provided by safeguarding stating they had identified training opportunities and made recommendations' informed my mp but received no response.

*I spent the next 2 years flip flopping between local authority **Safeguarding** and **CQC** trying to illicit answers including SARs requests regarding a record of a section 42 referral/investigation made by **CQC**, they stated they hadn't sent one.*
*Only until I requested **CQC** info and data regarding my name was I sent details of the **CQC** referral, it stated it sent 6 emails to the local authority. Falling well short of the total of concerns I sent.*
***Safeguarding** confirmed this by sending me these emails on request, it also showed a statement from my accuser (nursing home manager)stating I undermined staff and that myself and my employer were informed I would not be allowed to work at the nursing home again*
9 days later my employers terminated me with 1 reason given that I refused to go back to work.
*I informed and forwarded the above info to **CQC** which they did not respond to me.*

*I informed **CQC** that my employer claimed they never knew I made concerns prior to termination. I provided email proof to show I had **CQC** refused to comment*
*Along with the concerns which my employer never investigated I complained to the **CQC** about all the above which is a short synopsis of all concerns. Including my employer being given a recent high rating and compliments of their whistleblowing procedures.*

*After a 12-month interaction including a 6-month investigation by **CQC**.they concluded they don't carry out investigations and that I should contact **safeguarding.***
*Apparently, the statements made by the **CQC** representative are not that of the **CQC**.*

*The **SAR** request answer stating a **CQC** referral had not been made was incorrect and so I was now in receipt of that information. The **CQC** did not check my employer records during an inspection which took place in the time frame when I was contacting **CQC** about my issues.*
*I offered record sheets **CQC** were unaware of on several occasions previously, but they didn't feel the need to take up my offer.*
They refused to investigate the actions of my employer in how they treated me for whistleblowing,
*They rejected the claims from the nursing home manager that **CQC** closed the case as **CQC** were not part of the investigation.*
*On since challenging **CQC** on various issues regarding their findings they said they consider the matter closed.*

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<u>M. Ford</u>

*"I reported my concerns to **FTSU** who are widely considered by staff to be a sorry excuse of an entity, but where else could I go? Nothing was done, the attitude to me was one of, who do you think you are reporting a doctor? It's an environment where junior staff in particular cannot raise concerns about anyone senior. Doctors can report other doctors but rarely do so nothing changes. **CQC** just back up **FTSU** so failures are just covered up all the time"*

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Mrs M.G

"In May 2016 our 21-year-old son dropped out of university where he had been studying a degree in Math's, during his time at university he had suffered quite considerable anxiety and depression, unbeknown to us his parents, however he was in good form during the Spring and went to France with his pals to watch the Euro's. It was in

September that his anxiety started to increase, he had discovered that a hair loss pill Propecia he took when he was 18 may have been causing all of his symptoms, he was distraught and his symptoms getting worse. We accompanied him to a private Psychiatrist who put him on a medication (we were later to discover he had been on many SSRI's and antidepressants prior to this.)

Despite a concerted effort to help him with an organic diet, walks and reading to him whilst he lay curled up in his bed on 22nd December when I came home from work i found him staggering around and speech slurred, in his room we found goodbye notes, a rope and empty blister packs of pills, he was admitted to a Psychiatric unit about 40 miles away, this was because his GP was near the University and this was a different trust to the one in our locality, he was diagnosed with delusional disorder and on 10th January 2017 he was discharged to our local crisis team, he was only going to be discharged if they accepted him, they did. On 14th January and on one of the daily visits from the home treatment nurse we had discovered a substantial amount of pills in the post, my husband rang the nurse and told her and he asked her not to tell our son, not to break his confidence in us, instead when she arrived she "confronted" him (these were her words) when she left our son became very angry with us and walked out of the house, my husband retrieved him but he was refusing to stay at home, instead he wanted to go to his student accommodation where he had not been for six months, my husband rang the home treatment team and they asked my husband to bring him to them, he did. Whilst alone with the nurse she agreed that he could go to his accommodation as long as he signed a disclaimer to say he would keep himself safe, then he was gone, left distraught but helpless we were so thankful that he called next day to ask us to collect him from the local train station. The daily visits by a CPN (different one every day) continued but on 19th January, again when I came home from work (I am a Community Midwife in the local Trust) I found him in an incoherent state, we found he had taken 28 benzodiazepines, we called an ambulance and he was brought to our local A&E, my expectation was that they would keep him, they said they would do tests and probably send him home, I was so enraged by their attitude I drove home, at 1.30am I got a call to say he was ready to be collected, they had taken bloods done an ecg and everything was "fine" he was far from fine, I found him staggering around a disused area of the A&E dept, I took him home knowing that he had an appointment the next morning with the Crisis team Consultant, I would get it sorted out then.

The next morning his condition was no more improved, with great difficulty I got him to this appointment, as I arrived my husband text me to say he had taken an additional 45

pills, so somewhere between 3am and 10am he had taken an additional O.D. I asked the Consultant to detain him under MHA, he said he wouldn't meet the criteria, that I could just take him home, I couldn't believe it, I told him that this was not care, that my son was a danger to himself and that he had young siblings at home, the youngest only 9. He knew I wasn't going to be easily fobbed off so he said he would ring his GP to get his opinion, the GP we had rang on 22nd December and referred our son for urgent attention to A&E, hasten to say the GP was very concerned, the Consultant came back to speak to me and told me one of my son's GP's were coming to make assessment under MHA (I had very little understanding of this process then but I do now, this was totally improper but you'll understand later) I was relieved at this point so I asked could I just nip out to get my son a sandwich, he was still in a terrible condition, even tried to follow me out of the building but I managed to get him seated, I was gone for 15 minutes, when I returned I found the Consultant on one side and a member of the HTT I recognized sitting on the other side of him, they announced my son had agreed to voluntary admission, I didn't dispute this as I was glad he would be looked after and kept safe. Just after 2pm my husband came, and I left to collect my youngest from primary school.

My son was admitted for a week, from Friday to Friday, they increased his antipsychotic and was released on weekend leave, when he returned on Monday 30th January there was no longer a bed available, the Consultant told my husband that they would refer him to Community addiction services (I thought this was standard, but now I realize the Consultant had got it wrong, he assumed our son was an addict, he wasn't). Due to a delay in medication coming from pharmacy my husband called me and asked me to collect our son after work, I was shocked he was being discharged but these were the professionals, they must know what they are doing, the nurse handed our son his meds and told him to "behave himself".

On 1st February and no sight of the home treatment team our son declared he was going to his Granny's for a rest, the next morning in fact, she had booked him a flight to Birmingham, we asked him not to go but we couldn't stop him, his trust in us demolished by the CPN on 14th January. On 2nd February someone from the Community addiction service rang my husband to arrange an appointment for our son, he said he couldn't get through to our son's mobile, he told my husband the earliest appointment available was the 28th of February, my husband accepted this on our son's behalf believing he would be long home before then.

On Friday 10th February and one of many calls I made to my son whilst he was away, I noted his speech slurred (I wasn't too well myself that day, off sick from work with a

heavy cold), I asked his Granny had he taken anything and she said no, he in fact told me it was the increased dose of Olanzapine, that concerned me but his daddy was going on Monday to collect him and bring him home (flying from Belfast to Birmingham) On Monday whilst I was on the phone to my son making sure he had his bag packed to come home he collapsed, an ambulance took him to the Queen Elizabeth hospital, my husband arrived but was asked by the Doctors to search the room he was staying in to see what he had taken, at this point he was on a ventilator, I had just booked a flight to go over immediately, I never left the house as just as I was leaving my husband phoned me to tell me he had gone.

The cover up

On 1st March an admin staff from the Trust rang our home, she wanted to know if our son would like another appointment as he had missed the CAS appointment the day before, through my grief and absolute disbelief I told them my son was dead, I told them mental health services would be hearing from me. No time was wasted, this was a Wednesday, my son buried the Sunday before, by the following Monday the GP had received a litany of correspondence predated from the Trust relating to my son's care, false information and the scene was set, of course I knew nothing of this at the time, a serious adverse incident investigation was triggered, at the end of June two senior members of staff came to our home to interview us for the process of the investigation, one being the chair of that investigation, I handed them my letter of complaint and asked for it to be included in my sons records (It wasn't in the records received by the Coroner) within it I had asked several questions that I wanted addressed and for them to be included within the report.

After much correspondence with delay tactics being used we received our son's medical records in late August, we had received his GP records and the other Trusts records in July, when we received them we were in disbelief, an alleged appointment for 2nd February was recorded, when our son failed to attend they issued a new appointment for 6th February and I allegedly rang and cancelled it, I did not, also of note was the assessment by the HTT Consultant, he stated our son had been discharged from the HTT but was urgently referred on 20th January when his behavior had become more "erratic", this was a downright lie, the appointment was scheduled. We also knew from our son's GP records that when this Consultant had made contact with them on 20th January he had told the GP he thought this was a suicide attempt, he also told the GP he would get another GP from the locality to make an assessment under MHA, remember he told me one of my son's GP's were on their way to do this? he had lied, instead he coerced my son into voluntary admission when my back was turned and

failed to do a capacity assessment to ascertain if he understood (he did not have capacity). The telephone call and his belief this was a suicide attempt were not recorded in the records, in fact what was written was that his mother was refusing to take her son home rendering him homeless and that was the reason for admission, "the family could not cope". These records were completely rewritten.

Also, the appointment for CAS stated that this was urgent but because our son was in England he couldn't avail of an early appointment, so his father agreed to one on the 28th February, another lie, it was never urgent. There is much more in the way of falsified records and tampering, the alleged appointment for the 2nd February was with the Community mental health team, apparently when CAS found out our son was in England they contacted CMHT to tell them, two different services a mile apart in the town, they really aren't that efficient, in fact when I closely scrutinized these records it appears from the handwriting that the person making this call was also the person who received it.

With the inquest looming (we had it postponed from May to September to await the SAI report) there was no sign of the report, on 11th September just two weeks before the inquest we contacted the Coroner's office asking for another adjournment as we had not received the report, the Coroner's office advised they had received it on Friday 8th September, we asked them for a copy, they told us the trust asked for it not to be shared with the family, again disbelief, the Coroner's office intervened and told the trust to share it with the family, we received it on 14th September, just 12 days before the inquest, it was clear why they did not want us to set eyes on it. (Remember I am an employee of this Trust) The lies continued at inquest, I was not there but a regulation 28 PFD was issued to the trust as they told the Coroner they did not have a policy which stated follow up appointments should be shared with carers or family, more dishonesty, they did, a policy dated September 2016, I printed it off at work the following January when I returned after bereavement.

The regulators.

I reported many healthcare professionals to their regulators in 2018, I will run through those professionals and the responses I received from those regulators.

HCPC.

I reported an Occupational therapist who in a record dated 24th January wrote in her assessment of my son that he told her the worse times in his life were when he misused prescription drugs, he had no such history, I pointed out that my son was not referred to

her until the 25th January so how was she able to make this assessment the day before? The date of the 24th corresponded with the MDT meeting which could clearly be seen that the date had been changed, in fact to deceive they changed the 5 to a 3 and then to a 4. I sent the HCPC the referral letter, they said it was difficult to tell what the date says, I can assure you it states 25 and could in no way be interpreted as any other number. This was a record completely rewritten to give the impression that our son misused prescription drugs, hence adding to the belief that our son's recent overdoses were part of an ongoing problem. The HCPC said there was no case to answer as the ***Ombudsman*** *had stated he had no concerns with this practitioner, this was despite the* ***Ombudsman*** *telling us he had no dealings or influence on regulators investigations.*

<u>The GMC.</u>

I reported two Consultants, the home treatment team Consultant and the Consultant who discharged our son.

To say this body is corrupt is an understatement, I will just list what I reported each for.

Consultant 1: Failure to assess under MHA, lying to patient and mother about GP being on their way (the SAI stated the GP was phoned and cancelled, extraordinary considering he was never coming in the first instance) failing to perform a capacity assessment, coercion of a patient into voluntary admission, failing to record that his belief that this was a suicide attempt, rewriting the record after the event, writing a letter to the GP stating our son had been previously discharged from the HTT which was received by the GP surgery on 7th March, failing to record the amount of pills taken and the time they were taken, failing to order blood tests (we have asked for the blood results on that day as a F2 recorded she took them sometime after 5pm, the trust maintain bloods were not taken as they were taken the evening before, in truth they are withholding them from us as a comparison with the previous evenings results would show our son had taken an additional OD which in turn would show he did not have capacity and would highlight the false records) The words I actually used about this Consultant were willful neglect, recklessness and Gross negligence.

Consultant 2: Failure to hold a discharge planning meeting, failure to refer back to HTT on discharge (he maintains he knew our son had been under HTT but had been discharged and he felt no need to refer him back, he did not know, again a complete rewriting of the records.) Failure to request appropriate follow up, unconscious bias, assuming our son was a drug addict or had a history of misusing prescription drugs (hence why the OT made that record, to cover his back) failure to liaise with the HTT and a failure to liaise with the Consultant from the other trust, lying to the Coroner when he

told her this was not a suicide attempt so no risk assessment was deemed necessary.

*I meticulously copied all of my son's records at the **GMC's** request, this took days, they wanted GP and the two trusts records. Their response was basically that the care was appropriate, our son had been deemed as having capacity, there was no need for a discharge planning meeting and follow up was appropriate (the false appointment). There was sarcasm throughout, referral to our son misusing prescription drugs as if it were factual. I had withheld one part of my complaint about the HTT Consultant because I was sure that he would face sanctions, how foolish of me, so when the **GMC** were being obstructive and clearly demonstrating they were going to support the cover up I came at them with a rule 12 application, I had discovered when at my GP's requesting referral for myself to a private Psychiatrist that the Consultant with the HTT also practiced privately, I advised the **GMC** that this was a conflict of interest and intimated that this Consultant instead of assessing my son under MHA was in too much of a rush that day to get to his private clinic (we have no private in-patient facilities in the locality for mental health so to me this was a real conflict of interest) On October 31st the **GMC** responded to me, you could almost hear them laughing, this was not new evidence and the original decision stood. I will talk more about the language used later. In early December that year the Consultant in question resigned from his directors role within the private practice after a short tenure of about 2 years, significant because he must have started there shortly before he was involved with my son.*

As for the other Consultant they stated the care was appropriate, MDT meetings were held, there is no requirement that family members be involved in such meetings (our son was living at home, we were his carers, we had no involvement in the admission or discharge) What he said at inquest was correct and according to the records.

The NMC

In total 5 nurses were reported to this body, again I will list what each was referred for.

1. Confronting our son after being asked by parents not to, destroying our ability to protect our son, allowing him to go to student accommodation with 3 days' supply of medication just four days after discharge from another unit following a suicide attempt, failing to safeguard his life.

2. CPN in A&E failing to assess appropriately, failing to listen to the mother when she told him her son had just told her "you will be burying me soon I can guarantee it" failing to consider the diagnosis of delusional disorder, failing to arrange assessment under MHA, discharging inappropriately and failing to correspond as he said he would with the

Consultant of the HTT (Interestingly there are so many records which show our son was still very much under the HTT on 20th January)

3. Nurse on the ward who failed to share the alleged follow up appointment with family, failing to follow the hospital policy (the one they said they didn't have at inquest) This nurse was never interviewed for the SAI nor was she a witness for the inquest, keeping her safe from perjury were she to be asked any challenging questions.

4. CPN with the Community mental health team who recorded falsely that our son did not attend appointment on 2nd February, then recorded he did not attend the alleged appointment that I am supposed to have opened and cancelled, she even recorded that I had rang and cancelled it, falsely recorded she rang my son on 8th February but there was no answer and no way to leave a voicemail (completely false as after my son died I continued to ring his phone so that I could hear his voice on his voicemail facility) failure to follow hospital policy of someone deemed at risk to themselves or others (again none of these policies were mentioned in the SAI) the policy states they should contact family members, locate where the person is, if necessary contact the Mental health team in that area or the police, they course they had not done a risk assessment on discharge.

5. Manager of the Community addictions service, following my question for the SAI of what was the definition for self-harm this person had answered by using the first three lines of the ***Royal college of Psychiatrists*** *own definition but she then added a line of her own which stated that "even the most experienced drug user can accidently overdose" I complained that this was a deliberate attempt to mislead the Coroner into believing our son was an experienced drug user.*

NMC *responses.*

Nurse 1: They could see nothing wrong with this nurses actions, when I continued to press them on this matter after almost two years they have finally come back with "it has been a long time and this nurse has practiced without restriction" I pointed out to them that I was a registrant and as far as I am aware it is usually the ***NMC*** *that issues restrictions, they were taken aback but maintain their stance and have started corresponding with my husband instead.*

Nurse 2: I have no idea, he appears to have fallen off the radar despite them investigating, I believe they are waiting for him to retire, buying him some time.

Nurses 3&4 are currently still under investigation, I see this as them being the fall guys for the Consultants negligence, that they failed to share and follow up on the missed fake appointments, the trust and the regulators are going to continue this stance of the follow

up appointments existing but there is too much evidence against them to show they didn't.

Nurse 5: This is the complaint that clearly demonstrated to me how corrupt the regulators are and how they collude with NHS Trusts. The initial response came back as this person had no involvement in the SAI so could not have possibly written this statement, I corrected them and told them that in December 2017 I had a meeting with this manager and the chair and author of the SAI report, when I asked the author why she had written this comment in response to my question the CAS manager said actually it was me that wrote that, she had declared not five minutes before that she knew nothing about my sons case, had not read his records and did not know I was a midwife in the trust, I covertly recorded this meeting.

I spoke over the phone with Phil Otton of the ***NMC****, I also recorded this conversation, I offered to fly to London with the recording so that they could hear it, just say the word and I will go. They continued with the investigation until recently, just this Summer gone I received their response on this matter, this nurse has retired, they have never heard the recording so cannot comment, besides it is just terminology the trust use when they are talking about self-harm.*

<u>My findings on the regulators.</u>

The ***regulators*** *collude with NHS trusts, as I received many responses from each regulator there is a common thread, the language used, the sarcasm and the denials, I put it to each of them that these responses were coming directly from the trust, they were merely copy and pasting onto their headed paper, I live in NI and have done for over 20 years, I am originally from Birmingham, I could hear their dialect in these responses, the regulators do not in effect do anything, they pass the complaint directly back to the Trust and get them to deal with it, at the same time the trust is being informed of exactly what you know and what your thoughts are. Then there is the collusion with the* ***Ombudsman****, together they conspire to close the complainant down try and drag you past three years, we availed of an independent expert report when I was beginning to notice the collusion, unequivocal negligence on the part of the HTT Consultant, who by the way continues to practice in the Trust. It is clear that the Trust decide who will face sanctions by the regulator, more often than not it is the lowly nurse who unbeknown are coerced into the cover up with the promise of protection, I am afraid no nurse can have any faith in the* ***NMC*** *or their employer, nothing has changed since the Morecombe Bay scandal, just a new face at the helm with the promise of change with no intention of, then when this CEO of* ***NMC*** *goes for poor conduct another will take*

their place and so it goes on.

*There have been many events in the last three years, I found out pages 77-82 of my sons care pathway were withheld from the coroner, the discharge section, also pages 3-5 which contain the index of the pathway. I have also learned that an event was held by the RCPSych here in NI by **RQIA** (I haven't mentioned this organization but they are the same as **CQC**, I complained to them but I might as well not have bothered, their CEO used to be the nursing director in the offending trust, her response was a nothing to see here attitude, she has since moved to **Public health**, the recently retired CEO of the offending trust has taken up the post of interim CEO of the **RQIA**, I am trapped between a rock and a hard place, a journalist has taken up our story neither of these people have agreed to comment.) In attendance at that event was Wendy Burn, President of the Royal college, the Mental health director, who I believe along with the CEO was instrumental in the cover up of my sons negligent care presented it, this was in May 2018, just a month after they eventually responded to reg 28, again pressure from family, they were so arrogant they did not think they had to respond because the inquest was in England, anyway they implicated themselves with their response. Their presentation gave praise to the trust, their care was appropriate, they need to look at information sharing and family members in follow up care, a complete bluff, using taxpayers money for this deception. I rang the **RQIA** in a rage, it was the journalist through another family member who made me aware, just this summer, they have since removed the section that refers to my son. I am going to continue to fight this establishment, we have lodged a case with the high court, they are now stuck between a rock and a hard place because they will be well aware any settlement made will be used for applying for a new inquest, it is just that the length of time this whole process takes that makes families give up.*

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M Talbot

1. I was left with no thyroid medication for 10 years after having half my thyroid removed in 1991. This caused me to have Hypertension, Heart Failure, Chronic Kidney Disease, Atherosclerosis (blocked arteries).

2. My Hypertension was not treated for 3 years; doctors medical negligence has ruined my health and shortened my life.

3. Every GP and medical professional thereafter have tried to harm me and tried to

change my diagnosis of Heart Failure, Chronic Kidney Disease , one GP ordered blood test for my Kidneys levels and the blood test result showed that I did not have kidney disease I knew this was wrong because I had numerous blood test results showing kidney disease and I had copies of my medical records going back years which all showed kidney disease, I found out after having a meeting with the hospital Lab manager that the bloods sent by my GP to be tested were not my bloods but belonged to the health assistant who took my bloods.

4. I moved to Edenbridge 3 years and 10 months ago, I have had 3 different GPs at my GP Medical Practice, 1 GP misdiagnosed me, 1 GP gave me medication which could cause a heart attack in the future and the other GP gave me medication (which I took for months) which was contraindicated for Heart Failure, Chronic Kidney Disease and Atherosclerosis this medication has seriously harmed me and I should not have been given this medication because of the following: -

(a) It was contraindicated for me (see above),

(b) My GP misdiagnosed me and it was the wrong medication for my correct health condition,

5. I have been left with damage to my body by being given medication (2 years ago) which was contraindicated for me because of health conditions I suffer from (see above) I have also been left untreated (for 2 years) for the correct health condition I suffer from (Secondary Hyperparathyroidism) ,I am a very unwell elderly person because of all this.

6. In March 2020 I made a complaint to my GP practice Manager about being given medication which was contraindicated for me (see above) and for being misdiagnosed and left damaged by the contraindicated medication (see above) and being left untreated for the correct health condition I suffered from (see above) The practice manager completely ignored my complaints email so in May 2020 I sent a follow up complaints email to the GP practice manager this complaints email was also ignored and remains unanswered to this day, this is in breach of reg 20 The Duty of Candor.

7. I sent copies of my complaints emails which I had sent to my GP practice manager to the ***CQC*** *and told them that my GP practice manager had totally ignored the 2 complaints emails I sent the practice manager told the* ***CQC*** *that this was a breach of reg 20 The Duty of Candor and told them my health had been seriously damaged by my GP giving me medication which was contraindicated for me (see above) and that my GP misdiagnosed me and that I had been left untreated (2 years ago) with the correct health condition still to date left untreated for this correct health condition.*

*8. The **CQC** have done absolutely nothing about all the above, I begged them to protect and safeguard (this is within the **CQC** remit) me from my GP and my GP, s Medical Practice still the **CQC** have done nothing leaving me to more harm from my medical practice and new GP.*

*9. The **CQC** sent my GP practice manager copies of the emails I sent them after this my GP promptly retired, I was given a new GP who is covering up for his fellow colleague, my GP who harmed me and has now retired.*

10. My New GP is trying to do away with all the points of complaint I made by putting my points of complaint down to other things.

*11. I sent copies of my complaints to **NHS England** they lied to me and told me they had seen the results to the investigation to my complaints to my GP practice manager so I asked them to send me the results of the investigation to my complaints to my practice manager they replied that they could not do this because it is in a form that I would not understand. They have done nothing to help me.*

12. I am being left damaged by being given contraindicated medication by my previous GP left untreated for a health condition I suffer from which my GP, s have ignored (see above) I am an elderly person (79 years old) who is being left to suffer and die.

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<u>J Carter</u>

"I *worked in the NHS for nearly 15 years prior to whistleblowing. My concerns were never acted on and I was treated as if there was something wrong with me for raising such issues in the first place. I do not want to go into too much detail but what I reported was how elderly people were treated, routinely food and fluid being withdrawn for no medical reason at all. I was driven out for raising this. I could not get a lawyer so could not bring a case, I was told if I was a doctor then of course it would be a lot easier to get my case heard. The lawyers all agreed my employer had treated me unfairly but told me that reporting a doctor was impossible"*

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<u>A Samuels</u>

"My *Mother was abused and neglected in a care home, I tried the get the homes management to act but it was clearly not going to happen, I went everywhere,*

***Safeguarding, CQC, NMC** and **PHSO** and back again. Round and round in circles. They were all completely incompetent and not capable of investigating anything. It was the most frustrating, time-consuming, and heartbreaking experience of my whole life, heartbreaking because my mother continued to suffer right up to the time, she suffered yet another serious, unexplained head injury and died without regaining consciousness.*

Grief is a physical pain, you just want accountability for the suffering caused, there's not a single organization of any use, they just gaslight you when you expose their incompetence. They try to protect themselves by ignoring the glaring inconsistancies in their investigations. You are just sent round and round in circles and the work you have to put into the correspondence is a full-time job.

What are these people paid for? They are a complete waste of space"

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R. Smithe

"It's my experience that regardless of how much evidence you have or how serious the issues are, the whistleblower takes all the risk to bring this information to the attention of the regulator and no action is taken. Regulators are not capable of carrying out a credible investigation, they are not even able to apply common sense"

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C. England

"*Regulator: Fundraising Standards Board*

In 2015 I became aware that a commercial company was persistently misleading the public by implying online on its own website and on others that it was a "charity". The company was Whistleblowers UK and 9 years later, the people responsible for that are still getting away with misleading the public without penalty, now under the name WhistleblowersUK (without a space).

*The company continues to request donations at every opportunity, even though I had reported my concerns to the company itself twice via its website (no response received), to the **Charity Commission** and to **Companies House** before being directed to the **FRSB**.*

*Please note that I had been directed to the **FRSB** by another regulator, **Companies House**, and all the **FRSB** did was to suggest that I go back again to **Companies House**.*

I was left with the feeling that it is easy for any company to continue operating dishonestly and that no regulator is willing or able to confront obvious dishonesty.

It takes a lot of thought before concerned members of the public raise concerns with official organisations. First, they have to find out which is the correct regulator, so may have gone to other organisations (as I did) and MPs originally. The effort is a complete waste of time when no adequate response is forthcoming, and many people may give up reporting concerns to any regulator as a result of such an experience. "

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D. Finley

*"I am a care home whistleblower and my experience of **Safeguarding** and **CQC** has made me wonder why I bothered reporting to them, I wish I had gone to the media first and at least the abusive staff would have been removed not sent on training and allowed to continue working and abusing people. You can't go to the media after as they won't believe you as they say the regulator did not uphold this so that must be ok then. Theres no one to investigate and hold people to account, all I wanted was the concerns acted on, there was plenty of evidence but no one who bothered to read it. It cost me my job to report abuse and I feel really let down by those whose job it is to act"*

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Eileen Chubb

"**The Charity Commission,**

To The Board of The Charity Commission.

An Open Letter, From The Trustees of Compassion In Care, Charity number 1102282

18th February 2024

*In August 2020, at the height of the Pandemic, whilst this charity was coping with over 50% increase in calls to its helpline, we were contacted by the **Charity Commission** regarding allegations that had been made.*

We knew that the source of the allegations was Georgina Halford Hall the CEO of WBUK and secretariate to the APPG on Whistleblowing and parliamentary pass holder. (This was later confirmed) as we had at this time already been subjected to a campaign of malicious allegations to various organisation's by the same individual.

*Whilst we knew the allegations to the **Charity Commission** were malicious, we assured the **Charity Commission** in writing that they had our full cooperation and that we understood they must investigate.*

*After the first few months it became more apparent that as each of the malicious allegations was disproven with robust evidence, that the **Charity Commission** officer was becoming more and more angry at the fact that we were innocent of any wrongdoing. The stance taken by this officer was one that amounted to " If I cannot get you on that malicious allegation, I will try to get you on something else"*

*We obtained a specialist charity lawyer who was shocked at the treatment we had been subjected to. When the **Charity Commission** dropped all but the following, we realised we were being politically attacked by an instrument of the state. The **Charity Commission** specifically said the following,*

We should not campaign for Ednas law,

We should not object to the, Office for the Whistleblower

We should not to criticise WB-UK or the APPG on whistleblowing and specifically to not refer to them as a "Corrupt gravy Train"

We should remove the book, There is no me in Whistleblower, the case for Ednas Law, persisting with the accusation of a litigation risk and ignoring the fact WBUK had previously attempted a malicious SLAPP action using the lawyer, Johnathan Coad, an attempted SLAPP, which was not pursued because there was no merit to their case.

*Our lawyer said all our activities were legal and he could not understand the **Charity Commissions** conduct.*

*We then made a formal complaint to the **Charity Commission** who chose to dismiss our concerns until Private Eye read all the evidence and printed articles about the injustice we had suffered. The **Charity Commission** than made a public apology because they could not explain their disproportionate, bullying behaviour given the evidence. Private Eye also pointed out that whilst the **Charity Commission** were persecuting us, they were failing to act on serious concerns about other charities, where there was actual wrongdoing, such as selling fake cancer cures.*

*We asked the **Charity Commission** to implement their own policy on prosecuting malicious complainants because we feared that WBUK Halford Hall would continue to target us with malicious allegations, harm our vulnerable beneficiaries and impede our work. We said that any failure to act by the Charity Commission would embolden the culprit Georgina Halford Hall of WBUK. The Charity Commission failed to act.*

As direct consequence of that failure this Charity has been subjected to four years of slander, smearing, harassment, and blatant lies, including the use of anonymous twitter accounts operated by Georgina Halford Hall (Confirmed by police in writing) to intimidate and smear both ourselves and whistleblowers who are volunteers and to mislead the public.

These events culminated on Friday 16th February at 21.00Hrs when we were contacted by a journalist by text and had the following put to us,

" I spoke with Georgina H.H she said, you were sanctioned in some way by the charities regulator, is this true?

She also said you have declined to speak with her about it, is this true"

This was an official press statement from WBUK Georgina Halford Hall, in relation to a proposed article which would include reference to Ednas Law.

*The inference can be taken from this statement that MPs, the media, and public have also been falsely told this charity cannot be trusted because we did something wrong and were sanctioned for the **Charity Commission**. Furthermore, Halford Hall infers she was given both this information and was authorised by the **Charity Commission** to ring this charity about this alleged sanction.*

Georgina Halford Hall has been enabled and emboldened by the Charity Commission to the extent that she can issue the above official press statement.

*The harm and distress this has caused is immeasurable. This has been exacerbated by the **Charity Commission** conduct in steadfastly refusing to disclose vital information via FOI and Subject Access, resulting in us having to obtain a specialist, who is in the process of extracting this information from the **Charity Commission**, disclosure of which we have always been legally entitled to.*

*There is an ongoing Met police investigation into The **Charity Commission** conduct of 2020 because there was already enough evidence to raise the issue of Misconduct in a Public Office and abuse of power.*

This letter will also be forwarded to Police, we have taken the decision to make these events public in order to protect ourselves and our vulnerable beneficiaries and our volunteers from any further harm or abuse of power.

*To date the issues, we have raised have not been responded to by the **Charity Commission** or the **DCMS** select committee who have been copied in to all correspondence from day one.*

*The **Charity Commission** are a political puppet who have been used to attempt to silence a charity for championing their beneficiaries interests and who have therefore challenged the agenda and conduct of both the APPG on whistleblowing and its secretariate.*

That a small but effective charity could suffer such an attack sends a chilling message to all charities. We continue to fight for accountability and transparency.

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C. England

"***Work role when contacted regulator CSSIW:*** *Care assistant in a nursing home.*
Issue reported: *Suspected abuse of people with dementia & poor working practices. Management failures to respond appropriately to concerns.*

I have also had other experiences of various statutory regulators, for myself and in assisting others as a volunteer with the charity Compassion In Care. Out of many regulators, only two took effective action on the issues reported to them.

Care & Social Services Inspectorate Wales (CSSIW)**, now renamed **Care Inspectorate Wales took prompt and appropriate action in response to concerns.

I had emailed the local inspector asking for advice on what a colleague and I should do next, as he had reported to the managers of our nursing home his suspicions of abuse by a particular member of night Staff after various incidents. None of them were overtly physical abuse but he was uneasy about her manner towards some Residents. He asked me for help as I was a union workplace rep. I wrote that we would like to understand more about Protection of Vulnerable Adults procedures and would like first to ask her advice confidentially (she knew the home, the family who owned it and the managers very well) so we could then discuss with management.

The Inspector rang me promptly, took time to listen attentively, and when I had explained what my colleague had told me she asked if I had ever witnessed anything that worried me.

I felt that the Inspector had the experience to understand that It is not an easy to report suspected abuse and that there are what might be called "borderline situations" when you have a gut feeling that something is wrong, query it, then senior colleagues give what seems to be a plausible explanation to reassure you.

It was her manner of listening and questioning, probing beyond the immediately presenting situation, that enabled me to open up. All regulators need those skills in responding to concerns. *She seemed to understand that care workers do not go to the regulator for minor things and that it is often only after a pattern builds up that you feel it is a last resort after reporting concerns internally and being fobbed off.*

I told her of several concerns which in retrospect I felt I should have reported externally to the Inspector immediately and it was a relief to be given an opening to do so then. Anybody who has not worked in care may think it is always obvious, but it is often not because we all need to operate on a level of trusting what senior colleagues tell us.

1. *I had objected when a Resident with whom I had been allocated one-to-one duty 7.30pm to 7.30am had been taken to a secure unit at around 8pm with only 1 Staff to 5 men whose illness caused a tendency to aggressive behaviour. I had been told "this is what we always do" but I refused to sign the one-to-one observation sheet when instructed to near the end of the shift which I had spent helping care for other Residents and cleaning duties. I knew that he would have been left unattended in the secure unit for extended periods while the sole care Staff there was helping the other five Residents. During that time, he may have been assaulted or fallen. This was the first time I had done a care nightshift there and had already questioned situations on dayshift, but I did not know night shift practices so was fobbed off when I queried it.*

2. *The nursing home would quite often allocate Staff to "one to one" duties with 2 Residents at once for a 12-hour shift, often when Staff were off sick and Staff generally do their best to co-operate in urgent situations. However, significant additional payments are received when a Resident is allocated funding for one-to-one duties, and I do not know whether deductions are made to this funding when it is not provided.*

3. *Amongst various poor working practices, some Residents were put to bed extremely early e.g. 5.30pm and left staring at the ceiling for hours without food or drink until breakfast at 9am next day. Some were woken at unreasonably early times e.g. 4am, all for the convenience of Staff and rivalry between shifts to stop the other one complaining.*

4. *On an evening shift overlapping with nights, I had seen a Resident who had been locked in his room, which I had queried with a senior Staff, and I was given what appeared to be a plausible explanation, but it was the fact she had laughed that had worried me most.*

This experience with a regulator was positive because:
*1.**The Inspector understood how difficult it is for a care worker to report to a regulator,** especially in a home where we felt loyalty towards the family that owned it, to our 2 managers and our colleagues, most of whom were very caring, but our greater loyalty was to Residents.*

2. She took what I felt was appropriate action: an unannounced inspection within 3 days.
*I had said t I did not feel that any of the Residents were in immediate danger so I felt this was an appropriate timescale and I could tell by the stunned reactions to **CSSIW's** arrival that she had not warned managers in advance. I had not been told that it was going to happen.*

***3. She kept my confidentiality** though managers and some Staff guessed the whistleblower was me because I had already raised concerns internally. I chose to tell Staff immediately that it was me and a few were pleased as they agreed various things were not being done correctly, particularly on nights, but the majority, including managers and owners, were not at all pleased.*

***3. This inspection was soon followed by a properly conducted formal investigation.** The regular night Staff, I and any others who wished to offer information were interviewed at another location for confidentiality. We were sent the notes of interviews to make corrections.*

*4. **The regular night shift workers all had to work dayshifts for 2 weeks under observation.***

***5. A Fitness To Practise hearing followed several <u>years</u> later by the Nursing & Midwifery Council for the Night Nurse-In-Charge** about a Resident being locked in his room. I was surprised because I had never said he had done this, I believed it was the senior care Staff. But evidence was given by another Staff that he had reported to managers that he had seen locking in of two Residents and had later reported it to the **CSSIW** investigation. The Nurse said he had warned managers that staffing was so low that he had to lock in people temporarily for safety.*

***Outcomes:** The Nurse was commended for his honesty at the **NMC** hearing though had restrictions placed on his practice. The managers escaped any accountability even though one of them had lied at the hearing. Much later, an ex-colleague told me they had reported poor practice and managers had taken action on it. Some months later, after I had asked*

to change to a zero-hour contract and had supported another whistleblower there who reported abuse of a dying Resident, the nursing home stopped offering me work even though it was very short-staffed.

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L. Tomlinson

" I worked in the NHS, I do not want to say in what capacity as it may identify me but, not as a doctor. I repeatedly raised the same serious issues with my employer via the proper channels. The issues really put people at risk and it never occurred to me how hard it would be to get them addressed. It was just so hard, I still breakdown and cry when I think back to it. When it became clear that the trust were not going to do anything as they only wanted to protect their reputation, I decided I had to go to the ***CQC.***

My employer knew it was me because of the nature of the issues, The ***CQC*** *basically asked the trust if my concerns were true and the trust told them I was a disgruntled employee and nothing changed other then my life was made hell and I was forced to find another post, which involved me having to move house and all the upheaval that involved.*

I tried to find a solicitor but was told my case would be easier if I was a doctor raising concerns about another doctor but because I was an xxx my case would be too time consuming. I was really worried about the issues and tried to get a journalist to report on the issues but they said the same, if only I was a doctor my concerns would have more appeal as a story. Whistleblowing basically turned my life upside down and for what? A regulator whose idea of an investigation is to ask those responsible if it's true. The ***CQC*** *are far too close to trust management. Several years later serious issues emerged re this hospital, it really upset me to see the consequences for people"*

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M. Lynch

" Ex Health & Social Care Assessor
Employed by Microcom Training (Glasgow) Ltd *which was referred to as a charity in company documents and was an SQA &* ***SSASco****t approved training centre.*

Issues I reported in 2006 and am still reporting now:

- ***Scottish Vocational Qualifications Levels 2 & 3 were awarded fraudulently*** *to candidates who did not have the required ability, knowledge, understanding or experience, eg a hairdresser and a kitchen worker.*

- ***The fraud brought huge financial gain to Microcom Training*** *because it received substantial payments for each candidate awarded a Level 3**.***

Consequences:

- ***One death in a care home due to unsafe handling of medication****. One of my candidates told me about this case. Medication administration was later removed from the qualification after I had raised the issue.*

- ***An ongoing risk of harm or death to people receiving care because an unknown number of*** *people given fraudulent qualifications are now working in roles with responsibilities for which they are incompetent.*

It has taken a lot for me to write this as it has been going on since 2006 and has taken a toll on my physical and mental health to know that people are at risk, and nobody is taking action to protect them.

Job*: My role was to meet candidates at their workplaces on a fortnightly basis over a period of months to assess their practical and written work for Scottish Vocational Qualification Level 3**.***

Over time I started to realise that many people were being signed up for the Level 3 course, which did not reflect their job roles. Some needed their manager's help to enter simple details on the form e.g. their own names, national insurance numbers etc and had very limited English. They could not communicate effectively with me, so would not be able to care for people with complex needs or read care plans or medication instructions.

*When I brought this to the fore, I became a target, then I found out that people were being qualified at unacceptable rates and timescales**.** Some found difficulty writing or did not understand the paperwork, some had no care experience at all, eg they had worked in a care home kitchen for 3 weeks. My boss would sit in the office and qualify work faxed over from their workplaces. She put through candidates that I had point blank refused to assess because it was obvious they could not qualify for Level 3. I could not let this continue because if they had a Level 3 qualification, they would be able to give out medication and the nursing Staff in these places told me they were not happy about this. I told them to report the issue too, but I do not know whether any of them did.*

One day my boss brought in three candidates who were clearly not capable for Level 3 but she assessed them all as passes in one day. She had not expected me to be there that day. Candidates should be assessed over a period of months in their workplace to check their knowledge, understanding and work practices.

I was made redundant shortly after whistleblowing to Microcom Training and I believe this was entirely due to my refusal to take part in the fraud. I had been told I could obtain an extra £3000 per month if I did what they wanted me to do in passing the candidates.

I made a Tribunal claim and my solicitor gave me a fax from Microcom Training's solicitor. I was told I would be offered £30,000 and it would include a gagging order. I declined the offer and I continue to report this matter. ***It was never about money for me, it is about risk to people, and I would do the same again.***

I was made aware of a death in a care home in Strathaven where a newly qualified carer was put on night shift. Whilst she was administering procyclidine to someone, leaving the /drugs trolley unmanned, a resident drank procyclidine from an unopened bottle and died. This put a terrible fear through me, and I had to act so I then went about reporting it to all the regulators and people listed below. This was people's lives we were dealing with. I have a large file of evidence including audio tapes available for inspection.

Throughout my years of reporting this to regulators, nobody has taken effective action. They tried to shut me down, but I will not be silenced because I know people are at risk. *Some told me outright lies. At one stage it was claimed that* ***Ofqual*** *had taken part in an investigation but later I discovered that it had not even existed then. Regulators were deliberately obstructing and misleading.*

Some told me it was all too long ago to investigate. Other times I was told there was no record of my letters to Parliament or others, but it was a lie because I had proof of delivery. I was told records no longer existed because they had been destroyed after 3 months. Records of whistleblowing reports should never be destroyed. One Member of the Scottish Parliament has tried to help me. So have the police but they had to tell me to go back to the regulator.

One ***regulator*** *wrote that the candidates had been given accreditation for prior learning, but they did not have any such prior learning. They were incompetent and some did not even understand the paperwork.* ***Allowing them to qualify for jobs responsible for medication and many other aspects of care is dangerous.***

My experience is why I now support Edna's Law because it would have stopped the risks when I reported them and so it will protect people from harm and death.

Regulators & others I notified *of this dangerous malpractice:*
Microcom Training
Scottish Qualifications Authority *(I notified six people there)*
Scottish Enterprise
Audit Scotland

Ofqual
First Minister of Scotland *(Nicola Sturgeon)*
Two other Members of the Scottish Parliament
Scottish Parliament & Ombudsman
Disclosure Scotland
Church of Scotland
Govan Police & Police Scotland Rutherglen to report fraud

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E. Chubb

" Richard Turner was in charge of the regulator of the Bromley **SRI**. We contacted this regulator on 19th April 1999.
Prior to contacting the regulator seven whistleblowers had been reporting widespread abuse of vulnerable people to our employer BUPA, when those concerns were ignored, we went to the regulator.
The **SRI** took immediate action, removed the abusive staff from the home and commenced an investigation into the abuse.
A team of **SRI** investigators were based at the home full time and interviewed all staff over a period of months. All relatives were also interviewed and relatives of former residents who could be traced were also interviewed, as were visitors to the home such as the hairdresser.
The whistleblowers were interviewed many times and given full feedback.
An independent pharmacist was also used who upheld the drug abuse and the fact residents were given unprescribed medication, had paid relief and other medication withheld and that excessive unauthorised doses of sedative drugs were being given.

Two damning inquiry reports recommending that the main abuser, Maria Keenahan should not be allowed to work with vulnerable people. Richard Turner was immediately put under pressure to tone down the inquiry report, he refused.

The **SRI** gave evidence in the subsequent BUPA 7 whistleblowing Tribunal case. Richard Turner was cross examined for four full days as his witness statement said the Whistleblowers were telling the truth about both the abuse of vulnerable people and that we were forced out of our jobs as a direct result of whistleblowing and the **SRI** had witnessed the harassment we were subjected to, Most damming of all he confirmed that the main abuser had been hidden in 4 other BUPA homes after it was made clear to BUPA that this person was a risk. That paperwork had been forged to hide the fact this abuser was working. The **SRI** removed this abuser from all four homes.

As whistleblowers we know that the **SRI** did their absolute best to stop the abuse, that they were pressurized to both tone down their conclusions and to keep those

conclusions secret. In effect members of the **SRI** were attacked by both BUPA and those at Bromley Council who were involved in awarding BUPA the care home contract. Four years later BUPA lost the contract after widespread concerns about all six BUPA homes in Bromley including Isard House. The new care company also reported finding a raft of serious failings when they took over the homes.

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W. Roberts

*" I saw vulnerable people abused because they were gay, I reported this internally but nothing happened about it so I went to the **CQC** and they were indifferent. I got the distinct feeling that they had no comprehension of this kind of abuse. They said they had noted my concerns for their next inspection, I may as well have been reporting that the new curtains in the home were a horrible colour, I would have got the same response"*

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C England Part Two **NMC**

"**From:** Christine England

Role when reported: Ex Care Assistant at a nursing home.

Regulator: **Nursing & Midwifery Council (NMC).**

Issue reported: **Deputy Manager of a nursing home lied in evidence to an NMC Fitness To Practise hearing.**

Background: (please see also my positive comments on **CSSIW** in separate document) I had reported several issues to the Care and Social Services Inspectorate in Wales (CSSIW) which led to it holding a formal investigation. One issue was that I had witnessed a Resident locked in his room and had queried it with a Senior Care Assistant.

The **CSSIW** reported it to the **NMC** and later I was asked to make a statement to a legal representative appointed by **NMC**. Much later I was asked to attend a four-day Fitness To Practise hearing as a witness for the **NMC** against a former Night Nurse. I had never reported him and did not even know that he had been involved as I thought the Senior Care Assistant had locked the door.

The **NMC** charge was that the Night Nurse had locked people in their rooms on several occasions. Later a Care Assistant told me that he had seen two Residents locked in and had reported it to the Manager and Deputy Manager, and later to the **CSSIW** investigation. I think the Night Nurse himself told the **CSSIW** and the **NMC** of other incidents.

The Night Nurse gave evidence **that he had raised concerns with the Manager and Deputy Manager about inadequate and unsafe staffing levels on night shifts** and that he sometimes had to lock people in their rooms for short periods for their own safety.

The Care Assistant told the hearing he reported it to the Manager and Deputy Manager.

The **NMC** commended the Night Nurse for being "***patently honest and open***" so clearly the hearing Panel believed that he had told the Manager and Deputy Manager.

In oral evidence the **Deputy Manager was asked whether any concerns had ever been raised with him and he stated that none had been. This was an outright lie** because the Night Nurse and the Care Assistant had raised specific concerns about the locking in, and I had raised concerns about various other matters.

If the Fitness To Practise panel had reviewed the statements with more care and paid closer attention they would have realised at the hearing and would have questioned the Deputy Manager about the conflict between his evidence and three other witnesses.

My complaint to NMC: I reported the Deputy Manager for being untruthful in sworn oral evidence and explained exactly where to find the evidence in the statements and in the **NMC** notetaker's transcript of the hearing. I did not report the Manager because I had not seen his witness statement and he was not present to give oral evidence.

Outcome:
The **NMC** insisted that I must provide the evidence and that to obtain the transcript I would have to pay around £1200 which it is unlikely that most complainants could afford.

I told the **NMC** it only needed to retrieve the evidence from its own files but as I could not afford to pay for the transcript my complaint was closed.

I felt that the **NMC** did not want to admit that it had the evidence and that scapegoating the Night Nurse was its preferred and more convenient option as he did not have a lawyer, only a family member supporting him at the hearing, whereas a lawyer would have been able to cross-examine the Deputy Manager on his untruthfulness in oral evidence.

Summary:

- **The NMC failed to act on the evidence of untruthfulness**.
- **The NMC prevented me from pursuing the complaint**.
- The Manager and the Deputy Manager got away with non-compliance with the **NMC** Code by **failing to act on concerns raised by the Night Nurse and Care Assistant.**

- **The Deputy Manager got away with lying to the hearing that no concerns had ever been raised to him.**

- The Manager and the Deputy Manager retained their **NMC** registration.

- **Without accountability, both are likely to continue ignoring concerns raised.**

- The local paper published a report "*Nurse rapped for doors locked shut*" but did not include the fact that he had warned the Managers of having to lock doors and why, probably because no journalists had been present at the hearing to know the true circumstances. It is very unfair to scapegoat one person and **journalists should be wary of authority bias, ie believing a regulator without asking for the registrant's side of the story as well.**

- **The families of the Residents were never told by the NMC or the CSSIW** to the best of my knowledge, that their loved ones had been locked in their rooms so this regulator fails to provide transparency for the public. I believe that recordings of all hearings should be available (redacted where necessary) on its website.

- **A substantial amount of public money was used on NMC's inadequate. long drawn-out investigation and the original hearing,** involving thousands of pounds for legal work and a barrister, and accommodation/travel expenses for the panel members and witnesses for a 4-day hearing, without true accountability or rectifying the causation issues at the end of it. **All this could have been avoided if the concerns had been acted on when first raised by the Night Nurse.**

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T. Parkingson

" *As a whistleblower I went to **CQC** but I felt they were not really interested, They went through the motions of noting what I said but the home was rated good and is still rated good but its anything but good, it's awful. The **CQC** know about the issues but you would never see that if you read their inspection report. I think the **CQC** do not want to upset the care home company, they would rather turn a blind eye.*

*It's a real scary thing to be a whistleblower, you know it could cost you your job, but there's nowhere to go with the information. I could have made a complaint about **CQC** but what's the point now? The people I was worried about are dead and it's too late to save them. I will get out of this, working in care, as soon as I can find another job, it's just not worth it, all the tears. They say they want people who care but it's not true"*

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M Munroe

*“We were told by the **ICO** that because we can’t get my mums care home records even with a Letter of Administration that they would help us if the home hadn’t replied back within 28 days. This is the fifth time of asking the home and they haven’t even acknowledged my email.*
*So, I rang the **ICO** and spoke to a rather rude gentleman who told me they couldn’t help me and to go to a solicitor. I have found that the staff at this office are not consistent with what they are telling us. Every time I ring i am given completely different information. I thought their job was to help people not to pass them to some other organisation who might or might not help. If this is the case, why do we have an **ICO** office at all, because they certainly do not help whatsoever.*

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E Chubb

“ I*n **2017** a batch of personal information was released by **CQC** via a Subject Access request, this included a series of emails between the following individuals, the emails were dated **2014.***

Sir Robert Francis CQC

David Behan CQC

Andrea Sutcliffe CQC

Des Kelly (Former BUPA care homes Director)

*Many of the emails had substantial parts redacted which clearly related to me. The substance of the emails related to **Robert Francis QC** sharing evidence given to him in confidence with Des Kelly, and senior people at the **CQC**.*

*Whilst Robert Francis later had to apologise to me for this breach after I made a formal complaint to **CQC**, the substance of the complaint I made to the **ICO** related to the **CQC** redacting information I was legally entitled to see.*

*The **ICO** concluded that I should have made the complaint in **2014** which was the year the redacted emails were dated, but I pointed out again to the **ICO** that I only received the emails in **2017** and saw them for the first time and that I could not have complained about something three years before I came became aware of it, I had supplied proof of this in my original complaint.*

*The **ICO** were abrupt and rude in their response and said again that I should have complained in **2014** but how could I have done that? I am not a clairvoyant.*

*Given the importance of who was involved in this redacted **CQC** email exchange and the nature of the information redacted, this caused a serious injustice to me and resulted in **CQC** withholding vital information that impacted on my own whistleblowing case.*

Regulators protect each other at the expense of the public interest every day"

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T. Hunt

" *I had not worked at this home very long but had worked for the company for a number of years. I transferred to this home after I relocated to the area.*

There were three care workers from abroad who seemed to be working excessively, nearly every shift with little time off. I thought this at first very unusual as it's a very demanding role and time off is important.

As I got to know these staff a little better, I realised something was very wrong. They lived together in accommodation provided by the company and were very frightened about complaining about anything as they were worried, they would lose their right to work in the UK.

They would constantly be asked to work another shift as maybe someone was on holiday or off sick. Sometimes these staff were so almost asleep on their feet and it was really dangerous.

I did not want to get the staff in trouble as it was their fault and they were being exploited. I did not know where to go as what was happening was an accident waiting to happen.

These staff would often be working twenty-four hours at a time and they really looked ill and I felt so sorry for them.

*I made a report to the regulator **CQC** they said they noted my concerns but I got the feeling they did not really get as they asked me if I thought these staff were working illegally but it was not about that.*

*I called the local council who sent me to **Safeguarding** but they said it was nothing to do with them as it was not a safeguarding issue.*

I did not want to get the staff in trouble and decided to ask the home manager. They just said the staff were working legally and that there was nothing to worry about but I got the distinct feeling that I had hit a nerve.

A couple of weeks later the 3 staff all disappeared suddenly at the same time. When I asked where they had gone, I was told to another home somewhere up north"

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L. Warrington

" *I am a whistleblower and was badly let down by my solicitor who lost vital information in my case, I made a complaint to the* ***SRA, Solicitors Regulation Authority***

My complaint was not upheld in spite of all the evidence, I tried to politely point out their conclusions were flawed but they would not even acknowledge the valid points I was raising. These people are incompetent investigators and when you point out their incompetence their attitude is outright hostility. The concerns I raised were valid and I had suffered serious injustice as a result but, the ***SRA*** *just added to the injustice"*

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R. Tully

" I contacted the ***SRA*** *about the solicitor in my whistleblowing case, he without my consent did a deal for his costs with my former employer, he then refused to continue to represent me if I refused the settlement that would have benefited him the most as his costs were part of the deal. The* ***SRA*** *were completely useless, deliberately obtuse and took no action at all."*

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C. Fisher

" *My employer withheld really important information that I was entitled to and which I need for my whistleblowing case. I did not have a lawyer and representing myself. I contacted the* ***ICO*** *and told them my employer had repeatedly been asked for this information but was refusing to give and I explained my court case was getting nearer and without this information I would be in trouble, the* ***ICO*** *told me to get my lawyer to do the request, I had already told them I had no lawyer as I could not afford one as I was sacked after whistleblowing, they said they could not help. It cost me my case and my former employer was laughing, I am sure. If you want to silence a whistleblower just deny them disclosure of information. The* ***ICO*** *were just another layer of all the injustice you face trying to get to any accountability"*

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P. Walsh

*" I contacted a **regulator** about serious fraud, I supplied all the evidence and then waited for action to be taken, nothing happened other than a friendly phone call to my employer seeking their assurances that there was no fraud. I will never risk reporting anything again and would say to other people do not do it, it's a lot of personal risk to take for nothing, there's nowhere to go with such information"*

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M. Bright

*" As a whistleblower I have taken my concerns to **CQC, Safeguarding, NMC** and you are just sent round in circles by people who are incapable of investigating ****up in a brewery.*

Half of them have no common sense and the other half just do not care and if you try to complain, they investigate themselves and say they have done nothing wrong. People's lives depend on these organisations, they only protect themselves"

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R. Andrews

*" The **ICO** are completely incompetent, I do not know what this regulator is for other than wasting money and giving the public false hope that there is someone you can go to with concerns. When the **ICO** failed to act on my concerns they caused so much injustice to myself yes, but what about those I was trying to protect? They just do not care about the consequences of their incompetence"*

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L. Winterton

" My mother lived in her own home and was very independent and mobile right up to the time she had a fall and broke her hip, it was downhill from there, not because of her injury but because there was no care. If she had physiotherapy she could have returned home and lived a good quality of life, but instead the hospital said she should go to a care home for rehabilitation first and then return home.

The home had a rehab unit and the rest of the home was for permanent patients, It soon became clear that this was the worst money-making setup. The rehab was a joke, far too many patients and way too few staff.

Because there was no rehabilitation, I was forced to find my mother a nursing home because of the neglect she lost all mobility. I settled on a nearby home and at first it seemed good but a lot of the staff left about the same time and it went downhill overnight.

My mother was left without food and drink in her room most days, she lost so much weight. I kept raising concerns but it made no difference. I went to ***CQC*** *who said they would add the information to what they would look at on their next inspection, how long do* ***CQC*** *think can live without food and fluid?*

I also went to ***safeguarding****, the home told them my mother refused to eat and they just accepted that.* ***Safeguarding*** *even said people with dementia can have poor appetites, my mother did not have dementia firstly and secondly, she ate everything I gave her as if she was starving, which she was. I could have screamed with frustration at their incompetence.*

I got a call from the home to say my mother had taken a turn for the worst and an ambulance had taken her to hospital. A few days later a doctor told me my mother was end of life and that fluids and nutrition was being withdrawn. I could not believe it, the home had let my mother starve until she was so weak she ended up in hospital and the hospital withdraw food and drink, she died 5 days later.

Seeing an elderly parent who is walking about, happy, and independent one minute and reduced to a frail neglected shadow of herself within a few months, not because of her age or health but because she came into contact with the health and social care system is heartbreaking and so frustrating.

I went everywhere, ***CQC, safeguarding, PHSO.*** If any of these organisations were worth a jot then we would not have the health and social care system we have. They do not want to their job, there just there to stop people getting accountability ”

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L. Wise

“ *I am a whistleblower who went to the* ***regulator*** *in the sector I work in. I wrote a detailed statement listing all my concerns and where the evidence could be found. I had never been in contact with a* ***regulator*** *before this and I stupidly presumed they knew how to investigate such concerns.*

The whole experience was frustrating, demoralising, and shocking, they were either lazy, stupid, or just did not care. I really could not believe how bad they were. There is no comprehension whatsoever of the risks staff take to report these issues. When I raised concerns about this ***regulators*** *so called investigation, they really only then put any effort in, unfortunately the effort was put in to protecting their own reputation”*

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K Winton

The Old Deanery and the Regulator

The old Deanery care home is one of the biggest in the UK and caters for people with various needs including a nursing ward. The care home regularly struggled to staff the home and there was a revolving door of staff and this was a regular occurrence. In 2012 after years of service, a group of people whistle blew to their employer about the conditions they were working in and concerns they had about fellow colleagues and the impact this had on residents. We had expressed concerns to our mangers time and time again.

Nothing was addressed. new problems occurred, and we continued working. The care home owner had also decided to sell the care home, cut the staff hours and pay as a result a lot of staff left in a short space of time.

The remaining staff could not cope, were at breaking point, yet still the management did not listen. Some staff cared and tried their best but problem staff behaved worse.
*The **CQC** who regulated the home would come in and do inspections of the home.*
*These 'inspections' were prearranged and **CQC** inspectors were taken around the home By particular staff and management.*
*The **CQC** also attended social events such as BBQs at the home. Before **CQC** inspections they would make sure before **CQC** came that the home had been deep cleaned.*
*When **CQC** attended the home, it was the same staff members that were with them, other people were moved 'out of the way'.*
*Areas that were not staffed or staffed by only one person, were not looked at by **CQC.***

*After the Whistleblowers went to the management and nothing was done, we went to **CQC**, the **police** and **Social Services**. **CQC** answered our calls and took information from us.*
*All the whistleblowers were suspended shortly after, when we asked the **CQC** if they could do this, they said they could.*

*Several of the whistleblowers were working on the same shift, yet were suspended at the same time, there was no staff to cover their shifts. **CQC** went into the home and carried out an inspection during this time and rated the care home as just "needs improvement" but then after a short while, they had another inspection and rated the care home good whilst Panorama was in the home filming undercover.*

*The whistleblowers never returned to their jobs, **CQC** stopped answering the phone to the whistleblowers and requested we did not call them again.*

*In the meantime, BBC panorama was working with the whistleblowers and recorded a number of serious incidents involving the staff members that the whistleblowers had initially raised concerns about. The BBC Panorama was broadcast and appalled the nation and the abusive staff were jailed as a result. Yet nothing was done about the **CQC** and no action was taken about the fact **CQC** knew this was going on and did nothing about it.*
***CQC** did not contact the whistleblowers or involve them in any improvement plan.*

*About year later a huge conference was sponsored by BUPA in Brighton about the issue if the media was the only way to stop abuse in care homes. In this conference the head of the **CQC**, **Andrea Sutcliff** gave a speech in front of hundreds of people. In this speech she said the **exact words** 'The whistleblowers never spoke to the management or **CQC**, they just went straight to the BBC, **CQC** knew nothing about the issues, this was the biggest lie I had ever heard, since we had phone logs and emails from everybody, it was quite bewildering to hear this. **CQC** just protect themselves."*

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S. West

*" I reported serious issues to my employer and when it became clear that no action was going to be taken, I went to the **Regulator.** I knew nothing about regulators at all as had never had contact with them. I just expected that they would have the ability to investigate. When I saw the investigation conclusions, I was so shocked, I could not believe what a complete cock up they made of the information I had passed to them. I may as well not have bothered. Whistleblowers are taking risks for nothing, I wish I had gone to the police but because the **regulators** report stands, the police would likely not believe me now"*

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I, Moss

"Review of Local Authority & Regulators' investigations into abuse & neglect suffered by my Uncle in 3 care homes over a period of 8 years from 2013 to 2021

My Uncle suffered verbal & physical abuse, assaults, and neglect as well as humiliation in 3 separate care homes. This not only affected his mental health, but also his physical

health. This resulted in him being admitted to hospital on numerous occasions due to severe dehydration and severe urinary tract infections.

*1st Care Home**:** placed into special measures in 2019 and reopened Home*
*2nd Care Home**:** Weston-Super-Mare*
*3rd Care Home**:** Winterbourne, South Gloucestershire*
*4th Care Home**,** Southmead Bristol,*

*I stayed with him on numerous occasions in all 4 care homes, sometimes days on end to protect him and ensure he had sufficient fluids, which was a common problem and led to multiple urinal tract infections. I moved him 4 times to so as to prevent further abuse and neglect after I realised that the care home providers were incapable of providing appropriate care and the regulators, in particular the **Care Quality Commission (CQC**) who would not take immediate action. In all cases I raised with the **CQC** they stated that they would only use this information at future inspections/audits of the respective care home. This proved totally and utterly unsatisfactory as my vulnerable Uncle was subjected to continual abuse. I can only surmise what torture he endured whilst myself and family weren't present?*

*I continuously challenged the care providers but this led to my Uncle being abused I presume in retaliation for me raising constructive concerns. Covert camera footage, not published by the media, revealed this retribution by Carers. The whole footage was reviewed by **Avon & Somerset Police and the Nursing & Midwifery Council (NMC),** but not mentioned in their respective reviews/reports**.***

As outlined in my full evidence, which is available for inspection by relevant persons, I contacted the following in an attempt to prevent repetition of the abuse, neglect and poor care:

- ***Care Providers,***
- ***Local Authority Safeguarding (Both North Somerset & Bristol City)***
- ***Local Authority Social Services (Both North Somerset & Bristol City)***
- ***The Care Quality Commission***
- ***The Nursery Midwifery Council***
- ***The Social Care Ombudsman***
- ***Avon & Somerset Police***

All of the organisations and regulators were either dismissive, unhelpful, aggressive, unsupportive, or even implied that I was the contributory cause of the problem.

*I raised concerns to all of the regulatory bodies and raised multiple complaints to the Local Authorities, **NMC** and **Ombudsman** service and received some apologies, but in reality, these were meaningless and without sincerity to myself and my family.*

One Care Home Manager had the audacity to quote in the Bristol Evening Post that I was a serial complainer after he successfully evicted my uncle 3 days before Christmas 2019.

To be clear I dedicated nearly 9 years of my life trying to protect my uncle from repeated abuse and poor care and only by installing a covert camera in 1 care home did my uncle receive any semblance of justice when one Carer was sacked and another received a written warning. During this period, I wrote in excess of 1500 emails and letters to all of the local authorities and regulators. As a consequence of my experiences, I suffered from symptoms of PTSD, including difficulty sleeping. All this when I myself was suffering from atrial flutter.

When I installed a covert camera in my uncle's bedroom in August 2019, Avon & Somerset Police did review the footage very quickly and actually visited the Care home within 24 hours with a representative from ***North Somerset Council****. Apparently, this did cause quite a deal of panic for the staff, who had to summon the Matron & the Care Home Manager, who were shown video clips by the Detective Constable, as highlighted previously by myself.*

Unfortunately, it was quite clear from the onset that the Police investigators involved did not have much, if any, experience in safeguarding standards. This was later admitted when they informed myself and my wife it was the responsibility of North Somerset Council to review all of the covert camera footage versus safeguarding and good caring standards. See reference to ***Social Care Ombudsman****.*

However, even though as highlighted in the passage from PC Hall's response to my Uncle's MP, Dr Liam Fox, the Carers' actions did not exceed the criminal threshold, which I felt was set too high for the following reasons: -

- *The covert camera footage revealed my uncle crying on at least 2 occasions when he was scolded for soiling his bed.*
- *The covert camera footage revealed that my uncle was clearly slapped on his bare thigh, 10 times, to wake him up early in the morning.*
  This was described by Avon & Somerset Police as possibly as the sound of the Carer hitting the side of the bed.
  No reconstruction was carried out to determine if hitting the side of the bed was indeed the sound heard on the footage.
  Using advanced software, it could be clearly seen that my uncle's thigh had been smacked.

- *The covert camera footage revealing that my uncle was threatened by another Carer and tapped on his body. He was clearly frightened. For a more abled person, like myself, that would be grounds for charge of an assault.*
- *The covert camera footage revealing yet a different Carer handling my uncle roughly and aggressively using a hoist on her own. His care plan required 2 carers at all times.*
  The hoist hit the bed and my uncle was clearly in pain, shaken and frightened. The footage revealed the same Carer was more interested at looking at herself in the mirror.
- *The covert camera footage revealing my uncle being aggressively and excessively bed washed causing extreme pain and he could be seen crying for help.*
  His hands could be seen reaching out and he pleaded for the Carer to stop when she insisted that he should straighten his leg. The Carer dismissed his concerns with a reference to him being a "drama queen".
  My Uncle had a condition called "tendon lock" in his left leg which prevented him from straightening his leg even after intensive physiotherapy, which was documented & presented to the Care provider.
- *The covert camera revealed that he was left to chew his vomit after being sick. On 2 occasions 2 carers complained about his reaction and blamed him also for having excrement in his hair.*
- *My Uncle was elderly and was obviously suffering from vascular dementia. As I mentioned if a right minded, relatively fit adult suffered similar threats, action would have been taken.*

After repeatedly challenging Avon & Somerset Police with assistance from the charity, Compassion In Care, I resorted to contacting both the Professional Standards Committee and the Avon & Somerset Police Commissioner. Unfortunately, I made no progress.

Extract of letter of DC Hall to Rt Hon Dr Liam Fox

"Although the care provided by a number of the staff towards Mr (redacted) would appear to fall below that of the duty of care expected, their actions would not constitute an offence of Care worker / wilfully neglect an individual (offence under section 20(1) and (2) of the Criminal Justice and Courts Act 2015."

& Somerset Extract of letter from Avon Police Commissioner

"You undoubtedly wish to overturn the decision not to prosecute. The normal way to challenge the outcome of a police investigation is by applying for a Victims Right to Review

(VRR). Unfortunately, a case does not qualify unless a suspect has been interviewed under caution, which did not happen here. Further details can be found our website (link stated).

I understand why you are upset and I sympathise. I find cases like this very frustrating because they expose the limitations of the complaint review process. A review can only look at whether the police dealt with your complaint in accordance with the regulations, so if you were alleging that the police had failed to take your complaint, or not updated you, I could help, but when it comes to resolving a difference of opinion it can be very difficult. The police have explained their stance – you have explained yours. If I express an opinion on the case disposal decision, I would be exceeding my authority, because unless I commission re-investigation of the original assault (which I am not permitted to do) I would merely be expressing an unsupported opinion. Likewise, I have no power to direct the police to re-open criminal investigations, so please consider my response within the limited context.

*Your complaint was investigated by the **Professional Standards Department**.*

They explained why the police were unable to prosecute. What they did not explain was the legal threshold which must be met before the police can prosecute."

Clearly this is the only way abuse and neglect can be exposed unless whistleblowers feel confident to come forward. In my uncle's case a whistleblower, in my uncles last care home, Bristol did contact Avon & Somerset Police via a 101 call but were reluctant to make a statement due to the "bullish" nature of the regional manager. Therefore, Avon & Somerset Police, could not take any further action. My own hope is that I can convince an organisation/news outlet to publish all of the footage to highlight all of the appalling abuse my uncle suffered

My Uncle was abused & neglected in his 1st& 2nd care homes. He suffered from spinal issues, which were identified by my wife and myself, and not by the care system. This included an inability to stand following an operation to fit a shunt to negate hydrocephalus, which resulted in having a urinal catheter fitted. He was later to suffer from chronic kidney disease from 2016, vascular dementia from 2018 and finally COVID in early 2021. Although he partially recovered from COVID he lost his sense of smell and taste and therefore refused his food. He died in February 2020, like many residents, alone.

In his 1st Care Home, I witnessed blatant abuse and neglect. I suspected that he had been abused on a number of occasions prior a visit in 2016. He had been left to sit in the lounge

with his left trouser leg soaked in urine. The Carer dismissed my concern and stated it was a tea stain. I was obliged to use a tissue and wipe his trouser leg and present the evidence to the senior Carer. I then had to roll up my uncle's trouser to expose the root cause, which was revealed as a catheter bag full of urine backing up to my uncle's penis. This was a serious safeguarding issue that could have led to a urine tract infection and urinary tract infections. He suffered many UTI's at his 1st care home.

When I reported these concerns to the Care home manager, I was informed it must have been a temporary contract employee and she was extremely reluctant to investigate further.

*I raised repeated concerns to **North Somerset Social Services** & **North Somerset Safeguarding**.*
*I attended a meeting with **Safeguarding** and it was quite apparent that our concerns were dismissed. Once again, I felt under interrogation and the Council were reluctant to interview Carers. One incident involved my uncle's hoist tipping over with him still secured. Eileen Chubb, who attended one of these meetings, insisted that the incident should have been investigated and reviewed by an Occupational Therapist as my uncle could have suffered a serious injury, if not death. This advice was ignored.*

Extract from conclusions delivered by North Somerset Council into fall:
We did not consider it proportionate to carry out a reconstruction of the incident with the hoist as we secured sufficient information from the enquiry (sic) to fully substantiate the concerns and consider it more beneficial to put recommendations in place to minimise the risk of further incidents. We do acknowledge that advice from an Occupational Therapist may be for value and this is something that I will raise with the local authority compliance team to review and action if necessary. On behalf of the local authority as commissioner we can appreciate this was a very upsetting incident and we apologise for any distress caused."

My repeated concerns were either dismissed or/and ignored and my uncle was eventually admitted into hospital and diagnosed with severe dehydration, poor kidney function, an electrolyte imbalance & low folic acid. Social Services insisted that they interview my uncle at Weston-Super-Mare Hospital alone. After only talking to my uncle for only 2 minutes after he had fully recovered, they supported my request to move my uncle to another care home. According to the Social Worker my uncle stated he wouldn't return as the staff X Care home were "Rough & Riff Raff". North Somerset Social Services did not interview my uncle, even after he suffered a "fainting" episode in their presence.

In his 2nd care home, my uncle was initially treated respectfully but this quickly changed following the appointment of a new Assistant Matron.

*After multiple concerns were raised by myself and family with the care home management and local authority **safeguarding** and Social Services, were dismissed or dealt with tentatively in an untimely manner, I decided to install a covert camera. The footage over a period of 4 weeks revealed the abuse as later highlighted by the NMC provisional investigation.*

My brother and I were invited to meetings with the North Somerset Assistant Safeguarding Director.
At the first pre meeting we had to prepare minutes ourselves.

*During this period meetings were held by North Somerset Council, the **CQC**, Avon & Somerset Police, Social Services, and the manager of the care home. Neither myself and members of my family were invited and nor did we receive suitable notice of meetings and therefore little time to respond and organise around our own occupations.*

My brother, my wife and myself were invited to a formal review of the investigation carried out by North Somerset Council. Key points/observations:

- *The meeting start time was delayed by North Somerset Council representatives turning up late.*
- *Final investigation report was not issued prior to the formal meeting with family members, thus providing no time to prepare for the meeting and review the outcomes.*
- *Questions and points of clarification during the meeting on the whole were dismissed and, in most cases, or not even referenced in the minutes even though we agreed to have the meeting recorded as they had requested.*
- *After repeated "assertive" questioning the investigator admitted that he hadn't reviewed all of the footage due to a "lack of resource"*
  Note: Avon & Somerset Police PC responsible for reviewing the footage recommended that all footage should be reviewed by North Somerset Council as part of a safeguarding investigation as they did not have the necessary staff trained in safeguarding principles.
- *Assistant Head of North Somerset Safeguarding was aggressive toward the end of the meeting because she had to go to another meeting, directly afterwards.*

- *The final minutes of the meeting did not reflect what was discussed and the actions generated did not reflect what was agreed, even though the meeting was digitally recorded.*
- *As a consequence of family members raising numerous omissions from the minutes, we submitted a FOI request which revealed that the Council had deleted the recording even though it had been stated that the recording would be made available. SAR Ref 3702036*
- *On at least 2 occasions since the formal review meeting North Somerset Council indicated that they would charge interest on the monies outstanding for my Uncle's Care. I challenged this and the demand was rescinded.*

The ultimate insult was that my uncle was given 28 days' notice of eviction from his 2nd care home in December 2019, because in the Care Manager's opinion, I had made false claims after the incidents in August that year. These claims were backed up by camera footage but ignored by North Somerset Council.

I received no support from North Somerset Safeguarding/Social Services in particular for facilitating a move to my uncle's 3rd care home. This was especially relating to his medical condition and requirements. I had to report this myself to the Bristol Ambulance service during working hours 3 days before Christmas. His 3rd care home reported that they also did not receive any of my uncles' medical notes. After complaining once again I did receive a formal apology from North Somerset Social Services.

- *In all I exchanged in excess of 200 emails with North Somerset Council and even had to prepare an "action tracker" to remind them of their respective actions generated from all of the meetings I attended. I therefore submit the handling of concerns by my uncle's family members was handled unprofessionally and without sufficient empathy.*

  Finally, with assistance from the charity, Compassion In Care, I submitted 2 freedom of information requests to North Somerset Council from early 2013 to 2017. The 1st FOI revealed the following:

  - *2 Police investigations into falls and death of a service user*
  - *Verbal abuse by staff member investigated and upheld.*
  - *Several complaints relating to lack of staff*
  - *One person physically harmed another person using the service. 18 alerts in all.*

Obviously if this information had been published by North Somerset Council, I would have moved my uncle to another care home earlier. The 2nd FOI for the period 2017-2018

revealed no further alerts apart from my own complaints, which was emphasised by North Somerset Council.

*I first contacted the **NMC** in December 2019 following the reviews conducted by North Somerset Council & Avon & Somerset Police of the covert camera footage I gave them in September 2019 following incidents at X care home.*

*The initial period involved dealing with an **NMC** assigned case officer and attempting to send video clips via a File transfer utility, which consumed a considerable amount of my time, especially when the case officer failed to download the footage before the expiry date. This was extremely frustrating as this wasted more of my time and eventually it was agreed that they would accept a hard drive, with all of the covert and mobile phone footage and audible recordings.*

Over the course of the next 24 months I had to deal with at least 6 more case officers and had to resend information, which once again was exhausting and stressful.

*In all, I complained about 5 Nurses involved with my uncle's care at X Nursing Home. This included the Matron, Assistant Matron and 2 Nurses as well as an Advanced Nurse Practitioner (ANP) from the local surgery. In some cases, I had to edit clips from the covert camera footage to assist the **NMC** & North Somerset Council in their investigations.*

*The **NMC** had the audacity to complain about the lack of clarity of my submissions and whether I had sent the relevant footage. After making a complaint to them in May 2020, I received an apology and yet another case worker was assigned to my uncle's case.*

I provided evidence relating to my concerns that the nurses had not effectively managed my uncle's care and at times had been aggressively dismissive in response to my concerns as well as allowing Carers to abuse my uncle, resulting in 1 Carer being sacked.

This evidence included, correspondence, audio recordings with the Matron & Assistant Matron,
covert camera video footage and video footage from my mobile phone, all of which took a considerable time to collate and send.

*This initial review and assessment conducted by the **NMC** made the following observations after reviewing the covert camera footage:*

- *Michael being left in bed with little evidence of staff encouraging him into activities;*

- *Michael being left in bed soiled in excrement for almost 40 minutes despite a member of staff advising him that they would be 'two minutes';*
- *Care assistants making inappropriate comments towards Michael when they were providing personal care;*
- *When Michael vomited after being given personal care, no evidence was seen of Michael being offered mouthwash or water to rinse his mouth;*
- *Poor manual handling techniques including Michael frequently being moved by a single person despite being 6 feet tall and weighing 92kg;*
- *The poor manual handling technique resulted in Michael frequently being in a slumped position in bed;*
- *Michael not always being offered a napkin to protect his clothes during mealtimes nor was he given the opportunity to clean his hands before meals;*
- *Michael not being engaged with a choice of clothing each day. Staff were seen to dress him in a clean t-shirt each morning but he remained in this for the next 24 hours and we saw no evidence of nightwear. When Michael was in bed, he was often naked from the waist down which did not promote his privacy and dignity;*
- *Staff were not seen to clean Michael's teeth or mouth;*
- *Staff were seen to put the TV on but left it on the same channel without asking whether Michael wished to watch TV, or which channel he wanted to watch;*
- *Staff were seen to be wearing jewellery and nail varnish which represents an infection control risk;*
- *Some staff were also seen to not wear full infection control measures such as aprons and gloves when conducting personal care.*

*The **NMC** had also been informed that a **Safeguarding** review considered that standards of care did fall significantly below acceptable standards leading to disciplinary action and dismissal of staff. Further investigation of the Matron, Assistant Matron and another care home nurse was therefore recommended based on the observation that: -*

• There was a failure to provide leadership as Home Manager to make sure people's wellbeing is protected and to improve their experiences of the healthcare system.

*In April 2021 I received some quite remarkable questions from the **NMC** relating to my uncle's condition and whether the nurses were having much contact with my uncle. I suggested that they reviewed the covert camera footage in their possession. They asked questions about my uncle's care plan, so I suggested that they review them to see if amendments were made. I raised concerns that my uncle was not allowed to eat where he preferred. I was unbelievably asked why that concerned me and my family and what I expected the nurses to do in such circumstances. My reply was that they should listen to my uncle's wishes and treat him with respect and maintain a duty of candour. Also, why I thought my uncle didn't have capacity to make decisions. I pointed them to the*

independent report that highlighted he didn't have capacity and that he had been previously diagnosed with vascular dementia. It was as though I was being interrogated.

They also intimated that they couldn't locate a nurse under investigation and suggested that I pursue that enquiry myself. This particular nurse had left a note on the GP surgery system that I should not be allowed to make an appointment with my Uncle's GP. I informed the NMC that when I challenged this restriction, the GP rang me personally and apologised and informed me that the ANP had made this decision based on a conversation with the care home Manager, which had been derogatory in nature toward me. The GP had not been consulted by the care home about my uncle's deteriorating health, but agreed with me that my uncle's erratic behaviour, similar to Tourette syndrome, had been a result of a medication side effect. The NMC refused to contact this GP as it might reveal that a nurse was under investigation! Absolutely ridiculous. Obviously, my uncle didn't really matter to them.

In addition, they refused a formal meeting. At that point I knew I was wasting my time.

As a consequence, I raised a further complaint with the NMC and directed my complaint ***to Andrea Sutcliffe*** *CBE, CEO of the* ***NMC*** *and yet no response even after writing to my uncles, MP, Rt Hon Dr Liam Fox and Rt Hon Jeremy Hunt.*

In all I exchanged in excess of 450 emails with the ***NMC****, not including the 3 witness statements I had to prepare in a limited time, which not only put me under an extreme amount of pressure but provided insufficient time to review and consult with family members. This was quite absurd when you consider the NMC had been reviewing the cases for over 3 years. This was the basis for my 3rd and final complaint and was therefore allowed some more time to prepare.*

Finally, In November 2023 after 4 years of investigation I received notification that the there was no case to answer for any of the nurses under investigation. Not even an apology for the care homes nurses' clear failings as highlighted by the initial ***NMC*** *investigation.*

Key points from the case examiners report, but certainly not exclusive as there so many errors and misinterpretations of the evidence, including footage from the covert camera.

- *Complaint**:** My Uncle received insufficient fluids.*
  *Response**:** CCTV does not provide a detailed or accurate account of fluids administered.*
  Further, the CCTV does not capture 24 hrs a day.

Comment: The Covert camera <u>did provide</u> at least 2 x 24hr coverage of how much my uncle drank. It was clearly visible. The camera didn't run continuously but was activated by movement, which clearly the case examiners did not understand.

- *Complaint: My Uncle was not encouraged to get out of bed*
  Response: Evidence suggests my Uncle had capacity.
  Comment: My Uncle was diagnosed with vascular dementia from March 2019 and according to medical advice may have suffered from that for the whole time he was at X care home.
  *Also, the **NMC** stated that NS Council reported there was no evidence of abuse, but that's because they didn't review all of the footage from the covert camera. In one clip he was actually assaulted/threatened and discouraged from getting out of bed.*

- *Complaint: Failed to uphold standards of hygiene.*
  Response: We saw 1 time a staff member changes the resident's pad without gloves.
  Comment: The clip exposed a Carer was actually wearing gloves and then using her mobile phone. From a FOI it was reported by North Somerset Council that the care home was not taking hygiene seriously and they feared the consequences, prior to the COVID outbreak and after my uncle was evicted.

- *Complaint: Matron/Assistant Matron did not escalate concerns about the resident's medical condition.*
  Response: We have not seen any documentation that suggest that the home or you were aware of this diagnosis.
  Comment: The care home was registered to care for residents with dementia and therefore should have had nurses to diagnose such a condition. Why didn't they?

*In addition, there was no reference to the independent assessment that my uncle was assaulted and maltreated and scant reference to the initial concerns raised by the initial **NMC** investigation.*

Basically, a totally flawed investigation and a waste of time of energy and most importantly no justice for my uncle yet again. I am in the process of appealing the decision. (January 2024)

***CQC** Response*

*During my uncle's residence at his 1st Care Home, from 2012 to 2017 I made several calls and exchanged correspondence on numerous occasions with the **CQC**. My 1st impression was that the call handlers were at times quite abrasive and dismissive. They clearly were annoyed at times and frustrated that I wasn't aware of processes, but as I explained I was just seeking advice and asking for support after witnessing some dreadful experiences involving my uncle, who in my opinion was clearly being neglected and bullied. Evidence which included a deterioration in his mental health, repeated UTI's and obvious signs of dehydration. They insisted that they could not take immediate action and reiterated several times that I should consult the local authority Social Services & **safeguardin**g departments. This was exactly what North Somerset Council said about the **CQC.** I reported to the **CQC** on several occasions about the following:*

- *Lack of staff*
- *Staff feeling undermined and not supported. On 1 occasion I reported to the management, North Somerset Council and the CQC that I found 1 Carer "sobbing" as she thought she was failing the residents. I had to console her.*
- *Staff feeling demoralised and at times aggressive.*
- *Management reluctant to take my concerns seriously*
- *Constant smell of urine and excrement.*
- *A temporary member of staff trying to lift a resident from her chair when she actually required a hoist.*

*In one instance the **CQC** attempted to infer I was the only person who raised concerns about the standard of care. However, as highlighted, the FOI highlighted multiple issues as well as two investigations by Avon & Somerset Police. During the period 2015-2017 I attended at least 4 "Best Interest" meetings with the care home management and North Somerset Social Services. No actions were completed satisfactorily and in the final meeting it was suggested that my uncle be moved to another care home as I was raising so many concerns. This was not picked up by subsequent **CQC** inspections. Presumably because the Care home was poor at collating and retaining records?*

I provided additional evidence on occasion in late 2017. Whilst my brother and I were collecting our uncle's personal items following his move to XX Nursing Home, we heard another resident constantly calling for help and assistance. I knocked on the door of the elderly female's bedroom and it was clear she was confused and just wanted basic reassurance. She stated that the carers were "bloody useless". I eventually found a Carer and after approximately 50 minutes a Carer visited. The sound recording was sent by

*myself to the **CQC** for review and after a couple of weeks a **CQC** official contacted me over the telephone. Questions included the number of the bedroom and how many Carers were on duty, which was difficult to ascertain as my brother and I saw so few.*

*Two years later, in October 2019, the **CQC** eventually placed XX Care home in special measures and in their report most of the concerns I had raised over a 2-year period from 2015-2017 were referenced, namely:*

- *There was a system to investigate complaints, however it was not evident it had been consistently used and records were incomplete.*
- *It was evident that the governance systems in operation at the service at both internal and provider level were currently ineffective.*
- *It did not demonstrate a consistent person-centred approach.*
- *During this inspection we found that people's needs were not always met due to inadequate staffing levels.*
- *People, their relatives and staff said care needs were not always met and we made observations to support this.*
- *Staff were not always fully supported in their roles, and in addition to being below the providers training completion compliance level, staff had not received regular supervision and appraisal.*
- *The **CQC** spoke with staff who confirmed they had not been receiving their supervision and staff new to care had not been appropriately supported in the early stages of their employment.*

Most of the concerns raised by myself were identical or similar to those raised during the audit/inspection carried out in 2019. Why did it take so long for them to follow up my concerns?

I suspect as per my experiences with other investigators/regulators I was considered as a nuisance and even a serial complainer.

In conclusion the CQC always appeared to be happy to refer me back to the local authority, who in turn implied the CQC should deal with my complaints. No ownership and accountability came to mind. Echoes of Mr Bates v The Post Office.

*The **Ombudsman PHSO** in their final report stated that Avon & Somerset Police did not recommend that North Somerset Adult **Safeguarding** should review the footage in their correspondence with my Uncle's MP, Dr Liam Fox. (See reply from PC Hall to Dr Liam Fox MP). My integrity once again was challenged and a bias toward North Somerset Council exposed.*

*This was clearly incorrect and subsequently confirmed by the Police to both myself and my wife in person. The **Social Care Ombudsman** believed that North Somerset Council were correct to rely on a very brief report by Avon & Somerset Police, even though the **NMC** highlighted numerous concerns regarding the overcall care my uncle received. This basically justified the Council's approach even though they admitted they didn't have enough staff to review the footage. It was quite clear the **Ombudsman**'s intention was to dismiss my concerns, which I believe was partially in reaction to the complaints I raised about their approach and attitude toward myself.*

Extract from letter from DC Hall & Rt Hon Dr Liam Fox

*As the police investigation has been completed and no criminal offences have been identified, the investigation will now be picked up by our partner agencies (**CQC** and Adult **Safeguarding** Team) to carry forward and review the level of care given to Mr (redacted) and for the appropriate action to be taken. They will also have a role in scrutinising the disciplinary action taken by the owner / manager of XX Nursing Home.*

Agreed recommendations

Within one month of our final decision:

- *the Council will reduce the amount Mr D's estate owes for care fees by £6179 to acknowledge the substantial injustice caused to him when he was not properly safeguarded from abuse and provided with good care.*
- *the Council will lead on an apology with the Home to Mr B and pay him £600 between them to acknowledge the significant distress he experienced because of the failure to safeguard his uncle from abuse and provide good care.*
- *the Council will remind its officers of the importance of recognising the status of those who LPA (lasting power of attorney) when giving advice related to a person's mental capacity."*

Final decision

I uphold Mr B's complaint about the care and support provided to his uncle by the Home which was partly health funded and commissioned by the Council. I do not uphold Mr Bs complaint about the way the Council followed its safeguarding procedures. The Council and the Home have agreed to our recommendations to remedy the injustice caused. I have completed the investigation."

The final recommendations included an offer of £6179, which had already been offered by North Somerset Council safeguarding prior to their formal investigation.

The Social Care Ombudsman *failed to criticise the Council for the following:*

- *Failing to review all of the covert camera footage, mobile phone footage and audio recordings.*
- *Failing to conduct a satisfactory audit of the care home and discuss issues raised by myself and others*
- *Failing to invite myself to key meetings with the Council, Social Services, and the care home management or/and provide sufficient notice for myself and my family members to attend.*
  (Note: both myself and brother were working full time during the period of investigation)
- *Failure to accept Avon & Somerset Police recommendations. Implying North Somerset Council were correct in following the observations made by police. As a consequence approximately 90% of the covert camera footage had not been reviewed by North Somerset Council safeguarding department, which was apparently acceptable even though the* ***NMC*** *reviewed all of the footage. This had an Impact of the final decision of the* ***NMC****.*
- *Failure to liaise with the* ***NMC*** *and review the results of their provisional investigation.*

Therefore, with the assistance of independent solicitors I initiated a further complaint against the ***Social Care Ombudsman****. However, this was dismissed even though anomalies were identified by the solicitors.*

*Bristol City Council Safeguarding & Social Services investigations into incidents in XXX care home**.***

My Uncle was transferred to his last care home in early 2020. I had a very frank discussion with the Manager and explained the abuse and neglect that my uncle had suffered in previous care homes.
I made it quite clear that I wanted any safeguarding issue reported to me immediately as his vascular dementia was clearly affecting him.

Unfortunately, access to my uncle was restricted from early April due to COVID. As usual, in the initial few months I received regular updates and then I was informed by the

care home Manager that my uncle had been involved in a safeguarding incident. It was described to me as a Carer assaulting my uncle, placing her hand over my uncle's mouth when he spat out when woken in the early hours to turn him in his bed. She also forced my uncle's arms to one side. Incorrectly the Carer was put on light day duties rather than a suspension, but the following day she resigned.

*I contacted **Bristol City Council Safeguarding and Social Services**, but they were reluctant to investigate as XXX Home did not have a contractual arrangement with the Council.*

*I exchanged dozens of emails with **Bristol City Council Social Services and Safeguarding** and even my local Councillor. Unfortunately, I made no progress.*

*XXX Care Home inadvertently issued a newsletter and exposed all of the contact details of families whose loved ones resided at the care home. This was a clear data breach but neither the Council services, **CQC** or the **Ombudsman** reported this to the Information Commissioner's Office **ICO**. As a consequence, I had access to all of the families' contact details. I wrote to all of them highlighting the alleged incident involving my uncle. Six families came back to me with concerns. I met up with two of them and they described how their loved ones had been assaulted, one by a Carer and another by a fellow resident.*

My initial request for a formal meeting with Bristol City Councill was rejected.

Correspondence with(Director - Adult Social Care)

Dear Mr Moss

I look forward to meeting with you on Friday 22nd October at City Hall in relation to the concerns you have raised about XXX Nursing Home. Attending this meeting will be Councillor H H, Councillor TR, (Adult Safeguarding lead) and myself. At the meeting we will be able to talk you through the Safeguarding Adults procedures, the roles and responsibilities of the Local Authority and other organisations/bodies and hopefully provide some reassurance on our response to your concerns.

I am aware that relatives of other residents at the home are also attending this meeting. Just to let you know, due to confidentiality and data protection requirements, we will not be able to discuss individual cases and any response or findings related to individual residents within the wider meeting. However, we will be able to take back any new

concerns raised in the meeting and respond to any safeguarding or quality issues that are indicated liaising separately with individual family members about their particular concerns. It is also important that any concerns are reported through our referral procedure which can be done via our online form at…"

We collectively approached Bristol City Council and voiced our concerns and were invited to a meeting with the Director of ***Safeguarding****, my local Councillor, and others. We all highlighted our experiences and frustrations. My major concern was related to the lack of transparency and the lack of knowledge relating to our experiences. In addition, I attempted to establish why my FOI had virtually been totally redacted. Toward the end of the meeting, which was recorded and minutes provided, I basically lost my patience as there appeared to be no apparent resolution being offered by the Council. At that point I raised the redacted responses to the light and referenced a line from Kevin Costner and the film "Hidden Figures". I tried to "look beyond".*

These concerns were highlighted in the minutes and actions were generated.
The agreed actions from the meeting were as follows:

1. *TJ to ensure that all known safeguarding concerns from the families have been addressed. This Council is unable to share information relating to other families. These were not addressed. One family member observed a duty nurse sleeping on nights and unable to find carers. The family member had to escort residents with dementia out of her mother's room.*
2. *Ensure Bristol City Safeguarding followed their duty in relation to the original issues to ensure everything that could have been done as been done.*
   All 3 families were frustrated with the responses.
3. *Review any new complaint received from the families present and send a response.*
   The complaint response was eventually received & subjected to criticism by solicitors.
4. *Cllr R to approach Darren Jones MP in relation to him agreeing to meet the families together, rather than individually*
   This action was not completed.
5. *Councillor H to see if any national work is being undertaken in relation to collaboration of agencies*
   This action was not completed.
6. *Council to look at the two recent reviews and provide a report into my uncle's alleged assault.*
   This action was not completed.

Prior to the formal meeting, myself & others managed to access the care home on a weekend by pressing the "reception" button in the front of the care home. I sent a copy of the video of this to the ***CQC,*** *Bristol City Council and the Care company CEO, but no action or investigation was conducted as far as I was aware. This was a major*

safeguarding issue and it was quite evident the care home was accessible out of hours when no receptionist was present.

Once again, the concerns raised by myself and those of others were not dealt with satisfactorily.

*Our loved ones were failed by the local authority & regulators**.***

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P. Moore

" *In the last couple of years, the care system has really changed for the worse. You used to know all the staff you worked with but not anymore. The staff just come and go without warning, a van will show up drop of a couple of workers each day, these staff will often work back-to-back shifts and after a few months just move on. It's really bad as they do not even know the people they are caring for and some staff cannot speak English at all. It's impossible to do this job without being able to speak English. The standards of care are just awful. I rang the **Safeguarding** people about the situation but they just did not care"*

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P. Dawson.

" *I worked in an industry (Not Health and Social Care) I went to the **Regulator** on a pollution issue. I expected an investigation as the evidence was there but the **Regulator** chose to ignore that information and just took the paperwork my employer presented at face value. The **regulator** is completely on the side of the industry and they just bury bad news raised by whistleblowers."*

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D. Brewster.

" I worked for care agency, have done this kind of work for over twenty years. Part of every shift there are what we call doubles, that is a client that needs two care workers to attend to their needs. In the last year and a half, I have been doubled up with a set of constantly changing staff, some cannot speak English and you cannot tell them what needs to be done.

*If you are using a hoist with someone who cannot speak English and knows nothing about care it's so dangerous, there were countless near misses and one day a lady nearly fell from the hoist, I went to **Care Inspectorate Wales** and reported this as my employer ignored my concerns. The **CIW** told me they had checked my employers records and found all staff were fully trained in moving and handling, except the staff that were the risk were not in the records. The regulator are either completely stupid or just do not want to deal with this issue"*

....

D Noade

" Ex-employee of a Residential project for people with learning disabilities which had a contract with a Health & Social Care Trust (the Trust)

***Regulators**:*

Regulation & Quality Improvement Authority (RQIA)
Northern Ireland Social Care Council
Safeguarding
Police Service of Northern Ireland (PSNI)
Charity Commission for Northern Ireland

Issues reported:

Abuse of adults who have learning disabilities.
Victimisation by employer and harassment by its Staff.
Charity draw in which Finance Officer & her family won £21000 of £25000.

Background: I was new to the care industry after many years working in the building trade. My work with the vulnerable adults drew plenty of praise from the management until I quietly raised some concerns with my manager.

Over the months I'd begun to feel concerned for the Residents for a number of reasons. For example, a member of staff who couldn't read, asked me to read out the instructions on medication she was administering.

Also, the manager offered me money belonging to the Residents to pay for my lunch. When I politely refused, she tried to insist I take the money and said I shouldn't be questioning her. After that I was victimized by my employer and by the Trust.

Abuses of Service Users:

- *Staff freely taking money from Residents' purses/wallets, a widespread practice, considered normal, by management and staff.*
- *Residents paying for staff meals.*
- *Service Users' shopping lists made up of items requested by staff.*
- *List passed to each shift to be added to by staff for weekly shop.*
- *Food ordered which was not suitable to service users care plans (e.g. contrary to instructions by Speech & Language Therapist due to choking risks).*
  List included mainly items the Service Users could not eat steaks, cakes etc.
- *Practice of eating out continuously, detrimental to care plans.*
- *Neglect, eg a Resident having to manage his own urinary catheter.*
- *A Resident's requests to see me were rejected, breaching his human rights.*
- *Psychological bullying, eg a staff member when on duty telling Residents he is an undefeated boxing champion and even coming in on his days off wearing his boxing outfit, all done deliberately to frighten the Residents as a warning to do as he said. Some told me they were scared of him.*

My employer's treatment of my family and myself for raising concerns:

- *Despite an exemplary employment record, I was forced from my job for speaking out about abuse of vulnerable people.*
- *I have been fully supported by NIPSA, my MP and charity Compassion in Care in looking for answers as to why it took 3 years to address concerns about abuse which were confirmed by Northern Ireland Vulnerable Adult **Safeguarding Team**, the Trust and the **RQIA** in 2014.*
- *Harrowing prolonged ill-treatment of myself, my wife and my then primary school children from 17 staff of my employer.*
- *I was ambushed into a meeting with the Trust for which I was unprepared.*
- *Breaches of confidentiality by the employer.*

- *I was to be disciplined on the Trust's comment that 'the Trust would not want him working with service users.' The Trust later said the minutes were wrongly recorded and the sentence should have ended with ...'until after the trust investigations.'*
- *NIPSA rep refused to allow disciplinary proceedings as my employer had breached Employment Law for Disciplinaries & Grievances and natural justice was not afforded to me.*
- *The employer's referral to **NISCC** also reflects unequal treatment supported by Trust comments, based on hearsay of 3 staff who I had reported for abuse.*
- *The employer's Chief Executive Officer (CEO) alleged that I had made threats against staff and was told she would need to provide evidence but provided none. I told the police that I was recovering from heart surgery when the alleged threats supposedly occurred.*
- *Solicitors' letters citing defamation.*
- *I received a solicitor's letter for being in possession of letters that were sent to me by my employer.*
- *Blatant attempt to cause hardship, fear, and anxiety to my family: at Christmas 2016 my wife received a solicitor's letter in response to her letter pleading for a Committee member to help bring an end to the harassment of our family.*
- *PSNI had to intervene to stop the staff's ongoing harassment of myself and my family at our home. PSNI officer gave the Chief Executive 4 warnings and she asked police if they could ''keep this in-house?"*
- *Police Notices of Harassment were issued to the 17 staff harassing us.*

*I clearly explained to all the agencies I dealt with about the abuse but nothing was done. I reported the abuse internally and to the Trust and **RQIA** but at first, they decided to let my employer investigate themselves. They then gave responsibility for a later investigation to a department in which a very senior Social Worker worked, whose very close family members were named in my complaint.*

I was suspended after two directors of my employer phoned me to ask about issues after a mutual family connection told them in an attempt to help me. The directors sounded shocked and horrified by what I was telling them and thanked me for bringing the issues to their attention.

Some weeks later one of them arrived at my home and gave my wife a letter of suspension and told her "He's not in the right job. He needs to find a job that's right for him.''

*Investigation by the Trust and **RQIA** confirmed that all I had told them was true but concluded I was not fit to work with vulnerable adults. They gave no reason to either my union, the Northern Ireland Public Service Alliance (NIPSA) or myself.*

*The Trust and the **RQIA** worked together to instruct my employer explicitly not to let me work with vulnerable adults and reported me to **NISCC** which meant I could not register to work as a Carer. All this was done with no evidence of any wrongdoing by me.*

*The **regulators** became part of the process of punishing me and my family and I don't say that lightly. I have a young family whose father had lost his job and was kept in limbo for 4 years as my employer stopped my salary and the Trust and regulators prevented me from working as a Carer.*

*I made a formal complaint which was investigated by the Vulnerable Adult **Safeguarding Team**. My complaint was upheld and seven requirements and recommendations were made by the **RQIA**.*

So why was I seen as a threat to the care system? Why did the directors and managers not know there were problems in the homes and do something to fix them? Why did they leave me and others open to this toxic working environment?

*The Trust apologised much later in writing. 4 years after my suspension the **RQIA** apologised in the presence of my NIPSA representative for saying they did not want me working with Service Users, and I was promised the apology in writing but it never arrived.*

Breaches of confidentiality by my employer caused news of my suspension to spread like wildfire and, for example, my wife and 5-year-old daughter were humiliated at the school gates when a person quizzed my wife about my suspension.

*I suffered a heart attack which I believe was caused by the enormous stress I was put under after reporting the abuse to my employer, the Trust, and the **regulators**.*

At one stage my wife wrote to a member of the Residential project's Committee as they are related by marriage, begging for intervention to stop the staff harassment at our home but the letter must been given to my employer's management as we received a letter from the home's solicitors citing defamation.

When I was due to return to work, my GP phoned to say that my employer had requested all my medical records which they were not entitled to see. He asked me for an update on my case and referred to the home's management as "toxic".

Although my doctor said I was medically fit to return to work, the employer would not let me and said that I was considered unfit to work with vulnerable adults but no reason was given.

Outcomes and my comments:

***RQIA** issued Enforcement Orders:*

- *2014 Vulnerable **Adult Safeguarding** Team investigated issues raised by me.*
- ***RQIA** issued 7 Requirements/Recommendations.*

- *Issues recurred over next 3 years.*
- *20.04.17* ***RQIA*** *Finance Inspection Enforcement order issued regarding supported housing at another project run by my employer because it had taken no notice of* ***RQIA*** *requirements for 3 years.*
- *2017 Two serious concerns meetings with* ***RQIA****. The employer was made to refund money to tenants.*

Freedom of Information requests forced the ***RQIA*** *to disclose some notes of meetings and emails, which revealed a Trust employee had said I should not work with vulnerable adults. This was repeated in notes of meetings between my employer, the Trust and the* ***RQIA,*** *again without any reason given.*

When I questioned this, the ***RQIA*** *said they had repeated the sentence in error – as it should have read, I shouldn't work with vulnerable adults until after the investigations. We were still following up some important but unanswered questions but they refused to deal with me anymore.*

My employer: *I was later told that practices and procedures were changed as a result of my whistleblowing and employees were now subject to disciplinary action. This is difficult to believe because I had reported abuse to the management who were never held accountable for not taking action to prevent it, nor for victimising me.*

The Trust: *The Trust still refuses to give me or NIPSA the requested information which they say is confidential. Yet this has caused me the loss of my job and trauma to me and my family over long stressful years.*

NISCC: *The* ***NISCC*** *lifted the suspension on my registration after my lawyers intervened but there is still no explanation as to why I was suspended in the first place. I told* ***NISCC*** *that my employer was using the regulator as a stick to beat whistleblowers with.*

Employment Tribunal: *I withdrew my Employment Tribunal case in 2017 and accepted a settlement because my employer refused to take me back to work. Also, I had substantial bills to pay solicitors for 3 defamation cases taken against me by the employer's management and staff.*

Police Service of Northern Ireland: *I was forced to call the* ***PSNI*** *to intervene in ongoing serious harassment at our family home by 17 staff of my employer. Photographic evidence*

was given to the police. This was provocative and intimidating behaviour which my young children witnessed.

The police were very good and one Officer in particular was a decent fair man who helped me and my family on more than one occasion.

No investigation into the financial abuse of Residents was carried out so far as I know.

***Charity Commission of Northern Ireland:** My ex-employer is a registered charity, well supported particularly in the local community by those who believe their contributions will enhance the lives of the vulnerable learning-disabled Residents.*

*I wonder do the donors know how much money the charity has spent on lawyers to support them in their lies to destroy a dedicated employee, all with the knowledge of the Trust, **RQIA** and **NISCC**.*

Charity's Prize Draw
*25th Anniversary Prize Draw 21 December 2017, just months after enforcement order issued and 2 serious concerns meetings with **RQIA** on financial abuse, the charity ran a public draw, £25 per ticket and £25,000 prize money. £21,000 of that went to the charity's Staff. £16,000 went to the Finance Officer and her immediate family.*

Video of the draw is on the charity's Facebook page for 21st December 2017. The results were not published even though it was a public draw.

*In August 2018 I informed the **Charity Commission of Northern Ireland** of my suspicions about how it was run. I do not know if it was investigated.*

Long term impact on me and my family:

Whistleblowing on abuse has taken a huge and ongoing toll on my health and my family. After listening to how abysmally I was treated by all the relevant agencies, and the tactics used against me, someone gave me an article "20 Diversion Tactics Highly Manipulative Narcissists, Sociopaths and Psychopaths Use to Silence You" by Shahida Arabi. From that I recognised the tactics used to silence me.

An example of this is "gas-lighting", frequently used to deny the truth. As just a new employee I suggested and was encouraged to take the Residents out on day trips. We set off on many, particularly to areas by the sea which the Residents enjoyed best. When we returned from a trip to Carlingford the management was full of praise and said the Residents must have had a wonderful time, which they did. But when my employer and the Trust were listing my supposed misdemeanours, they accused me of "taking the Residents out of the country without consent".

Deaths of 2 Residents since I left

I submitted a detailed file to the Trust about the neglect and abuse of these two men at my former workplace. They survived decades in ***Muckamore Abbey Hospital*** *where it is now known there was widespread abuse but survived only a few years at my employer's Residential project. I do not know if their deaths were investigated but I believe they should be.*

Financial abuse elsewhere in care sector

My case began because I refused to take Residents' money and it makes me wonder how many other homes are involved in financial mismanagement. eg in May 2017 the Irish News reported a ban in 2013 on new people being referred to a residential home in County Armagh: "accused of overcharging care home residents by thousands of pounds for hot meals and outings."

Summary:

*I continue to seek answers and to hold accountable all involved in the abuse of Residents and in victimising me for reporting that abuse. What I got from the start was my employer telling me to go to the Trust, then the Trust saying you're not our employee, go to your employer. When asking very important questions about how the regulator and Trust staff behaved, the Trust****, RQIA*** *and* ***NISCC*** *were all blaming each other and it left me running around like the Keystone Cops.*

When issues of abuse cannot be raised safely, which my case shows they cannot, then abuse will flourish as it has at my former workplace.

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K Walters

" I raised concerns about a doctor who often decided to withdraw food and fluids from people of a certain age. There was nothing seriously wrong with these people and they could just return home with a bit of care and attention. Three patients had been admitted with UTI or kidney infections and needed antibiotics and plenty of fluids, they were being denied food and fluids. I went internally with my concerns and nothing was done about this, I went to ***RQIA*** *the attitude was, you are not a doctor how dare you challenge a respected doctor. I had to go sick after this as my life was made hell by this doctor who told all my colleagues that I was a liar and did not know my place. I went through the process but it was on paper that I was the problem. It cost me my job and I went to several law firms who told me that they could not take my case as I had no chance of winning against the word of a doctor and that without proving the whistleblowing that I could not*

prove the dismissal was linked to it. One lawyer told me they preferred to take whistleblowing doctors cases."

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J. Harrison

" *I am a whistleblower from X sector and went to the **regulator** of this sector. I provided comprehensive evidence of my concerns. It was like pulling teeth, I had contact with 3 people overall at this **regulator** because I had to go higher after each failure to investigate and address the concerns. The first two investigators were lazy and complacent, the most senior individual was completely captured by the industry in question. In the end I just gave up because there was nowhere to go"*

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E. Valerie

"*My sister was sexually assaulted in a care home on at least five occasions, my sister is unable to speak due to a brain injury. The reason I know about the assaults? A whistleblower contacted me after they tried to get someone to act on their concerns but nothing was done. I went to **safeguarding** who said they would investigate, like a fool I trusted this but it was only weeks later when I saw their report that I realised they were completely incompetent. The report was full of errors and vital evidence given by the whistleblower was missing, I was appalled and addressed all the points in writing but they refused to deal with these full stop. I got my sister out of that home which was not easy as they really obstruct you. I have kept in touch with the whistleblower who is now working in manufacture as the events in the home completely disillusioned them. I am so grateful to this care worker for trying to protect my sister. My sister is now in a really good home but its rated good by **CQC** just like the awful home. How are we to trust these ratings? I would never have believed that such serious abuse could go on without any action being taken and I am so grateful my sister is now safe, I hope I never need to use a **Safeguarding** board again as they are utterly useless and they do not want to upset these care home owners"*

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T. Freeman

*" Your life is turned upside down by whistleblowing and for what? A **regulator** to completely ignore all the evidence you bring to them. This **regulator** is no more than a political puppet who just goes through the motions of investigation but reaches impossible conclusions that the evidence completely contradicts, where do you go when the first*

regulator fails, no matter where you go no one will believe you because, this so-called expert ***regulator*** *said black is white so everyone believes this and you are completely discredited"*

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L. Connery

" *My experience of* ***Safeguarding*** *and* ***CQC*** *is that they are just government-controlled entities to contain people who raise serious concerns about abuse. I cannot see any other reason for their existence. All those I came into contact with were completely indifferent to the issues I was raising. It does not matter how much evidence you have, they either completely ignore it or misinterpret it deliberately. As for having meetings with them, when you see the minutes, they are completely unrecognizable as to the true issues you raised. Its like trying to thread through treacle and the more they write down the muddier the trail becomes to anyone reading the correspondence and that's done deliberately to make you look unreasonable"*

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J. Medcalf

" *When My mother was in the W. W care home and was experiencing serious neglect and was at risk of harm, at first, I didn't know who to turn to. I first contacted the* ***PHSO Ombudsman****, who told me to contact* ***Safeguarding*** *about all the issues in the home. I was told* ***Safeguarding*** *would respond within 6 weeks, 3 months passed and I heard nothing. It was only when I rung* ***Safeguarding*** *and left a message that they rung me back and informed me that my case had been closed because everything had been done in a timely manner. Completely untrue. Whilst* ***Safeguarding*** *even admitted that serious incidents had taken place but had not been reported by the home as they are required to do by law, whilst not upholding my concerns.*

I rang ***CQC*** *who actually said my mums case amounted to neglect and risk of abuse.*

People think ***Safeguarding*** *is the best place to go to complain but they are not fit for purpose because they coverup the true facts and as for* ***CQC*** *how can they keep allowing the K family to keep running care homes when their reputation is so bad and why is one of their worst homes not even listed by the* ***CQC*** *on the providers page?, especially when it has such a long history of poor care? These things should not be covered up and all the information about a care company should be easily available for the public to view so their relatives are not placed in homes with such terrible histories of inadequate ratings. Why are care providers allowed to close a home before enforcement action is taken and then go on and be allowed to open other homes?"*

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R. Shanahan

*" My mother was dying of thirst in a care home, I went to **Safeguarding**, I heard nothing from them and rung them, they told me they had closed the case without even contacting me or even looking at all the evidence I had gathered. I had expected to be interviewed as a witness, to have all the documentation considered as evidence, nothing of the sort happened. They closed the case and said there was no evidence but there wouldn't be would there. I went to **CQC** who told me that they noted my concerns but as **Safeguarding** had already investigated it, they could only generally note the issue. My mother died in hospital 3 months later, the doctor who saw her in A&E made a **safeguarding** alert because she was seriously dehydrated. The whole system is a joke and the concept of investigation is seriously beyond those we have to rely on when lives are at risk"*

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L. Jones

*"My employer had whistleblowing policies and an external whistleblowing helpline, it was absolutely useless, the people you are speaking with have no bloody idea about the area you are working in and I ended up feeling like I was trying to report a faulty washing machine rather than trying to get someone to act on issues that put the public at real risk. After three months of chasing this and nothing what so ever happening, I went to the **regulator** and really thought at first that something would be done.*

*Four months later and still no action was taken, the **regulator** did nothing, the whole thing was pointless. These **regulators** are only there to protect those their supposed to be regulating. Seven months and so many hours gathering the evidence and explaining everything and for what? I wouldn't be party to the harm being caused and I could not stop the harm because it was too late and the harm was done. At the time I considered taking the case further but what was the point of that when the harm was done? I am now working in a completely different industry"*

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I. Murphy

" *I am a whistleblower from an industry (other than health and social care) I had extensive concerns about certain unethical practices within the company I worked for. I used the whistleblowing policy but no action was taken and I almost immediately became aware of hostility from management. No action was taken on the concerns at all so I went to the* ***regulator.*** *As time went on and nothing was done, I contacted the* ***regulator*** *several times more and was spoken to very abruptly and in the end the two people at the* ***regulator*** *I had contact with, told me that my concerns were not going to be taken further and that I should not contact them again. I could not comprehend this as my concerns were evidenced but clearly the* ***regulator*** *had no intention of taking action.*

You suddenly find yourself in this situation where all trust has gone, I had worked in this industry for nearly two decades and was very competent and respected, suddenly all that crumbled to dust. I could carry on working and keep my head down or start again somewhere else, doing something different and in the end, I resigned and found another job in a related but separate industry.

Four years later the environmental damage was all over the news, I will have to live with the fact that I failed to stop these issues but when you raise concerns with your employer and nothing happens and then you go to the ***regulator*** *and they protect your employer then the last thing you need is yet another* ***regulator****.*

My employment role involved being approved by the industry ***regulator,*** *reporting to my employer was bad enough, reporting to the first* ***regulator*** *brought hell down on me, if I reported that first* ***regulator*** *to another* ***regulator,*** *there is no doubt in my mind that I would find myself no longer certified to work"*

..

A Fernandez

" *I used my employers whistleblowing policy and contacted the helpline number listed. The concerns related to the conduct of the company I worked for.(Not Health or social care) I just kept waiting but it just carried on and it soon became clear that my concerns were never going to be acted on.*

I contacted the ***regulator*** *and waited for two months before I realised, they were never going to take any action. There is no way that I was going to go anyway elsewhere else to report it because it made the* ***regulator*** *look bad because they are bad, but I have to be approved by that* ***regulator*** *before I can work"*

..

M. Nicholls

" *I have come into contact with the following regulators.*

CQC

NMC

ICO

SRA

I was failed by every single one of them. I am a rational person, working in a professional capacity myself. I presented the evidence again and again and patiently explained all the errors in their conclusions.

My mother died of thirst in a health setting, all the evidence was there to uphold this fact.

The NHS trust, their lawyers and PR people were an absolute nightmare but the regulators enabled the coverup because that is exactly what happened, a complete coverup that denies people the truth and when you lose someone you love in these circumstances, the truth really means everything.

I could not even grieve for my mother as it took hours of paperwork every day trying to just get the answer to one simple question, Why?

I did not want to sue them, I just wanted to know why it happened.

*By the end of the whole process, I was exhausted, hugely frustrated at the constant obstacles and blatant lies being told and there was nowhere else to go. There is no accountability at all and as soon as the first **regulator** reached a completely wrong conclusion, fully contradicted by documentary evidence, it is an uphill battle because these regulators endorse each other. The injustice is compounded every step of the way and this is why there is just so much avoidable loss of life and suffering.*

*These **regulators** are totally complacent and incompetent and take no responsibility for the consequences of their actions"*

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A Gregson

" *I reported a colleague to our employer but as time went on it was clear that no action was going to be taken so I took my concerns to our **professional body**, I do not wish to be identified, so I do not want to name the **Regulator**.*

I had serious concerns about this colleagues conduct and there was evidence of impropriety. I did not take this step lightly as I knew the risk of being a whistleblower as had seen the consequences of speaking out.

*The **regulator** decided to investigate and close the case due to lack of evidence without even interviewing me or letting me hand over any of the evidence I had in my possession.*

How can this even be called an investigation?

*I was told I could take the matter further and complain about my **professional body** but as I previously mentioned I had seen what happens to whistleblowers and I really feared that the **regulator** would react in the same way as my employer did when concerns were raised about them.*

Speaking truth to power is at the heart of this. I did not want to find myself in that position, I just wanted to be able to report genuine concerns and have them investigated without having to take on an organization that has such power over me, I had no choice but to drop it."

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Summery

This volume contains only a fraction of the available evidence submitted to us and we have used typical witness statements from all those submitted to highlight the common trends that have emerged so far.

Regarding those NHS whistleblowers who have faced serious discrimination by the legal professional and media because they are not " Whistleblowing Doctors" Since we identified this theme the below story appeared in the telegraph,

https://www.telegraph.co.uk/news/2024/05/15/nhs-bosses-destroy-careers-whistleblowers-avoidable-deaths/

We responded to the Telegraph letters page with the following observations,

"As a national charity who has supported over fourteen thousand whistleblowers and ten thousand families of victims, we write regarding your article dated May 15th by Janet Eastman,
"NHS bosses destroy lives of Whistleblowers*"*

"We regularly publish reports based on our national helpline data, one such theme that has emerged and will be published in the next few days in the first report in a series of five such reports," A journey of injustice" which features evidence from health and social care whistleblowers such as nurses, student nurses, HCAs and other staff grades, who have been told by lawyers that they cannot take their case because they are not
Whistleblowing Doctors
These whistleblowers have also been told by a number of journalists that they prefer to write stories about the hardship faced by Whistleblowing doctors because they are trying to save lives.

In the past month we have spoken to four nurses, 3 ambulance staff, 3 HCAs and one cleaner whose whistleblowing consists of issues that are matters of life or death. This is not unusual.
This is why we campaign for Ednas Law to protect all whistleblowers equally.
This issue is about all sectors not just the NHS, for example
.Probation officers who report the downgrading of high-risk offenders,
.The girl who works in the corner shop and reports the owner for selling illegal vodka,
. The hospitality staff who report blocked fire exits,
. The construction staff that report dangerous working practices,
*they are **all** trying to save lives.*
Many of these staff can be on Zero hours contracts or barely the minimum wage, they have no financial buffer, no savings, are living hand to mouth, yet these staff speak out to protect lives every day.
This charity is founded and run by whistleblowers, we have all been on the front line and every day we speak to people who have been forced out of their job for doing the right thing, only Edna's law will protect both the public and whistleblowers.

Please remember the next time you write about the destroyed careers of whistleblowing doctors, that whistleblowing lifesavers come from all sectors. Also, when writing about the NHS please represent nurses, ambulance staff, HCAs, and all other grades, because they are the majority of NHS whistleblowers.
Eileen Chubb"

We have been working with whistleblowers and families of abuse victims for over two decades and knew that regulators, safeguarding, and other organisations were failing but since this call for evidence, we have been shocked by the sheer scale of the injustice faced by all those who try to raise concerns.

This evidence cannot be ignored, these reports bear witness to something that cannot be fixed by money or a shiny new inspection regime, the rot goes so much deeper, to the very foundations of these regulatory organisations.

From the bottom up and the top down, there is nothing that can salvaged and we need to rebuild from scratch.

Government needs to put the rights of people, the public interest before its own interests and political agendas.

The **Charity Commission** is a typical example of a politically weaponised regulator, who targets charities who challenge a political agenda and have done nothing wrong, whilst ignoring widespread concerns about charity's who advance a political agenda. See the work of "The Good law Profect".

Health and social care regulators in the UK, Northern Ireland, Scotland, and Wales are viewed as being completely captured by the care industry and the NHS.

Ombudsman are viewed as an entity to contain or delay those few cases it accepts whilst turning away the vast majority of people who contact them.

Professional Bodies such as the **NMC, GMC** and many more are viewed as there to protect their members not the public.

Energy, Water and **Environmental** regulators are viewed as captured by the industry they regulate

The Information Commissioner ICO are viewed as completely incompetent and dangerously complacent and as causing whistleblowers and family's injustice.

Financial Regulators are seen as captured by those they regulate

Much more evidence on these issues is to be published in forthcoming volumes.

As with everything that is wrong in the UK, it can be traced back to the loss of democracy in our political systems.

Serious questions need to asked as to why a law as bad as the proposed **OWB** has been endorsed by so many in parliament and by regulators?

Why has the revolving door of political cronyism corrupted all our public institutions?

Why is so much avoidable loss of life, abuse, suffering, miscarriages of justice, fraud, and coverups being accepted as the norm by those with the power to do something to help people.

Why is the cash of vested interests dictating law and policy at the highest level in parliament?

This report is about **you** the public**,** because the suffering and injustice listed here will one day be your fate if real change does not happen.

I would like to thank every single one of those who have submitted evidence so far, we know how much it cost to open such wounds and bear witness. The call for evidence remains open.

Finally, I would like to finish with some data, the call for evidence, good or bad about Regulators, Safeguarding, Ombudsmen and Professional bodies.

Total Responses **26,750**

Positive response three, not three thousand, not three hundred, just **3**

This report is dedicated to all those who have needlessly lost their lives, suffered for the want of care, been abused, and to all those whistleblowers who risked so much to stop the wrong but were never heard.

Eileen Chubb