Written evidence from Colin N Rock (PHS 27)

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

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The Public Administration and Constitutional Affairs Committee (PACAC) is responsible for scrutinising the work of the Parliamentary and Health Service Ombudsman (PHSO). Thereby… "where these reports highlight failures in the quality and standards of Civil Service administration, PACAC may use them to hold the government to account."

Introduction and outline of experience

1. I have previously offered evidence to this Committee, and have detected no benefit of outcome in serious matters of PHSO failure to provide Value as "The last point of appeal for complaints from people who have suffered great distress and loss".
2. I hope to illustrate why it is my firm conviction that the PHSO cannot be trusted to perform Government purpose in health related matters and which appeared to be beyond its aptitude. I believe has been demonstrated too often for public safeguard.
3. Having sought resolution—and closure for me—over 11 years, in a complaint of NHS negligence and maladministration in events before my son's suicide, the PHSO has continually defied accountability and transparency in Principles for Good Administration, Good Complaint Handling or of Remedy. I did not question that my son chose to take his life; I questioned the negligent care and provocation before that decision, and was at that time in **live complaint to NHS Services** (GP[i] and Mental Health Trust[ii]). In the event, both chose to deceive, rather than apologise, compensate, and learn.
4. I ask that Committee members try to place themselves in the position of devastated complainant, whilst judging my evidence. It is not easy facing the ploys of NHS respondents, or the PHSO shenanigans, whilst in PTSD from injury or immediate family loss, let alone of a 'child' whom although adult, bore the brunt of careless threats, inappropriate care, or professionals that complained "they had difficulties", yet never peer-referred, discussed, consulted, or involved patient's carers under the local and NICE national policy of assistance.

   - It likely is the case that uninformed, process-naïve complainant is led unwitting into every snare set by the 'defence'. Complainants too have 'difficulties', and I claim full use is made of that by 'lay' (untrained) PHSO workers, in a process arcane to newcomers.

5. KPIs: I will not be drawn on statistics set and measured by the PHSO because I do not expect them to be an indication of actual benefit in *showing **PHSO Value***. I have no confidence that KPIs reflect measure of ***quality of work*** *carried out in line with Government aim or PHSO Principles.* I am aware (anecdotally) that some cases never

reach the PHSO, and I believe *those choices are* due to PHSO's reputation of prejudice against complainants, with the potential for extended distress.

6. The PHSO claims independence of State, but has yet to show independence of judgement, with strong indication bias against the complainant. Instead of focusing on PHSO measurements, it may be useful to take a holistic view of instance and evidence indicating maladministration permitting duplicity and actual harm under the banner of 'Value and excellence in of Government work'. Ineptitude has been seen as follows:

- By failure to 'test', verify, or substantiate Services (defendant) evidence against contemporary and contracted NHS procedures and agreements, as one might expect.
- By reference to inaccurate or meagre defendant evidence; by manipulating "professional" and "commissioned" responses through subjective amateur selection, or of 'claimed' off-the-record evidence as if legitimate. Lies have been permitted without check and with complainant veracity disrespected as a result.
- By destruction of complainant evidence in mocking their "expectations of services" (e.g. of NHS provision), despite these expectations never having been made clear or discussed (as required by PCT/CPG/NHSE specification and contract), during that negligence.
- By personal destruction in repeated mental assault of the complainant by tricks and disparagement; the added pressure of bullying tactics; not listening; refusing to respond or be transparent; other injurious manipulations—*gaslighting*; dismissal or inexpert interpretation of rules or guidelines, as PHSO 'advantage' befits.
- By failure to make adjustment for complainant health, disability or disposition, under these circumstances, and having no drive to do so under PHSO weak direction.
- That is; by use of tactics contrary to EU or UK Equality law (regarding adjustments) whilst the plaintiff continues to suffer pressures. I believed Equality was a legal entitlement, and not a favour negotiable on request-iii.
- Harm however, was committed, and is continued today however, despite knowledge of disability, and with destructive consequence. PHSO, PACAC and (as I understand) the MPS, have declined investigation into potential criminal offence in the above areas. I can confirm there was no such consideration or adjustment available from 2009 to 2016 in my case. This would make it unlawful, even without worse substantiated practices (given elsewhere here).

7. It has been noted that **in the matter of responding to FOI and SAR information requests**, PHSO has been tardy, equivocal, and obtuse. Whilst (in **FOI**s) the PHSO had provided verbatim guidelines and policy, it has been the experience that these are transliterated in practice; sometimes excused opaquely as 'discretion'; at other times varied without elucidation; and yet others as 'fantasy' to expect compliance (as for example during PHSO Customer Services complaint).

8. In **SAR**, PHSO responses have been clearly lacking in content which explained given PHSO opinions, and at other times have proved PHSO duplicity and corrupt intent; delayed after response 'timeframe' or simply ignored—as omitted in Behrens' (2018) and previous PHSO's responses (to 2016).

9. The current PHSO has shown no interest. Serious points of complaint in the above have not been addressed. They were brought to PHSOs J Mellor and R Behrens' attention—and to PACAC attention, repeatedly—latterly in April 2020 at https://committees.parliament.uk/writtenevidence/2545/pdf/
10. Aside, it might be worth noting that where, even for partial uphold, derisory awards in matters of negligence of a level suggesting the need for serious disciplinary process, do not get that action recommended by PHSO, for Services benefit-[iv]. But I can understand that the PHSO might claim it's not their problem i.e. Out of scope?
11. Summing up my points, the Committee has been made aware of harm committed by the Office of PHSO, against UK law and prolonged even after notifications of such harm. I claim that previous evidence has been ignored, and the PHSO has shown no regard whatsoever to extended in-process harm caused to complainant. The PHSO has not once questioned this harm, but I can publish details if necessary. Complaints made to PHSO as early as 2013 were exacerbated, then manipulated to dismissal in 2017, after frequent tedious and harrowing requests between those dates, despite PHSO management promise, years since.

- My evidence illustrates a picture of maladministration and incompetence of the PHSO and hence value in terms of aim and function.
- Since a frivolous handling by the current PHSO R Behrens (mid 2018) it is patently obvious from actions and admissions that complaints had been illegitimately dismissedv for more than 4 years of my son's deterioration, and the Committee should bear in mind that at the time of my son's avoidable death, there was an active NHS complaint pending attention. It was not the first complaint in five years of NHS knowledge.
- It was not exposed at the time that NHS parties had lied, unquestioned by the PHSO, and not revealed to me except by SAR (Subject Access data Request) for information withheld (illegitimately, in PHSO process description) since the departure of the previous PHSO.
- In sharing my experience with other organisations I have discovered similar experience in other cases, and the frustration felt that nothing has changed for the better, and the PHSO appeared to operate to an arcane agenda with no legal responsibility or accounting.
- My complaint is not resolved as reported by PHSO Behrens to PACAC in 2018. It was closed despite appeals for explanations as to Outcome. The complaint was closed despite my request for clarification of various statements made by the PHSO, which conflicted with the truth of matters.

12. I give this evidence as my final contribution to the PHSO Committee's affairs, and it has been difficult for me to give in shorter form. More specific details appear in my last submission made earlier this year (2020, see above) which I urge members to read. It refers to the death of my son and NHS and PHSO combined attempts to cover up serious negligence leading up to my son's death. However, as Appendix to this submission I attach details—as brief as I can make—of key points in timeline. My *opinion* on these matters is only where stated, and *not* where the PHSO wishes to *exploit as fantasy.*

13. PHSOs Mellor and Behrens refused to elaborate on unsupported counter-claims, and it has since (by SAR) been revealed why I suspect this.

- *Practitioners involved in my son's care had apparently lied. This would have thrown doubt on all previously NHS claims attributed to these persons in any Court cross-examination. It should be noted that whilst PHSO eventually provided delayed evidence, practitioner employers BSMHFT would not.*

14. In the matter the local Services Agreement (or MOU)—withheld from me for ten years—it was used speciously to permit BSMHFT CEO to admit to a *Social Services* legal failing, BUT strangely *disregarded in its agreement on cross-service cooperation in service provision and complaint referral.* The PHSO was patently dishonest in *forgetting the implications* here.

PHSO casework performance, including performance against KPIs

15. As stated it's my understanding that KPIs are set and measured by PHSO and in that consequence I hold no trust, based on previous conduct and evidence. It is my firm belief that work reported as completed to PACAC is not correct—indeed, fallacious. I will only suggest that KPIs are set *and* construed to create a favourable picture of PHSO work.
16. **Performance**: In its declared role the PHSO has shown not the slightest respect or appreciation that, despite rejected warnings and complaints, having your son die following five years of sparse and negligent care—*is no reason or indication of **"distress and loss"**;* a prime failing throughout handling, and brought home by the dismissive response of Behrens (2018), and which supremely illustrated my point: this defies credibility.
17. **Harm**: It appears to me that a PHSO *base-assumption* over twelve years has been NHS synonymous with infallibility; Complainant synonymous with fabricator… and easy *lone* target.

- This was illustrated early-on (2010), by the conjecture "[Nick's avoidable death] was not worthwhile an investigation". This, despite being 18 months in complaint delay, revealed no thought that such senseless statement might be regarded as harmful when received by a devastated and grieving complainant (I'll call this harm #2; see endnote vi). I was not alone in receiving this shameful retort; throwing early light on PHSO thinking and competence.
- The PHSO continued its tone of infallibility for 5 years, however. Prejudice, supposition, opacity, and obtuseness continued unrelenting despite complaints at great emotional fatigue to me (harm #3). This was and remains unacceptable behaviour by three incumbents (viz. A Abrahams; J Mellor; R Behrens).

18. My complaint remained open as an intensified 'injury' up to January 2016 when, after another spurious[vii] investigation (as Historic Complaint, 2015-2016), the complaint was closed: but only after being 'adjusted', under pressure, to favour NHS parties (harm #4). Marked as 'closed', but its terms were never justified or explained as required under PHSO Policy (harm #5). It would remain open until mid-2018 (harm #6). Again, **PHSO Principles were neglected**.

- Sadly, since my own son's death, I have been made aware of other avoidable young deaths attributed to irresponsible and inconsiderate mental health care; potentially avoidable had PHSO priority been to listen and learn rather than *defend* and save face; where the *'gold dust' of patient experience was hoarded exclusively for PHSO Public Relations 'cachet',*

Staff management and training

19. Evidence illustrates that good management has been very severely in want. Serious gaps in staff training and oversight of work, show a pervasive and arrogant culture of indifference to complainant evidence, from first contact. Combine this with caseworker deficiencies in understanding case material, demonstrated by careless opinion and inexpert rationale, with nil regard for complainant situation or disability, and a recipe for failure is born: but perfect for NHS patronage.
20. As 'independent' service the PHSO is entirely driven by customer demand and contact. The dismissive nature of staff—in my experience—is endemic, from management to front line: the PHSO has shown zero responsibility for the command it carries in this respect.

- *It is not its role to make the customer fit the process*. *Process is secondary to aims.* If aims are not met—i.e. are source of continual and disregarded complaint—I see it as the duty of PACAC to identify areas of process failure. Yes, problems have occurred because process was not followed (only partly the route for Judicial Review), but where process was clearly lacking; e.g. in inept evidence checks, or in service complaint handling, there is no recourse but through PACAC intervention to request process change. in my opinion PACAC have shunned this, however.
- As noted elsewhere financial independence lends not an ounce to independence of judgement.

21. The process is flawed in my opinion and familiarity. This benefits no-one except 'defendant' services; pleased to direct incapacitated complainants to *death-by-fatigue*, whilst defendant parties continually renew themselves (see endnotes). I hold that the entire process leads to severe prejudice against the consumer—the complainant.
22. Endemic also is the permitted practice for PHSO to be 'creative' in assumptions and interpretations of data; showing a *prejudicial 'selectivity'* in complainant and defendant opinion—whether professional or pundit—commissioned by caseworkers. The PHSO freely oversteps their *amateur* status, where crucially unbiased analysis and presentation of fact is required.
23. There was never any indication during my painfully protracted case that training was given, or any skill was indicated, in the line of *independent investigation*. Details I give illustrate an extreme ineptness of staff in this field: the failure to follow-through lines of inquiry or substantiation of fact traceable to *secure source*. The potential and possibility of error and injustice do not appear to be—and were not—appreciated. I believe this was exacerbated by PHSO agenda based on weak 'triage' of details given—potentially—under duress or under an injured or disabled stance. This was

made obvious under PHSO messrs Abrahams and Mellor. Current PHSO R Behrens was expected to show a new leadership. This failed to materialise, in my opinion.

24. Of my several FOIs placed on the matter of training, PHSO responses have shown glaring omissions which gave need to question the behaviour which triggered the request. I will give details of breaches of required codes of conduct and courtesy, and failures to consider Equality and Disability, over the entire period of my case being open.
25. Whatever the response (in Disability, diminished resource, failure of NHS duty of communication, then failure of PHSO transparency), my evidence claims the existence of PHSO discrimination and harassment due to the misguided interpretation of such and the neglect of such provision in training.
26. Neither PHSO management nor training prepares workers to be adequate or fit for purpose, or comply with intent of the law, in my opinion.

Value for Money

27. This is hard to be objective with in monetary terms, but I do have comment. I am concerned that the end-to-end **Value, and cost of failure** are yet to be thoroughly taken into account by PACAC.
28. It is my opinion that, due to previous contrived responses and incidents, the PHSO cannot be trusted to carry out true estimate, and the consideration of PHSO self-set and self-measured KPIs will have very little value in this exercise. **May I recommend that independent research be carried out** into the full cost of PHSO failure including knock-on costs yet unmeasured?
29. **Cost of harm caused by PHSO** on complainants as made aware to PHSOs Mellor and Behrens and, apparently, still of zero appreciation. For the entirety of my complaint whist in effect still open and unresolved (2009-2018), the PHSO had no complaint procedure and in fact refused complaints numerous times ***despite known distress*** *being caused, even where complainant has broken down during a call*.viii.
30. **Cost of overlooking or dismissing NHS negligence** and effect on the case including potentially, cases of similar or identical failure pattern. The PHSO showed itself incapable and in denial of *patterns of failure, or cause and effect* failure (chain of events). This may be due to the lay nature of its caseworkers and their overall management. Several FOI requests of my own confirmed the PHSO had ***no training*** *intrinsic to investigative practice*.
31. **Cost of parallel actions** brought about by PHSO denial and procrastination. In respect of PHSO rejection in 2010 (failure not admitted until 2015) frustration prompted seeking private legal claim. This was NOT in lieu of *NHS complaints procedure having the opportunity to learn* from the negligence seen. In the event, NHS provider BSMHFT denied all claims, as if *nothing to learn*.

- The Trust imagined in its duplicitous offer of *legal settlement* it would absolve them of duty to deal with failures and exposure, and halt due process in NHS Complaint procedure.
- I was advised that due to *characteristic NHS legal chicanery* and potential costs to me in the undertaking, it would be prudent to terminate the claim at NHS cost.
- Not until 2015 did PHSO admit the invalidity of its 2010 response, and investigate the case. In closure of this investigation (2016) I discovered that the PHSO had conspired

with the PHSO inferring that I had “won” the legal case and, moreover, “had received compensation”.

- This was pure invention by BSMHFT who, having denied any failure whatsoever, were consequently not obliged to pay “Compensation” at tax-payers expense—and *for nothing learnt*. If it were compensation, it did not seriously represent this *in my son’s death aided by the lack of attention, and intimidations, he and I had complained of over five years.*
- **NB** It was the scant and inaccurate NHS GP and Trust records that facilitated NHS and, later, PHSO manipulation of specifics. Not a single NHS intervention or decision was correctly documented or discussed. This was *in breach of NHS expected standards* especially where there was contention or patient conflict (as admitted at Inquest). BSMHFT relied on what it referred-to as ‘notes’ which did not account for attendees, patient questions or conflicts retrospectively raised as MHT problems.
- Later PHSO opinion “records looked normal”, was made *after amateur dismissal of abundant critical omissions*.

32. It is my opinion that many injuries even *avoidable deaths* are sustained due to the PHSO being keen to show “no crusading for complainants”, yet collaborating with Services well versed and resourced in the complaint contest ‘game’.

- *That is*: no adjustment or support for—or belief in—complainants who suffer far less resource, suffer potential trauma and disability in representing their case throughout the fatigue of PHSO laborious demands and negative responses. (I had contacted local complaint support services, with no significant response.)
- *I was derided* by PHSO for not being able to obtain evidence I needed to contest PHSO vacuous claims despite, under post-traumatic stress, my having to research and acquire relevant material (NHS procedures, structure, hierarchy, mechanisms, records, persons involved) delayed or just not provided by local NHS; and of course there were certainly no records of *negligent actions*—just omissions. I found NHS procedures which had been disrespected and disregarded by several Professionals involved.
- For the exhausted or traumatised complainant, the PHSO ‘held the Aces’ and kept them ‘close to the chest’. *If opacity and intimidation failed*, caseworkers contrived to *assault “complainant expectations”* of clinical obligation and candour.
- It was as if the NHS and PHSO were **together playing a well-rehearsed game**. This showed finally in the collusive understandings and double-speak—each trying to conceal disregarded information. Thinking about it, I was derided for expecting that NHS would follow any prescribed procedures at all. *It was impossible to know against what standards a complaint should be made: it would likely be dismissed in any case.*

33. **In summing up Value** – it cannot be judged without considering the entire impact of PHSO work and actions. I have given instance of shameful PHSO behaviour: bullying, derision, mocking, damaging ‘throwaway’ comments, ridicule of my ‘expectations’, denials of evidence given in good faith, of patient/complainant harm; yet perfunctory acceptance of ‘professional’ statements, often given as assumptions, as

reassessments of historic matters, as recollections, or of critical matters not recorded or supported by captured, secured, *released*, medical records.

Impact on other organisations.

34. Claiming Independence the PHSO must surely disclaim all impact on other organisations, apart from where negligence and abuse continues to be a theme of failure in such organisation, or where PHSO findings are properly evidenced, relevant and sound—always assuming that a body deems corrections to be within budget.
35. Also as an 'independent' body the only impact on other organisations that the PHSO could pretend to claim, would be as a model of its 'Principles': can it be impartial, trusted and useful to Government purpose? Without that, it would have no value or need claim impact.

- But I claim Principles were broken regularly without a single concern shown—over at least 10 years, in my case.

36. I know that the perception of the PHSO *was* respect by NHS bodies that I had the misfortune to be enmeshed with, and I was *told* they took outcomes seriously.

- Unfortunately this was tempered by the somewhat 'adulterated' PHSO Outcome, since each body disputed it, and pleaded or bargained for changes to be made to *undermine* its impact.
- The PHSO was then—I have to assume—persuaded to maintain a *secrecy* until a final version was negotiated, signed and sealed by NHS parties. In my case the collusion was obvious; and later confirmed through **overdue SAR** data release, after Outcome and Behrens' claim of 'personal review'.

37. Other bodies: On reporting GP negligence to the GMC however, I was astonished that such Professional Body would delay action until complaint had been judged by the [lay] PHSO. In reliability, I would not consider this a desirable impact for UK health interests.

- For instance, the PHSO never did recognize the harm Solihull GPs had permitted on my son Nick (against GMC expectations – see endnote), yet praised the GP for actions devoid of positive impact.

PHSO's provision of reasonable adjustments to service users.

38. In the entire lifetime of my case being open (2009 – 2018) the PHSO failed to offer, take regard, observe or assess any requirement under UK law in this matter. Of **several FOIs** placed on this topic, the PHSO had no policy, instruction or guidance having any effect on staff in its responsibility.
39. **FOIs** also showed training in the matter was absent. PHSO contact since (2019-2020) has indicated it still lacking, unfortunately. Experiences exampled here should illustrate the difficulties this has presented over that time, and the harms caused without recognition or investigation—despite numerous complaints.

40. *During my entire experience the PHSO has failed*—in fact refused—to operate any 'adjustment' or even complaint management system, or shown any compunction to do so. According to **several FOIs** on this matter, various responses were:

- "Complainants can challenge decisions through a Judicial Review". This was typically disingenuous: the question was not about 'Decisions'. It confirmed JR process concerns challenging the decision, however. Did this encompass redress for PHSO toxic behaviour?
- As a misrepresentation, it would be potentially intimidating to complainants enticed by a '…free and independent service…' realising the effort involved: the cost, and the chances of winning against PHSO 'discretionary' or ill-defined procedures, then against PHSO bureaucracy and power of resource.
- The ***FOI response*** confirmed "…there is no organisation that can specifically look into [service issues]". QED: there is *no complaint procedure*. PACAC: this requires attention in my opinion; *in the interests of future patient safety and future legal claims* outside PHSO sphere [ix].
- Previous evidence (to PACAC, May 2020) demonstrated PHSO lack of procedure due to the profoundly arrogant claim of infallibility in responding: "the PHSO does not consider itself to have abused any complainants" and: "[complaint] answers… are based on staff communicating with complainants regarding 'difficult'… subjects" and "*requests* for reasonable adjustments". The PHSO then claims this being "in line with the Equality Act." On this entire theme (complaints; abuse**) 'FOI' responses** often appear made from 'cloud-cuckoo land'.
- My experience has been the antithesis of given responses, with **no communications on harm or any sense of causing it; exacerbation of trauma through design or ineptness; no offer or cognizance of 'adjustments'; and no compliance with *Equality Acts* through harm caused.** This situation would be farcical if it weren't so dire and damaging to people. In this alone the PHSO is not fit.
- As a devastated, frustrated and *frustrating complainant* you may be *cast "vexatious"* and straightaway in the wrong on any matter; evidence and claims manipulated: *gaslighted*, in popular terminology,
- I was advised by PHSO 'Feedback' duty only this year that complaints should be raised with the Caseworker i.e. the *abuser* which, in the setting, is impossible where that team likely becomes *incommunicado;* and also inappropriate advice in such serious breach of Law.
- So, there is no end-to-end procedure or accountability in service complaints, and the **PHSO is being perfidious in claim of having a Quality System which takes no account of 'negative feedback' supressed at source, and rejects the very notion of any harm caused.**

41. In the matter of PHSO conduct there are, ostensibly, "guidelines available"—but still *open to arbitrary interpretation and no respect in actual practice*.

- *As referred-to elsewhere in my evidence, the PHSO mocked clinical guidelines, so why should their own guidelines hold any respect?*

Time taken for the PHSO to respond to correspondence, including Subject Access Requests and Freedom of Information requests.

42. I have highlighted some FOI and SAR references throughout my submission.
43. The matter has always been a bone of contention and I believe the Committee has been made aware of it via other sources. Even the simplest response requested was typically delayed until the last 'statutory' day.
44. Other tactics have been to give simplistic or irrelevant response to extend the timeline or, as I have experienced, to deliberately confuse the issue (change the question) or give other defensive or unhelpful deviation.
45. SARs were particularly subject to delay especially if likely to be contentious in argument in content or on source of PHSO 'evidence' used in giving opinion.

- In a very apt and relevant request I had to remind Information duty that it was only partially fulfilled. The delay involved the release of information used in (a) accepting false evidence from two NHS professionals and (b) the existence of an exploited joint agreement between local health services for cooperation and sharing of resource "for patient benefit".
- The above omission involved information used duplicitously by the PHSO in collaboration with NHS parties to 'develop' its Outcome in NHS favour, yet devalue "my expectations" of *total Services cooperation,* against advantage.
- It was of no benefit to my son however: there was disharmony between Services (admitted by a worker in 2009), and the cost in terms of time and frustration led to years of delay and, ultimately, Nick's death after negligent care and indifference by Services.

46. In final comment I should highlight attitude so destructive in typical PHSO response, indicating an institutional 'conditioning' against complainant. It was after my effort conquering trepidations [x] in meeting the *new* PHSO personally in London (Oct 2017) and the promise of fresh practice in a 'personal review'.

- I was first disabused by Behrens' "delegating the task"… so it would not be *personal*. I had provided much information (written and verbally) and had set much store in hopes in expectation of a new approach and impartiality.
- The delayed outcome was devoid of explanation regarding opinions and discrepancies in PHSO investigation (2015-16) and unexplained conclusions (mentioned elsewhere).
- There was no documentation of Behrens' *delgated person's* review (as confirmed later by **SAR**). I recollect I had responded to Behrens in similar manner of dismissal and derision which it delivered. Too much had passed that had not been considered.
- On later approach to PHSO Customer *feedback duty,* I was then derided for my *expectation* that Behrens might have honoured his promise. This added weight to my opinion that **neither PHSO body nor leadership was fit for purpose.**

47. I would like to assure PACAC and PHSO that I have taken considerable time and effort over years to verify and document specifics, and 'expectations' of the NHS— particularly resonant at this time of COVID-19 NHS expectations. This has involved consultation with: a leading GP expert witness; two specialist medical-legal

assessors; several *trusted* health professionals within BSMHFT; a leading QC; the bodies of NHSE, GMC and NICE; and, perhaps most revealingly, anecdotal feedback (all informants of which will remain unidentified in any exposure) from mental health sufferers and carers having to face crisis alone under BSMHFT indifference and 'coal-face rules' citing lack of support and other deficiencies [against NHS Trust Policies and Guidelines]. Giving further account appears pointless whilst PHSO assessment of value and competence is at cursory and broad level and with potential conflicts of interest in representation.

- Almost in entirety, people involved in my son's care ignored duties and responsibilities [xi], and this is not something the unskilled caseworker can dismiss offhand.

48. Under stricter command or inducement I would be able to release copious NHS and PHSO communications and documents including names and unadulterated transcripts for assessment, should my case ever be considered for *scrupulous, independent and transparent investigation, which I believe is currently beyond PHSO ability.*

Appx. 1. Summary of Events, follows Endnotes (below)

Endnotes

[i] Bernays and Whitehouse GP Practice, Solihull, B90 3DT (implicated in complaint but not notified at that time due to unclear or undefined boundaries in PCT, Social Services, BSMHT and GP responsibilities). Now managed as Solihull Healthcare Partnership.

[ii] Birmingham and Solihull Mental Health Trust BSMHT, Birmingham Office B1 3RB and Lyndon Resource Centre B92 8PW (complaints refused by both centres only weeks before son's death). The body gained approval as Foundation Trust BSMHFT, in 2009, shortly after the flawed investigation of my son's death.

[iii] With regard to continual renewal of PHSO and defendant highly resourced capability in contest e.g. varying interpretations of policy and practice; varying assumptions and the introduction of amateur discretions; the resource and volume of 'defendant' 'PHSO Liaison' posts and departments (as at BSMHFT), and the frustrating renewals and replacements of communicants involved. This 'replenishment' targets the singlehanded complainant; surely tenacious, but **potentially traumatised, to become progressively disabled and harmed by PHSO intransigence and opacity**.

[iv] As I understand NHS working, NHS contractors sign-up to agree to documented procedures and professionals under oath of promise to do their best for patient outcome. But the PHSO holds amateur opinion to the contrary by mocking patient expectations as they did in my case. It's by professionals ignoring their *terms*, people are harmed or put to avoidable suffering. It is hardly a Resolution that PHSO in scorning these requirements dismiss my research which shows otherwise. I have endured continuation of harm in this respect.

[v] CEO J Short BSMHFT covertly admitted in 2016 that careers had not been involved by the Trust (nor offered carer assessment—see note below), in over 5 years of need. That was 13 years late and 8 years after my son's 'death by disengagement' of Services (and yet in ~2012 at my son's Inquest, associated psychiatrist on the case admitted he or his team—it was not clarified—had a problem with engaging reluctant patients. This was not a Trust-wide problem however, and there had been policy and training in place for precisely that situation. It was confirmed to me (from BSMHFT records) that persons on his team had had that training. NHS admissions and actions since futile legal Claim proved my point: someone had lied and was still obviously lying, and the PHSO let it pass.

[vi] *Harm #1* being regarded as the lack of candour and comprehensive failure of any NHS party to operate The NHS Complaints Procedure, with commensurate *delay total of ~12 months*. Both parties were later to misadvise the PHSO in repudiation of this delay, each claiming the fault as mine, but neither following contractual rules nor local health area cross-service Written Agreement or, indeed, personal promises (by BSMHFT [named] directors, Dec.2008). Again there was a lie, or PHSO was deliberately misled or induced to ignore through compromise.

[vii] *Spurious* due to (a) bizarre claims and statements made (as given elsewhere), causing (b) distinct harm to me, and with (c) PHSO utter refusal to explain lay opinion, then (d) delivered to an agenda coinciding with memories of the desolate period of our son's avoidable death, against my request, and (e), the 'Resolution' was claimed statistically as

Endnotes

'Part Upheld', despite the Upheld not being my complaint of the negligence affecting my son, but a PHSO invention of little concern.

[viii] A written complaint in 2013 was held open (despite [named] senior management pledge to investigate) for four years, before being accepted for investigation in 2017. In this instance the PHSO created the points of investigation, rejected my clarification (becoming suddenly incommunicado) and made no reference to instances of complaints (accumulating and becoming more intense since 2009). The PHSO has lied about this.

[ix] To remind PACAC; I took legal action after the PHSO's first dismissal with abusive prejudgment (2010). Several legally-considered claims relevant to NHS negligence were put to NHS, but each was denied. The NHS body BSMHFT however offered settlement simultaneously and before Court Proceedings. Settlement of that action was advised despite its meagre value considering implications in *negative costs liable to me*, but engineered into NHS scheme in rebuttal. The NHS Complaint process was not complete however and I had right to fair independent consideration as expected, for the learning it might achieve for other's benefit. It transpired not to be the independent system 'as promised'… and there was no learning. I believe that others died for comparable reasons: NHS provocation, disengagement and isolation of the patient.

[x] *Trepidations* related to harms suffered through PHSO toxic behaviour and contact; the increasing efforts to obtain sense and understanding, or of any explanation as to why PHSO Principles were continually breached; having to relate traumas over and over again to deaf ears with set 'agendas'; derision; opacity; broken PHSO undertakings etc. Harms including extension of original PTSD; panic attacks variously as social isolation, claustrophobia, agoraphobia; breakdown of trust in any professional or controlling body or organisation; delayed then postponement of major surgery; sleep deprivation, body function disability, heart rate, palpitations, mental disability, mental focus, concentration, visual disturbances and, related to all these, the effect in restricting normal life in previous skills and interests, restriction of travel and normal enjoyment of life. In response Behrens continues to deride these impositions as "they're just not happy" with "their decision". I'm sorry but this appears to be criminal disregard.

[xi] Duty of Professionals: I quote from GMC website:

"The primary duty of all doctors is for the care and safety of patients. Whatever their role, doctors must do the following.

1. > "Engage with colleagues [including non-Professional] to maintain and improve the safety and quality of patient care".

- *Failed by GP and BSMHFT mental health team members and their administration, and this was the subject of complaint.*
- *> "Contribute to discussions and decisions about improving the quality of services and outcomes".*

Endnotes

- *Refused by BSMHFT, and this was the subject of complaint. Neither did the MHTeam involve or consult carers in discussions and decisions about improving outcomes.*
- *> "Raise and act on concerns about patient safety".*
- *Refused by GP and Psychiatrist on different occasions, and this was the subject of complaints*

2. > "Demonstrate effective team working and leadership".

- *Failed - there was no such teamwork at BSMHFT Centre and this was the subject of complaints*

3. > "Promote a working environment free from unfair discrimination, bullying and harassment, bearing in mind that colleagues and patients come from diverse backgrounds".

- *Discrimination, reckless pressure and harassment were key elements of my son's negligent care, and was his complaint, unheeded by GP, Psychiatrist and CPN (2004 & 2008) and was the subject of previous and further unheeded complaint.*

4. > "Contribute to teaching and training doctors and other healthcare professionals, including by acting as a positive role model.

- *Behaving as positive role models were not features demonstrated in attendant staff. I have specifically kept away from personal assessments of this on scarce association. Contact after the sessions was terse and offhand. I was not present during other interventions as BSMHFT falsely claimed to PHSO. My acute unease with previous incidents and treatments prompted me on a critical occasion to record BSMHFT MHT discussion (including complaints) without permission— BSMHFT was advised of this later.*

5. > "Use resources efficiently for the benefit of patients and the public.

- *Failed, and with severe effect on my son on more than one occasion when NHS staff were wastefully called to assessments despite being unnecessary, and damaging to my son in its threatening effect. A Psychiatrist later claimed to PHSO "it was policy". I questioned this through FOI. It was not policy to include other teams. This was a subject of complaint to BSMHFT at the time, and later to PHSO when I learnt by SAR that BSMHFT had lied to PHSO. PHSO Behrens concealed this matter in his 'review'.*

It should not be necessary for me to draw attention to the points that the PHSO disregarded all of these factors and complaints; also evaded by R Behrens in personal ("trusted partner") review (2018).

Appendix 1

Summary of events

Appx. to evidence to PACAC Committee October 2020 regarding PHSO activities against core purpose and Principles, and based on complaints regarding witnessed negligent care leading up to my son's death avoidable, I claim, by thoughtful application of locally implemented NHS practice. Approach to PHSO in 2009 under A. Abrahams was soon after responsibility for NHS complaints was adopted. My claim was failure of NHS and co-operatively engaged social workers (unaware to me at the time), to give satisfactory account before and after my son's suicide; avoidable if NHS procedures had been recognised and employed.

Events

1. My son Nick became unwell while at Gloucester University in his third term. He received no attention there. He had a breakdown, and had to end his course. Back at home, he had symptoms of a mental illness but would not seek help.
2. After a year of no improvement his GP was made aware but would take no action nor advise how we should proceed. This was presage to five years of NHS contact difficulties—that is, getting the right attention when it was needed. It would continue up to Nick's suicide 5 years later.
3. It was difficult to get any attention over this time. GPs obstructed access to services who then, by ignoring Nick's wishes—and our input as carers—contributed to Nick's recognised ideas of services' persecution, and dismissed complaints.
4. We had to bypass the GP 'NHS gatekeeper' to get anywhere. Nick's first assessment by senior professionals (NHS mental health providers BSMHFT) was organised, low key, and considered. However when Nick's case was handed over to their mental health resource team (MHT) things began to go wrong, and Nick's health deteriorated markedly.
5. The MHT did not follow the senior professional's recommendations for gentle approach. MHT attendances were threatening to him and appeared haphazard in manner. Nick related he'd felt threatened, but reporting of this was obstructed by administration staff (later found to be under unclear instruction). Meetings were *not* documented. Carers (we, as his parents) were *not* involved.
6. As crucial communicants, the MHT never identified us as carers nor as having advantageous contribution or involvement – for example to keep in touch or be involved in a care programme. Nick was left unmonitored and unsupported for many months. The MHT said he was happy and employed. He was neither, during those months medically unsupported; and there was no feedback channel for NHS to be informed of this later claim.
7. We were keen to be involved in Nick's care and potential care progress. His health declined and there were no communication arrangements. GPs would not respond to complaints, and trying to contact the mental health or social services was made difficult by delays, and lack of contact or responsible person. A fair assumption is that the MHT could have advised on handling his illness day-to-day and help with recognisable difficulties. They did not.

8. We were never advised that the NHS Trust had—over 8 years previously—devised, funded and implemented procedures for exactly their situation [difficulty in engaging with patients].
9. Years later at my son's Inquest, the BSMHFT MHT representative told Court that [they] had a problem with patients who were 'reluctant to engage'. This 'reluctance' was typical symptom appreciated nationally by NHS. In Nick's case it was never tackled locally for over five years of involvement.
10. I requested our MP's assistance due to NHS distance from care. Only three weeks before Nick's death—at a requested urgent MHT meeting—they were warned of Nick's worrying deterioration and possible consequence (and the meeting was delayed 5 weeks by Services disorder).
11. A written complaint was refused with apathy by the MHT, and then by BSMHFT administration; apparently because the trust did not recognise input from carers as a valid request. The stalled complaint was 'live' and unprocessed at the time of Nick's death.
12. When to Trust got around to looking at the complaint it was a different picture. We were in trauma and devastated. The Trusts agreed to process complaints and advise and cooperate with GPs involved. There was an understanding that the Trust would carry this out, bearing in mind that we had no knowledge of NHS structure in complaints or actual procedures.
13. The Trust reneged on this. Complaint responses were delayed, insincere, specious and inadequate in their dismissal of 5 years scant interest or care. The GP was not advised of the complaints and implication to investigate under NHS procedures.
14. This caused a 6 month delayed [second] application to the PHSO, who in their own time gave the speculative dismissal "[Nick's avoidable death] was not worthwhile an investigation". The harm of this statement was felt throughout the grieving family.
15. This led to legal consultation and further delay of Nick's Inquest.
16. In response to Coroner's questions, one of the MHT professionals involved gave opinion that he considered the Trust procedures [to implement NICE guidelines for patient best outcome] *were not appropriate and unlikely to have been of benefit:* i.e. an assumption and patent admission of failure on MHT's part. The same witness told Court he also had a problem with patient engagement in care.
17. It was very clear after the Inquest that legal claims would be justified and appropriate.
18. Claims were placed on BSMHFT but were denied, against professional medico-legal assessment. Despite denying all charges NHS volunteered legal settlement.
19. The PHSO was approached again in consideration of clear evidence and to permit NHS complaints system to be followed through.
20. The PHSO's discharge of these failures was that *I expected too much*. In particular they dismissed NICE (clinical best practice) as just "guidelines" and, I was derided for expecting other documented procedures to be followed.
21. In Nick's five-year abortive care process involving scarce and threatening interventions; followed by his sudden death; our harrowing experience hearing insubstantial argument and unsupported assertions given in litigation, investigation, and vastly protracted PHSO process, critical NHS claims were just not substantiated by contemporary medical record. No considerations, care plans or 'decisions' on courses of action had been recorded by GP or Mental Health Trust, as required by NHS process and contract.
22. Recently, research revealed that NHS conjecture, statements and defences were based

on ‘private notes’ of those involved i.e. not Trust-controlled medical records. Despite several attempts to obtain clarity in PHSO opinions, by request of caseworkers, then by SAR, records were delayed or withheld (against SAR).

23. GP medical records were sparse and erroneous. As with other Services, vagueness and ambiguity afforded later denials and speculative claims. There appeared to be unjustified bias by PHSO to accept false claims and an incapacity to carry out required scrutiny.
24. The situation of prejudice and defendant ‘collaboration’ appeared, and still appears, to be pervasive at PHSO.