Written evidence from Shire Latif (PHS 14)

Public Administration and Constitutional Affairs Committee
Parliamentary and Health Service Ombudsman Scrutiny 2019-20 inquiry

Report Prepared for all 3 Committees

1. The Joint Committee on Human Rights

Legislative Scrutiny: Health Service Safety Investigations Bill

- Any significant human rights issues raised or likely to be raised by the Bills identified above
    - Whether the Bills could do more to enhance the protection of human rights.

2. HSSC - Safety of maternity services in England Inquiry

3. PACAC Annual Scrutiny Session of the PHSO 2019-20

Table of Contents

1. Reason for contribution 1
2. Closure of the Healthcare Commission (HC) 2
3. Creation of HSIB 2
4. HSIB National Maternity Investigation – EKHT – Basic Analysis 3
5. The medical record and its importance 4
6. Judicial Review 4
7. Brexit 4
8. Conclusion 4
9. About me 5

References 6

1. Reason for contribution

1.1.
Secrecy and cover up don't support patient safety. Lives, human rights and justice are at direct risk.

1.2.
Following a whole series of maternity scandals across large settings the Chair of The Health and Social Care Select Committee (HSCS) has requested a public inquiry into maternity services across England. 1

On from the Morecambe Bay scandal, a growing list of affected units:

University Hospitals of Morecambe Bay NHS foundation trust (UHMBT)
Shrewsbury and Telford hospital NHS trust
East Kent hospitals trust

1.3.
Mistakes in Healthcare are one thing.
The Court of the Coroner now has to investigate cases involving the provision of unsafe clinical maternity care.

1.4.
This contribution of mine has been prepared to assist all 3 enquiries and perhaps others.

HSCS will look at:
The extent to which the recommendations of past work on maternity safety by Trusts, Govt & others are being implemented
Clinical negligence and litigation
The "blame culture"
Training & support for NHS staff
The work of HSIB 2

2. Closure of the Healthcare Commission (HC)

The Healthcare Commission stumbled on a cover up network that had previously established itself for a period of at least 20 years. It had more than sufficient evidence to prosecute those involved in perverting the course of justice through the falsification of medical records.

Instead this government chose to close safety investigations and the consequences for doing this have been devastating for families.

3. Creation of HSIB

3.1.
From the cruelty of cover ups to a new system created under the guise of patient safety, learning and air accident investigation.3

HSIB was set up by Mr Hunt to conduct national investigations. It was allegedly only tasked to investigate 30 investigations a year and help national learning. Later it took on the remit of investigating 1,000's of maternity safety incidents.

3.2.

HSIB differs from the Healthcare Commission in terms of safety investigation in that to avoid any further scrutiny it seeks to prohibit disclosures following investigation.

It is said that HSIB reports will not be admissible in any civil, criminal or regulatory body proceedings, unless the High Court makes an order that the interests of justice in admitting the report outweigh the adverse impact of doing so.

3.3.
That essentially means that the Healthcare Commission, whilst by no means perfect were more open and transparent as a public service than the newly formed HSIB investigation branch.

4. HSIB National Maternity Investigation – EKHT – Basic Analysis

4.1.
"Bearing in mind this report was published in Jan 2019 you will understand our surprise when on 14th June..."

A last minute letter, more in hope than expectation to stop the process of the coroner court from scrutinising baby Harry's death properly.

4.2.
Following the HSIB national investigation into the death of baby Harry Richford, the findings of the HSIB investigation, reports weren't shared. 4

Coroner: - Christopher Sutton-Mattocks 3 Feb 2020

The coroner released his Prevention of Future Deaths Report (PFD) regarding Harry's death

Concern 19

Important independent reports do not appear to have been shared within the East Kent Trust's staff, for instance the HSIB report into Harry's death appeared during the inquest to be unknown to a number of the staff.

Recommendation 19

The East Kent Trust should consider a review of its policies in respect of the sharing of important
investigations amongst all relevant staff so that important learning takes place to prevent any
future deaths.

4.3.

I note from announcements so far the CEO will not face any prosecution by the CQC in the Harry Richford case for failing to refer birth deaths to the court of the coroner. She remains in position.

A regulator that fails whistleblowers (even its own) is bound to fail patients.

5. The medical record and its importance

5.1.
The medical record is a legal document

5.2.
At a higher level of cover up tampering with records through falsifications in order to ultimately
pervert /obstruct the course of justice is a common law crime.

6. Judicial Review

Judicial review is the only mechanism by which ordinary people can challenge the lawfulness of
decisions made by public bodies.
Numerous attempts have been made by this government to restrict the ability of citizens to
force the government to act within the law.

Judicial Review is not a process of conducting politics through other means. It is the court of last resort.

7. Brexit

I have a real fear the power of Brexit and the 80 seat majority will see draconian powers being introduced
such as the HSIB bill by this government.

8. Conclusion

8.1.
The same cover ups that have previously led to harm have now led to complete complacency in the speciality of maternity care. NHS Leaders see the cover up as an opportunity, absolutely nothing to do with fear.

8.2.
Should this bill be allowed to proceed, complacency in care will lead to zero scrutiny

8.3.
HSIB was created to add another layer of carefully crafted cover up since the demise of the Healthcare Commission which was previously tasked with investigating safety incidents and the handling of complaints in the NHS.

8.4.
In my view HSIB was formed to replace the HC.

8.5.
This bill places both mothers and babies at increased risk. The bill is there to suppress any further scrutiny beyond the HSIB investigation unlike at present.

8.6.
The default position for at least the past 40 years for NHS leaders has been the cover up. This bill has all the designs of obstructing the rule of law.

8.7.
PHSO is looking to reverse the MP filter so that the public is able to refer complaints directly. HC should return.

8.8.
Plans for HSIB were drawn up well before Brexit.

8.9.
I support Robbie's Law.[5]

9. About me

9.1.
Unfortunately my son acquired a hypoxic birth injury.

9.2.
My son's condition was investigated in 1998/1999 by a medical expert. He supervised and reported on the first MRI scan 1999 which revealed hypoxic brain injury. His injury was left unexplained at that stage by the referring investigating clinician.

9.3.
In July 2001 our whistleblower who was a GP explained this injury through the MRI report he retrieved from Oxford's John Radcliffe Hospital (OJR). He prohibited access and then claimed within a few days the report had been lost. It was then removed from the local hospital.

GP still managed to re-refer my son a few days later but how are you supposed to treat a patient without having access to his core medical records?

9.4.
The safety investigation into this matter was halted due to the forced closure of HC.

9.5.
With the MRI 2011 abnormal (supported by a clinician and lawyer) how can the scans of 1999 and 2006 be Normal? The PHSO clinical advisor claimed for that to be possible the earlier scans provided would have to be of another person.

9.6.

Pleadings in Judicial Review 2 by CQC state they will not be prosecuting for the breach of the Duty of Candour therefore they effectively both support and endorse the cover up.

9.7.
OJR has so far prohibited all disclosures relating to his own MRI scans and the falsified versions supplied to official investigators. Trust lawyers have requested that they/she be removed as a defendant. She is the national data guardian and advisor to the government. I have declined despite numerous requests. The correct decision and closure in this case is not possible without open and full disclosure from OJR.

9.8.
Our negligence lawyer has explained that the clinical negligence claim cannot proceed without his MRI scan showing hypoxic injury. CQC claim otherwise in JR2.

9.9.
There is clear and convincing evidence in this case therefore I will not be paying a single penny in costs to any of the defendants. I'd rather face the prospect of going to jail.

9.10.
If nothing else listen to these medical experts 6 attack on your right to know 7 and finally 8

October 2020

References

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- (5) http://www.drphilhammond.com/blog/2013/01/25/private-eye/private-eye-medicine-balls-1332/
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