20200922-C2055716_McGowan_PHSO

PHSO (Rob Behrens)
Mencap (Mr Dan Scorer)

22 October 2020

Oliver McGowan C2055716 – Cessation of PHSO Investigation

References:
A. Rob Behrens to Mr and Mrs McGowan 080720.
B. 20200203-C2055716_McGowan_PHSO_Clinical_Advice_Parent_Comments.
C. OM LeDeR review Redacted ID: 25131812
D. Final Copy Stage 2 OM LeDeR process dated October 2020
E. Report of the Independent Adviser to the Review dated Dec 18.

1. We are writing in response to your letter at Reference A which you wrote in response to our letter at Reference B. Oliver's LeDeR Independent Review has now concluded and is at Reference C. There is also a Stage 2 report into the wider learnings identified from Oliver's LeDeR at Reference D which highlights some of the issues with Southmead and the service Oliver received leading to his avoidable death.

2. After reviewing our complaint to the PHSO and the work you have done to date it is with regret that we must inform you that we have lost all confidence and trust with your investigation. The clinical advisers commissioned by the PHSO have formed their opinions based on leading questions and misinformation from factually incorrect 'key facts' supplied to them by the PHSO that we had not seen before they were sent.

3. Our letter at Reference B details all our issues and concerns and your response to this at Reference A leads us to conclude that the PHSO investigation is not independent, fair, excellent or transparent in Oliver's case. Therefore, we have reached the point where there is a total breakdown of trust and we see no value in the PHSO continuing with Oliver's investigation.

4. We have been very disappointed with our experience of the PHSO service. Moreover, I am disappointed that our issues fully align with the issues highlighted by Liam Donaldson at Reference E. I will highlight some pertinent points to support our position:

Recommendation 2: ***"There should be greater contact and better communication with complainants."***

"Other opportunities should be created to involve and consult with the complainant without compromising the independence of the investigation. Should clinical advisers meet complainants? As a general rule, face-to-face is best. It is highly desirable and potentially very valuable that there should be an option for clinical advisers to meet complainants in very complex cases, those with a serious adverse outcome, or in circumstances when there are multiple care providers involved."

Comment: This did not happen in our experience of the PHSO service. We believe this was an opportunity missed. Our recent experience of the LeDeR Independent Review demonstrated real value for the independent advisers speaking to us to get our perspective of the events rather than just using hospital notes. You will note that LeDeR has commented on the poor

quality of the hospital notes. It is apparent that the PHSO employs advisers to conduct a Structured Judgement Review case note review only. It is our opinion that this is not appropriate for the following reasons:

- Case note review methodology generally considers the last episode of a person's care and does not look beyond this to the whole pathway of care, not just the most recent episode.
- Case note review generally considers the actions (or inactions) within a single agency and not the actions (and inactions) across a range of different agencies involved in the person's care.
- Case note review generally considers only what is documented in the case notes being reviewed and does not gain the perspective of those who knew Oliver best, us and the Community Learning Disability Team, to obtain a broader range of perspectives about the sequence of events leading to Oliver's death.
- Case note review generally considers one or a few pieces of the 'jigsaw' about Oliver's care and experiences who died a "Potentially Avoidable Death" which the panel agreed unanimously at Reference C. Without doing this, there will be no consideration of the bigger picture, bringing all the pieces of the jigsaw together from multiple sources, and looking at the way in which they all fit together.

Recommendation 3: "*The opinions of patients and family members on clinical events should be given proper weight and emphasis."*

"...family member's observations should be given particular weight...

Comment: This has not happened in our experience. A missed opportunity to address the bullet points above in the comments against recommendation 2.

Recommendation 10: *"A Director for Patients and Families should be appointed to develop a more complainant-centred service:*

"There has been a breakdown of trust with some complainants... It is vital that the PHSO rebuilds trust with complainants... The culture of the organisation needs to be more attuned to patients' and families' experience of the NHS and how their voices are heard and respected."

Comment: Nothing has changed in our experience since this report.

4. There has been a total breakdown of our trust in the PHSO service and we see no value in the PHSO continuing Oliver's investigation. However, you are welcome to use the points we have raised in this letter and the reports we have provided to you from Oliver's LeDeR Independent Review at References C and D to improve your service; confidence; and trust in your decision making which regrettably we have lost. You may also wish to keep these on file to refer to in cases of complaint against Bristol Childrens Hospital, National Hospital for Neurology and Neurosurgery, Southmead Hospital or Bristol, North Somerset & South Gloucestershire CCG in the future.

Regards

Mr Thomas McGowan
Mrs Paula McGowan