

RUTH'S STORY



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About us

Russ Mitchell, retired in 1997 as Chief Superintendent with Devon and Cornwall Police, based in Plymouth. Chairman of Plymouth Hospitals NHS Trust at Derriford for four years, 1997-2001. Anne Mitchell, mother of two girls. We have written Ruth's story using evidence and facts from documents, hearings, inquiry reports and our own conversations with those involved. We have used bold and italics to highlight particularly pertinent events.



Our daughter Ruth was born in Plymouth on 13 April 1972, a healthy baby of 8 lbs 6 oz. She had jet back hair and, when she was a girl, she was full of life, with a fantastic, bubbly personality. She had lots of friends because she was so outgoing and sociable. At school, she was very bright, and she loved all sports, especially swimming, but most of all, she loved art. She left Eggbuckland Community College with six 6 O-levels and 4 CSEs and went to Plymouth College of Art to study graphic design.

It was at this time that she started to leave her old friends behind and she took up with new friends. We first became aware that there were issues when she was 17 or 18, when we discovered that she hadn't been attending lessons at the art college. It transpired that she was going to places we didn't know with people we didn't know.

She left art college after a year or 18 months, before completing the course, and took a few jobs, all of them good ones with career prospects. At one time she was at the Inland Revenue and the last full-time job she had was working in the treasury office at Plymouth City Council.

But Ruth became attracted for some reason to the dangerous side of life and her life choices became risky. She went to live with a man who ended up physically abusing her, so she came back home for a while. She got the

job at the city council, but she then met another young man and they got into the rave scene.

We later learnt that she started taking cannabis and recreational drugs, including Ecstasy, which was all the rage at that time. We know now that it upset the chemical balance of her brain. We think that this is where the schizophrenia started. The result was that she developed that enduring mental illness.

Ruth and her partner had a son in 1994. We understand that the change in the hormones during pregnancy and the fact that people in their early 20s are apparently vulnerable to developing schizophrenia, were also catalysts. Ruth didn't take any drugs when she was pregnant, and the baby was born very healthy, nearly 9 lbs, a beautiful boy.

But it was when she was pregnant that we noticed that things weren't quite right with Ruth. She started seeing things and hallucinating. She and her partner had a flat and she would say: "Someone is here. There's an old man who sits in the corner, and people are watching me all the time." This paranoia is symptomatic of schizophrenia. This is when it all started.

Ruth's mental health deteriorated and by the time her son was about 16-17 months, her relationship with her partner was affected by her behaviour. Ruth was getting worse and he couldn't cope with it any more so moved out.

At that time, we were still seeing a lot of Ruth and we were able to witness the changes in her behaviour and issues of risk, not only to her, but to her son. Ruth started to fall apart, and her son was vulnerable. We tried to get help from her GP, to no avail. They wouldn't speak to us because of patient confidentiality.

Because Ruth was an adult, patient confidentiality was always an issue. The health professionals always seemed to hide behind it or they presented it as an obstacle to listening and acting upon what we said, or to disclose anything. We could get no help. It was incredibly frustrating.

One of the problems was that because Ruth always presented well, people thought she was alright. It's much easier to get help if you have a physical illness, rather than a mental illness.

It came to a head one day when Ruth rang us and said: "I'm at Derriford Hospital." She had taken her son there because she was afraid he had taken some of her medication. In fact, he hadn't so it was a false alarm – but we felt it was only a matter of time before this sort of tragedy unfolded. We spoke to the hospital consultant and said: "Look, our grandson is at risk here." Ruth was looking after him as best she could, but the sad fact was that she wasn't well enough, and we were very worried about both of them.

But it was quite clear that the hospital wasn't going to do anything, so I decided to call my own duty Inspector at Plymouth Police to say that, as a member of the public, I believed my grandson was at risk and I requested he used his powers under the Children and Young Person's Act so that our grandson could be put into a place of safety.

The Inspector spoke to the consultant and told him I was a senior police officer and there was a complete volte face from the consultant. The next thing we knew, it was all arranged. It also meant that Ruth was properly examined.

I felt I was betraying my daughter, but we had to do it for the sake of our grandson as well as for her. She needed help.

That started the official involvement of Social Services and Mental Health Services (MHS) in Ruth's life – in 1996. When Ruth's partner heard all about this, he came back for a period of time because he was worried about their son.

1996 – the start of mental health care involvement

Mental Health Services (MHS) were provided at that time by the Plymouth Primary Care Teaching Trust (PPTTC) which assessed Ruth and

placed her on an Enhanced Care Programme Approach (ECPA), with a care coordinator, a community psychiatric nurse (CPN) called Joanne Campbell.

From very early on really, we were never convinced that the focus of Ruth's treatment was where it should be. But you get what you get, and you get the quality that you get and there's nothing you can do about it other than to ultimately complain, which is what we were forced to do.

In the early days, we had a reasonably good rapport with MHS, in the sense that we could talk to them. They were guarded but at least they listened to what we said, and we could act as a long-stop if Ruth's behaviour was getting a bit extreme, because at this stage, we were still seeing Ruth quite a lot. Our grandson also had a guardian, appointed by Social Services, and he was very good at his job.

One night, Ruth was found crying and screaming at her home and she was sectioned under the Mental Health Act. We had a phone call to say: "Can you come down and get (P) (our grandson)?" It turned out that the police had forced in the door and our grandson had been taken for his own safety.

He lived with us for about six months after this because Ruth was poorly. We were only 10 minutes away from Ruth's home at that time, which helped. Eventually, he had to go to a foster home for a while because Ruth was getting worse and we couldn't cope as we were both still working at this time as well as trying to manage the overall situation.

A nurse called Rachel Bryant took over from Joanne Campbell as Ruth's care coordinator. She was an Occupational Therapist (OT), not a Community Psychiatric Nurse. This was accepted practice, apparently, because there weren't enough CPNs to go around, although we didn't find out she was an OT till much later. It's an example of a lack of resources being put into Mental Health Services.

The problem with Rachel Bryant was that she accepted a lot of what Ruth said by way of self-report. Nothing was ever corroborated by a third party, so she'd feed back to us what Ruth had said, such as: "Ruth isn't drinking now, she hasn't been drinking for weeks." But we'd go to Ruth's house and the bin would be full of empty bottles. When we passed this information on to the OT, she treated us like we were making it up. We know that Ruth's periods of binge drinking indicated that her illness was troubling her. It was a visible sign of her mental illness.

By now, Ruth had moved into a lovely house, a new build in Manadon owned by Plymouth City Council. It had a lovely little garden and we furnished it from top to bottom. But we had to fight hard to get it, because of the inadequacies of Mental Health Services.

For instance, Rachel Bryant had assured us that the council was aware of Ruth's mental illness and with the baby, she told us Ruth would receive extra points under the housing system. But it dragged on and on and in the end, with Ruth's permission, we went to see the housing officer. It transpired that they never had a clue that Ruth had a mental illness. We now know, through Freedom of Information (FOI), that the Housing Department was never formally informed by MHS of Ruth's psychiatric status.

They found out by default later, because tenants complained about Ruth's behaviour. But they were never formally told from day one that Ruth was vulnerable and had special needs. This was a damaging failing by MHS.

We were told that Ruth's illness was enduring, so she wasn't going to get any better. The best we could hope for was that she would stay reasonably stable. However, her heavy use of alcohol and binge drinking was counter-productive to her medication which meant her moments of stability didn't last for long. After about a year or so in the house, her partner came up to see us and said he was leaving for good and was taking

their son with him, for safety's sake. They got local accommodation initially and he took care of our grandson. He eventually left Plymouth.

Ruth never got her son back again. She just wasn't well enough to look after him properly.

So, Ruth was now on her own in the house and we'd visit her once or twice a week. We'd also pass by to make sure her lights were on, so we'd know she was ok. She wouldn't have a phone, so we couldn't ring her. She was paranoid that people were watching her and said there were cameras outside. Her degree of paranoia was quite severe, and she considered a phone would be part of this "surveillance".

Ruth's condition became more problematical and her unpredictable behaviour was upsetting her neighbours. One day she came to see us and said: "I've been to court. I was drunk in a public place and I've had to pay an £80 fine." We rang the care coordinator, Rachel Bryant, and told her about this and she said: "Oh no, that's not happened. It can't happen. If Ruth had been picked up drunk, I would have known about it. It's all registered, it would have been '*flagged*' up, I'd have dealt with it and it wouldn't have gone to court." But the incident had happened, and we later discovered that MHS had never '*flagged*' Ruth's vulnerable condition with the police so they were and continued to be unaware.

There was a time when we had something of a relationship with the care coordinator, albeit the conversations were all one way: we kept her informed, but there was never very much coming the other way. Our relationship with her and, it was to transpire, with our daughter, broke down to catastrophic effect after an appalling breach of confidence by the care coordinator.

On one occasion, Ruth had been out drinking and had met a man who tried to take advantage of her, no doubt realising her vulnerability. This was always one of our concerns, that Ruth was vulnerable to exploitation, both financially and sexually.

Ruth told Anne that this man had tried to break into the house and get her.

We reported this to the care coordinator, Rachel Bryant, and again expressed our fear that Ruth was at risk and extremely vulnerable. This was passed on in the strictest confidence, as a way of helping with Ruth's treatment because we were concerned about her welfare. However, Rachel Bryant confronted Ruth with this information, breaching our confidence.

The next thing we knew, Ruth was at our door, angry and upset that we had told Rachel Bryant. We had passed the information to a professional, hoping they would respect the confidence that was involved, but our trust was misplaced. Anne rang Rachel Bryant and told her what we felt about this breach of confidence, aware that it would probably drive Ruth into greater isolation, which it did with ultimately tragic consequences.

The standard of professionalism was always poor and for us, this breach of confidentiality was the final straw.

Ruth had waived patient confidentiality in the early years, but when Rachel Bryant broke our confidence, Ruth took it back.

After this, Ruth requested that information should not be passed on to us by MHS. It meant that we only ever heard Ruth's version of what was happening, which was all scrambled, and we had no information from MHS. We were never actually informed that Ruth had withdrawn consent on sharing information and were oblivious to this fact.

When Ruth was discharged to standard care in 2007/8, Rachel Bryant wrote to Ruth's GP and made a point of stressing that we weren't to be told anything. In the end, we were only seeing Ruth once a year for one or two hours, just before Christmas.

Rachel Bryant never worked proactively with us. So, we were surprised, a few weeks after Ruth's arrest for being drunk, to receive a call from her

to say: “Can you go down to Ruth’s right away because I’ve been there, and the house is all upside down.” Ruth had taken a saw to most of the furniture and put it outside the front of the house, all cut up. All the carpets had been taken up and cut into small squares and piled up outside, too. We asked Ruth what was happening, and she said: “I want wood floors.”

Ruth’s psychiatrist at this time was a Dr Ready. We wanted to have a meeting Dr Ready and Rachel Bryant. She arranged for this but never turned up herself. She didn’t even ring to say she wouldn’t be turning up. We could never get our heads around the way MHS work.

It seems like the consultant deals with the client pharmaceutically; the care coordinator deals with psycho-social aspects. They are supposed to work together, but the nurse works *with*, not *for* the consultant. It seemed as if the OT could make clinical decisions without reference necessarily to the consultant. They are responsible for their own practice. This had catastrophic consequences in Ruth’s case, when, on more than one occasion, the requests of the consultant were not carried through.

From Day 1, Ruth never wanted any involvement with MHS.

She would always ask: “When am I going to be discharged?” She never wanted these people in her life. And this is very significant. Because when it came to them stepping Ruth down to standard care, their argument was: “Well, Ruth doesn’t want to engage.” And: “There is always difficulty in engaging and if we push too hard, she will retreat, and she won’t be engaged at all.” They always used this as an excuse for not being proactive, by putting the onus on Ruth’s attitude, not on their ability to provide the care and treatment she required.

Ruth’s capacity was never properly assessed and her ‘best interests’ never seemed to be considered.

It is significant that Ruth always presented well, whether she was ill or not. It’s uncanny how she always seemed to sharpen up whenever she

had to go and see the consultant. She'd stop drinking for a day or two. She wasn't stupid. She would present a good image.

However, the Safeguarding Adult Review (SAR) published in November 2017, states that nobody ever corroborated what was being said by Ruth. All the decisions that were made, were based on Ruth's self-reporting, not the evidence of a third-party source. This meant that Ruth could go in and say whatever she liked – and it was accepted. Here you are, dealing with somebody with a serious psychiatric illness, and you're asking them how they feel, and they say: "I'm feeling great and I don't want you in my life anymore," and they accept it!

We've had the benefit now of reading Ruth's medical notes completed by the practitioners and there is evidence of alcohol right the way through. It's always there, so they knew. But because Ruth told them: "Oh I haven't drunk for six weeks and I'm going clean now," they accepted her words. As they were only interested in Ruth's self-reports, it meant there was a lack of focus on the real things that were going wrong in Ruth's life, which we complained to them about. These were: her continuing refusal to see her son; her drinking; and her social isolation, which was made worse by the gradual disengagement from us following Rachel Bryant's breach of confidence.

One day, Ruth said: "Mum, I'm thinking about moving. I've asked for a transfer and a woman with a baby wants my house, so she should have it." We were very worried about this and it transpires we had good cause to be.

This was the start of her complete withdrawal to an upstairs flat where she could shut herself away from everyone. It was the beginning of the end.

We rang Rachel Bryant and said we were concerned about Ruth because she was talking about doing a housing transfer. We were concerned about where she would be moving to because some of the places weren't

suitable for vulnerable people and she could end up being victimised. Rachel Bryant said: “That can’t happen Mr Mitchell because the housing authority knows Ruth’s status and they would inform me.”

Well, Housing didn’t tell her, because she hadn’t told them about Ruth’s illness. We are absolutely stunned as to why she hadn’t told them but kept telling us that she had. There is an area mental health team and on that team, there are representatives of the city council social services department, so it’s not rocket science. If there were issues, they could be followed through and checked out. But apparently MHS didn’t want to work that way.

So, according to Rachel Bryant, it couldn’t happen. The next thing we knew, Ruth had moved to a flat in Normandy Way, Higher St. Budeaux. It was an upstairs flat in a 1950s Cornish unit. We knew nothing about it until after it happened. Ruth was becoming quite estranged from us by this time.

And Rachel Bryant didn’t tell us where she was.

In the end, Ruth rang and told us. We went to see her at the flat and it wasn’t very nice in comparison to what she had given up. But Ruth said she was happy there. She preferred it because there were no near neighbours. But it was a crazy decision, leaving a lovely 2-bedroomed house in a nice area for a flat like that. Ruth went downhill after moving to the flat. And this brings us back to one of the really big problems we found with the mental health professionals.

They never, from Day 1, addressed Ruth’s capacity issues.

They never tested the mental capacity for Ruth to make the decisions she was making. We said: “How can you let her not see her son? What are you doing to address those issues? How can you let her make such a bad decision about her home?” Even though we raised these matters, they didn’t seem to take on board the capacity issues. It’s common sense, surely, that if somebody’s got a mental illness and they want to make

decisions, you look to see if those decisions are being made for the best interests of the person who's made the decisions. There is nothing wrong in respectfully challenging those decisions.

The top floor flat was reached by a steep flight of concrete steps. Ruth had a known alcohol problem. How did this make any sense? She only ever let us go inside the flat once and that was just after she moved in. The one thing she said that has always stuck with us was: "The best thing I like about it is that nobody can get to me up here." We think she was referring to visits from people. At her house in Manadon, people could look in through the kitchen window, or go to the back gate and see into the lounge. Up there, no-one would know if she was in or not because there was no way of seeing in.

She moved in there about 2004. And this is when her isolation really kicked in. She wouldn't let us in there. She pushed us away completely.

***When she moved into that flat, it was as if she was saying:
"I've shut the book now; it's the end." It was like she had
waved goodbye to us all.***

We were hardly seeing Ruth at all now, which was upsetting, and we were never formally told that Ruth had asked for confidentiality.

We struggled along until 2006/2007, when we'd had enough of it. In the middle of 2007, we made a formal NHS complaint regarding the focus of Ruth's treatment. Ruth was still under an Enhanced Care Plan Approach (ECPA). We went to see Dawn Walbridge, who was head of the health provider's litigation department, and the nursing director at the time, Sarah Mitchell. We put all our concerns on the table and they promised us a thorough and immediate inquiry. A couple of months later, we were called to a meeting at Mount Gould Hospital for "**some positive news**".

For the first time in years, we thought: "Thank God, somebody is listening to us. They've recognised some of the issues involved and Ruth is going to get some more help." But when we got to the meeting, we were told

by them: “We’ve done our investigation, but we’ve actually just been told that Ruth has been discharged from the ECP. Isn’t that good news?”

So, bearing in mind we had complained that we didn’t think that Ruth was getting enough care, they were now telling us it was good news that Ruth was going to get less care!

They obviously hadn’t investigated Ruth’s circumstances properly and had listened to the people who had control over Ruth’s life and who had already decided to step Ruth down. Dr Tocca was Ruth’s consultant at that time, but we are certain the prime mover was Rachel Bryant. She had said that she didn’t feel she needed to have Ruth on her case book any more. She said Ruth wanted to be discharged and there was a period of stability and she had stopped drinking. We know, and the SAR report makes clear, that that conclusion was entirely based on uncorroborated evidence all based on Ruth’s self-report, which is farcical.

Nothing had changed in Ruth’s life to warrant a ‘step down’ in treatment plan. In fact, things had got worse. She was more isolated than ever. We told them they were wrong. We said: “Right, we are now escalating our complaint because we don’t agree with this decision. This is a joke!” .We did escalate our complaint.

What we now know, as a result of information we received after Ruth’s death, is that our complaint agitated the system, and the then Deputy Chief Executive and Director of Operations, Stephen Waite, became involved, together with the Medical Director, Dr Simon Payne. We met them at Glenbourne Hospital towards the end of 2007 and explained our concerns. They said they would do an investigation. In the meantime, Dawn Walbridge also asked the Medical Director to do an internal review into Ruth’s case to make sure the treatment decisions were sound. If so, it would be a way of addressing our current complaint.

A lot of internal emails floated between certain clinicians as a result of this, which we now have copies of, although some are redacted. In these

emails, all isn't quite as it seems. It appears that something was going on in the background.

In the emails, the Medical Director himself is saying he doesn't agree that people should be discharged to standard care under these circumstances, but he knows some of his colleagues are happy to discharge stable but unwell patients to primary care. He says this is a problem associated with the "recovery agenda"? So, there was something going on at the time.

We then got to see an email from Ruth's own consultant, Dr Tocca, to the Medical Director, saying he wanted a second opinion on Ruth's capacity and he believed Ruth still needed a care coordinator. Unbeknown to us then, Dr Tocca was himself under conditions following a discipline matter dealt with by the GMC for having previously inappropriately discharged a mental health patient from Glenbourne Hospital. However, the Medical Director said he didn't want to carry out the second opinion because he was involved in our complaint.

In the end, no-one did it and no second opinion was never undertaken. The decision to step Ruth down was allowed to stand.

What was the "recovery agenda"- was it connected to MHS having to clear clients off their lists?

Did the transition of NHS organisations to private organisations require them to meet certain criteria?

Did they have to get their house in order to fulfil a business model that was required before they were allowed to do that?

We don't know, but Plymouth Primary Care Teaching Trust may well, at a management level, have been preparing for whether they wanted to go private by becoming a Community Interest Company (CIC). In the end, that's what happened. They became Plymouth Community Healthcare (PCH), then Livewell CIC and finally Livewell South West CIC.

We suspect the decision to step Ruth down was all part of the ‘recovery agenda’ and Ruth was picked as one of those to be shed. When I started to complain about it, in my opinion, they must have thought “we’ve got to cover our tracks here, we’ve got to justify this decision”.

They made Ruth out to be more stable than she was. If anything, she was getting worse. It doesn’t make any sense and if it doesn’t make sense, it isn’t right.

We later discovered it wasn’t right because in an assessment of Ruth’s health, they gave her alcohol rating as zero, meaning that according to them, Ruth wasn’t drinking at all at this time. We’ll come back to this later, when we dissect the dishonesty and failings.

Notwithstanding that ‘inaccuracy,’ it seems even the Medical Director, Dr Simon Payne, was unsure about stepping Ruth down, because he uses the term “for good or for ill”.

We met Mr Waite and Dr Payne twice and they said they would find a way of setting up some form of communication. Then, out of the blue, in May 2008, bearing in mind there had been an internal review, we received an invite from Joanne Campbell (CPN) to attend a meeting. She hadn’t been part of Ruth’s care for nearly 10 years. She met us in company with another CPN, a Ms. Cherry, and she put on the table an arrangement: If we were happy with it, she would go to Ruth’s quarterly outpatient appointments (OPAs) with the consultant. She would support the consultant therapeutically and inquire into the situational issues in Ruth’s life. She knew Ruth and was professionally more mature than Rachel Bryant, and we thought “well, this is the best we’re going to get”. So, we accepted the arrangement.

We had faith in the nurse as a qualified CPN that she would do what she said she was going to do. We believed the house visits with Ruth would be made by CPN Campbell.

Before the ECPA ended, Rachel Bryant was visiting Ruth three or four times a month. But these stopped immediately when the treatment plan changed, a fact which at that time we weren't made aware of.

We later discovered that Jo Campbell was Rachel Bryant's team leader and believe this care arrangement for Ruth was a way of ameliorating our complaint and enabled them to continue with their plan of stepping Ruth down from Enhanced Care, which is what happened.

***From this moment, Ruth's condition deteriorated
until her eventual death.***

Ruth was now on Standard Care, which now meant a consultant was the lead practitioner. **It would seem somewhere along the line the discharge to primary care (GP services) was dropped** and Ruth stayed in secondary services, and the Trust bolted on the arrangement with the CPN, which we found later **is not a normal or usual clinical arrangement.**

Although far from ideal, we felt at the time that it was better than what was initially planned because they were going to put Ruth back to primary care, with the GP responsible for everything. But it was to prove a disaster.

With the new arrangement, Joanne Campbell, we believed, would inquire as to Ruth's social situation and would then liaise with us, and, within the realms of confidentiality, let us know what she could to reassure us that Ruth was OK and if we could support her in anyway.

In stepping Ruth down, they had argued she was stable and wasn't drinking. And yet, the very first OPA after Ruth had been stepped down in June 2008 had to be abandoned because she turned up drunk!

We have also since discovered that CPN Campbell didn't even attend that appointment – this would be a continuing theme which we only became aware of after Ruth died.

We were also flabbergasted that as part of the arrangement, the CPN said she wouldn't contact us; we had to contact her. How? If we didn't know when the OPAs were? She said: "Just ring me any time, whenever you're worried." So, Anne said: "In that case I will ring you every day, because I am worried every day."

In the end you get so worn down with these people that you just think: "Well, this is the best we're going to get so let's see if it works."

To ring Joanne Campbell after the OPAs, we had to guess when the OPAs were. When we did manage to speak to her, she always said: "Ruth's doing well, she's not drinking, everything is steady." But unbeknown to us, nobody was going to Ruth's flat. She wasn't getting any home visits. **And we didn't know until Ruth died that Joanne Campbell attended just 4 out of 14 scheduled OPAs and the information she was feeding back to us, such as it was, was invariably based on the consultant's written reports of his meetings with Ruth.**

Joanne Campbell's non-attendance escalated, when she was promoted in 2009 and moved to another area in the city. She told her line manager, **Anne Prue** (remember the name, she crops up again later), that she had difficulty attending the OPAs due to the increased work pressure, but she was told to continue with the commitment.

These details emerged only during a Nursing and Midwifery (NMC) tribunal into Joanne Campbell's professional conduct in Ruth's case, which followed a referral by us after Ruth died. None of it was known to us at the time.

Joanne Campbell, it would appear, decided that the only way she could manage her workload was to stop going to the OPAs.

She should have stood her ground and fulfilled her professional obligations and duty of care. But she didn't. She just stopped going. She arranged with the consultants, certainly with Ruth's final consultant, Dr

Dinniss, that if Ruth did not attend 2 OPAs in succession, then the doctor would contact Joanne Campbell and she would go and check up on Ruth.

In the independent report by Dr Christopher McEvedy, (instigated following our official NHS complaint against the health provider following Ruth's death) he is unsure of the appropriateness of this arrangement. It would mean that if the OPAs were at four-month intervals, then Ruth could go eight months without being seen by any clinician.

And so, it was that Ruth was allowed to decline.

We weren't informed about things we should have known, such as when Ruth's consultants changed. It transpired that Ruth saw a total of 5 consultants between 2007 and 2012, which we discovered from Ruth's medical records. This lack of continuity, coupled with the infrequent meetings with her, amounts to poor continuity in her care.

All along, we were thinking that Ruth was receiving home visits and that she had a long-term consultant. Neither was the case. In attempting to maintain contact with CPN Campbell, it would sometimes take her weeks to respond to us.

In the end, due to the lack of feedback, we started sending cheques to Ruth every month so that when she cashed them, we'd know she was still alive. We didn't know what else to do.

***"It's really grim when you have a daughter who is so ill,
but you can't get any help."***

BENEFITS CUT – DISASTROUS AND AVOIDABLE

When she was under the care of a coordinator, Ruth received Disability Living Allowance (DLA) and it made up a substantial part of her income.

Once she left the care of the coordinator, we now know that her DLA ceased. The care coordinator on Ruth's behalf, always applied for it, so this stopped when this position was removed. It meant Ruth had a basic allowance of £60-£65 a week. Ruth didn't like brown envelopes coming from the Government because it was all part of the "conspiracy" she was convinced was aimed at her. She would never open official-looking letters.

In 2011, the Government brought out the Return to Work reviews. In November 2011, we rang Joanne Campbell and said we were concerned that Ruth, as she was on DLA, would be called in for a medical review but she wouldn't turn up and would lose her DLA. The response was: "Don't worry Mr Mitchell, I will sort that out. Anybody who is in Ruth's presence for more than 10 minutes will know she is extremely ill."

"I shall never forget those words, it is as if they are burnt into my brain".

Ruth wasn't getting DLA, and hadn't received DLA since March 2008 and Joanne Campbell knew this. And the reason we know she was aware of it was because at the OPA review on 24 March 2009, the consultant that day, Dr Niak, raised the issue of Ruth's DLA and he asked Joanne Campbell to look into it. In his handwritten notes, the consultant indicates "...concern for Ruth, suggest action by Joanne Campbell or social worker, lack of DLA noted. Jo to look into. Telephone suggested to Ruth; Jo to look into".

On 25 March, he wrote to the GP and again indicates a plan for Joanne Campbell to look into DLA, which, he says, would be discussed at the next multi-disciplinary team meeting. But it never happened. We always believed she was still getting DLA and Joanne Campbell told us Ruth was getting DLA even though she knew the true situation.

Dr McEvedy is an independent consultant psychiatrist based in London. He is an expert in his field and has a national standing. The review he did

on behalf of the Trust following our official NHS complaint after Ruth's death, was itemised, based on the matters we had complained of at that time.

It focused on various elements of our complaint about Ruth's treatment, including her DLA, which is where we learnt the implications of no DLA for Ruth. She hadn't claimed DLA for four years, which we never found out until after she died.

When you ask these people about Ruth's DLA and why they didn't do anything about it, they say: "Oh well, Ruth didn't want to claim it and Ruth didn't want you to know." **When we got Dr McEvedy's review, he is extremely critical of the lack of action to get Ruth DLA because it was "the larger part of her state benefits" and not receiving it "would have had a serious impact on her financial stability and therefore her ability to maintain herself adequately".**

Not having DLA contributed to her poor standard of living, her ultimate self-neglect and avoidable death.

Failing to follow the principles of the Mental Capacity Act 2015 (MCA) – is where MHS significantly failed Ruth and failed in their professional obligation to care for her. They didn't respectfully challenge Ruth's rationale for the decisions she was making or the consequences of her actions.

The Safeguarding Adult Report (SAR), published in November 2017, following our referral to the local Safeguarding Adult Board, makes this clear. The SAR report highlights that there were several occasions where there were indications of a deterioration in Ruth's wellbeing, but nobody tested her mental capacity, even though they saw she was having difficulty. They still didn't take any action. How could Ruth's decisions possibly be regarded as in her best interests?

The OPA in March 2009 highlights clearly that Ruth is deteriorating. Dr Niak wrote that Ruth "mentions lately finding it harder physically to

manage herself, feeling dizzy, difficulty with concentration, feeling low in energy and tired most of the time..." and "we also thought of considering allocating a social worker to help Ruth in her day to day activities. This will be discussed at our next multi-disciplinary team (MDT) meeting".

It never happened!

After an OPA on 21 July 2009, the consultant's notes indicated "an uneasiness about Ruth's insights into her finances" and highlighted a capacity issue: "She was calm and pleasant initially, although she got anxious when we were discussing various options of DLA care plan and she was found to be unrealistic with regards to her current abilities to manage things with no support ... We are aware historically that she does not like to have the mental health services involved with her day to day care ... With regards to her thoughts, she was found to be distracted at times ... she doesn't feel she needs DLA, though she has to be very tight on her budget...she is only in receipt of income support ... she still doesn't want any telephone connection or mobile phone in order to touch with services. Please see TAG Assessment for risks [TAG is a Threshold Assessment Grid, a mini-review]. Considering her current situation with regards to her ability to consider various options for herself, we felt it was appropriate for her to be discussed at our MDT meeting, perhaps thinking of support worker allocation and also considering Assertive Outreach Services (AOS) as she is not very good at engaging with services. For now, we have decided to continue with the medication etc ..."

But his suggestions were not addressed, and no discussion appears to have occurred!

So as early as 2009, there are concerns from senior clinicians and matters should have been looked into more closely then. There were only two OPAs in 2009 and at the one in July, Joanne Campbell didn't turn up.

We believe the degeneration in Ruth's life started from the moment she was stepped down from enhanced care. But difficulties clearly manifest

themselves, as far as the consultants are concerned, in 2009; and although they suggest things should be done, they were never acted on. We never knew anything of their concerns.

The visits to Ruth's home by the mental health service provider had stopped as part of her being stepped down. But people from other organisations did visit for routine issues.

Housing tenure had switched from Plymouth City Council to Plymouth Community Housing. They were totally unaware that Ruth was a psychiatric patient. Equally, when the police were called, usually because of a neighbour's concern for her welfare, they weren't aware for a very long time that Ruth was a psychiatric patient because mental health had not *flagged* it. So, nobody was formally visiting Ruth as a psychiatric patient. The routine visits that occurred were by workers from housing to do repairs, such as a plumber and a carpenter.

Kate Spreadbury, the lead reviewer and author of the SAR report, makes the point that these people were able to communicate with Ruth. So why couldn't the mental health practitioners? Why couldn't there have been an informal network of feedback through people that Ruth accepted?

The most significant visit was from the gas board. The landlord must by law check the gas system every year for an annual safety check. Either Ruth could no longer afford the gas after losing her DLA, or she just didn't answer the door to the gas official; either way, the **gas was cut off**. She didn't have gas or hot water because she didn't allow a safety check in April 2008.

***As a result, Ruth had no heating or hot water in her flat for the last four-and-half years of her life.
And we never knew.***

Plymouth Community Housing have since told us that Ruth hadn't been *flagged* up to them as a psychiatric patient. Apparently, a lot of tenants don't like gas and go over to electric. But if they had known Ruth was a

psychiatric patient, they would have reported Ruth's decision not to have gas to the mental health authorities and action could have been taken accordingly.

Ironically the social landlord PCH is a member of the Safeguarding Board/Panel.

We had reached the stage now that we were only seeing Ruth for an hour or two a year in a week or so before Christmas. We'd meet her, and exchange presents, and we'd give her some money for the Christmas period.

In December 2010 we arranged to visit Ruth as usual. We will never forget it.

It was a few days before Christmas, there was snow on the ground – it was the first of two bad winters we had – and Ruth was very inappropriately dressed in summer clothing. She was very unwell and incoherent. We went for lunch and she was very picky with her food, which was another issue. She'd lost a lot of weight. We rang Joanne Campbell at the clinic and left a message to pass on our concerns. The clinic assured us that the message would be passed on.

Unbeknown to us, on 2 December 2010, the neighbour downstairs had contacted the police with concern for Ruth's welfare. The police broke into Ruth's flat and found her in a state of disarray with her prescribed medicines thrown around the room. They feared that Ruth had taken an overdose so called South West Ambulance Service Trust (SWAST). They noted that the flat was extremely cold.

SWAST paramedics did a very good job, which we only found out about in the SAR report. They spent some time at the flat, established that Ruth hadn't OD'd and that she was a psychiatric patient in the care of Mental Health Services. The paramedics started their own Vulnerable Patient procedures, which formally referred the incident to Adult Social Care and MHS. They also rang the night duty manager at PCH stating they were

concerned about Ruth's welfare in the cold flat. The night duty manager left a note for the oncoming PCH safeguarding officer, who contacted Joanne Campbell with the information.

No gas heating or hot water for 4 years 2008-2012:

Four days later, on 6 December, Joanne Campbell visited Ruth and found her with no heating. Ruth told her: "I don't want gas." This is when Joanne Campbell finally discovered that the gas had been cut off. She was concerned that Ruth was in a very cold, possibly hypothermic situation, so she drove home and fetched a convector heater which she took back to Ruth as a first measure. Campbell also noticed that the flat was "sparse".

It has transpired that Ruth's gas was cut off in 2008 because she would not let the gas engineer in to carry out an annual safety check – it was never restored, and Ruth had no alternative heating source in her flat. So, for the remainder of her life - 4 years - she had NO HEATING OR HOT WATER.

But CPN Campbell did nothing.

She didn't question Ruth's capacity to refuse to have heating in her flat and she didn't instigate the Vulnerable Person Policy. Again, unbeknown to us, she allegedly contacted Dr Dinniss sometime later, and an OPA planned for late January was brought forward to 11 January, but that was her only action. She left Ruth there with a convector heater which she couldn't afford to run and without hot water or other form of heating.

"A heroic action"!

At the Nursing and Midwifery Council (NMC) tribunal held following our referral regarding the nurse's conduct, one of the tribunal panel members described this as "a heroic action". Failure to discharge a professional duty of care didn't seem to matter to them.

Although there was a vulnerable adult intervention policy in place, known as VARMM, it turns out that the mental health professionals didn't like using it as it is too time consuming, an aspect which is covered well in the SAR report.

The procedures are there for a reason, but mental health nurses prefer to use their clinical judgment, whatever that means.

Joanne Campbell, more than 12 months later, said she had made a clinical judgment, but nothing is in writing. The NMC's own rules on record-keeping state that when you make a clinical judgement of this nature, you should write down your reasoning behind it, so you can defend your actions should something go wrong, and if there is no record, it didn't happen.

At the OPA on 11 January 2011, Dr Dinniss wrote everything up and requested the intervention of a community social worker to give Ruth some short-term support including financial assessment. Concern was also recorded that Ruth was drinking again and that a man had gone back to the flat and her door had been left unlocked.

But his request for intervention was never actioned by anybody.

The email from Dr Dinniss requesting this action was sent to Joanne Campbell, an assistant clinical manager and a community social worker – and none of them took any action.

Indifference and inaction is a recurring theme.

It's worth noting that in the winters of 2010-11 and 2011-12, temperatures in this district reached -10c. It was very cold for a significant number of consecutive days, which activated the Government's Cold Weather Payment Plan.

Ruth would have been entitled to them, in the same way she was entitled to DPA, which was never reinstated because no-one sought to get it reinstated.

We assumed Ruth had heating, hot water and disability living allowance because Joanne Campbell never told us otherwise.

When we met Ruth in December 2011, we were distraught to see the condition she was in. She looked terrible. She had shaved her head and she turned up wearing men's clothes. She had very poor dental hygiene and was incoherent. She was also very thin. We were more worried about her than ever. She always used to dress immaculately, had lovely hair and liked to wear a little bit of make-up.

She was now, clearly, extremely ill.

We rang Joanne Campbell and told her that we were alarmed by Ruth's condition. She said she would go and see Ruth and "sort it all out".

But she never did.

At her tribunal, Joanne Campbell admitted she took our call on the way out of the office, as she was finishing at the end of a busy day. **And then she forgot about it.**

Joanne Campbell didn't even turn up to the next OPA on 14 February, because it was half-term. She checked to see if Ruth had attended, which she had. She therefore assumed everything was alright.

This was the last OPA that Ruth attended, and Joanne Campbell didn't turn up to it. Even worse ...

CPN Campbell never told Dr Dinniss that we had rung her in December to report that we were very worried about Ruth.

Ruth didn't attend the next scheduled OPA in July (neither did CPN Campbell) and she was found dead in her flat on 2 September 2012. We were away at the time, on our way to visit our grandson in the north of England.

Generally, police involvement with Ruth followed phone calls by her neighbour with concerns for her welfare. On this occasion on 2 September 2012, the neighbour thought something was wrong because he'd heard Ruth moaning during the night some time previously and then everything went quiet. Ruth was clearly unwell, physically, and subsequently died. The post mortem explained that Ruth would have been in a lot of pain because of the embolism which was revealed in the post mortem. By the time the police got there, Ruth had been dead a day or so at least. They were struck by the lack of any furnishings in the flat. The officer who rang to inform us said: "Mr Mitchell, there's nothing in your daughter's flat." He couldn't seem get his head around the circumstances he had found.

For many years, we feared that one day we would get that phone call.

Ruth didn't have anybody in her life that we knew of, so she was totally alone. We feared she might die from alcohol abuse or taking an overdose or falling down the concrete stairs, or committing suicide – which we feel is what happened to her at the very end.

She only had a couple of things left in the flat; she'd got rid of everything else and had planned for the rest of her things to be taken away on 11 September 2012.

I went there 2-3 days after she was found, to meet someone from Plymouth Community Housing. There was a small kitchen table and a kitchen chair, a compact portable fridge and a microwave. She was sleeping on the floor on bare boards, with a bean bag for her head. No floor coverings, no curtains, no sofa, no bed, no TV, no stereo and no food,

just some unopened bottles of vodka. No hot water. No magazines. The only thing left was one book that her aunt and uncle gave her when she was christened, and it was a child's bible. In amongst her meagre possessions was a note Ruth had written, asking the housing authority to remove the last remaining pieces of furniture from her flat. They had agreed to visit on 11 September to remove the furniture, so Ruth would then have had nothing.

Although we'd had a feeling of foreboding for years, we didn't expect Ruth to be allowed to die in this way. We rang the charity, Inquest, and the woman we spoke to there couldn't believe how Ruth died. She felt it was a basic infringement of Ruth's human rights because it amounted to inhuman treatment, to allow somebody to live and die like this.

Late in the day, the police had become aware that Ruth was a psychiatric patient, but only because of previous incidents and their own inquiries. There was never any official notification to the police from MHS that Ruth was a psychiatric patient or that if they were called to her address, they would need to know about her illness. She was never *flagged*. The police marked Ruth up on their computer of their own volition. Likewise, we don't think Ruth was ever *flagged* by housing, either, so they agreed to take the furniture away, unaware of the circumstances.

From 1996, Ruth was never put on any register as a vulnerable person due to her psychiatric illness. And certainly, since the break-up of her relationship, when she started to live in isolation, with a severe illness, never was she put on any formal register with any social organisation.

One would have thought that a patient with a severe and enduring mental health illness, especially something as debilitating as schizophrenia, as a lone female living on her own, with her parents flagging up a lot of the vulnerability issues, that somebody somewhere would have said 'hang on a minute, we need to put this person on the at-risk register'. That would have alerted other agencies. But it never

happened. And so, all the times Ruth brushed with the police or when there were issues with the flat, no-one officially knew she was a psychiatric patient.

It's possible to live with schizophrenia and lead an almost normal life. At one time, Ruth was getting the Disability Living Allowance she was entitled to, she was living in a nice house, she was eating well and looking after herself. It all fell apart after they took her Enhanced Care away. And that decision had nothing to do with Ruth's condition because she wasn't getting better.

The Ombudsman's Report into Ruth's care later refers to the HoNOS (Health of the Nation Outcome Scales) Ratings, which is the criteria used to clinically assess people, based on the previous 2 weeks of the patient's life.

We have a suspicion that Ruth's report was compiled to make it look like she had got much better, to justify the treatment decision when her care was stepped down. When it came to alcohol, Rachel Bryant put in a rating of **0 (zero)**. And yet her first Outpatients Appointment with the consultant as part of the new arrangement in 2008 had to be abandoned because Ruth turned up drunk.

We wrote to the General Medical Council in 2015, after facts came to light that Ruth's consultant at the time, [Dr Tocca, had inappropriately discharged of a patient from Enhanced Care](#). However, the GMC said that as Ruth's treatment decision had happened in 2007, they couldn't do anything about it as it was after the GMC's 5-year rule— even though we had only just found out about it. The GMC, like some of the other statutory bodies we've been involved with following Ruth's death, didn't want to know. None of them take any action unless they are forced to do so.

It remains a fact that the consultant was working under sanctions at the time Ruth was stepped down, and yet nobody thought to review his part in the decision as part of those sanction requirements. This was so, even

though Dr Tocca himself appeared reluctant and had raised concerns, requesting a second opinion on Ruth's capacity, which never happened due to a mix-up between him and the medical director, Dr Simon Payne, who was involved in our complaint about stepping Ruth down.

Although almost all the blame lies with Mental Health Services, we feel the GP also let Ruth down. Ruth didn't want to be involved with MHS but allowed some help for other health issues from her GP. Ruth would engage when she wanted – where she saw the people weren't trying to control her. This was how she viewed MHS, which was symptomatic of her illness.

However, under National Institute for Health and Care Excellence (NICE) guidelines, the GP is required to do a holistic review every year and we don't think that happened. Equally, they didn't feedback to Mental Health Services on the occasions when Ruth didn't turn up for such appointments.

We cannot believe that Ruth is the only one.

There must be other cases from that time that followed a similar pattern. We suspect people were stepped down because Mental Health Services had too many people on their books and they didn't have the staff to deal with them all.

A choice was made to step down those patients who they deemed to be stable long-termers. Because Ruth always presented well and always said she didn't want the involvement of MHS and "didn't want to engage", she was one of those selected.

Not wanting to engage is a common symptom of her illness, and yet MHS used this as a reason to let her go. Instead of addressing it, they twisted it and used it to their advantage. Had it not been for our intervention, Ruth would have ended up under the supervision of a GP.

In retrospect, she might well have been better off with this arrangement because she would have seen the practice nurse several times a year. As it was, MHS didn't involve anyone else, including us. How could we help if they didn't tell us anything and if they didn't listen to us?

The health professionals didn't follow through their duty of care and they didn't even comply with their own agreed policies on safeguarding vulnerable adults (VARMM). These procedures were established because of a Serious Case Review following a self-neglect case that occurred in Plymouth in 2005 – it was supposed to be 'a lesson learnt' – but clinicians ignored that lesson.

They didn't even follow through on their own clinical judgement. They didn't document the rationale behind their decisions. In Joanne Campbell's case, she didn't raise the fact that she had made a clinical decision regarding her lack of action in December 2010 until 18 months to 2 years after the event, when she was interviewed by Trust managers because of the referral we made to the Nursing and Midwifery Council.

Their reasoning for everything was "that's what Ruth wanted". At the inquest, Joanne Campbell dismissed it as "well, Ruth wanted to live a certain way". That's how they defended themselves. But because there were never any home visits, nobody ever witnessed how she was really living, other than Joanne Campbell's enforced visit on 6 December 2010.

What is undeniable is that they knew then that there was no heating. Furthermore, Joanne Campbell acknowledged that Ruth did not have the same standard of accommodation that she had when she first knew Ruth. And this is our point: Anyone who hasn't seen anybody for a length of time would recognise the difference in Ruth's condition, and a professional would surely see the need to do something and not just walk away.

They never once addressed her capacity.

If we were still seeing Ruth regularly, we would have been able to do something. But Ruth didn't want to see us, which was because she was very ill, and MHS never wanted to involve us. Ruth's demise was down to their decisions and their failure to act. And what makes it worse is that there were occasions when the consultants called for intervention – and still nothing happened.

In January 2011, for the first time ever, Ruth agreed to allow MHS to intervene in her life. She agreed to accept the support offered by Dr Dinniss, which he recorded in his medical notes. Throughout her involvement with mental health, she had resisted their involvement. But she obviously recognised herself that she had got very low. But the support never materialised, even though the consultant emailed three health workers requesting short-term support.

When the post mortem was conducted, it was clear that the pathologist was disturbed by the presence of ketoacidosis in Ruth's system.

The primary cause of death was a pulmonary embolism and the early onset of bronchopneumonia. The secondary cause of death was a potentially fatal dose of ketoacidosis. Ruth was malnourished and weighed only 50 kilos (7st 8oz). The pathologist explained that if someone is malnourished and develops this condition, it attacks the immune system. If someone gets bronchopneumonia, they start to feel very unwell and remain immobile for long periods. This can cause a thrombosis to develop and lodge in the pulmonary artery, leading to death.

During the inquest in July 2013, the Plymouth Coroner, Ian Arrow, intervened when the pathologist was talking and asked him to move on. We have the transcript, which shows this. Mr Arrow was more willing to take on board that there was alcohol in the flat and that Ruth had a history of alcohol misuse, so he concluded that Ruth had probably been drinking. But the toxicology report from the post mortem shows no

alcohol in Ruth's system prior to her death. There was no food in her digestive system. She hadn't taken any of her prescribed medicine either. She was physically unwell, and mentally unwell because she wasn't taking her medicines that kept her stable.

We believe she was making a determined effort to take her own life by starvation because she had obviously reached that point for ketoacidosis to develop. You get this if you're a diabetic, an alcoholic or starving. The pathologist said there was no sign of chronic alcoholism in her system at all and none of her organs were affected by alcohol. She wasn't a diabetic. So, the only conclusion we're left with is malnutrition, which is corroborated by her weight. When Ruth was well, she was a very strong young woman.

We think she starved herself deliberately.

This explains why she wanted the flat emptied.

She was saying 'goodbye' to the world.

The Coroner had the narrative all written out, which he produced from his pocket. He didn't break the proceedings before reading it. He just said: "I don't want anybody to interrupt while I'm reading this" and he read it out. We felt strongly that there was something very wrong about this. His narrative was stating that Ruth had died of natural causes and that the probability was that she had been drinking prior to her death and she had self-neglected. How could he conclude that she had been drinking? How could he ignore the issue of ketoacidosis? It seemed to us that the pathologist had tried to emphasize the starvation aspect. He certainly raised it as part of the equation.

The coroner excluded this in his verdict. We also believe Campbell misled the coroner with an out and out lie about her attendance at the OPAs, saying she had attended the majority of them. I pointed this out to the coroner and he said "yes, noted, carry on".

What makes us angry is that at that time, we didn't have all the evidence recorded here because it was before we had the results of the McEvedy inquiry and access to Ruth's records.

We submitted our official complaint to the health provider in April 2013 and the inquest was on 4 July 2013. Between our complaint and the inquest, the trust had appointed Dr McEvedy to carry out an independent review. At the pre-inquest review, we pointed out to the coroner that the independent review was going to be carried out – but he ruled that the inquest would be going ahead. We wanted him to wait, but he went ahead anyway.

The inquest was premature, and the coroner's conclusion is not accurate and embracing of the full circumstances of Ruth's treatment, the omissions and misjudgements made. With everything we know now, there's a case for having a second inquest so that the correct conclusion based on the full evidential circumstances can be reached.

OFFICIAL COMPLAINTS: A 5 YEAR BATTLE FOR THE TRUTH

We did learn some things at the inquest, notably the reservations we had about the community psychiatric nurse, Joanne Campbell, were confirmed. After the inquest, we made a referral to the Nursing and Midwifery Council about Joanne Campbell and listed many issues regarding her professional practice.

The independent McEvedy inquiry, following our complaint to Plymouth Community Health (PCH), was already ongoing. The problem with this report was that it was based on the subject headings we put in our complaint and the lawyers required him only to answer these points. He therefore could only report on that basis.

When PCH finally admitted some, but not all, of our complaints, we then referred those outstanding issues to the Parliamentary and Health Service Ombudsman. By then, we had a lot more information. All the truth had to be dragged out.

During the time our complaint was being investigated, Ruth's son successfully won an independent negligence case against PCH, who admitted that:

"... but for the admitted failings, a full package of care would have resulted in an improvement in the deceased's mental state and negative symptoms that would have, in turn, led to an improvement in her insight and collaboration with the clinical team and on the balance of probabilities the continual decline that led to the deceased's death would have been averted".

The litigation could only apply to PCH post-October 2011, when the health service changed from the previous Plymouth Primary Care Teaching Trust (PPCTT) – even though the personnel involved were the same throughout.

Lastly, we referred the circumstances of Ruth's treatment and care to the Plymouth Safeguarding Adults Board, who carried out a review which was published in November 2017. This review, led by Kate Spreadbury, an expert in her field, looked at things in a much more holistic way. The Safeguarding Adult Review (SAR) finally drew all the strings together.

Nursing and Midwifery Council (NMC)

The way that the NMC investigates referrals against nurses is unbelievable. The truth is: they don't investigate. They pass the referral allegation to the Trusts involved to 'investigate'. In Ruth's case, it meant that managers who were part of the decision-making leading to the

referral were effectively investigating themselves and the nurse complained of, with whom they worked.

But that's only half the story. The real story is the dishonesty we've had to endure during this process, which has significantly added to our distress as bereaved parents.

The NMC is a statutory regulatory body. Statutory regulators are there to try and help people in our position. When you look at their mission statement, it's about maintaining the professionalism and good practice of nursing and midwifery. When you deal with them, it's quite the reverse. They are, in practice, an unofficial defence organisation for nurses. This isn't just our opinion. If you look at past annual reports of the Professional Standards Authority, who oversee the work of the NMC, they've made similar comments about the apparent bias of the NMC and of its tendency to defend nursing when applying statutory regulations – it should be impartial, but it is not.

The NMC needs to radically alter the way it deals with referrals, and our case is a perfect example.

We made an honest referral in the legitimate expectation and belief that it was going to be investigated impartially. But in making that referral, we did not expect to be confronted with two managers from the very Trust that employed the person about whom we had made the referral.

This would be the same Trust, subsequently found by the Health Ombudsman to have been guilty of systemic failure in Ruth's case.

The NMC were happy that Trust managers who, it transpired, knew the nurse very well, were to investigate our referral to the NMC.

We made the referral on 6 August 2013, a month after the inquest. Our complaint was that the failings in the care by Joanne Campbell, then employed by Plymouth Community Healthcare as a community psychiatric nurse, contributed to Ruth's death.

The referral was assigned to a woman at the NMC called Mrs Kemi Fajoye. The NMC use the job title of '*case investigating officer*' (CIO) – which is such a scam as these people investigate nothing. They merely collate replies from employing Trusts. The CIO doesn't even validate the information provided.

In our case, she was to become overwhelmed with the amount of evidence I sent to her to a point that she asked me to stop sending her any more evidence.

When the referral eventually went to the Investigating Committee(IC), which met on 30 July 2014, it decided there was no case to answer. This committee decides if a referral should go forward to the Care and Competency Committee, which is a tribunal hearing. The Investigating Committee ruled out our referral and it did not go forward. Its basis for making a decision rests on the case work prepared and presented by the CIO.

We contacted Kemi Fajoye as the decision letter received from the NMC rang **big alarm bells**. It appeared the IC had not heard all the circumstances of the referral. This would have been the responsibility of Kemi Fajoye and the way she had prepared the case papers.

We had previously identified and sent a list of 12 issues in our referral, but the IC referred only to one event – "***an isolated incident***".

When we made our dissatisfaction clear, the only response we kept getting was "there's nothing we can do about it, you'll have to take it to a Judicial Review". The costs in doing so are prohibitive, which I believe the NMC know. So, we wrote to the CEO/Registrar of the NMC, pointing out a possible 'miscarriage of justice' in the regulatory process. We had the support in this of our local MP, who also wrote to the NMC CEO/Registrar, who is Ms Jackie Smith.

What a response we received.

She replied to our MP and me stating that following a wide review conducted by one of her senior managers, she could find no fault with the NMC case decision.

Remember, the NMC is there to protect the reputation of nursing by dealing with inappropriate nursing practice and unprofessional conduct, on your behalf. It is a public authority, funded by the tax-payer.

Ms Smith said the referral had been considered properly, the decision had been properly made by the Investigating Committee and there was nothing the NMC could do about it.

In effect, if you identify to the NMC an injustice and ‘miscarriage’ in the regulatory process, the NMC will not put it right.

There is a three-month window in which to apply for a Judicial Review. We wrote to Jackie Smith to say we were proceeding to a Judicial Review. The NMC strung it out for as long as they could. Then, two weeks before the end of the three months deadline, I sent what’s called a ‘letter before action’ to the NMC and CPN Campbell, advising them we were going to go to a Judicial Review and stating our reasons why.

In response, we had a phone call from the NMC by a para-legal and then an NMC barrister, pointing out that appellants in the Judicial Review process should be allowed 14 days for a response to a letter before action. I said: “I can’t because you’ve used up all of my time by constantly delaying. You only have seven days and I am happy to explain this to the court. In fact, I already have told the court why I have not allowed the usual 14 days because you’ve prevaricated and delayed and consumed my time, even though I had said to you that I would consider a judicial review from the very beginning, if the NMC would not remedy the miscarriage.”

Within no time at all, we had another message from the NMC to say they would seek to quash the original decision and they would take it to a

Judicial Review. A complete turnaround, from what Jackie Smith said the NMC were unable to do – **HOW BIZARRE!**

We had registered the proceedings, so they knew we weren't bluffing and that they had to respond. They had hoped we would go away, which no doubt is what usually happens.

The NMC now conceded that not all the evidence had been looked at by the IC panel, which Jackie Smith had earlier denied, quoting a 'wide review' by one of her senior managers as proof, and blaming what she saw as my unwillingness to accept what was in reality **a perverse decision and a miscarriage of justice by their own organization.**

How is that protecting the public interest and maintaining the professional standards of nursing!

Why was a perverse decision made in the first instance by the NMC?

Here's one possible influence ...

In 2007/2008, when we were so concerned at the treatment issues concerning Ruth, we went to see the then Director of Operations/Deputy CEO at the Health Trust, **Stephen Waite**, to discuss our complaint about Ruth's care being altered. His close involvement in the subsequent decisions affecting Ruth's treatment has, we believe, never been fully and formally declared to his Chairman or Board as required by the Companies Act.

At the NMC Tribunal in 2015, Joanne Campbell stated in evidence under oath, that she had been called to Mr Waite's office in early 2008, and was consulted by **him** and **Ms Anne Prue**, who was also with **Stephen Waite**, about the complaint we had made concerning Ruth's planned changes in treatment.

She alleges that the result of these discussions was the subsequent arrangement that was put forward to us as a way of ameliorating our

concerns about Ruth being stepped down. You may remember this involved Joanne Campbell attending Ruth's OPAs etc, which was presented to us in a letter on 8 May 2008.

Mr Waite approved and sanctioned Joanne Campbell's involvement. **Ms Prue**, a qualified nurse, was the area manager and also agreed with the arrangement. We believe she was Joanne Campbell's line manager at that time.

Don't forget this was the manager who Joanne Campbell alleges told her "you've got to get on with it" when she reported to her that she could not keep up the commitment to Ruth's OPAs etc in 2009 following her promotion.

Ms Prue has also never declared that interest and in fact states she has 'no recollection' of these events.

In 2013, when the NMC referral arrived at the Trust, Mr Waite, now the CEO, put Anne Prue in charge of the investigation into our referral complaint against Joanne Campbell!

The other 'investigator' was **Ms Nicky Arthurs**, a close associate of Joanne Campbell who turned up to support her at Ruth's inquest.

So, the net result of our referral to the NMC regulatory body was that the people involved in Ruth's case ended up 'investigating' their own decisions, overseen by a CEO who was also allegedly involved!

Anne Prue and **Nicky Arthurs** came to our house during the referral investigation and said they were representing the NMC, which they weren't. We questioned their involvement. They assured us that if we were unhappy with their report, they'd put it aside and they'd appoint someone who is external. They'd worked with Joanne Campbell for years, so of course we didn't believe that they would complete an independent

report. And we were right. When we got their report, we told them it was biased, and they took umbrage at this.

Anne Prue later denied ever saying that another report would be done if we weren't happy with it. We made a referral to the NMC, saying Prue and Arthurs, both trained nurses, had misrepresented themselves and had told us lies.

All to no avail, the NMC kicked it to touch!

Plymouth Community Healthcare (PCH)

Running parallel to this was our ongoing and original NHS complaint. We started this on 25th April 2013, having sent earlier correspondence to the PCH for access to Ruth's medical records under the Access to Medical Records Act and other related matters under the Freedom of Information Act (FOI).

PCH (**Mr Waite**) denied us access to Ruth's records, because Ruth had requested confidentiality in life and her wishes would continue to be respected by PCH, even though the Access to Medical Records Act permits him to exercise discretion and allow access if he wanted to. **He stated in correspondence at that time, that amongst other reasons, "PCH has no information which would lead it to conclude that disclosure would be in the substantial public interest".**

I will leave it to you be judge of that statement and the motivation behind it.

We had made it clear we weren't litigating; we just wanted to know what happened. Our formal written complaint therefore went ahead under NHS complaints rules.

What a distressing process this was.

Constant delays were caused by the deliberate failure of PCH to acknowledge correspondence, a common and frustrating occurrence that was counter-productive. Initially, we wanted to work with them collaboratively; we just wanted answers. Because of our complaint, the trust lawyers commissioned an independent medical review, which led to the McEvedy Report.

The whole point of having a local solution and an independent review, such as the McEvedy Report is that it's a chance to avoid the need to involve the Parliamentary and Health Service Ombudsman (HSO). If a local solution isn't found, or if there's only a partial admission of failings, it then goes to the Ombudsman.

We got fed up with all the delaying tactics and contacted the Ombudsman, whose office agreed to become involved. There were many issues around at this time involving PCH. One such instance was when we were sent a copy letter from PCH to the HSO which had originated from **Mr Waite**. We were appalled to see he had sent a derogatory letter to the Ombudsman, implying that we had reached a resolution to our complaint and we were in some way misrepresenting ourselves to the HSO.

I believe he tried to undermine our integrity by what was quite an unpleasant letter, and to make us look vexatious.

It was later explained to us personally by Mr Waite and the head of litigation, Dawn Walbridge, that the drafter of the letter mixed up the complaint we made in 2007 and this current complaint and had therefore wrongly informed the Ombudsman we had resolved our complaint. The letter was written as though we had already settled the complaint but were still moaning and causing further trouble.

We sent a letter to PCH, expressing our dismay. We also wrote to the Ombudsman to say it was a deliberate attempt to cast doubt on our integrity and credibility.

To resolve things, Stephen Waite contacted us and asked to come and see us on the 29 October 2013. He came to our house with Dawn Walbridge, and he apologised for the way the letter, which he had signed, had been written. He explained that the letter didn't express what they meant to say.

He also agreed to supply a copy of the draft report from Dr McEvedy. Mr Waite had apparently received an interim report from Dr McEvedy on 17 September 2013 and hadn't told us – until that moment.

In fact, having agreed we could have a copy, we never received the draft report from Mr Waite. He later reneged on the agreement on the basis that he didn't have the consent of Dr McEvedy to share it.

Another disingenuous act by the CEO of a health service provider.

We continued to demand a copy of the draft report – and notified the HSO of our problem. Mr Waite then sent a letter suggesting we abandon the McEvedy Report, based on the time that Dr McEvedy was taking to finalise his review report, and commission a consultant psychologist to carry out a fresh review.

You may be aware that there is a vast difference in the depth of experience and qualifications of a psychologist as compared to a consultant psychiatrist, who must first qualify as a Doctor of Medicine before specialising in psychiatry. We refused.

We believe that once PCH had read the draft report and realised it was condemning, they were reluctant to reveal its contents and wanted to start again with a less qualified practitioner.

It could be suggested that PCH wasn't happy that Dr McEvedy, an independent medical practitioner, had been so critical of Ruth's

treatment, but remember it was PCH which commissioned him to be an INDEPENDENT REVIEWER!

We could smell a rat for what it was!

Although we had still not seen his report, we could smell a rat for what it was, and we told PCH we were sticking with the McEvedy Report, no matter how long it took him to report. We were so right to do so...

We eventually met with Dr McEvedy on the 3 January 2014 and he gave us a copy of the draft report without hesitation. He couldn't understand why we had never been given a copy of the draft by PCH and said he never had an issue about us having the report, which PCH had received on 17 September 2013. There were no changes to the findings in his final report from the draft, merely an enlargement on one or two of the details.

The McEvedy Report highlighted a number of failings in Ruth's care. It stated that Ruth's ability to care for herself had "deteriorated very significantly" in the year or two before her death and a safeguarding process involving social services should have been initiated. This could have led to Ruth having better accommodation and supervision and the deterioration "could have been identified earlier and ameliorated".

Now we had to wait for PCH's response to the report. They dragged it out until August 2015, when they admitted most, but not all, of the findings in the McEvedy Report. The main dispute was over the events of 6 December 2010 (when CPN Campbell learned that Ruth had no heating). They didn't accept the failure to act in what we had termed an untoward incident on the basis that it was not an untoward incident. I will leave you to judge that one.

This left the Ombudsman only dealing with those elements of our complaint that were not accepted by PCH.

The Ombudsman, found, as did Dr McEvedy, that the incident of 6 December was a failing because Joanne Campbell didn't take adequate action - "her response did not go far enough".

The Ombudsman's report, published in March 2016, "partially upheld" our complaints and said: "Opportunities to prevent [Ruth's] deterioration and death were completely lost." It also found that there was a "systematic issue" in the care arrangements for Ruth, "over and above a failure by one individual".

The report said there was a failure to adequately reassess Ruth's care plan in light of her increasing self-neglect; a failure to carry out a capacity assessment in 2011; a failure to review Ruth's financial circumstances; a failure to get a second opinion concerning Ruth's mental capacity; and a failure to produce an action plan as a result of the complaint investigation. Most of these failings had been identified by Dr McEvedy in his report – **and remember this report was commissioned by PCH as a means of addressing our complaint.**

IT WAS THEIR REPORT AND THEY WANTED IT BURIED!

The way we were treated by PCH following our referral to the NMC concerning Joanne Campbell's fitness to practice is disturbing.

We went to see **Stephen Waite** and **Dawn Walbridge** at his office at Mount Gould on 7 April 2014. We went through our problems with the NMC report compiled by Prue and Arthurs, specifically the lack of objectivity and independence it reflected, given the circumstances that were revealed at the inquest about Joanne Campbell.

Mr Waite promised us he would appoint the **Director of Professionalism**, a Mr Baines, to review the NMC report. He went on to explain Mr Baines

was new to PCH and had been part of the Winterbourne Investigation (a scandalous affair involving care for special needs patients in Avon). He assured us he was untainted and competent to undertake a review.

I told Mr Waite that I had submitted three rebuttal papers to the NMC, pointing out various issues in Ms Prue's report, that identified factually incorrect information, and highlighted other statements that were issues of subjective opinion that couldn't be backed up. He asked if he could have a copy of the papers **as he wanted to ensure Mr Baines was aware of the issues I had raised during his own review**. Despite obvious reservations, we agreed to supply a copy to assist the Director of Professionalism to do his review.

Mistakenly at this time I, but not my wife, had faith in these people.

Professionalism – what a misnomer!

We went to see Mr Baines on 1 July 2014. He informed us that he had completed a review aided by a newly-appointed non-executive. He reported they could find no issues of note.

We said: "You've got to be joking. Have you read our three rebuttal papers?" And he said: "What three rebuttal papers?" We told him we'd given them to Mr Waite and Dawn Walbridge in April for the express purpose of aiding his review, so he could see our objections when he did his review. But he'd never been handed them. **He was embarrassed as Dawn Walbridge worked to him as part of his department!**

We strongly suspect our rebuttal papers were inappropriately used, we must have been naive to believe otherwise.

Mr Baines did say that the PCH/NMC review undertaken by Prue and Arthurs should have been more independent and he also agreed that there were things that weren't done properly. He acknowledged that they should have got someone to do the report who wasn't so close to Joanne Campbell and that there should be greater independence in the way complaint reports were handled in the future.

He also confirmed that PCH had not reviewed CPN Campbell's practice/patient base because of Ruth's case.

That day, we were in his office for three hours. Every time we had a meeting with any of them we had to go through our daughter's demise all over again. It was very distressing.

Mr Baines said he would meet us on the 1 August 2014 – **"give me a chance to put it right"** is what he said. He stated we would get a report a few days before we would meet in order to have a constructive meeting. We agreed.

Our meeting date arrived and we hadn't had an advance copy of his report. There was a reason why we didn't receive an advance copy: **he had not completed any review** and there was no report. We rang up the afternoon before our scheduled meeting and spoke to his secretary. She said he'd ring us back. He didn't.

We rang him the next morning and he confirmed there was no report, but he asked to visit us at our home to explain. I said there was no point in him coming to see us that day. We said: "Have you done the report?" He said: "No ... but let me come over to see you to explain." We told him: "There is no point to that and we're not speaking to any of you at PCH anymore. We keep on having to go over our daughter's death; it's extremely distressing and we've had enough."

The lies, the failure to act, and the constant delaying tactics made a local resolution with them impossible. In our complaint handling chronology for the Ombudsman, we stated: "The complaint has been handled without any real regard to the circumstances and nature of bereavement of a family member." It was unpleasant, distressing, and emotionally and mentally draining.

The NMC bent over backwards for Joanne Campbell, which was always going to be the case, given the ‘investigators’ were Anne Prue and Nicky Arthurs. And despite what everyone else has said, they refused to admit that her decision not to take action in December 2010 was a failing.

It wasn’t until the NMC tribunal in 2015 that we finally listened and learned of Campbell’s clinical rationale for the judgment of risk made in December 2010. **Her rationale was that providing a heater was all that Ruth wanted at that time. No action was taken to address the capping of Ruth’s gas supply and her subsequent lack of heating and hot water, because Ruth didn’t want it.**

This is not a clinical rationale and she couldn’t be bothered to keep records, so it was never written down. She didn’t follow through the VARMM procedures following the ‘Fred’ Serious Case Review recommendations of 2005. She didn’t follow through her own professional duty of care which dictated that there should have been intervention in December 2010. She relied on sorting it out at the OPA of 11 January 2011. But even then, no action was taken despite Dr Dinniss’ request, and the PCH blamed Plymouth City Council because the referral for additional support was made through a community social worker.

What Mr Waite didn’t say to us was that the email also went to two other people – an assistant clinical manager and Joanne Campbell. And none of them took any action. It’s that sort of disingenuousness that has disturbed us throughout. PCH would not disclose who the assistant clinical manager was, due to data Protection Act issues.

Finally, the NMC investigating committee which met on 17 March 2015 put forward for a number of charges against Joanne Campbell. They didn’t think she’d acted dishonestly but they did agree to put forward the other charges and they even added, independent of our complaint, their own allegation that she had failed to test Ruth’s mental capacity.

The panel considered that Campbell didn’t pose an ongoing nursing risk and that her practice was not impaired. However, they were mindful of

the case of – *NMC v CHRE & Grant* – in respect of the nature and seriousness of the allegations and the public interest.

They noted the alleged conduct had taken place over a four-year period and there was sufficient evidence to suggest that Mrs Campbell was aware throughout this period of the issues about Ruth and yet apparently failed to act in her interests by failing to maintain adequate records and failing to escalate what should have been clear and obvious concerns appropriately.

The case culminated in the possible **avoidable death** of the patient, who had been living in inappropriate circumstances for an extended period and the panel recognised the importance of public interest in cases such as this and the importance of the NMC being seen to be maintain professional standards through its regulatory process.

So, our case went before the NMC’s Care and Competency Committee, the tribunal. We were over the moon! We thought: “At last, things are going to be done properly.” How wrong we were! To them, it was like pay-back time! They did whatever they could to make sure things went badly for us.

The first indications came in August 2015, when the tribunal was set. We got to London, only to be informed that Campbell stated she wasn’t ready as she hadn’t seen a barrister. She’d had months to get ready. Surely this is all part of a tactic. The case was adjourned, and we had to wait until January 2016.

Bear in mind the following fact:

On 14 July 2015, we were told by letter that Campbell had indicated a guilty plea to these charges:

Did not fulfil the terms of the agreement set out on 12 May 2007

Did not attend one or more OPAs

Did not keep Patient A's parents informed

Did not maintain adequate records

Did not escalate safeguarding concerns on 6 December 2010; 12 January 2011; and 20 December 2011

In the light of the above, your fitness to practice is impaired by reason of your conduct

The letter from the lawyer at the NMC had said: "The charges are admitted in full by Mrs Campbell. At the start of the hearing, the charges will be read out. Mrs Campbell will formally enter admissions and the panel will be invited to find the charges proved by way of these admissions."

But when the case was finally commenced, she pleaded not guilty. And that was just the start of it...

NMC Tribunal - "You won't get justice here"

Nicky Arthurs was booked in to give evidence on the first morning, a Monday. On the morning, she rang to say she was running late because of traffic and wouldn't get there till 2pm. We all waited for her. She gave the first part of her evidence in the afternoon – **and was then allowed to go home and give her evidence the next day over the phone from Plymouth. It was on loud speaker, but anyone could have been there with her, prompting what to say.**

How can you gauge the reaction of a witness if they're not there in person? You can't. It was a cock-up.

They cobbled it, and I had to sit in the back room till Thursday so was not able to hear any of the evidence. I was the only witness called by the NMC. The NMC didn't call Dr McEvedy; the panel didn't even discuss his report. Arthurs was allegedly a witness for the NMC, but remember her past association with Campbell at the Inquest, acting in support as her 'friend'.

Then we get to the independent NMC barrister. Although representing the NMC, she spent a lot of time during the tribunal proceedings assisting the barrister for Joanne Campbell, who seemed out of his depth. It wasn't our case, it wasn't brought by us, so we had no control over it.

We will never forget our first meeting with the NMC barrister before the tribunal commenced. She asked what we wanted from the tribunal and we replied: "We want to be here to get some truth and justice for Ruth." She then said: "You've come to the wrong place – you won't get justice here, if that's what you're looking for." And she said that not once, but twice.

We can only conclude from her remark that from her experience of NMC tribunals, their working must be perverse. This one certainly was.

The tribunal heard the NMC's evidence, which was basically just me. CPN Campbell's barrister was filibustering and dragging it out. It was only scheduled for a four-day hearing and they kept on adjourning, time after time. Whether it was a deliberate tactic or not, the fact is we ran out of time. At the end of four days, the chair of the tribunal announced it would have to be adjourned and that we'd reconvene in March, six weeks later.

So now they had six weeks to prepare their response. And the chair of the panel said to the barrister representing Joanne Campbell: "No doubt you will come back with a 'no case to answer' argument."

The tribunal heard all the NMC case and then had a 6-week break, so the defence could put their case together for the rest of the hearing. I've never known anything like it. The chair, a non-practising barrister, is appointed independently by the NMC. The tribunal was held in London, at two NMC premises.

It was a perverse version of an independent hearing.

In March, the defence presented their evidence. Joanne Campbell was placed under oath and she gave all her explanations for which they'd had six weeks to prepare. They believed what she said, although a lot of it was brought with no corroborative evidence.

This is not a criminal court but there should be the same rules of conduct. At the second hearing, 'our' barrister didn't challenge much at all. We don't recall much discussion about the non-attendance at the OPAs. The panel found her guilty on the record keeping and on the failing to escalate the safeguarding issues in December 2011, and found no case to answer on everything else.

The Tribunal panel must give you a written explanation for their judgments and in their letter, it's quite clear their decision is wrong in the sense that their calculations and interpretation that they put on the OPA visiting schedule is incorrect.

For instance, when Ruth didn't turn up to one OPA with Dr Tocca and Campbell, and Ruth hadn't been seen for a little while, they decided to leave the meeting venue and visit her flat but got no response. They counted that as two visits. They had to knock down our allegation that she had lied to the coroner's court when she had said she had attended **the majority** of the visits.

The other thing they did was to only count the OPAs where Ruth attended; those OPAs that Ruth didn't attend were discounted, but it is a fact that Campbell attended only 4 of the 14 scheduled OPAs over 4 years.

The tribunal, however, reduced the list and then double-counted. This is dishonest. Ruth missed four OPAs, but is that relevant? In any event, out of those four, Campbell wasn't there for three of them anyway. And irrespective of what the patient does, the practitioner should be there as it is a pre-planned OPA requiring the clinicians to be there. By taking off the four that Ruth didn't attend and double-counting one of the OPAs, they managed to reach 5 out of 10. We had to sit there and listen to it.

We believed that if the proceedings were unjust, the Professional Standards Authority – a sort of Ombudsman – would intervene. But this isn't so. By its rules it can only intervene if it believes there is an ongoing threat to the public by the continuing practice of the nurse. In this case, although they could agree that the panel got the numbers wrong, they couldn't intervene. The NMC barrister should have challenged it, but she didn't.

The whole NMC process has left a very bitter taste because we feel what happened was unjust and not what we expected from a statutory regulator. We should have remembered our earlier brushes with the NMC. The bottom line is that PCH didn't deal appropriately with the matter and the NMC proceedings left a lot to be desired.

The NMC tribunal committee found Joanne Campbell's practice not to be impaired but did find that she had made some errors. And this is the disturbing element: the NMC will not take action unless they believe the nursing practice is impaired and is likely to continue to be impaired. But how would they know? Because the rest of her work wasn't being investigated? We asked PCH about this. You would have thought they would have looked at other cases to make sure that this sort of occurrence wasn't happening to other patients under her care. They said it was "an isolated event" in an otherwise unblemished career. This occurred over a five-year period, so it was not an isolated event, it was continual.

The panel noted that Campbell remained employed by the Trust but had voluntarily stepped down to a more junior role.

NB: We had no proof of this and remain suspicious if it had happened – PCH told us she received a written warning, but not for what conduct!

Ruth's inquest – disturbing issues and wrong conclusion

There were several issues concerning the inquest, one of them being that an awful lot of evidence has come out since, which we knew was a possibility.

The McEvedy report was available in January 2014 and the coroner could have waited until then because of its relevance. It highlighted failings in safeguarding and contained very clear indicators that things weren't right systemically in the health trust. This evidence should have been heard at the inquest.

The coroner's narrative verdict had obviously been pre-prepared, which we are uneasy about. The verdict that has currently been entered into the public record does not accurately reflect what happened in terms of the causes of Ruth's death, how and why she died.

The coroner has not had the opportunity to examine the evidence of systemic failure that existed within the organisation, both at a corporate and individual level, so he has never had the opportunity to comment on that and public interest has not been served.

We believe the State has not fulfilled its obligations to properly investigate the deaths of one of its citizens whilst under medical health care (an obligation under the European Court of Human Rights).

Ruth was in medical care/treatment in the community under secondary health services and the State has a responsibility to properly and fully investigate the cause of that person's death. We don't feel that has been effectively carried out or achieved.

We had written to the coroner to ask him to consider a second inquest following the McEvedy Report, but he declined to re-open the matter. We feel more than ever that a verdict decision should be based on all the evidence. There were many anomalies. For instance, the Coroner read out

a statement from Ruth's neighbour which said she was often drinking, and that seemed to be significant in supporting his narrative verdict, despite the toxicology report indicating that Ruth had not been drinking prior to her death. We do not deny Ruth abused alcohol, but at the time of her death it does not appear to be a major issue.

The Coroner was and remains unaware of all the evidence relating to systemic failure and clinical negligence, **BUT WHICH** is contained in evidence he didn't receive, albeit that it was in the system and available for discovery.

He did not hear the evidence from the Police or the Ambulance Service which stated when they were called to Ruth's flat in December 2010 she wasn't drunk. He did not press Joanne Campbell about her failure to act appropriately in December 2010, or that her absences from the OPAs impacted on Ruth's situation.

He did not hear the evidence relating to the missed opportunities to intervene in Ruth's circumstances, despite concerns expressed by consultants.

He had the narrative verdict prepared, and based on what little evidence was available.

We do not believe the coroner has fulfilled the State's obligation to effectively examine the circumstances of Ruth's death. It was an insufficient inquest. The facts of Ruth's death are incomplete, and the verdict is inaccurate and does not properly reflect the circumstances of Ruth's demise.

The only way to challenge an inaccurate verdict is to go through the Attorney General's Office and seek permission for a second inquest, which costs a lot of money.

This, however, is another example of being in a system which can provide recourse through the High Court. **BUT ONLY IF YOU HAVE THE MONEY. Woe betide you if it goes wrong** - you get hammered by costs.

So, is there justice in this country?

We are left reliant on the hope that the authorities do instigate a second inquest. If we pursued it, all the interested parties – corporate and individuals – would all be represented by paid-for barristers. And we could end up paying for all their barristers if matters go against us.

It's about bringing forward all the new evidence and about the accuracy of the verdict - it's in the public interest for these issues to be aired. It is the responsibility of State to investigate fully, and that hasn't happened.

The coroner gave the medical causes of death and then said Ruth had neglected herself. He also said she had been drinking, but that was wrong. The toxicology report said there was no alcohol in her system. It was based only on the fact there were bottles in the flat and the evidence of an elderly neighbour. Ruth had a drink problem, we don't deny this, but at the time of her death, there was no alcohol in her system.

Ruth was very poorly, in pain, dying from her embolism. She was not drinking. The coroner is the only person who thinks that. He has ignored the evidence. To him, it was Ruth's fault that she died. We believe that's what lies underneath this, and it is extremely disturbing. Ruth self-neglected because she was very ill and deteriorated because the health professionals weren't really dealing with her and were guilty of gross clinical neglect.

Nursing and Midwifery Council (NMC) – dishonest and obstructive, reforms needed

We made an official complaint to the police for the alleged ***misconduct in public office*** by the NMC and its staff.

The NMC had stated it had completed a full review and there was nothing they could do about the original IC decision not to proceed in the first hearing. In fact, the initial investigation was never done properly. Kemi Fajoye was overwhelmed and she ignored most of the evidence – this was conceded by the NMC in the Judicial Review process.

Following its initial investigation, the police confirmed that the evidence was on the file, but at the back and not brought forward and was not made the subject of any of the charges.

We put in a Freedom of Information (FOI) request, asking details of the charges that were proffered in the first investigation, and the NMC refused to give us any information.

We also wanted to know the name of the care coordinator the IC panel had referred to. The NMC refused to tell us, quoting the provisions of the Data Protection Act.

We eventually established, by going to Plymouth Community Healthcare, that there was no nursing care coordinator. Mr Baines, Executive Director at PCH, acknowledged this. We put this back to the NMC, and pointed out it had failed to action our referral against Joanne Campbell by placing the professional onus of care on someone who didn't exist.

Again, this was later conceded in the Judicial Review process by the NMC.

We later established that, under PCH policies, a single practitioner, in Ruth's case the consultant, can also be regarded as the care coordinator. Is this where this notion came from? If so how does that make sense? The consultant only saw Ruth for about 25 minutes once every three or four months, if that. In these cases, who is going to look after the physical and social aspects of the patient? Because that's what the care coordinator normally would do. How could the consultant perform the role of a care coordinator, on top of his/her own responsibilities? They can't make the home visits or sort out the social care. It's impossible.

A consultant could only ever be a care coordinator in name only. In any event, it wasn't what the NMC implied, because they said it was a separate person, but would not indicate where it got that information from.

Of course, Joanne Campbell still had a role to play as per the agreement reached in 2008, but this was ignored in the NMC file presentation which also failed to show her omissions and failures over a 4-year period.

The existence of a 'care coordinator' was a red herring.

Running alongside this was our battle with the NMC over FOI, trying to get information on the referral investigation it carried out.

We ended up going to a First Tier Tribunal (Information), where the parties who were against us were the NMC and the Information Commissioner, who had supported the NMC against our request for information.

The NMC sent a QC to the tribunal in Plymouth to defend their case. The Information Commissioner did not to appear and was not represented. The tribunal chairman, a legal academic, and two other members, found in our favour. They said I had a right to the information we had requested.

***Not only that, they were very critical of the
NMC's investigative process
and recommended that it be reviewed.***

The Director of Corporate Policy and Referrals for the NMC, a trained barrister, came down from London with the NMC QC and produced a statement which they use in every case they attend. It's a stereotype statement, which we discovered by looking at other cases on the internet. So, we challenged him immediately at the hearing: "What research have you done in this case? Because this is the same statement you gave in another case, and that case and that case and so on." It was clear that

they had never been challenged before. It was a stereotype response wheeled out in every case.

During his evidence it became quite clear that he really didn't have a clue about our particular case, BUT he did reveal how the NMC work, in that there is no investigation carried out by the CIO's, that the NMC rely on responses from the employing Health Trust to formulate a case.

Importantly, he confirmed that the NMC would not intervene and correct a decision by one of its competency panels even if it was aware **A MIS-CARRIAGE OF JUSTICE WAS PROVEN TO HAVE OCCURRED. HOW BIZARRE IS THAT!**

Although we won, we never got the information because the NMC ignored the decision of the Tribunal, which has no enforcement powers. **WHAT'S THAT ALL ABOUT!**

Devon and Cornwall Police proved to be out of their depth, as they admitted they had never had a case like this before, and eventually no action was taken against the NMC. They didn't really want to get involved and they never interviewed a single witness before writing the complaint off. To this day I believe the police investigation was unethical and possibly illegal.

Based on our experience, the NMC make life very difficult for you. They put up a barrier of obstacles and lies and spend thousands of pounds on barristers, because they don't want you to know the circumstances of how your loved one has died.

All the regulatory organisations that oversee practice or conduct seem to regard those who complain as the enemy.

It's not that they collude or conspire; but because of the way the system works, it's how things end up. So, you feel you are taking on all of them

as well as the organisation or clinician you have complained about. The bodies that are there to regulate on our behalf, are not doing so. You must fight them all the way to get to the truth.

Health providers – lack of transparency and honesty, obstructive and refuse to admit failings

To this day, if Joanne Campbell's evidence is correct, we do not believe Stephen Waite has ever correctly declared his close involvement in the 2007 agreement to step down Ruth's care.

The health provider is now a Community Interest Company (CIC) and under the Companies Act, its directors have a statutory obligation to declare any interest or conflict. We believe Steve Waite never has. Neither has his registered manager, Anne Prue.

Their alleged involvement emerged at Joanne Campbell's NMC tribunal, when she gave evidence under oath, that she was called to the office of Mr Waite in May 2008, and in the company of Mrs Prue, discussed our complaint/concerns regarding Ruth's treatment plan change.

You may recollect at around this time, the Trust had conducted an internal review and not everyone agreed Ruth should be the subject of a treatment change.

Mr Waite acknowledges that he received a telephone conversation about this agreement from Joanne Campbell, but, Mrs Prue says she has no recollection of anything.

Neither therefore recollect such a meeting, although the NMC allowed and accepted the uncorroborated evidence from CPN Campbell and said

she was credible. Therefore, they regarded her as telling the truth. On that basis she must have recalled events accurately.

Dan O'Toole, the then Deputy Chief Executive, acknowledged that the agreement was agreed by the trust senior management, unnamed.

Why is this important? Because the arrangement for Ruth's care was never operationalised correctly.

What does that mean?

The involvement of Joanne Campbell and her commitment was never entered on Ruth's records or the Trust clinical management system. As a result, she was never the subject of any form of clinical supervision. Because the agreement WAS NEVER entered into any record, no other clinician had any idea of what CPN Campbell was expected to do.

No one knew of her commitment to Ruth, apart from, we presume, Waite and Prue.

Steve Waite and Anne Prue were part of the original discussions. Joanne Campbell's daily record sheet of 8 May 2008 (redacted) indicated Stephen Waite was involved in the decision-making and was consulted. Did he meet with Anne Prue and Joanne Campbell as suggested to discuss the arrangement and agree it? Joanne Campbell says so.

Steve Waite, remember, was the Director of Operations/Deputy CEO at this time and had a professional responsibility to ensure normal and accepted practice in record-keeping and clinical supervision was established – he evidently did not.

The statutory regulator in relation to CICs sits in an office in Cardiff and they're supposed to make sure that CICs are run correctly. I wrote to the regulator and said: "Here is the Ombudsman's Report (we didn't have the SAR report then), I think Mr Waite and one of his registered managers, Mrs Prue, have failed to declare an interest under the Companies Act and there is systemic failure in this organisation which is delivering services

under managed NHS contracts to the most vulnerable members of our society. What are you going to do about it?"

A letter came back to say in effect: "Thank you very much for your letter etc, we do not have enough resources to deal with every complaint."

When we wrote to the Parliamentary Ombudsman, who is responsible for overseeing that statutory regulator, they replied to say something along the lines of: "You've had an explanation from the CIC regulator."

In 2007, Stephen Waite was Deputy Chief Executive/Director of Operations of the NHS Trust. He then moved up to chief executive of Plymouth Community Healthcare, then to chief executive of Livewell and latterly, chief executive of Livewell South West. He has been there all along, in an executive position, with direct responsibility. Anne Prue, now a registered manager with Livewell South West, was also involved from 2007-8 onwards.

Steve Waite has apparently never declared that he was party to the initial agreement for Ruth's care after she was stepped down, and he really should have stepped aside from any involvement in our complaint about that treatment decision. He was involved in the arrangement that was put into place which ultimately led to Ruth's death. Waite and Prue were privy to and approved that arrangement that has been so criticised since.

We made it clear from Day 1 that we just wanted to know what happened to Ruth and that we had no intention to litigate, which we have never done. How much have they spent trying to stop us finding the answers? It must be hundreds of thousands of pounds.

The people who should be really concerned about this are the Care Commissioning Group (CCG). There are clear indications that institutionally, Livewell South West are not honest – it lied to the Care

Quality Commission in 2016 in its inspection of the organisation - and, yet they are delivering services to very vulnerable people.

It's a bit like watching a TV programme about Cowboy Builders, who all get exposed. These builders get into trouble and then they change the name of the company and move on. The same thing is happening here, because it's the same managers, the same clinical practitioners, as far as Ruth was concerned, but the name of the organisation changes.

Mr Waite has stated in correspondence that what happened to Ruth occurred in another organisation. But what he doesn't say is that these successive organisations are merely '**name changes**' and that he's been the senior manager at executive level along with others, in each of these name change organisations, all along closely involved.

It is the same organisation and the same people are there doing the same jobs; all they've done is transferred their allegiances from the NHS to the new company. They are now in effect, private contractors delivering NHS services and they not covered by the same governance as the rest of the NHS, such as the Freedom of Information Act, or it would seem accepted clinical supervision and practice.

Mental Health Services (MHS) – working in a 'silo'

The mental health services in Plymouth failed Ruth terribly following systemic failure right across the organisation. We have heard of other cases since, with the same organisation, so we know there are issues about how they deliver their service. For us, at a personal level, we thought for a long time, that the emphasis was never on the right things. They allowed Ruth to go a certain way. Their failure to respectfully challenge Ruth's personal decisions, which they could do under the Mental Capacity Act, amounted to **professional indifference and neglect**.

We trusted the mental health professionals at one point and this was a mistake. We believed following the new care arrangements of 2007-8, that Joanne Campbell would be visiting Ruth at home, and the consultants would be seeing Ruth with the CPN, at the OPAs every three months. As all the reports have shown, not only did Joanne Campbell not fulfil her professional obligations for that agreement, neither were the consultants seeing Ruth as frequently as every 3-4 months. Sometimes it would be 6 months or more. Campbell attended **4 out of 14 OPAs over 4 years**. This was a failure by the nurse and the supervising organisation.

Following our official complaint, the deputy chief executive of PCH, Dan O'Toole, wrote to us in September 2014, accepting that the agreement of 2008 was outside normal clinical practice, outside a normal care approach, was instigated by Joanne Campbell but was agreed by the senior management of the Trust, and importantly was never entered in Ruth's records or the trust management systems. It was never therefore subject to clinical supervision as would normally happen with a treatment plan.

Nobody knew what was going on or what CPN Campbell should be doing.

Nobody was supervising Joanne Campbell in respect of Ruth, neither within the normal clinical management structure, nor when she sat down with her line managers to review performance.

Ruth's situation and the care arrangement were never the subject of any supervisory inspection because it was never made a point of record and the clinical managers were never told about it.

The only people who knew were Stephen Waite, Joanne Campbell and Joanne Campbell's line manager, Anne Prue. It's clear that the consultant must have been aware of Joanne Campbell's involvement outside of the OPAs but probably didn't know the detail and they were not responsible for supervising CPN Campbell.

Whenever we rang Joanne Campbell, she gave us the impression she was going to all these meetings. It transpired that she wasn't, and she has admitted that the information she was referring to when we spoke, came from the consultant's write-ups of those meetings she failed to attend.

The biggest criticism comes in the SAR report, which says mental health services were working in a silo, without involving anyone else. The full report is on this website.



It is hard to describe how we felt about the SAR report which had at last revealed all of the appalling failings in Ruth's treatment. Sadness, anger and a sense of vindication in how the evidence made clear what circumstances led to Ruth's death – more than five years later. That it was avoidable hurts immensely.

As with the McEvedy report and the Ombudsman's investigation, this evidence was only forthcoming following a referral originating from us. Otherwise, none of this evidence would have come out.

The SAR report flags up in very simple terms that the Mental Capacity Act isn't about just letting people do what they want to do. Whilst the essence of the Act is that because someone is mentally ill, it doesn't mean to say they can't live the life that they want to live, there is a responsibility on those clinicians to look at the decisions that people make to ensure these decisions are in their best interests and capacity is present. If not, there is a procedure they've got to follow.

In Ruth's case they never did. They never looked at Ruth's decisions to live in a socially isolated way, to break all ties with her family and to break all ties sadly with her son against her full capacity in making those decisions. They never challenged her on those decisions and never once asked: "Why are you doing this? Isn't there another way things can be done?" Thus testing Ruth's understanding and rationale.

The Ombudsman's Report likewise said there was no capacity assessment done for at least two years prior to Ruth's death, when there were clear signs Ruth was failing.

At Joanne Campbell's tribunal at the Nursing and Midwifery Council (NMC), Nicky Arthurs, a senior manager for the Trust, struggled to outline the guiding principles of the Mental Capacity Act, when questioned by the panel Chair. She is only a senior manager and registered nurse dealing with mentally ill patients, perhaps it is not important that she knows!

In her SAR report, the lead author, Kate Spreadbury, said that there was no professional ownership of Ruth and nobody knew Ruth as a person.

Nobody took the trouble to find out what was happening in Ruth's life. All they were doing was going through a process and they were going through that process badly.

They didn't treat Ruth as a human being; they didn't treat Ruth as a human being with a severe illness; they just let her go. Over five years, the same three mental health name change providers, the same personnel, all allowed her to wither on the vine through professional indifference and neglect.

For Joanne Campbell to have known Ruth over such a long period of time, and not to see how far Ruth had deteriorated is astounding. A 10-year-old would have seen it straight away.

Mental Health Services allowed Ruth, through indifference, incompetence and professional neglect, to go down a certain road and they condoned it, they were complicit in it. The way Ruth was treated and allowed to die in those circumstances is a scandal. The way the health service has tried to obstruct the truth coming out has been a scandal. The way we, as grieving parents, have been treated is a disgrace. Will things ever

change? Will lessons ever be learnt? It's a nice thought. But, as far as we're aware, all the people involved have been allowed to carry on working in their jobs. For them, it's business as usual. They will go on in the same old way.

For us, it will never be business as usual ever again ...

WHAT HAPPENED TO EVERYONE?

CPN Campbell apparently received a written warning, but we have never been informed in precise detail what sanction PCH applied and for what misconduct.

Mr Waite and Ms Prue – nothing.

PCH aka Livewell SW – still carrying on in the same old way, (Take a look at the CQC report 2016, linked on this website).

NMC – no change in its approach that I detect.

CIC Regulator – still no action.

BUT REMEMBER THE NHS MANTRA – “Lessons have been learnt”

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REPORTS AND INQUIRIES FOLLOWING OUR OFFICIAL COMPLAINTS:

McEvedy Independent Inquiry following our complaint against the Plymouth Teaching Primary Care Trust. Report published Feb 2014, with failings found.

Negligence litigation case taken by our grandson against Plymouth Community Healthcare (which followed PT PCT). Case successful October 2015.

Parliamentary and Health Service Ombudsman. Report published March 2016, with failings found.

Nursing and Midwifery Council tribunal. Findings announced March 2016, with failings found.

Safeguarding Adults Review. Published November 2017. 11 findings and 12 recommendations made for future practice.

R&A Mitchell, February 2018.