

**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

**1. Background to the Investigation by Donna Ockenden:**

This investigation was commissioned in accordance with the Health Board's 'Concerns Policy' (Appendix 1) and procedures and with reference to the "Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse" (2012) (Appendix 2). The investigation was commissioned following a formal raising of concerns by the family of a former Tawel Fan patient (Family A\*\*)

**2. Original Concerns at outset of investigation:**

Under the Health Board's Concerns policy PTR01 (appendix 1) Donna Ockenden was advised that a number of serious allegations have been raised which required investigation. These are:

- a) Care and treatment of a complainant's [REDACTED]\*\* (Family A) during [REDACTED] inpatient stay on Tawel Fan Ward between [REDACTED] 2012 – [REDACTED] 2013.
- b) Content of a covert recording of a nursing handover presented on the 23<sup>rd</sup>/12/2013 allegedly recorded 5/10/2013 (Appendix 3)
- c) Further concerns that were raised on the 18<sup>th</sup> December 2013 (detailed within the North Wales Police video interview with complainant from Family A\*\* on the 9/01/2014) and themed for the Terms of Reference (Appendix 4) as follows:
  - d) Lack of professional, dignified and compassionate care.
  - e) Lack of 1:1 care to maintain patient safety.
  - f) Unsupervised patients.
  - g) Lack of nurse staffing to adequately care for patients.
  - h) Lack of fundamentals of care.
  - i) Concerns regarding standards of operational safety briefings and the quality of nursing handover.
  - j) Professional concerns breaching duty of care.
  - k) Patients nursed on the floor.
  - l) Patients distressed and not supported in an environment which does not promote independence and resulting in restraint.

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**External Investigation into concerns raised regarding the care and treatment of patients  
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**Final Report September 2014  
CONFIDENTIAL**

- m) Regimes/ routines /practice on the ward which may violate individual patient's human rights.

**3. Purpose of the Investigation as advised by the Health Board**

Donna Ockenden was advised that the main purpose of the investigation was as follows;

- To establish the facts about the nature of care delivered.
- To include representatives from the Local Authority and NW PPU thus ensuring the investigation was both multi-agency and interdisciplinary and free from individuals who had any personal involvement in the care provided.
- To request and incorporate the views of external experts where appropriate and if necessary.
- To establish whether problems occurred in the care provided or service delivery, emphasising the need for improvement (where this was necessary/ appropriate).
- To determine whether there were lessons to be learnt from the case.
- To identify clearly what those lessons were, how they will be acted upon and what would be expected to change as a result.
- To provide a clear report to include recommendations relating to the allegations being investigated, the management or organisation of the service and setting and any improvements or sanctions needed to avoid a recurrence of the incidents (as set out in Section 2 a- m above) and /or prevent further abuse.
- Donna Ockenden was advised by the Health Board prior to commencing the investigation that if a criminal matter came to light during the investigation, the investigation was to stop immediately and a referral be made to the Local Authority Adult Protection and/or NW Police Public Protection Unit. (PPU)
- Donna Ockenden was further advised that if a professional concern came to light during the investigation, the concern was to be escalated immediately within the Nursing Directorate of the Health Board.
- At the end of the final report Donna Ockenden was requested to produce an action plan in conjunction with local leads.

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**Final Report September 2014  
CONFIDENTIAL**

**4. Review Panel Objectives**

The Review Panel Objectives as advised to Donna Ockenden at the outset of the investigation were:-

- a) To conduct the investigation with honesty and integrity and seek to establish the truth through an impartial and objective approach.
- b) To ensure the appropriate incident investigation techniques are utilised.
- c) To consider all factors raised by the incident – and whether these adhere to statutory obligations, national clinical guidelines and local procedures.
- d) To identify and transmit /escalate without delay to appropriate staff any information requiring immediate attention.
- e) To work closely with all relevant stakeholders, keeping them informed of progress or engaging contribution when required.
- f) To agree the outcome of the investigation.
- g) To identify local and organisational lessons and mechanisms by which they can be shared across BCUHB.
- h) To identify any lessons which may be shared with partner agencies, the Welsh Government or other external bodies (i.e. HIW) for wider consideration.
- i) If the allegations relate to acts or omissions by one or more employees of the organisation the investigation will take into account possible organisational and management issues including:
  - Policies, guidance and systems available to support and direct staff to carry out their responsibilities.
  - Supervision arrangements and evidence of implementation.
  - Training and employee development.
  - Communication between and across the different levels and part of the organisation.

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

- The culture of the organisation (e.g. whether there is consistency in how service users and staff are treated.)
- The investigator will take into account recent inspection reports, recent compliance notices and other enforcement actions.

**5. Stakeholders both internal and external to the Health Board**

**5.1 Workforce and Organisational Development (internal)**

To obtain advice and guidance from Workforce and Organisational Development if employment issues are raised with consideration given to the notification to the relevant professional bodies in line with BCUHB disciplinary procedures. Concerns were escalated throughout the investigation to appropriate senior members of the Health Board including the Deputy Director of Nursing and the Nursing and Medical Directors. Donna Ockenden was advised that internal investigations have been undertaken in accordance with the Health Board's Disciplinary Policy where allegations have been received in respect of named employees. It is envisaged that the investigation reports will have been completed internally by the 30th September 2014.

**5.2 North Wales Police PPU or Denbighshire Local Authority. (external)**

Donna Ockenden was advised that further consideration was to be given to any further concerns raised during the process and those which were believed meet the POVA threshold. These were to be referred immediately following Adult Protection Procedures with North Wales Police PPU or Denbighshire Local Authority.

**5.3 Complaints/ Concerns Department (internal)**

Donna Ockenden was advised that all correspondence within the BCUHB complaints department relating to Tawel Fan ward would be made available to her.

**5.4 Patients and families who have experience of Tawel Fan ward (external)**

An anonymised breakdown of the families met with and interviewed as part of the investigation will be provided with the final report. Only one patient (Patient I\*\*) was interviewed at [REDACTED] request and [REDACTED] had been admitted to a ward within the Ablett Unit rather than Tawel Fan itself. In conversation with Donna Ockenden [REDACTED] stated that both [REDACTED] who had been frequent visitors to the Ablett Unit had multiple concerns about care they had witnessed within it. Patient I had made contact with the external reviewer as [REDACTED] believed firmly that the issues / concerns witnessed by [REDACTED] family during [REDACTED] acute illness and [REDACTED] were relevant to this external review of Tawel Fan. [REDACTED] However the initial information shared by [REDACTED] about the Ablett Unit mirrors that of other families experiencing Tawel Fan ward.

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

**5.4.1 Contacting families for the purpose of this External Review**

Most of the names of the families met and contact details for those families were provided by other families. There was concern expressed by all of the families who met Donna Ockenden that other relatives living local potentially still 'had a story to tell' regarding experiences on Tawel Fan ward. All families stated either at interview or subsequent to their interview that they felt that the Health Board should have made greater and proactive efforts to contact families whose relatives had been admitted to Tawel Fan to ensure their experiences were recorded. This information from the families has been fed back to the Executive team both verbally and in email.

One family, (Family C\*\*) wrote as part of their formal complaint that they only found out about the closure of Tawel Fan and the subsequent external investigation through reading the local newspaper [REDACTED]

[REDACTED] The family stated that hearing of the external review in this way caused them considerable distress. They subsequently made contact with Donna Ockenden as external investigator through their own efforts. At the time of writing this final report this family's complaint remains unanswered despite over six months having elapsed since it was sent to BCUHB.

Three relatives and friends of former patients of Tawel Fan ward made a request to Donna Ockenden for a telephone interview in the 24 hours prior to submission of the interim report. As these were people who spent a great deal of time on Tawel Fan ward in the months before closure it was entirely appropriate that their stories were recorded and their feedback included in the final report. These are in addition to families referred to in the interim report as their stories could not be recorded in time for the submission of the interim report.

**6. Other sources of information made available to Donna Ockenden at the outset of the investigation**

- The covert recording and transcript of the nursing staff handover. (see Appendix 3 for transcript)
- The North Wales Police video recording of the interview with complainant from Family A dated 9/01/2014. [REDACTED]
- POVA allegations and outcomes to date related to Tawel Fan ward.

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**Final Report September 2014  
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**7. Timescale**

At the outset of the investigation the timescales to be adhered to were advised as that apportioned to a Welsh Government Level 2 Investigation. However this was to be kept under review as the investigation proceeded. An extension was necessary due to the large volume of interviews required. (See Section 11 for details)

**8. Summary of responsibilities as advised to Donna Ockenden by the Director of Nursing Betsi Cadwaladr University Health Board (BCUHB)**

Donna Ockenden as investigating officer was asked to produce and present an agreed final report, having reviewed the concerns as set out above, to determine:

- 8.1 Whether the concerns are proven.
- 8.2 Underlying issues contributing to any proven allegations.
- 8.3 Did the culture on the ward lead to the restriction or curtailment of the dignity, privacy, choice, independence or fulfilment of individuals who are or could be deemed vulnerable, and could this result in 'institutional abuse' as described in section 6.6.2 All Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse.
- 8.4 Advise on any immediate or long term remedial steps they consider may be required.

**9. External Investigator**

Donna Ockenden, Co Clinical Director, NHS England (London Region), and former Director Family Health Clinical Care Group (South London Healthcare NHS Trust, NHS London)

**9.1 Commencement of investigation:**

Donna Ockenden as external investigator was appointed 21/01/2014.

**10. Consideration of Guidance from Professional Bodies including the Nursing and Midwifery Council (NMC 2010) and General Medical Council (GMC 2013).**

**N.B.** It is recommended that copies of the NMC and GMC guidance referred to below are **read and considered simultaneously and in full with this report**. This will support the readers understanding of the relationship between the standards required of registered nurses and doctors by the NMC and GMC, the issues occurring on Tawel Fan ward and the original concerns as set out in the Terms of Reference. (See Appendices 6, 5 and 4 respectively.) Those professional standards and requirements from both the NMC and GMC that are of particular relevance to Tawel Fan ward are outlined below in section 10.1 (NMC 2010) and 10.2 (GMC 2013)

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**Final Report September 2014  
CONFIDENTIAL**

- 10.1 Guidance from the Nursing and Midwifery Council (The NMC Code of Conduct, Performance and Ethics 2010) is found within Appendix 6 and is explicit about the responsibility of Registered Nurses**

**The Code (2010) states:**

'The Code is the foundation of good nursing and midwifery practice, and a key tool in safeguarding the health and wellbeing of the public.'

Registered Nurses must - 'Make the care of people your first concern, treating them as individuals and respecting their dignity...' 2010 (Page 2)

**The Code states that as a registrant:**

- 1. You must treat people as individuals and respect their dignity
- 2. You must not discriminate in any way against those in your care
- 3. You must treat people kindly and considerately
- 4. You must act as an advocate for those in your care, helping them to access relevant health and social care, information and support (Page 2)

**Registered Nurses must - Respect people's confidentiality**

**The Code states that as a registrant:**

- 5. You must respect people's right to confidentiality
- 6. You must ensure people are informed about how and why information is shared by those who will be providing their care
- 7. You must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising (Page 2)

**Registered Nurses must - Collaborate with those in your care**

**The Code states that as a registrant:**

- 8. You must listen to the people in your care and respond to their concerns and preferences

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**Final Report September 2014**

**CONFIDENTIAL**

- 9. You must support people in caring for themselves to improve and maintain their health
- 10. You must recognise and respect the contribution that people make to their own care and wellbeing (Page 2)
- 11. You must make arrangements to meet people's language and communication needs
- 12. You must share with people, in a way they can understand, the information they want or need to know about their health (Page 3)

**The Code states that:**

**'As a professional, you are personally accountable for actions and omissions in your practice, and must always be able to justify your decisions.'** (See Page 1)

**The NMC states clearly each registrant has a responsibility:**

**'To work with others to protect and promote the health and wellbeing of those in your care, their families and carers, and the wider community'**

**And that all registrants must:**

**'Work with colleagues to monitor the quality of your work and maintain the safety of those in your care.'** (See Page 4 Section 22)

**The NMC states that all registered nurses must:**

**'Delegate effectively' and 'establish that anyone you delegate to is able to carry out your instructions.'** (Section 29 Page 5)

**And:**

**That it is the responsibility of registered nurses to ensure that 'the outcome of any delegated task meets required standards'** (See Page 5 Section 30)

**The NMC is clear that all registrants have a responsibility to 'Manage risk' stating that all registrants must:**

- 32. 'Act without delay if you believe that you, a colleague or anyone else may be putting someone at risk' (Page 5)
- 33. 'Inform someone in authority if you experience problems that prevent you working within this code or other nationally agreed standards' (Page 5)

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**Final Report September 2014**

**CONFIDENTIAL**

- 34. 'Report your concerns in writing if problems in the environment of care are putting people at risk.' (Page 5)

**In addition registrants are told:**

- 35. You must deliver care based on the best available evidence or best practice.

**The Code is explicit that Registrants must - 'Keep your skills and knowledge up to date.'**

**Registrants must:**

- 38. Have the knowledge and skills for safe and effective practice when working without direct supervision
- 39. Recognise and work within the limits of your competence
- 40. Keep your knowledge and skills up to date throughout your working life (See Page6)
- 41. Take part in appropriate learning and practice activities that maintain and develop your competence and performance (Page 6)

**The Code is explicit that Registrants must:**

- 42. Keep clear and accurate records of the discussions you have, the assessments you make, the treatment and medicines you give and how effective these have been
- 43. Complete records as soon as possible after an event has occurred
- 44. Not tamper with original records in any way
- 45. Ensure any entries you make in someone's paper records are clearly and legibly signed, dated and timed
- 46. Ensure any entries you make in someone's electronic records are clearly attributable to you
- 47. Ensure all records are kept securely (Page7)

**Registrants must: - Deal with problems and must:**

- 52. Give a constructive and honest response to anyone who complains about the care they have received
- 53. Not allow someone's complaint to prejudice the care you provide for them
- 54. Act immediately to put matters right if someone in your care has suffered harm for any reason

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**Final Report September 2014**

**CONFIDENTIAL**

- 55. Explain fully and promptly to the person affected what has happened and the likely effects
- 56. Cooperate with internal and external investigations (Page 8)

**Registrants must- Uphold the reputation of your profession and must:**

- 59. Not use your professional status to promote causes that are not related to health
- 60. Cooperate with the media only when you can confidently protect the confidential information and dignity of those in your care
- 61. Uphold the reputation of your profession at all times (Page 9)

**10.2 Guidance from the General Medical Council (GMC) is similarly explicit for all Doctors holding GMC registration.**

The GMC document **'Good Medical Practice (2013)'** (See Appendix 5) sets out the duty of care of doctors owed by doctors to patients in such circumstances and states that doctors must:

- Contribute to and comply with systems to protect patients; part of this includes a responsibility to: 'take part in systems of quality assurance and quality improvement to promote patient safety.....taking steps to address any problems...' (See 1.22, Section 1a)
- Reflect 'on your standards of practice and the care you provide (See 1.22, Section 2b)
- 'Review patient feedback where it is available (1.22, Section 3c)
- Promote and encourage a culture that allows all staff to raise concerns openly and safely. (Section 24)

To 'Help keep patients safe' the GMC states that doctors must:

- Respond to risks to safety
- Contribute to adverse event recognition (See Section 2.23, 2b)
- Take prompt action if you think that patient safety, dignity or comfort is or may be seriously compromised. (Section 25)
- Immediately tell someone who is in a position to act straight away if a patient is not receiving basic care to meet their needs. (25a)
- Raise your concern in line with our guidance<sup>11</sup> and your workplace policy and you should also make a record of the steps you have taken if patients are at risk because of inadequate premises, equipment\* or other resources, policies or systems, you should put the matter right if that is possible. (25b)

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**Final Report September 2014  
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- Ask for advice from a colleague, your defence body or us if you have concerns that a colleague may not be fit to practise and may be putting patients at risk. If you are still concerned you must report this, in line with our guidance and your workplace policy, and make a record of the steps you have taken.<sup>11 12</sup> (25c)

The GMC (2013) states that 'Whether or not you have vulnerable<sup>1</sup> adults or children and young people as patients, you should consider their needs and welfare and offer them help if you think their rights have been abused or denied.'<sup>13 14</sup> (27)

The GMC states that doctors must 'Communicate effectively.' Of particular relevance to the care of patients on Tawel Fan ward where carers were likely to have been very involved in the day to day care of their loved ones prior to admission to the ward the GMC states that doctors must:

- 'Be considerate to those close to the patient and be sensitive and responsive in giving them information and support' (See 3.33)
- Be readily accessible to patients and colleagues seeking, information, advice and support when you are on duty (See 4.34)
- Be 'open and honest with patients if things go wrong.
- Respond promptly, fully and honestly to complaints and apologise where appropriate and not allow a patient's complaint to adversely affect the care or treatment you provide or arrange.' (See Section 6.61)

Throughout the report attention will be brought to the NMC (2010) and GMC (2013) standards outlined above.

**10.3 Status of this report.** It was agreed with the Executive Team that a final report would be produced for and presented to the Health Board Executive team in September 2014. The previously presented interim report and its findings is now superseded by this the Final Report once presented to / received by the Health Board.

**10.4 Interim briefings to the Executive Team and their representatives**

Throughout the investigation and production of this report Donna Ockenden has provided regular briefings to appropriate senior personnel within BCUHB. These include the Executive Nursing and Medical Directors and Deputy Director of Nursing. Weekly telephone meetings between the Deputy Director of Nursing and Donna Ockenden have occurred throughout the investigation. As outlined in the Terms of Reference issues identified throughout interviews and enquiries that required immediate escalation were then escalated appropriately and without delay to the Deputy Director of Nursing and Executive Medical and Nursing Directors.

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As a direct result of feedback raised by a number of relatives regarding potential concerns around the number of patient deaths either on Tawel Fan ward or shortly after discharge the Health Board has commenced a detailed 'Tawel Fan Mortality review' spanning a time period of two years up until the temporary closure. This is almost at completion at the time of finalising this external review.

Families involved in the investigation (8 families and 1 patient) have been kept up to date with progress on an as required basis by Donna Ockenden ensuring that no inappropriate information was shared with them.

**11. Methodology for undertaking investigation:**

The investigation commenced at the end of January 2014 and a first set of interviews commenced on site with a two day visit to Ysbyty Glan Clwyd (YGC) the week commencing the 24<sup>th</sup> February 2014. The purpose of this initial visit was to visit Tawel Fan ward, meet key members of staff and families who were available. Whilst interviews were occurring large quantities of documentation including local minutes and operational documents from within the CPG, all Wales and Royal College standards around dementia and elderly care were provided to Donna Ockenden.

**11.1 Numbers of staff/ relatives interviewed.**

By the end of August 2014 Donna Ockenden had personally conducted 40 staff interviews and 18 interviews with family members / close friends of long term patients on Tawel Fan ward. One patient was interviewed at [REDACTED] request, (the request made through North Wales Police PPU) although [REDACTED] had been admitted to a ward adjacent to Tawel Fan within the Ablett Unit rather than Tawel Fan itself.

The majority (13) of the 18 family interviews were face to face on site at Ysbyty Glan Clwyd (YGC) with 5 being conducted on the telephone, one family interview was completed by Donna Ockenden in person in two parts [REDACTED]

[REDACTED] Of the 40 staff interviews/ discussions 3 were held on the telephone with 37 being conducted face to face. Following on from the first site visit further site visits took place during March, May and June with interview days typically running from 0800 hrs to beyond 2030hrs to maximise the number of interviews that could occur.

All interviews were digitally recorded with the transcripts prepared off site in West Sussex by a confidential typing service that had no knowledge of North Wales, the Health Board, Ysbyty Glan Clwyd, the Ablett unit; its staff or patients. This was agreed in advance by the Health Board in order to assure interviewees of confidentiality. It was agreed that original transcripts in full would only be seen/ handled by Donna Ockenden and the interviewee. However, all interviewees were made aware that issues requiring escalation including those potentially impacting on patient safety

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would be escalated to the executive team (and possibly regulatory bodies) by Donna Ockenden.

Anonymity of the interviewees was achieved via each staff member being labelled as 'Staff 1, 2' etc up to 40 and family members labelled as Family A, B etc. Some family members came alone, others were accompanied by relatives. In total 17 family members/ close friends representing 8 former Tawel Fan patients were interviewed plus one patient, (a total of 18 people who had witnessed care in the Ablett unit/ Tawel Fan at close hand and over an extended period of time)

Of note during the interview is that staff members being interviewed who raised concerns generally appeared very cautious and reticent and asked extensive questions regarding the confidentiality of the process before beginning the interviews. In order to encourage staff members to be open and honest in their interviews Donna Ockenden gave assurance from the Health Board that original transcripts prepared for the purposes of this report would only be handled and seen by herself, the interviewee and the confidential transcription service in Sussex.

Staff were however informed by Donna Ockenden that where they had concerns about any aspect of patient care or safety Donna Ockenden and the staff member **both** had an obligation to report and escalate those concerns appropriately both within the Health Board to Executive level and if required to their professional body.

- Of the 40 members of staff met to date 6 members of staff (15% of those interviewed) raised concerns that could be described as serious or significant. No evidence was provided to show that these concerns were ever put in writing.
- Former members of staff were interviewed both raising very significant concerns that they felt they had raised verbally within the CPG whilst employed. No evidence was provided to show that these concerns were ever put in writing.
- A further 5 members of staff (12.5% of those interviewed) raised concerns that could be described as minor or moderate. The concerns raised in this second group were often organisational and relating to environment or staffing rather than concerning direct patient care. No evidence was provided to show that these concerns were ever put in writing.
- The remaining 27 members of staff (71%) expressed no concerns and frequently stated throughout interviews that Tawel Fan ward was a centre of excellence, expertise and provided specialist dementia care despite being unable to produce any evidence to support these statements.

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In what could be described as an almost entirely opposite scenario of that stated above - of the 18 family members/ close friends interviewed only two family members - representing one deceased patient - (11 % of those interviewed) described themselves as very satisfied with the care their relative had received. All of the others interviewed (89%) had serious or very serious concerns regarding the care their relative had received on Tawel Fan ward.

Most of the larger group of relatives with concerns stated they had raised these concerns either formally via the Health Board Concerns and Complaints process; or stated they had raised concerns formally and informally at the time of their relatives stay on Tawel Fan with senior managers within the CPG. None of the relatives spoken to described themselves as being satisfied that their complaint or concern had been resolved regardless of whether it was formal or informal. Typical responses from families included either:

- **A complete lack of investigation** (Family E- relative sustained broken arm that was unnoticed by ward staff until brought to the attention of the ward staff by a daughter. No evidence has been produced by the CPG that suggests it was ever investigated)
- In addition families A, B, and D \*\* (Total 7 relatives) reported raising concerns within the CPG at various levels over a prolonged period of time *'you did raise so many issues, but you just got so fed up of raising them all the time didn't you in the end because you weren't heard.* (Family A) In addition Family A\*\* noted *'It was a very blasé response to / they almost found it humorous I felt. It just wasn't taken seriously, there was a blasé approach to concerns.'* Family A further noted *'Of course staff didn't appreciate my questions and I was told to back off, get a life, let us treat him..'* (Page 7)
- Family D in their interview report of a number of injuries that were rarely if ever reported to them, often they would walk on the ward, note a new injury and have to ask how it occurred. They describe an injury to their father's nose *'I was told (it) had been caused by dad banging his head against the wall whilst he was wearing his glasses. On another occasion dad had a cut to his head and a flap of skin was hanging down I don't know if he was X Ray'd or if this should have been stitched but I certainly wasn't informed ...'* (Letter received 15<sup>th</sup> July 2014)
- In agreement with family D and others Family F remember visiting one day and finding that their father had cellulitis of his arm with extreme swelling, heat and pain. As with Family D they needed to bring this to the attention of

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

the ward staff. The [REDACTED] (staff number 14) said *'I'm glad you've just reminded me he's got a bad arm.'* (Page 9) No action had been taken by ward staff until the relatives raised concerns. All of the relatives spoken to expressed extreme concern for those in patients who had no one to visit them or had very infrequent visitors and all described weekend visiting when they felt responsible for the care of other patients in addition to their relative while the Tawel Fan ward staff remained in the office.

- **The length of time taken to investigate concerns** (Family C, complaint response not received after 6 months with no explanation until the local MP was involved and contacted the Health Board.) Families D and F both described a protracted complaint response that was never investigated to conclusion, Family A whose longstanding concerns led to the opening of this external review had raised multiple very serious concerns within the CPG which eventually triggered commencement of this external review.
- **The lack of an accurate written response or minutes of meetings** when requested repeatedly of senior managers within the CPG (Families A, B, D, E, H)  
Raising concerns with staff from ward level to a very senior level within the CPG. The [REDACTED] of Patient A describes meeting with the [REDACTED] and the [REDACTED] *'many times.'* (Page 8). *'I even wrote to XX, ([REDACTED] - staff member 9) 'to tell [REDACTED] that they were mopping up urine off the floor with patients own towels...she said [REDACTED] come and speak to me, [REDACTED] didn't actually.'* The [REDACTED] of patient A describes that a bucket, mop and hazard sign did appear despite the fact that the [REDACTED] did not respond to the family concerns by meeting but noted *'That does raise the question of why patients would be allowed to urinate all over the corridors for everybody else to walk in, because there was nobody there..(To supervise patients)*

The [REDACTED] (staff member 9) described a complaints resolution process for Tawel Fan ward [REDACTED] that was completely different from that experienced by the families who contributed to this investigation. [REDACTED] stated:

*'Initially, I would like to meet with the relative and discuss what their complaint was about and what they felt the complaint was about and I would like to discuss it with them and see if there was a resolution that could be made verbally and whether there were any actions we could put in place if needed and I would review what the complaint was about, whether that be by going through the case files, discussing it with the staff, discussing it with the medical staff, looking at it from a multi-disciplinary point of view*

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

*and I would feed back to the Concerns Team. If it wasn't resolved verbally in a meeting with the family, then we'd respond formally in a letter and if that wasn't satisfactory, then we would get an external person to come and review the information and the issues and to look at all the information that was pertinent to the complaint. (Page 7)*

*'I think in all fairness that until [REDACTED], they had very few complaints, it was very rare that we did have a complaint, you know in the time I've covered Tawel Fan, I think in the time/because I did cover it in my role prior to becoming [REDACTED] and we did a lot of work with regards to fundamentals of care on the ward in that three years [REDACTED] and I think on the whole the environment and the ward itself has improved a lot. We've had a lot of new furniture, the ward has been redecorated, the ward is certainly a lot more organised and tidy and it runs a lot more efficiently than it did do, so yeah until [REDACTED] we didn't have very many complaints prior to that.' (Page 7)*

Despite the assurance in the paragraphs above [REDACTED] Relatives were not encouraged to raise concerns or ask question about care and [REDACTED] of patient A noted *'There were lots of meetings but I was only ever told what was happening and not to ask questions and not to go home and read about it.'* (Page 12) ([REDACTED] of patient A described these meetings as occurring with [REDACTED] (Staff Member 16), [REDACTED] (Staff Member 10), [REDACTED] (Staff Member 14) and [REDACTED] (Staff Member 25). She states *'I felt bullied, I was bullied, that's how I felt.'* (Page 13) This theme of 'bullying' by staff is also found in the interview of the [REDACTED] within Family H:

[REDACTED] H was told by staff member 4 and records in her interview:

*'I know you will fight me over this H but I am bigger than you and I am here for that. You know I am right and I expect you to argue, shout and cry but you know that we will win in the end, I have bigger shoulders than you.'*

[REDACTED] H said in her interview: *'I felt bullied and intimidated by [REDACTED].'* (Page 1) and said:-

*'I want it clearly noted that I never believed the Health service had the right to imprison patients against their wishes but they kept telling me I had no say.....I feel I have let my mother down desperately.....I felt I had let her down desperately by their own deceitfulness of mental healthcare . In my view it had been a total disgrace. (Page 2)*

## **11.2 Plaudits received on Tawel Fan ward in the last two years**

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

Copies of plaudits have been requested from Tawel Fan ward by Donna Ockenden for the two years prior to closure. The purpose of this request was to ensure balance between the complaints/ concerns discussed with examples of good practice and positive feedback. Despite repeated requests to [REDACTED] of Tawel Fan ward only a very small number were provided to the external review.

One family (Family F) who sent in two thank you cards stated at interview with Donna Ockenden that they sent in the thank you cards through fear that their relative might need to return to Tawel Fan from his nursing home (as they had seen other patients do in the time their relative was admitted to the ward.) They hoped that by saying thank you via a card rather than raising concerns (although they had and still have grave concerns about the care provided) that their relative would be able to return to Tawel Fan without fear of the repercussions that they felt might follow on from a complaint. Sadly their relative died within 6 weeks of discharge from Tawel Fan ward to a nursing home. The family believe he was well cared for in his nursing home in the final six weeks of his life and ultimately died with the dignity he deserved. His sister said 'It's too late for our F now, too late but whilst I still have breath in my body I will fight to ensure that no one, no one ever suffers in the way [REDACTED] suffered on that ward. (Tawel Fan)

Similarly a Staff Member (37\*) who sent a thank you card to the ward team at the end of her time working within the team subsequently raised serious concerns about the behaviour of team members towards individual patients. The behaviour she witnessed towards one patient was an assault, (a slap) and is currently subject to a POVA investigation. The staff member was very clear that a number of other members of the Tawel Fan team witnessed this incident but did not report any concerns. Further details of this staff member (36) will not be provided in this report to preserve [REDACTED] anonymity although the concerns raised have been escalated appropriately within the BCUHB corporate concerns structure and [REDACTED]

**12. Findings of the report:**

These are themed in two ways both according to the original Terms of Reference as supplied at the outset of the investigation (Appendix 4) and consideration of standards published by and required of both the Nursing and Midwifery Council (NMC 2010) and the General Medical Council (GMC 2013)

Standards expected of registered nurses from the Nursing and Midwifery Council are published within The NMC Code of Conduct, Performance and Ethics. (NMC 2010) Standards expected of Doctors published by the General Medical Council are described within the document 'General Medical Practice - Good Practice Guidance' (2013) which sets out the duty of care of doctors owed by doctors to patients.

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

Where applicable each component of the original Terms of Reference has been cross referenced with relevant aspects of either The NMC Code of Conduct, Performance and Ethics. (NMC 2010) or the GMC's 'General Medical Practice - Good Practice Guidance' (2013) or in some cases both.

**12.1 Lack of professional, dignified, compassionate care.**

The external review has found evidence that this aspect of the Terms of Reference is linked closely to **multiple breaches** of standards within both the NMC Code of Conduct, Performance and Ethics. (NMC 2010) (see sections 1,2, 3,4, 5,7, 8, 9, 10, 16, 22, 23,24,29, 30, 31, 32, 33, 34, 35, 38, 39, 40, 41, 52, 53, 54 and 55) and breaches of standards within the GMC's 'General Medical Practice - Good Practice Guidance' (2013) sections: 4.16.3; 1.22.3c; 2.23.2b; 2.23.3c; 24, 25 a and 25b; 1.31; 2.32 ; 3.33; 10.2.2; 10.2.3; 10.2.4; and 10.2.7.

This concern is **upheld: (fully supported)** by the external investigation with reference to the following evidence:

- Family A\*\* noted the unsuitable environment often created by staff behaviour (or misbehaviour) *'The ward was extremely noisy, loud, very uncondusive to dementia care.'* [REDACTED] family A describes the behaviour of a [REDACTED] (Staff Number 10) *'[REDACTED] came out of a bathroom and bellowed and patient AA (from family A\*\*) said shut up and Patient FF, (from Family F\*\*) said shut up at the same time as well and I said 'use the bell, like you should, not holler out and loud..'* [REDACTED] family A noted that the feedback given made no difference [REDACTED] was still shouting the day (Patient A\*\*) was discharged.' (Page 8)
- Staff member 20 [REDACTED] agrees with [REDACTED] A's assessment of staff member 10 and stated that the [REDACTED] (staff member 14) frequently saw [REDACTED] (staff member 10) swear at both patients and staff. [REDACTED] said 'I'm 100% positive [REDACTED] knew about it [REDACTED] and (Staff Member 10) was swearing all the time anyway towards staff and patients, there was no difference at all.' (Page 10)
- Family F recall the difficulty they had communicating with the ward staff when telephoning on a daily basis to enquire of their relative's well-being. *'It was like banter wasn't it, everything was banter there..'* They would be told *'Can't you hear him shouting and swearing, he's alright...'* (Page 51)
- Family B\*\* note *'I always thought the ward smelt of urine when you came on'* (Page 2). They note the complete absence of nurse leadership on the ward *'The [REDACTED] (Staff 14) I never saw on the ward, I only saw [REDACTED] in the glass box, in the room there.'* (Page 3)

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**Final Report September 2014  
CONFIDENTIAL**

- Family A\*\* note the response given to them when they requested of Staff member 25 that Patient A be given a daily shower. This request was made because by this time Patient A was doubly incontinent [REDACTED] of patient A noted *'ooof, wrong thing to say, [REDACTED] exploded..... [REDACTED] was really cross with me. We haven't got the staff to do this .....showering every day... I said to [REDACTED] if you were doubly incontinent would you like a shower every day ... [REDACTED] just glared at me and glared at me and I said it three times and then [REDACTED] opened the door to let me out..'* (Page 10)
- Family B agree with Family A and note *'Her hair wasn't touched I don't think. her nails I doubt whether they were touched. She was smelly quite often and I did ask why couldn't she be bathed everyday in view of the incontinence and was told they had far too many patients for them to bath them as regularly. I asked daily.'* (Page 4)
- Family B\*\* noted the way that soiled or wet clothes (following incontinence) were sent home. *'I would get a bag full of wringing wet washing you know with cardigans in and things like that, that to me I just wouldn't have thought it was necessary; you know they could have at least separated dry stuff from soaking wet stuff and slippers that were absolutely soaked with urine..'* (Page 4)
- Family F recall the relative of Family E who regularly undressed and was left in a state of undress for long periods of time. Family F were told *'She does it all the time or he does it all the time, don't worry about it. (Mrs E) she always used to take her top off and try and get naked and they used to be like Just like your dad. There they are the two strippers..'* (Page 35)  
Family F\*\* recall that their relative was always unkempt, dirty and smelly despite multiple requests to the ward staff for their relative to be bathed/ washed. They said *'The smell from F was horrendous....it was a mixture of all different smells...we said to them can you take F because this is just one instance. He absolutely stinks....We couldn't sit by him because the smell was that bad, but we had to ask them so they went and took him/ they brought him back to us with all....faeces down his legs.....We had to go and get wet wipes ourselves and clean him....'* (Pages 10 and 11) They also recall *'He used to get his dinner and put it all over his hair didn't he? Yeah but they (the staff) wouldn't do anything. But it was just left. It was heartbreaking, really and I'm glad for the last 6 weeks of his life he was looked after...'* (Page 33)

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

Family F\*\* also recall staff member 14 [REDACTED] cutting their relative's hair despite having no hairdressing training. They recall *'That one day where (Staff Member 14) had cut his hair. 'It was up, you know when you were a kid and you had the basin put on your head...that's what it was like and I went in on the Friday [REDACTED] (staff member 14)'I think I've cut F's hair too short..'* (Page 26)

Family A\*\* noted that rarely there was kindness and when it occurred it stood out *'I did see a Nurse read to [REDACTED], (no interview as next of kin not known) who was a lady nursed in a bucket chair, [REDACTED] and I thought that was so tender, but I only saw that once. The staff were generally just hustle and bustle with running around and got to do this and got to do that and...not take hold of their hand and hold their hand.* (Page 11)

Family G\*\* [REDACTED] also experienced acts of kindness and were extremely satisfied with the care provided to their relative in the last three weeks of [REDACTED] life spent on Tawel Fan ward. [REDACTED] G\*\* [REDACTED] explained that *'everything the Ablett unit did was with the agreement of the family..'* He gave the example that his father was frequently hurting himself and he was very impressed that the ward staff *'put mattresses on the floor to avoid him hurting himself..'* (Page 1) Mr G\*\* was very clear that he wanted his feedback to be included in the main body of this report and said *'I want to make sure there is no kind of stitch up...'* (Page 1)

[REDACTED] G\*\* was similarly complimentary of the care they saw delivered to Mr G (deceased) [REDACTED] G stated that [REDACTED] felt *'the staff did their best to make him very comfortable and the staff were good at keeping them informed..'* [REDACTED] G said that *'Overall ....the staff were extremely kind, but .... cannot remember any staff names specifically..'* (Pages 1 and 2)

- Family A\*\* note a review of their relatives care plan and documentation by [REDACTED] \* (Staff Member 22.). Staff member 22 has raised concerns regarding the lack of detail in the initial assessment carried out by members of the ward team.\* [REDACTED] report states: *'It is relatively brief in parts and there are certain areas where elaboration could have helped to show more clearly who this person is and how he is affected by the situation he finds himself in. To have done so would have raised the quality of the assessment generally and allowed a broader understanding of unmet needs that have emerged, that would have led to a more patient centered assessment and given more opportunities to promote his dignity.'* (Page 20)
- [REDACTED] of Family H\*\* wrote:-

*'What I have seen:*

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

Naked patients running around with no dignity shown

Patients with bruises and my own mother included

A [REDACTED] picked up under [REDACTED] arms and placed heavily in a recliner

- There was no staff a lot of times in the lounge area
- No one came freely to speak to me about my mother and when I was asked I was fobbed off'

[REDACTED] H\*\* Statement written April 2014)

- In agreement with [REDACTED] H and others the [REDACTED] of Family C\*\* stated:  
*'I think the distress for the family was that you know we thought our mother has been placed in a home where they cater for people with Alzheimer's and the fact that they couldn't manage that and that the only alternative was to put her in a mental health ward so the distress going there, (Tawel Fan) I mean there was lots of different people running around, but the guy that used to crawl around in his underpants .... [REDACTED] C)*  
*'In his underpants and sometimes not in his underpants.....Except for a shirt, he'd have a shirt on.'* (Page 10, [REDACTED] C)
- In agreement with Family H and family C the family of Mr A in their diary which spanned six months note on the 21st November 2012: *'Asked to think about DNR (Do Not Resuscitate) on phone by XX [REDACTED] Staff Number 14) 'and then in person this afternoon with Dr X'* (unknown member of staff so not interviewed..) To make such a request of a wife on the telephone further adds to the multiple breaches of the NMC Code (2010) that are outlined above. It is an approach that completely lacks compassion and kindness and one I have never encountered before in almost 30 years of healthcare experience.
- Family F in support of all other families informed me of a visit one day in Winter. [REDACTED] of Family F said, *'I went up to see him after that and he was sat in a chair and he only had a pair of shorts on and he was freezing, so I went to get him some pillows and a blanket to put over him, they couldn't find a blanket...'* (Page 9)
- Despite the feedback from all of the relatives described above there was a complete lack of acceptance by the staff in Tawel fan ward that such problems existed. The vast majority of the staff, nursing, support workers and medical staff continued to protest that the ward was a

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

centre of excellence despite no evidence presented to date that this was the case. The staff preferred to believe and openly state that one family and one family only were responsible for the 'Troubles of Tawel Fan Ward' Throughout the many staff interviews conducted the feedback was largely the same. The report cannot consider and include all of the staff comments on this subject but will include a small sample:

- Staff Member 4\*\* [REDACTED] stated of Tawel Fan *'I've never been prouder to work anywhere. I knew we had difficulties, I knew there were things going on, I didn't think it would come to this level. It's knocked me sideways, it's an incredibly complex and challenging and unconventional ward. The care that we offer as a Team I think and we know that the care that we offer as a Team has been sound because we've been nothing but under the microscope for the last six months because of [REDACTED] ...'* (Page 11 )
- Staff Number 19\*\* [REDACTED] was asked what had led to the closure of Tawel Fan ward. She reported high levels of stress related staff sickness leading to poor staffing levels. These poor staffing levels were caused by:- *'A small number of relatives, probably down to one in particular was putting massive pressure on staff. Staff were going off sick, it was/the ward was becoming/it was becoming a place that nobody wanted to be, probably because we were all in fear of what was going to be directed at us next because there was just really what we saw to be petty little nitpicking complaints that over a period of 14 months it sort of ground everybody down, myself included you know everybody were under immense pressure, but this had all been brought to light many months before and nothing was ever done.'* (Page 2)
- Despite no evidence to support [REDACTED] claims [REDACTED] and [REDACTED] colleagues articulated:  
  
*'We felt that she was pulling other relatives into her sort of/if she had a complaint on a specific day shall we say, whether it was founded or not, supposing she had a complaint which she voiced something practically every day there was something whether it be his hair was parted the wrong side. I've had a complaint against myself because I tucked his shirt in when she doesn't like his shirt tucked in, so you get the nature of the type of complaints.'* (Page 2)

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

- [REDACTED] (Staff Member 4) agrees with [REDACTED] colleague ([REDACTED] staff member 19) and said at interview: *I'm surprised it has got as huge as it has. I was aware of one of our most complex patients that we've had and his wife who felt that everything we did was wrong, so I'm surprised it has got to this level because we thought we'd got a cap on it and we thought it was being dealt with/I feel let down by the Trust because we had shouted and thought [REDACTED] A\*\*should have been managed at higher level than [REDACTED] was.* (Page 2)
- Staff Member 19 added [REDACTED] *had come in on a daily basis and it was very rare that [REDACTED] didn't have a concern or a complaint or a point where [REDACTED] would undermine a member of staff or several members of staff. It was always filled with negativity, there was no positivity about how [REDACTED] was cared for, it was always negative. There was no thanks.* (Page 2)
- In agreement with [REDACTED] colleague staff member 19 ([REDACTED]) Staff Member 4 ([REDACTED]) seemed oblivious to the fundamental deficits in the care and treatment provided to Mr A\*\* and his fellow patients on Tawel Fan ward. Describing [REDACTED] A's concerns staff member 19 stated [REDACTED] *s complaining he's got talcum in his belly button or his hair is parted the wrong way or that we'd used the wrong shampoo or that [REDACTED] e was a very difficult [REDACTED]. [REDACTED] was quite aggressive and undermined us as a Team in front of other patients, other family members, and it was relentless and [REDACTED] said jump and we had to say how high, because we didn't say how high then, we would get the brunt of [REDACTED] for a while, [REDACTED] e would ignore you or huff at you or bark at you for a period of time until [REDACTED] saw fit where [REDACTED] could approach you again in a polite manner and to maintain that [REDACTED] /maintain that professional level was quite difficult from our point of view.* (Page 2)
- Unfortunately this focus on the alleged unreasonableness of [REDACTED] A's behaviour (of which no evidence has been found throughout the investigation) appears to have started at a very senior level. The [REDACTED] (staff member 9) also discussed it at length at interview and appeared to support the view that the problem within the ward was the unreasonable demands made by [REDACTED] A rather than the deficits in the basic care being provided to [REDACTED] A's [REDACTED] and numerous other patients.
- Staff number 9 [REDACTED] stated at interview:

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

*'But I know the staff felt under immense pressure because they did feel that no matter what they did, it was never quite right you know if they brushed his hair to the left, [REDACTED] wanted it brushed to the right',*  
(Page 5)

[REDACTED] added:-

I think in all fairness that until [REDACTED] A\*\*, they had very few complaints, it was very rare that we did have a complaint, you know in the time I've covered Tawel Fan, I think in the time/because I did cover it in my role prior to becoming [REDACTED] and we did a lot of work with regards to fundamentals of care on the ward in that three years prior [REDACTED] [REDACTED] and I think on the whole the environment and the ward itself has improved a lot. We've had a lot of new furniture, the ward has been redecorated, the ward is certainly a lot more organised and tidy and it runs a lot more efficiently than it did do, so ...until [REDACTED] A\*\* we didn't have very many complaints prior to that. (Page 7)

Appendices 21-23 inclusive deal with an enquiry into Rowan Ward in Manchester in 2003. Whilst the passage of time may at first sight mean this seems irrelevant there are key lessons that senior people within the CPG seems to have been unaware of from the Rowan Ward enquiry. Appendix 21 highlights the key steps for 'Suspicion of abuse within an institution.' These include 'staff complain of patients (or relatives) behaviour persistently or insist on medication to calm patients down; The ward is not clean, Patients are left in lounges by themselves without any activities.' A number of recommendations follow in the section entitled 'Minimising the chances of abuse.' Upon reviewing these the reader will note that very few if any of these recommendations are in place in Tawel Fan ward some eleven years after the publication of this report.

- In common with most other colleagues on Tawel Fan ward including nursing, support worker and medical colleagues Staff Member 19 and others (for example staff numbers 4, 5 8, 9 24 and 25) stated that they had seen or heard nothing that concerned them either when Tawel Fan ward was open or that they felt concerned about now after temporary closure with the benefit of hindsight or reflection.
- All staff members were given the opportunity in the interviews conducted to raise concerns in retrospect around issues such as failure to ensure the privacy and dignity of patients, to consider whether patients were ever treated or spoken to roughly or to consider

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

whether furniture was ever used as a restraint. In the majority of cases the Tawel Fan ward team remained resolute that the 'troubles' on Tawel Fan ward started and remained with one family only, the family of Mr A\*\*.

- Staff member 19 stated of one 'incident' with the family of Mr A\*\* *'And that is just one of a whole line of incidents that were never dealt with. If they had been dealt with we might not be sitting here now, that's the way I feel.'* (Page 14) Staff member 8, [REDACTED] is in agreement with staff member 19 and said *'I think a lot of it is down to a certain individual's anger at [REDACTED] condition and we took the brunt of the majority of it.'* (Page 3)
- In addition to unfounded accusations regarding complaints from Family A\*\* the ward team when interviewed individually also focussed extensively on their belief that Family A\*\* made unreasonable requests and demands of the Tawel Fan ward team. No evidence has been found during this investigation that any of the families including Family A\*\* made anything other than entirely reasonable requests of the ward staff. It is however acknowledged that even very reasonable requests that were often fundamental to the safety of the patients in Tawel Fan ward (for example repeated requests by families for assessment of swallowing function, medication review or explanation of injuries sustained ) were frequently ignored by the ward team. There appeared to be a culture prevailing amongst the majority of the Tawel Fan team that could be simply explained as 'Their Way or No Way.'
- Staff Member 2 [REDACTED] and staff member 40 [REDACTED] were both completely unable to describe a single innovation in patient care that the Tawel Fan ward team had introduced in the last 3 (Staff Member 2) or 5 (staff member 40) years. However staff member 2 defended [REDACTED] colleagues and the standard of care provided on Tawel Fan ward and said *'I feel confident that everybody did their best to maintain/ the girls on the ward are quite passionate about their patients.'* (Page 4)
- Another prevailing theme amongst those who maintain that Tawel Fan provided the highest standards of care was to 'not see' what went on around them or to concentrate on what happened in their direct presence only rather than ask questions or look around them at the wider picture or indeed to make any attempt to listen to or understand

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

the concerns of relatives or interrogate issues that must have been of very visible concern. (For example the injury rate or the fall rate.) Two examples of this are staff member 5 [REDACTED] who repeatedly answered questions regarding for example inappropriate behaviour during handover, lack of involvement of relatives, or patients potentially being shouted at with *'I can only comment on myself really'* or *'Whenever I was there no... or 'I personally wouldn't no, I can only comment on what I would do...'* (Pages 2 and 3) and staff member 40 [REDACTED] who responded that [REDACTED] had never *'really thought'* about the rate of falls leading to fractures on Tawel Fan ward; that there had potentially been *'quite a few falls'* but [REDACTED] was not aware that there had been numbers of falls that were of concern.

- Despite multiple relatives all raising similar and very serious concerns, (many of whom do not know each other and in some cases experiencing Tawel Fan at different times in the last two years) [REDACTED] [REDACTED] stated [REDACTED] had never seen anything on Tawel Fan ward that caused her concern. In [REDACTED] interview [REDACTED] (Staff Member 40) stated that [REDACTED] was on Tawel Fan ward usually on a Monday morning and a Tuesday [REDACTED] on a Friday afternoon. However when asked specifically about the quality of care [REDACTED] responded that *'it was difficult for [REDACTED] to make a judgement about the quality of care.'* as [REDACTED] was on the ward *'for a few minutes here and there..'*
- In light of what appeared to be more than a few minutes 'here and there' on the Tawel Fan ward weekly the [REDACTED] was requested by email to describe in detail the process for undertaking a ward round on Tawel Fan ward. No response was received to this request for information.
- Despite the frequent visits to Tawel Fan described above over a very prolonged period of time [REDACTED] stated very clearly that [REDACTED] was *'not aware of any issues regarding Tawel Fan prior to closure..'* and [REDACTED] had *'no concerns regarding the quality of care, safety and dignity of the patients within Tawel Fan ward..'* (page 1) Initially [REDACTED] also stated that [REDACTED] was not aware that any relatives on Tawel Fan ward had any concerns with the care that had been provided to their family member. On prompting however [REDACTED] was able to recall that Families A, C and F all did have ongoing complaints about care at one time or another.

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

- Despite evidence to the contrary from all of the families who visited patients over a very extended period of time Tawel fan staff stated and believed that they provided the very highest standard of personal care. Staff member 19 [REDACTED] *stated 'because we all know our job, we all know that our patient care was I would say second to none under very, very difficult circumstances...'* (Page 9) Staff number 8 agreed with staff member 19 and said *'All the patients you know they have always looked clean.....I don't think I have ever dealt with any complaints about patients looking dirty or being untidy.'* (Page 3). Almost all of the families interviewed disagreed with this viewpoint and described difficulty in getting daily baths for patients who were doubly incontinent, having to clean faeces from their family member's legs with baby wipes, having difficulty sitting next to their family member because of the terrible smell.
- Despite conclusive evidence from all the family members who visited Tawel Fan ward that there was no provision of activities for their relatives who were patients on the ward, (this was also validated by the Dementia Care Mapping Assessment see Appendix 7) the Tawel Fan team as a whole were able to describe fluently the existence of an apparently non-existent programme of patient focussed activities on the ward. Staff Member 19 stated:  
  
*'It was quite high on our priorities to try and get activities. It could be anything, it could be random from doing a jigsaw with somebody, playing dominos, playing ball, the contact was important because we had a lot of wander/some patients and the nature of the ward, they were able to wander so it used to sort of get rid of some of that sort of anxious sort of energy that they'd got, (Page 9)*
- Staff Member 4 [REDACTED] was asked to describe an initiative in the field of dementia care that had been successfully introduced in Tawel Fan to the benefit of the patients there. [REDACTED] provided a long and rambling answer that appeared to be around an improvement in documentation and other initiatives that had been heard of *'and we hadn't quite got round to'* and then went on to describe at length the activities programme at Tawel Fan.
- According to Staff Member 4 these included art work, pampering sessions, throwing and catching balls and balloons, a singing group, music therapy and taking patients for walks. Whilst this may have all

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

been accurate none of the families interviewed (who all visited the ward extensively throughout a typical week, throughout daytime and evenings on weekdays and weekends) ever reported seeing such activities taking place. Therefore, the accuracy of Staff Member 4's recollections might well be called into question by the families.

- Staff Member 4 said:- *'I think one of the/changes in practice. The paperwork shift changed massively. One of the things we were looking at and we hadn't quite got round to/you know was the intentional all rounding which we thought was a good thing. There was the transforming care. We'd been years with kind of generic paperwork and it became incredibly person centred. The fact that it was activities and transforming care not last year, but the year before we won some kind of/or came into the scoring of some kind of ward to do with transforming care and the Health Care Support workers and the interventions with the patients with activities.* (Page 14)
- [REDACTED] (Staff Member 9) also described a completely different programme of activities than anything ever seen, described or experienced by families. Staff member 9 said *'We are all working towards a dementia friendly environment. We have had a music project and an art project through the art therapies and we have had PAT dogs on the ward which are a huge benefit to the patients, so we do try to be dementia friendly and proactive.* (Page 9) None of the relatives in the last two years had ever met the Tawel Fan ward dog.

## **12.2 Lack of 1:1 care to maintain patient safety.**

Evidence supporting this concern within the Terms of Reference is linked closely to failure by staff to adhere to standards within both the NMC Code of Conduct, Performance and Ethics. (NMC 2010) sections 7, 29, 30, 31, 32, 33, 34, 40, and the GMC's 'General Medical Practice - Good Practice Guidance' (2013) sections 1.22.1a; 1.22.2b; 2.23.2b; 25a, 25b, 25c, 1.3.33; It also links closely to section 12.3 below **Unsupervised patients.**

This concern is upheld, (fully supported) by the investigation with reference to the following evidence:

- Evidence provided by family A that staff member 20 was providing 1:1 care for 2 vulnerable patients, one in the lounge, one in the ward garden when the relative of family A fell sustaining an injury. *'I would hear [REDACTED] saying how they were 1:1 in two patients..... [REDACTED] (relative of family C in the*

28

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

*lounge and [REDACTED] from family A in the garden and they were daft enough to sign the same observation chart, one person, (Family A)*

- Staff Number 21 agreed with this assessment of events by Family A and recalls Mr A falling when he left his 1:1 activities with Mr A to attend to Mrs C who had been shouting. However it appears that there had never been a formal understanding [REDACTED] as to what 1:1 observation actually meant. Staff member 20 explained it as *'I was just keeping an eye..'* (on [REDACTED] C). *'Somebody with [REDACTED] C) who has walked out whose left.*
- Family A state that staff member 3 in the recording of the ward handover\* (See appendix 3) refers to their relative needing to have a 'political 1:1 not a clinical 1:1.' In this it appears that an experienced [REDACTED] in common with [REDACTED] pay lip service to the need for 1:1 observation of vulnerable patients' thus increasing the risk these patients face when care that is planned for them is not delivered.
- In an account that is different from that seen by family A - Family C in their first interview note that whenever they visited [REDACTED] *'She had 1:1 care that was strictly adhered to as far as we were aware and when we turned up she always had somebody sat next to her and her behaviour was managed.'* However they report other very grave concerns concerning their [REDACTED] are before, during and after her stay on Tawel Fan leading to her death in YGC following a fall at her nursing home.

**12.3 Unsupervised patients.** (This aspect of the Terms of reference is linked closely to both the NMC Code of Conduct, Performance and Ethics. (NMC 2010) sections 7, 29, 30, 31, 32, 33, 34, 40 and the GMC's 'General Medical Practice - Good Practice Guidance' (2013) sections 1.22.1a; 1.22.2b; 2.23.2b; 25a, 25b, 25c, 1.3.33. It also links closely with section 12.2 above: **Lack of 1:1 care to maintain patient safety.**

This concern is upheld, (fully supported) by the investigation with reference to the following evidence:

- Evidence in interview from family A\*\* that due to lack of staff supervision patients on Tawel Fan ward frequently fought one another. When the [REDACTED] family A\*\* raised concerns with [REDACTED] [REDACTED] noted *'a) I was told by a [REDACTED], that that's what they do these patients and b) that they were short staffed but they won't likely get any more, so I wrote to very Senior Management..'* (Page3 interview).

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

- [REDACTED] family A noted *'I can confirm that when we visited him you would just see the patients wandering around the corridors unsupervised.'* (Page 4)
- [REDACTED] family A noted that the staff *'all used to congregate in the office...there is a time management issue isn't there if all they've got to do is be within the office and writing up their notes or chatting or you know they certainly weren't where they need to be.'* [REDACTED] family A agreed and noted [REDACTED] and I many a Sunday afternoon were looking after four or five patients as well as XX (their own relative) (Page 5)
- Evidence provided from Family B that unsupervised patients walked around and around the ward; *'this included some of the patients walking around with nothing on and patients who walked and walked around and around the ward and simply did not sit down.'*
- Family B further note the behaviour of one patient who was completely unsupported or cared for despite displaying behaviour that was distressing to other patients and the relatives of other patients who witnessed it. The patient is described as *'one lady who used to fling her arms around men and make inappropriate contact with male patients.....unable to recall anything put in place to distract this lady.....so therefore the pattern of behaviour.....continued- she would get up, she would walk around, she would fling her arms around male visitors and patients....with no staff really getting involved in trying to distract this particular patient or make thing more pleasant for other patients on the ward...'*
- [REDACTED] Family C stated of Tawel Fan *' It (Tawel Fan) was probably slightly worse than I imagined partly because there were patients who were running around the quadrangle and were just kind of running all day and urinating the corridors and there were people/when my mother was in her room - we were having to lock the door because people were trying to get in all the time the screaming so I don't know whether that's normal for a mental health ward or whether that's abnormal or whether that it is just what happens but it was a stressful atmosphere where you would hear people screaming, but I remember distinctly being in her room and people always trying to get up through the door and having to lock the door when she was inside, so there was obviously some/where people were not supervised all the time. (Family C, Page 10)*
- Family F agree and said of the patients they had observed *' They walk round in circles that's where all the fights start along there, all the staff are stuck*

30

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

*in the office, they're all locked in the office and all that patients do is walk round and round...' (Page8)*

- Staff Member 22 [REDACTED] summarised the situation on Tawel Fan ward eloquently as *'I think scrutiny is not welcome on the ward. I think you just need to go and look at the ward to see that and you can't see the door. When you come on the ward you are not made to feel particularly welcome in there and if what has been happening on that ward has been happening it has been very well hidden and you have to try really hard to do that I think.'* (Page 5 )

**12.4 Lack of nurse staffing to adequately care for patients.**

Evidence supporting this aspect of the Terms of Reference is linked closely to failure to adhere to standards specified within both the NMC Code of Conduct, Performance and Ethics. (NMC 2010) sections 29, 30, 31, 32, 33, 34, and the GMC's 'General Medical Practice - Good Practice Guidance' (2013) sections 2.23.2b; 25a, 25b, 25c,

This concern is upheld, (fully supported) by this investigation with reference to the evidence in 12.3 above and the following evidence:

- Family A\*\* noted that as *'the inpatient numbers went up and the accidents on the ward went up and the fractures went up and the black and blue faces and arms and legs went up.'* [REDACTED] family A noted *'It was preventable as far as I am concerned. Patients' that present in this way should not be left to their own devices.'* (Page 3 interview)
- Family D\*\* agree with family A and others and said *'I was never told if my [REDACTED] had fallen, become agitated, not eaten.....so if he had bruises because he had fallen or anything like that they never phoned me and said when you come in you might be a bit worried, your [REDACTED] got a black eye or this has happened or your [REDACTED] has got a cut to the head or anything like that with any bruises I was never told. I was only told after the event. I had to see him and ask the question.*

*One time I know he had glasses and he had a cut where his glasses had obviously gone into his head and I said how did he do that? She said oh he's been/one of the Nurses said to me he's been knocking his head against the wall, so I said well does anybody do/why didn't anybody contact me? Nobody ever told me anything that was going on. ' (Page 7)*

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

- Family C note the difference between their relatives care home and the ward: They describe therapeutic activities in the care home, sewing, baking etc but *'when they took her to Tawel Fan there was just nothing, nothing. It was just stop there and then and she was just basically sat down in a chair and this is your life..'* (Family C, Page 15).
- Family A noted of their relatives condition a short while after admission to Tawel Fan ward. They state *'The back of his head is full of lumps and bump, he never had any lumps before..... It's shocking, it's shocking..'* (Page 18)
- The statement of Family A\*\* is verified by Family B\*\* who on their frequent visits to the ward noted that 'a number of the patients within the ward were bruised.....one chap who used to bang his head continuously on the wall and he wouldn't stop....there were always two or three staff in the office and many of the staff seemed to spend the majority of their time in the office.'
- Family A\*\* provided a diary entry from the [REDACTED] 2013. 'Visited at [REDACTED]. Patient X was outside in the garden with [REDACTED] bottom on display. Could not find any staff initially, and then found 2 agency nurses sitting in TV lounge with calm patients. Informed one of them who got up, did not look at me and did not speak me.'
- Family C\*\* agree. [REDACTED] C\*\* stated *'and that was basically what they had to do. They just basically sat them in the TV room and that was where they were in....'* [REDACTED] C\*\* added *'I think it was quite distressing going in there and seeing my mum just sat around in not very comfy chairs ...'* (Page 13)
- [REDACTED] C\*\* added *'We kind of put up with the chaos thinking that she'd [REDACTED] get a diagnosis. It was not a calming atmosphere, there was no therapy to help her and I didn't think she was being treated, she was being diagnosed.'*(Page15)
- In Appendix 3 (the recording and transcript of the staff handover) there is a rambling conversation with bad language throughout it that seems to indicate there is insufficient staff on Tawel Fan ward which has led to patient falls.  
Voice? - [REDACTED] [REDACTED] been on 1:1 since [REDACTED]  
[REDACTED] \* put a POVA against us when XX pushed him over and there were only two staff on the ward because we had F over the way and you know... [REDACTED]  
Voice? - What happened with that POVA? Did a POVA go in over that?

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

Voice? [REDACTED] yeah

Voice 1- [REDACTED] [REDACTED] [REDACTED]

Voice? - [REDACTED] saying why didn't he call staff from the other units?

Voice 1- Why didn't you IR 1 it?

Voice 2- There was me, [REDACTED]

Voice 1- Because I was too busy [REDACTED] dealing with my patients.

Voice 1- 'That was a [REDACTED] of a bruise that [REDACTED] had wasn't it.'

- This excerpt from the transcript shows a number of recurring themes that continually link in with a number of concerns within the Terms of Reference, (See sections 12.1 Lack of professional dignified compassionate care; section 12.2 Lack of 1:1 care to maintain patient safety; see Section 12.3 Unsupervised patients; See Section 12.5 Lack of fundamentals of care: and see section 12.7- Professional concerns breaching duty of care; )
- The section also contains a number of breaches of The Code NMC (2010) especially Section 7: 'Failure to disclose information' - in this case where a patient is at risk of harm because of poor staffing; (32, 33 and 34) where there is a clear failure to manage risk and to inform Senior Management of an inability to work within the Code.
- The excerpt also validates the concerns and themes expressed in a number of patient and family interviews including families A, B, C, D, E, F and H.  
These overarching themes include shortage of staff that lead to patient injury, failure to seek help from other wards where staff might be available or to record the staffing issue on the Health Board Risk management system ('Why didn't you IR1 it?' Page 12). In addition the staff again use coarse language and appear completely unprofessional in their attitude to (and description of) their vulnerable patients.
- In their interview the [REDACTED] Family C\*\* reflect on the lack of a therapeutic approach towards care in Tawel Fan ward. *'The bedrooms were locked, they always seemed to be locked during the day so that they couldn't actually use their bedroom. They would have to sit in just like a room with all the patients. They would all be just in one room sat in front of the telly. [REDACTED]*

*It was just really really distressing. She was there to be assessed and we didn't know the process ..... [REDACTED]*

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

***We assumed that that was the right thing/you know what they do is the right thing in the way it was supposed to go. [REDACTED]***

- Family D agree with Family C also clearly recalling that 'all the doors were locked apart from the toilet .... The dining room was always locked – it was only opened for protected mealtimes and the rest of the time it was locked so there wasn't really anywhere for people to go, but the people walked round and round and round. There was nowhere else for people to go ...' (Pages 11 and 12.)

### **12.5 Lack of fundamentals of care.**

This aspect of the Terms of Reference is linked closely to breaches of both the NMC Code of Conduct, Performance and Ethics. (NMC 2010) sections 1, 3, 8, 9, 16, 32, 33, 34, and the GMC's 'General Medical Practice - Good Practice Guidance' (2013) Sections 3.33; 24, 25a, 25b, 25c, 27,

This concern is upheld, (fully supported) by the investigation with reference to the following evidence:

- In agreement with other families Family C highlight the vulnerability they felt at their lack of knowledge around dementia and how much they had needed support from the Tawel Fan team (which they had never received). ***'We had no support and...obviously we had never dealt with it before. Nobody in the family had ever had dementia before....'*** (Page 7)
- Family B visited the ward several times a week over a period of time in 2013. They were concerned whether their relative ate or drank enough. They noted that due to the concept of 'protected meal times' which arguably was a misplaced concept on a ward with many long stay elderly patients with dementia they were not permitted to visit their relative during meal times to assist with cutting up of food or to monitor food / fluid intake. The family were aware that their relative B was brought drinks. They stated when they were present they used to ensure [REDACTED] drank [REDACTED] fluids. However in all the time they visited Tawel Fan ward ***'I never ever saw staff do that for anyone else...'*** (Page 1)
- Family D\*\* agree with Family B\*\*. Family D stated: 'I never actually saw him eat apart from perhaps see him have a drink because the tea trolley would come around in the afternoon and [REDACTED] would have a drink. IT was protected mealtimes, so you didn't go in at those times, that's the rule...' (Page 6)

34

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

- Family F recall that long term medication/ treatment that had helped their [REDACTED] health and well-being over a prolonged period of time was never provided in Tawel Fan ward despite multiple requests to ward staff that it was reinstated. ***[REDACTED] suffered with [REDACTED] eyes, [REDACTED] glasses were never on him, just little basic things .like that [REDACTED] had eye drops all [REDACTED] life because of cataracts and then they didn't even know [REDACTED] was on eye drops, why didn't [REDACTED] have eye drops. [REDACTED] eyes kept getting sore with conjunctivitis...*** (Page 38)
- [REDACTED] C was an inpatient on Tawel Fan ward for approximately [REDACTED] in 2013. In agreement with other families and the Dementia Care Mapping report (below) they found the ward completely devoid of activities except sitting in an uncomfortable day room watching the TV. The [REDACTED] C recalls:- ***'There were no other activities there was never any time of doing jigsaws or colour books or even newspapers, I didn't see any newspapers you know things like that there was just nothing there..... [REDACTED] added ' We took in jigsaws for my [REDACTED] and they were just left in [REDACTED] room...' Page 14)***
- Dementia Care Mapping (See Appendix 7) was completed in Tawel Fan ward at the end of October 2013 found that the patients received care in an environment that was ***'uneventful, mundane and lacking in stimulation.'*** (Page 3\*). It is of considerable concern that a Dementia Care Mapping exercise was required to formally note the existence of an environment such as that described in the report\*
- In agreement with the families of relatives A\*\*, B\*\* C\*\* and others the report found that the patients observed on Tawel Fan existed in a 'neutral' environment overall with 'episodic periods of ill being, reflecting the lack of engagement and stimulation.' (Page 6\*) This is a directly opposite belief to that presented by most of the Tawel Fan ward staff who were interviewed as part of this investigation. The differences between the viewpoints were explained by Staff Member 22, [REDACTED] explained:  
  
***'Dementia Care Mapping is an objective independent observational method of patient behaviours and indicators of well-being and what the Tawel Fan staff are telling you is their own subjective measurement of their abilities, which is not evidence based'. (Page 9).***
- Family B\*\* (who visited their relative on Tawel Fan ward 3 or 4 times a week at least over a period of time in 2013 noted ***'there appeared to be no activity for the patients and that the television was on all the time continuously in***

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

*the lounge although very few people appeared to watch it although the staff were there they did not seem to be bothering about the patients at all..'* (Page 1)

**The Dementia Care Mapping Report\* recommended that:**

- The ward manager increase staff awareness of the benefit that their interactions with patients can have on their well-being.
- Orientation cues and signage should be available in every area; that written orientation should be bilingual and that 'orientation regarding day, date, time, place should also be available.'
- There should be a review of the clinical usefulness of daily blood pressure checks which the Dementia Care Mapping team considered was leading to a reduction in the time that ward staff were able to spend with patients.
- All case notes should contain a completed copy of 'This is Me' (see Appendix 8).
- Activities should be considered to support patients in response to faecal smearing since it is considered that ***'faecal smearing may be a response to a lack of activity and engagement.'*** The report noted that in one instance a patient who subsequently did smear faeces during the dementia mapping exercise ***'was keen to engage with others but had limited opportunities to do so.'*** (Page 15)\*
- All of the recommendations above would be considered to be at or below the most basic level of care expected from an expert team. The requirement of assessors to recommend the ward team 'consider' these issues should have led the senior leadership team within the CPG to have assertively followed up this report with a specific and measureable action plan that had a planned, effective and timely journey throughout the governance processes within the CPG. In addition there should have been an ***immediate review*** of all other inpatient areas within the CPG to assess those areas against the measures and recommendations within the report. (There should have been no requirement to await the next cycle of Dementia Care Mapping for this to occur).
- On receipt of this report there should have been a very clear message from the CPG senior leadership team shared throughout the entire CPG at every handover for a period of several weeks saying **'These standards of care are**

36

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

**not good enough'** Despite careful review of all governance, Senior Management Team and operational Minutes in the year prior to this Dementia Care Mapping exercise and up to the middle of 2014 I have seen no evidence that this occurred. Instead the [REDACTED] responsible for Tawel Fan ward who described [REDACTED] as visiting Tawel Fan daily stated that something completely different happened on Tawel Fan ward. [REDACTED] description of care on Tawel Fan was different from the perspective of the relatives from a number of families who visited Tawel Fan on a very regular basis and different from the perspective of the Dementia Care Mappers who had undergone both rigorous and formal training).

- [REDACTED] said in [REDACTED] interview:  
*'I think from what I observed on the ward, that was very visible a lot of the time and a lot of the staff are allocated to the lounge areas to sit with the patients and they would do hand massages or nail care as part of a routine if somebody was distressed and that was evident as part of/it would easily calm somebody down if they were anxious or agitated and you could visibly see somebody calming down and I think just taking that time to just sit with somebody and just be with them and maybe put their arm round them is something that you may not see in another environment'.* (Page 4)
- The recommendations and findings within the Dementia Care Mapping report are validated by a number of families including Family A\*\* (3 relatives) who noted:- *'They were very task orientated. The ward... was organised, well it wasn't organised it was arranged to meet the needs of the staff as opposed to meeting the needs of the patients.* (Page 6)
- [REDACTED] family [REDACTED] A describes a time when [REDACTED] was suffering from a significant chest infection. [REDACTED] had arranged to visit the ward to provide some of the one to one care that [REDACTED] knew [REDACTED] needed. On arrival at 12 midday [REDACTED] found [REDACTED] *'in the far end (of the room) lying flat with the empty unmade bed that would have been ...by the door shoved up against the bed. [REDACTED] was just staring at the ceiling, [REDACTED] in bed because [REDACTED] got a chest condition let's not forget and I shoved the bed out of the way, said hello to him and [REDACTED] looked terrified. [REDACTED] top sheet was wet, I lifted the covers and [REDACTED] was lying in a pool of stale urine and it's so stale it was brown...'* (Page 13) (Photographic evidence kindly provided in report by family (See Appendix 9)
- On raising concerns with the [REDACTED] about the above incident (Staff Member 9) [REDACTED] family A stated [REDACTED] was told by the [REDACTED] *'Psychiatric nurses*

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

*aren't very good at looking after physically ill people'* (Page 14). Despite multiple requests for information from the Senior Leadership Team within the CPG no evidence has been provided by the CPG that there was any response to these and the concerns raised by other families (including the families of patients F, E, A, C and D) that the nursing care provided to ward inpatients failed to meet even the most basic standards.

- In their diary spanning more than six months from July 2012, Family A note multiple occasions when medical review was required for their relative. This medical review was often significantly delayed. One example - see page 1-  
**October - informed staff that A was chesty. October- A physically unwell. November A very drowsy and physically unwell... November Dr listened to A's chest as best could - said it was clear!!!! A still not well. November - A still not well; November X (staff number 16) started Amoxyl; h November A diagnosed with pneumonia.'**  
 On this occasion it took 8 days to get a Consultant review and 9 days for a diagnosis of pneumonia after alerted staff to condition.
- From the many accounts of poor provision of basic nursing and medical care as described by relatives one might assume (if one had not visited Tawel Fan ward and noted it to be 'on site' at a District General Hospital with full A &E/ ITU / MAU facilities) that it was an isolated unit some distance away from all of the above services. It was not. However despite this and despite the fact that both (Staff Member 9) and (Staff Member 16) claimed to have visited the ward regularly there appeared to be issues with providing even the most basic care that neither (Staff Member 9) or seemed to be aware of.
- The described at interview the frequency of visits:- ***'I don't give them a time and date when I visit, because I am based at Ablett. I just wander in, on and off the ward as and when it is convenient to me so they never know when I am going to be there and I have never witnessed anything that I've been concerned about...'*** (Page 2) In further discussion the described visits as 'daily' (Page 3)
- Similarly at interview Staff Member 16 (Page 1) stated that involvement with Tawel Fan was ***'Almost daily it has been,'*** and ***'I provided almost daily input into Tawel Fan ward'***

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

**.....I was available for the ward mostly there, almost every day...' (Page 1)**

- **██████████ (Staff Member 9) described how ██████ assured ██████ that a high quality of care was being provided on Tawel Fan ward as:**

***'There is the observation isn't there and then we have metrics that we measure. Every 6 month there are the metrics that we audit against basically. The Ward Manager does the case note audits, ██████ audits against the care and treatment plans, how relevant they are person centred wise to the note-keeping and how they link in. We have the fundamentals of care audits, they are a more Wales tool and so there are a lot of auditable measures that we do go through. Part of fundamentals of care tool are each Service User and Carer questionnaires, although unfortunately with people who are cognitively impaired, sometimes it is very difficult to get them to be able to give meaningful answers to those questionnaires.'* (Page 3)**

- Despite repeated requests over more than six months for information regarding how quality, patient experience and safety had been measured Tawel Fan in the preceding two years ward none of the above information has been seen as part of this external investigation. The Deputy Director of Nursing has been very supportive to this external review in also trying obtain information regarding quality and safety. However neither of us have been successful in this regard.

- **██████████ then further added:**

***'We do heavily involve the carers and we also work hard to build up good relationships with the carers and so we encourage them to come to us as and when they do have concerns and I think it's that relationship that is important to deal with things as and when they arise so that they feel that the staff are approachable, but from a measure point of view, I think all the metrics we have in place as far as hand washing, infection control, pressure sores all those sorts of metrics that we measure on a monthly basis we have on the wards, the evidence to the visitors and to the patients if they are able to understand them.'* (Page 3)**

- From the information provided by all the relatives who took part in this external investigation the accounts above regarding the 'heavy involvement' of the carers / relatives does not appear to reflect their experience and does not appear to have happened. In addition throughout the entire length of this external investigation there were numerous requests made for

39

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

information on incidents, incident investigation and examples of learning from incidents. These requests were initially made to Staff Member 13 [REDACTED] and were continually delegated further down both the operational, administration and governance team by [REDACTED]. The Deputy Director of Nursing also gave this external investigation significant help in trying to obtain this information from the CPG Senior Team.

- It took more than 5 months to obtain for this investigation a 'list' of Datix incidents and throughout the investigation there has never been any provision of even one investigation report associated with this list of Datix incidents. Neither has there been any clarity on the existence or otherwise of any 'Red' (most serious) incident reports. After more than seven months this particular line of enquiry ended with staff member 12 [REDACTED] asking of another colleague whether it could be confirmed or not if Tawel Fan had ever had any red incidents in the previous two years. No response was ever received.
- Despite this complete lack of any evidence of a systematic understanding of risk management in Tawel Fan ward by the CPG senior team the [REDACTED] appears to be able to describe improvements in incident review/ risk management system of **which no evidence has ever been provided.**
- ***I think certainly since [REDACTED] have been in post we have been very focused on looking at patient incidents and the POVA referral rate has gone up a lot, ....so our focus has been on reviewing those incidents a lot more.***  
(Page 3)
- Family C\*\* note the rapid deterioration in their [REDACTED] continence on admission to Tawel Fan ward. On admission [REDACTED] C was fully continent and able to take [REDACTED] to the toilet. Within a very short space of time on Tawel Fan ward with no toileting routines and no clear 'journey' to toileting facilities clearly explained [REDACTED] C became first singly then doubly incontinent within a very short period of time. (Appendix 31) shows a copy of a poster removed from the inside door of a clinical supplies cupboard on Tawel Fan ward. It is entitled:- **"STOPNOW!!!" Stop using pull up pads on whoever you fancy. They are certainly NOT for putting one on top of another with knickers on top for your convenience on individual such as [REDACTED], who is not incontinent as [REDACTED] is able to indicate a need to use the toilet!!! Its lazy and wastefull**
- Whilst it is accepted that the disease process of dementia can and frequently does bring with it increasingly complex continence issues the family of [REDACTED] C

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

believe that the lack of any structure, ward routine and toileting hastened the loss of [REDACTED]'s abilities to toilet [REDACTED] very quickly and significantly following admission to Tawel Fan. **'At the end of March [REDACTED] was continent, [REDACTED] went to the toilet by [REDACTED], [REDACTED] became incontinent on Tawel Fan ward.....[REDACTED] preferred going to the toilet [REDACTED] [REDACTED] wouldn't have to be told to go and actually [REDACTED] became incontinent. [REDACTED]**

- [REDACTED] Family C noted **'None of the bedrooms had a toilet, so [REDACTED] had to find the toilets.'** [REDACTED] added **'It was quite a distance. You'd have to go down the corridor, to the right and then walk a bit of the corridor and the toilet was on the right hand side...'** (Page 16 and 17)
- This statement by Family C\*\* is validated by Family A\*\* who note that on admission to Tawel Fan their relative was continent and could feed [REDACTED]. Whilst they accept there was an inevitability to the disease progression which they understood- within a relatively short space of time (less than 12 weeks) their family member was unable to feed [REDACTED] and became doubly incontinent.
- Families C\*\*, F\*\* and A\*\* all express concerns regarding what appears to be indiscriminate use of 'PRN' medication to manage patients within Tawel Fan ward. **The [REDACTED] of patient A notes ' They are unprofessional beyond comprehension. When I ask a [REDACTED], when I go to visit has [REDACTED] [REDACTED] had some Haloperidol today, like yesterday? No [REDACTED] had something else, I say why did he have that today then, when it (Haloperidol) worked very well yesterday?....'** (No response [REDACTED] **'The medicine trolley must be a bit of a lucky dipper is it?'** (Page 23)
- Family F\*\* agree and state that due to what they believe to be over medication of their [REDACTED] **'some days we went there and [REDACTED] was like a zombie and when I say a zombie I mean a zombie...'** (Page 7) They added **'[REDACTED] was drugged up and lethargic [REDACTED] couldn't even lift [REDACTED] head up and [REDACTED] head was drooped down and [REDACTED] was dribbling, there was a pool of dribble on the floor and [REDACTED] just looked and [REDACTED] wasn't there at all...Two weeks [REDACTED] was like that, [REDACTED] used to be sat there like drugged up, drowsy, lethargic, a pool of dribble on the floor.'** (Page 32)
- Staff Member 1 ([REDACTED]) recalls the lack of awareness of 'modern medicine' in Tawel Fan and states there were **'quite a number of significant clinical situations that hadn't really been addressed, it had been sort of left to grumble along..'** (Page 2) In agreement with families C, F and A; Staff Member 1 stated 'there was just not really such thinking about other ways of

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

managing people with dementia other than just medication, about really trying to enhance psychological skills, just non pharmacological methods really and some of the medications just being really quite old fashioned actually, medications I've never had to use...' (Page 3)

- Family C\*\* describe that their [REDACTED] has never eaten red meat throughout [REDACTED] life and even during progression of her dementia remembered that [REDACTED] did not want to eat it. ***'The red meat didn't change because [REDACTED] would still say that [REDACTED] didn't want red meat and we insisted everywhere [REDACTED] went that you would keep [REDACTED] off red meat and just have fish.'*** The family describe how sad they felt that despite this request they would come into the ward and ask their [REDACTED] what [REDACTED] had been given for lunch and [REDACTED] would say 'I've had cottage pie, but I didn't eat it...' (Page 18)
- Family A\*\* in a diary entry of [REDACTED]. ***'I asked (Staff Number 8) how A [REDACTED] was. The response was 'didn't sleep well maybe because of the flicking of the pages of the magazine or because the light was on as staff can't sit in the dark.'*** This appears to be a further breach of the NMC Code of Professional Conduct and Ethics (2010 see sections 3, 8, 33,) It should be completely unacceptable that staff working on night duty nursing A vulnerable patient on a one to one basis actually prevent that patient from sleeping and resting because they found themselves unable to sit at night (whilst on paid night duty) in the dark or they required sufficient light to read a magazine and they subsequently disturbed that patient by turning over pages of a magazine throughout the night.
- Family D expressed concern on a number of occasions to staff about their [REDACTED] deteriorating ability to swallow. ***'You see even taking a drink my [REDACTED] would hold liquid in [REDACTED] mouth like a hamster does and you would have to say to him, "[REDACTED] can you swallow?" and [REDACTED] would really struggle to swallow it was really really hard for him to swallow so I was worried, every time I left there I was worried of what was going on..'*** (Page 8). Unfortunately the concerns expressed to a number of the Tawel Fan team went unheeded and were not listened to. The [REDACTED] family D said ***'All the time I am assured [REDACTED] fine, [REDACTED] eating, [REDACTED] was eating us out of house and home and I'm thinking well [REDACTED] losing weight, I don't see how .....***' (Page 9) Staff also falsely reassured Family D at a time when [REDACTED] D was clearly deteriorating very rapidly. The family report the ward staff saying ***'[REDACTED] chasing us round like I don't know what, but [REDACTED] could hardly walk/ well [REDACTED] couldn't walk.'*** (Page 20).
- Sadly despite frequent communication of concerns regarding their [REDACTED] inability to swallow from the family of [REDACTED] D to the ward staff of Tawel Fan the

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

concerns of the family were never listened to. ■ D was subsequently admitted to the acute medical unit at YGC, was diagnosed with aspiration pneumonia and died within a few days of ■ admission to ward 11. Even leading up to ■ transfer to AMU there was poor communication from the Tawel Fan staff in that transfer had already occurred before the family were notified. This case is now subject to a detailed internal mortality review by BCUHB following the concerns raised by the family. The findings are awaited at the time of submitting this report to the Health Board.

- Family F\*\* also describe their concerns regarding their ■ inability to swallow not being listened to by staff on Tawel Fan ward. They raised multiple concerns with many members of staff but recall one day specifically talking to staff member 4 **'One day I was giving him an ice cream and ■ was choking on it and I went up to (staff member 4) and went oh my God ■ choking, ■ choking...' (■ F) The response was 'Don't be so ■ silly...Tell ■ F, tell your ■ being stupid and I kept going ■ choking and I said can you get me a doctor, get me a doctor because I was really concerned about it. ■ was choking on that ice cream although you give babies ice creams...' (Page 17)**
- ■ agreed: **'Haha, haha! You're panicking again we got told, you're panicking.'** (Page 29)
- Shortly after this incident ■ F\*\* was discharged to a local nursing home where ■ died 6 weeks later. In agreement with Family C\*\* who expressed concerns about significant inaccuracies in the discharge information received from staff on Tawel Fan ward the nursing home contacted ■ F's ■ on ■ arrival to say they had been told **'they made out ■ could walk, ■ was quite independent.....'** ■
- ■ recalls being asked **'How long has your ■ not been able to swallow....Your ■ can't swallow, we've done a swallow test as soon as ■ (arrived).** The family describe how within a week of arriving at the nursing home **'we all got called, they didn't expect him to live 24 hours...■ had aspiration pneumonia because they had been giving ■ food and drink... (In Tawel Fan) They didn't expect him to live 24 hours because ■ was that poorly...'** (Page 28)
- The Family of ■ F have nothing but praise for the staff in the Nursing Home where ■ F spent ■ last 6 weeks. ■ **passed away but that was the best thing that anyone ever did for him was to put him there because at least ■**

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

*went with some....He went with dignity; he went with dignity and the staff  
there were absolutely brilliant...' (Page 29)*

**12.6 Concerns regarding standards of operational safety briefings / quality nursing handover.**

(This aspect of the Terms of reference is linked closely to breaches of both the NMC Code of Conduct, Performance and Ethics. (NMC 2010) sections 1, 3, 16, 23, 32, 33, 34, 35, 40, 41, 42, 48, 53, 61, and the GMC's 'General Medical Practice - Good Practice Guidance' 2013 sections 24, 25a, 25b, 25c, 27,

- This concern is **upheld, (fully supported)** the investigation with reference to the evidence heard on the recording of the taped handover. There is a poor and unprofessional approach to the handover when it is listened to in full. There is little if any structure, little or no relevant clinical information regarding the patients and a complete lack of professional assessment of the patients. Throughout the recording is heard a number of negative, derogatory and insulting comments regarding patients and their relatives. Abusive language is also heard. There are references to the use of bucket chairs used as a restraint of patients (which is a theme throughout staff interviews and will be discussed further in the report. In addition there are poor standards regarding the administration of controlled medicines heard throughout the recording.

In the excerpt below it is noted that [REDACTED] had signed for a medication prior to administration and then the patient had declined to take it.

- An unidentified voice (1) says: 'The [REDACTED] hasn't touched him?  
Voice (2) in response - No  
Voice 1: [REDACTED] **didn't take it on Thursday. [REDACTED] had signed for it and [REDACTED] was on about, [REDACTED] off I don't need medication, [REDACTED] off I don't need medication. [REDACTED] was like that, 'cos I was clearing cups, give me my cup, give me my cup.' And [REDACTED] went to go for me - 'don't you [REDACTED] dare..'**

The phrase '**don't you [REDACTED] dare**' above appears to show that the staff member known as Voice 1 responded with a plea from a patient to keep [REDACTED] cup with a threat. From the brief part of the conversation above it appears

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

***'I can't believe that the staff were that unprofessional and behaved in that way and secondly there were three qualified nurses in that room and I can't believe that the others didn't put a stop to it from my point of view. I was just shocked that something like that happened.'*** (Page 6)

- Family F describe multiple other occasions when clearly handover had not been used to appropriately update the Multi-Disciplinary Team on the condition, needs and priorities of the patients on Tawel Fan ward. They described when their relative had sustained an infected, painful and swollen elbow due to constantly crawling on dirty floors where other patients had urinated and had their bowels opened. They had previously expressed ongoing concerns that their relative was rarely if ever washed. They described Staff Member 20 (a Support Worker) grasping their relatives arm and their ***relative 'aaaah!....screamed because [redacted] arm was that sore, [redacted] (Staff Member 20) didn't even obviously know about [redacted] arm so I went why doesn't people know about [redacted] arm? you've done handover, why don't they know about [redacted] arm, oh sorry, sorry and it's just.....'*** (Page 9)
- Staff Member 20 [redacted] appears to have had a different view and defended the use of handover as part of a team that was 'good.' ***'There was good staff there and they worked tremendously hard, good team, good communication skills which I felt was very important because they had a handover in the morning and (if) there was something going on in the daytime we had all been told about it, so there was no problem and it made the Team so good and strong...'*** (Page 3)
- On this occasion following on from a handover that had clearly been completely ineffective the relatives report that their [redacted]/ [redacted] was subsequently admitted to the AMU in YGC for a week for antibiotic therapy and analgesia on this occasion. The theme of unprofessional behaviour is also an ongoing theme throughout other family interviews including families A, H, B and F.

Further to this transcript of the handover there are interactions between Tawel Fan staff seen on mobile phone 'screen shots' (provided to Donna Ockenden at interview by Staff member 14 (Appendix 32) and Facebook excerpts provided at commencement of the external review (Appendix 11)

- The Facebook excerpt involves members of [redacted] in [redacted] behaving unprofessionally and inappropriately with unknown others. (see Appendix 11) The [redacted] of patient A cites evidence that has already been submitted to the Health Board notes:- ***'Staff Member 10 starts it by saying Does anybody know where I can get a job abroad or something***

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

*like that and Staff Member 4 says tawelfan.com and further down the [REDACTED] (Staff Member 14) says 'hey most folks know you have to be on another planet to work on that ward. 'That's what [REDACTED] says of dementia care.....(they're talking about it) the only way they know, a very derogatory way..' (Page 23)*

- This is a **clear breach** of the NMC (2010) requirement: 61: **'You must uphold the reputation of your profession at all times.'**

[REDACTED] (Staff 4, 8, 14, 19 and possibly 2) of the [REDACTED] took part in this Face Book discussion. There were also a number of non NHS staff who appear to be friends [REDACTED] (Staff Number 10) The reputation of (and confidence in) the nursing profession and care of the elderly in North Wales is significantly diminished by this episode of behaviour [REDACTED] and their friends. Despite this clear evidence to the contrary in [REDACTED] interview Staff Member 8 [REDACTED] assures that [REDACTED] would never use Facebook to **'put anything about work.'** (Page 8)

- In Appendix 32 which was provided to the external reviewer Donna Ockenden by Staff Member 14 it can be clearly seen that an inappropriate and lengthy 'text conversation' took place across two mobile phones on December 24th 2013. There is clear reference to [REDACTED] within the text conversation between a [REDACTED] (Member of Staff Number 17) and [REDACTED].
- Apparently referring to the recording of the handover (Appendix 3) one [REDACTED] asks Staff Number 14 **'That's a breach of confidentiality and or human rights? Can't [REDACTED] get in [REDACTED]t for that?'**

Referring again to the taped handover staff member 14 replies;

**'Thing is the only time staff really ventilated bout [REDACTED] was in office on handover - supposedly somewhere they could express themselves .....so that they could be professional in front of [REDACTED] and everyone else... [REDACTED]**

[REDACTED] colleague replies:

**'It may well have been nutcase who recorded the conversation cos [REDACTED] said [REDACTED] was there. everytime [REDACTED] got away with something such as the computer incident and [REDACTED] coming back and finding [REDACTED] in bed nutcase was on the ward...'**

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

(\* [REDACTED] is a patient [REDACTED] of [REDACTED] also referred to in the text messaging)

Staff number 14 replies:

**'Thing is ....how would [REDACTED] know there was a recording..... [REDACTED]**

**[REDACTED] ... '**

**[REDACTED]**

In the lengthy text the [REDACTED] responds:

**[REDACTED]**

**[REDACTED]**

**[REDACTED]'**

## **12.7 Professional concerns breaching duty of care**

**(This aspect of the Terms of reference is linked closely to both the NMC Code of Conduct, Performance and Ethics. (NMC 2010) sections 1, 3, 16, 23, 32, 33, 34, 35, 40, 41, 42, 48, 53, 61 and the GMC's 'General Medical Practice - Good Practice Guidance' (2013) sections 24, 25a, 25b, 25c, 27.**

This concern is upheld, (fully supported) by the investigation with reference to the following evidence:

- Staff Member 6 who worked on Tawel Fan ward on an interim basis describes conversations overheard between a number of members of staff and a vulnerable patient who as part of the progression with [REDACTED] dementia had been known to be sexually disinhibited. In [REDACTED] interview [REDACTED] noted: **'Strange goings on there, I mean I'm glad to be honest that I didn't / I couldn't that I didn't / I couldn't have worked there all the time....they were talking and [REDACTED] was a bit rude you know as in being dirty men, because [REDACTED] wasn't all with it....but then they join in you see with the conversation, sexual conversation with [REDACTED], winding [REDACTED] up, having a laugh and a joke, but I don't find that funny.....They just egged them on and join in and these people don't have a clue what they're on about, they think it's hilarious, but I don't think it's funny.....some of the stuff [REDACTED] coming out with about doing this and doing that and they're going oh yeah I bet you have a good one.....You know ....encouraging [REDACTED] ... [REDACTED] saying stuff that [REDACTED] did with [REDACTED], so then they're asking questions then, saying oh yeah, oh yeah I bet you did a bit of this and I'm thinking...I didn't find it funny..'** (Page 9 and 10)
- Family C\*\* express serious concerns regarding the lack of communication between Tawel Fan ward staff, (nursing and medical); the community

48

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

services associated with dementia care (social services, community clinics etc) and the nursing home that their [REDACTED] was discharged to from Tawel Fan ward. They describe initially being reassured on Tawel Fan ward by what appeared to be a genuine interest in [REDACTED] condition. [REDACTED] of [REDACTED] C recalled: *'I think that it was the first time that somebody was taking [REDACTED] condition seriously. We were given a lot of advice and background information..... so I kind of felt quite comforted. It was only afterwards that we found out that what we had been told wasn't necessarily always happening...'* (Page 9). The family describe how [REDACTED] behaviour post discharge from Tawel Fan seemed to improve and they were led to believe that this was because of the calm atmosphere in the Nursing Home compared to the environment within Tawel Fan. However (completely by accident) the [REDACTED] [REDACTED] C described how [REDACTED] found out that [REDACTED] was taking [REDACTED] in [REDACTED] nursing home, on the instruction of her [REDACTED] and in line with the exit documentation provided by Tawel Fan ward to the nursing home.

- 'And I think the issue for us is ... that we were asked when [REDACTED] went into Tawel Fan ward to give permission for the anti-psychotic drugs which we did because we had no choice because she had been sent to Tawel Fan. I think that when we were told ....that [REDACTED] didn't need them - Therefore our assumption or our consent ended then, it wasn't an ongoing consent so we didn't give consent after we had been told that she didn't need them, so there is an issue of whether we/[REDACTED] care was not with our consent in terms of what the Care Home or the NHS was doing at that point.'* (Page 7 [REDACTED] of [REDACTED] C)

*'I attended ....three meetings and they were monthly at the Care Home where the NHS were coming in, I attended their meetings. They were saying that [REDACTED] behaviour was very different at the Nursing Home and that (it) was due to the calm atmosphere that my [REDACTED] behaviour was different at the Care Home.'* (Page 6 [REDACTED] of [REDACTED] C)

*'Our concerns were actually about what we were being told not implemented after she left and in fact I think a lot of our concerns were retrospective concerns when we found out that certainly what was being said in the case conference wasn't followed through or in fact we were told something completely different to what happened.'* (Page 4 [REDACTED] of [REDACTED] C)
- Family D\*\* echo the concerns expressed by other families and outline an initial reluctance for [REDACTED] to be admitted to the Ablett Unit. On admission their feelings were *'I don't really want him to feel afraid. I want to be able to see him on a regular basis, so they said well the only place*

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

*available was the Ablett Unit, so I agreed to the Ablett Unit because in my mind I'm thinking he won't be in there long, he's going to be alright.....'* Prior to leaving [REDACTED] for Tawel Fan the family recall being told by [REDACTED] members of staff 'You don't want him to go there...' (Page 5)

- Family D\*\* described the process of completing a Decision Support Tool (DST) in Tawel Fan ward shortly after [REDACTED] admission. *'It was done with two of the [REDACTED], one was called XX ( Staff Number 25) I believe and the other [REDACTED] by the name of XX (Staff Number 4) and the DST was handed to me which said we've got a meeting on 5<sup>th</sup> April to discuss your [REDACTED] and this is the DST as I see it, these are the competencies,'* On expressing concerns that this was a very different scenario to that they had experienced and been informed of very recently in [REDACTED] Staff Member 4 replied

*'Well they're too soft there, they don't really know much about mental illness, so this is how we see it and we're the experts in mental illness...'. I said well 'what if I don't agree, she said well you can/you know you can express your concerns but it is not going to change...'*

## **12.8 Patients nursed on the floor.**

Evidence supporting this aspect of the Terms of Reference is linked closely to both the NMC Code of Conduct, Performance and Ethics. (NMC 2010) sections 1, 2, 3, 4, 16, 29, 30, 31, 32, 33, 34, 35, 61, and the GMC's 'General Medical Practice - Good Practice Guidance' (2013) sections 24, 25a, 25b, 25c, 27, 2.23.2.b.; 1.22.1.a;

This concern is upheld, (fully supported) by the investigation with reference to the following evidence:

- The [REDACTED] family A noted *'I was witness to a gentleman patient lying on the floor when I visited [REDACTED]....I was there for about an hour and it was a chap who was....wanting to run all the time and clearly that wasn't safe, but [REDACTED] was allowed to run and obviously bump into things etc etc. This one time/ [REDACTED] was lying face down on the floor in the corridor within clear view of us and other patients.....so I said to [REDACTED] at the time (staff member 14) XX I said I've been here for about half an hour..... do you know [REDACTED] is on the floor in the corridor and [REDACTED] response was 'actually [REDACTED] less of a nuisance where [REDACTED] is, so I'm going to leave him there, and [REDACTED] was on a cold tiled floor, face down for/ and [REDACTED] was till there when I left an hour and a quarter later and I just thought/ and I came away and you just thought did I just see that, did I hear that?'*

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

- Family B support the evidence above from family A. During their visits to the ward which were several times a week over a long period of time in 2013 they state that they witnessed 'One man who used to crawl everywhere and there was another patient who used to lie on the floor for long periods of time...' (Page 2)
- Family C also recall the patient who continually crawled around the floor with no one from the Tawel Fan staff to help him. It was accepted that this was how ■ behaved and ■ spent most of ■ time on the floor, largely ignored. *'My ■ came with me on quite a few occasions...and ■ pointed out to the staff that this guy was crawling around and they said 'Oh it's OK it's just XXX.....that's what ■ does, that's what ■ does....Yes it's just XX and that's it, what ■ does...'* (page 13 ■ Family C)
- Family F recall another visit where they found their relative ■ naked on the floor. They said: ■ was naked on the floor' ■ 'naked on the floor' ■ ....slipped in ■ own urine ■. They both describe going to ask in the office for help to get their relative up off the floor and made comfortable and were told. *'Oh we're too busy at the moment we'll have to go and get a hoist, so ■ ■ ■ had to lift F off the floor and put him in a chair.'* Referring to their concerns that their relative had been over medicated during ■ time in Tawel Fan they stated ■ *wasn't even agitated, but ■ was just like in a state where ■ just wasn't with it....covered in a pool of ■ own urine, just left on ■ own...'* (Page 12 )
- Family F add; ■ *was constantly on the floor.....what they used to do as well and they used to say it's because it used to help him when ■ get agitated they used to let him get undressed and they used to lie him on the bathroom floor because they said he liked to do that. Well he had no mental capacity to say that, but they said he liked to do that and they sued to put him in the bathroom on ■ own...'* (Pages 13 and 14)

**12.9 Patients distressed and not supported in an environment which does not promote independence and resulting in restraint and:**

**12.10 Regimes/ routines /practice on the ward which may violate individual patient's human rights.**

Evidence supporting these aspects of the Terms of reference are linked closely to breaches of both the NMC Code of Conduct, Performance and Ethics. (NMC 2010) sections 1, 2,3, 4, 32, 33, 34, 35, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 52, 53, 54, 55,

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

and the GMC's 'General Medical Practice - Good Practice Guidance' (2013) sections 24, 25a, 25b, 25c, 27,

These concerns are upheld, (fully supported) by the investigation based on the following evidence:

It appears from the interviews of staff and families that restraint was used throughout Tawel Fan ward on a regular basis.

- Family A in their diary kept from July 2012 to April 2013. On the [REDACTED] 2013 Family A recorded the use of a bucket chair for their relative. They noted on their arrival their [REDACTED] **'...in bucket chair with no cushion.** (Staff Member 10 - [REDACTED] said A\*\*'....**sat in it [REDACTED].'**
- Family F state that they regularly saw use of furniture as a method of restraint within Tawel Fan ward. The [REDACTED] family F stated **'It was disgusting, they always used to push them under tables and stuff like that and I used to go and say oh, [REDACTED] just fell off/ yeah [REDACTED] always does it, it doesn't matter...'** The [REDACTED] added **'There was one gentleman who they used to put him under the table and [REDACTED] used to try and get [REDACTED] out. [REDACTED] used to rock on the chair to get the chair leg to move and eventually the chair would fall and [REDACTED] used to fall to the floor, so you used to go up and tell them what they're doing and then it was 'oh it don't matter [REDACTED] does it all the time...'** (Page 8)
- Family F also became aware that restraint was used in the 'care' of their family member. They became very angry when recalling their memories of this on Tawel Fan ward. When asked what kind of therapeutic care they saw put in place to help their relative [REDACTED] of [REDACTED] F replied **'nothing.....Nothing, put him in a bucket chair...A big blue chair that had wheels that tipped up at the back....'** [REDACTED] F's [REDACTED] added **'Bum stuck in it....[REDACTED] used to try, [REDACTED] used to do this...'** (the [REDACTED] then mimicked a 'rocking' motion whilst in interview) **'Because it was difficult to get out of...'** (Page 16)
- [REDACTED] (Staff Number 1) who worked within Tawel Fan ward [REDACTED] for around three years recalls **'It was the day before I left and up until that point I don't feel I had really seen anything that really kind of got me what's going on here, what's happening..'** (Page 4) **'I saw a lady in the lounge, [REDACTED] was on [REDACTED] own, [REDACTED] had a table up close in front of her, I could see that [REDACTED] wasn't happy, [REDACTED] was distressed, [REDACTED] was trying to push the table away and that was something that struck me as unusual, that was not something I had ever seen on that unit, but I guess what went through my mind was is this table being used as restraint?'**

52

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014  
CONFIDENTIAL**

- **█ also noted:- 'I could only see █ around at that moment and they were right down the other end somewhere and they were with a lady who was getting more vocal and shouting and I could hear the █ were struggling, that they were starting to raise their voices back which again struck me as odd, it's not something I had'. (Page 5)**
- The staff member recalls escalating this to █ (Staff Member 9) ***'that I just wanted █ to know what I had seen, about the shouting, about the table and really just said to █ just to keep an eye, because that just seemed odd to me. It's not something I had seen before...'***
- According to other Staff Members █ (Staff Number 24) and families who had been present on the ward this use of furniture as restraint) was behaviour that had been common place and custom and practice in Tawel Fan for some time prior to this external investigation. Staff Member 24 was asked if █ had ever seen patients restrained or 'kept in position' by the use of tables, chairs or bucket chairs. Staff Member 24 replied that █ had, but in █ interview █ appeared to not understand the significance of this. █ replied:-  
  
***'I have seen the odd times where like you say in a bucket chair. If they're trying to get up and risk of falls at times and maybe if they have got tired or something you might just pop them by/say a table like this, maybe put something in front of them in the hope that they'd settle or something, but there was always somebody in the lounge or there should be'. (Page 5)***
- Staff Member 24 appears to be stating that the use of furniture as restraint was seen as an acceptable way of managing the risk of falls in Tawel Fan ward.  
  
***In that respect I have seen you know/or even because I mean it's the last thing you want is somebody to fall, but people aren't put on a 1:1 supposedly for risks of falls and then they tell you you're not to catch them, but you do that without thinking don't you, if somebody's done/you've done it without thinking so I would say yes I've seen or sort of or maybe even with a chair you know like this and sort of sitting next to them and maybe do something in the hope that they will sort of forget about trying to walk and fall or maybe if you're finding them .....'* (Page 6)**
- In order to clarify exactly what was done with furniture on Tawel Fan ward further questions were asked and Donna Ockenden as interviewer also demonstrated exactly what was meant by demonstrating a table up close against █.

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

- Donna Ockenden asked Staff Member 24:-  
*'Would there be a scenario where someone would be placed closely to a table so I'm just imitating that, .....where they would be close to the table and there wouldn't be anyone with them, but this table here is being used as a mechanism of keeping them in their place?'*

Staff Member 24 replied *'If it is was uncomfortably like you're saying like that tight, I would have thought because with the flooring we've got it's laminated so the chair would slide back or the table would go forwards. I'm sure if they didn't want to stay there that much...'*

Donna Ockenden asked **'So would there ever be a scenario where someone was rocking back and forth to try and get themselves away from a table?'**

Staff Member 24 replied:- **'Well if I'd seen something like that it was obviously they're not happy, move and then maybe you'd see if they wanted to go to the toilet or something if that hadn't been tried'**. (Page 6)

It would appear therefore that there was a regular and accepted use of furniture to restrain patients on Tawel Fan ward. In the transcript of the Nursing Handover (Appendix 3) there is discussion between staff members about an incident where [REDACTED] A had returned to Tawel Fan ward walked into [REDACTED] bedroom at around 17.15 hours and found [REDACTED] awake in a darkened room with a chair positioned up against [REDACTED] bed. Staff Member 17 ([REDACTED]) was witness to this incident.

- The staff involved (Staff Members 2 and 4, [REDACTED] and Staff Member 9 - [REDACTED] in their interviews have all maintained that the chair was not positioned as a restraint but as a source of comfort to [REDACTED] A and that it was positioned at the head of the bed in order that if [REDACTED] A reached out he would feel an inanimate object and feel 'comforted.' It remains completely unclear how an inanimate object such as a chair could provide 'comfort' to a patient with limited spatial awareness. Both [REDACTED] A and staff member 17 both state that they saw that the chair was positioned midway down the bed being used as a restraint, preventing [REDACTED] A from getting out of bed, (and this negating the need for 1:1 supervision of [REDACTED] A as [REDACTED] would be confined to bed by the presence of the chair).
- Staff members 2, 4, and 9 have all stated in their interviews that they believed the use of the chair was documented in a care plan for [REDACTED] A\*\* that had been

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

in place for some time. ■■■ A categorically disputes this. In the recording of the transcript below (which staff did not know was being recorded) the staff appear to be saying that they had used the chair as a method of restraint. They describe submitting a POVA to **'cover our backs to say that it's not a restraint; it's for a comfort thing for him '**

- At the beginning of this investigation I was supplied by ■■■ A\*\* (which I passed immediately to the Health Board) a 'screen shot' taken of the Care Plan document properties on the Tawel Fan ward computer. The Care Plan for ■■■ A (see appendix 29) is dated manually as September 21st 2013 perhaps suggesting that the use of a chair as a comfort (and not a restraint- however inappropriate this 'chair as comfort' may be) and that this 'intervention' as part of ■■■ A's care plan was planned some time prior to the alleged incident with the chair.
- However the screenshot (See Appendix 29a) shows the Care Plan was created at 13:05hrs on the 4th October ( the day after the chair was allegedly used as a comfort but much more likely that the chair was used as a restraint) and that the care plan was subject to further modification later that day at 17:43 hrs. This evidence provided by ■■■ A of discrepancy in the care plan and the conversation below by Tawel Fan staff **who did not know they were being recorded** suggests that the chair was used as a form of restraint and that in amending the care plan on the computer and printing off a new one the staff felt they had covered all evidence of their actions.
- Further to this is the admission by Staff Member 14 ■■■ that the original paper copy of the care plan which would have shown whether the concept of 'chair as comfort' to ■■■ A was indeed something that had been in place for some weeks (as stated by ward staff and denied by the family of ■■■ A) had been shredded by her.
- Staff Member 14 attempts to explain why an important nursing document had been torn up and then shredded: ***"We've got a Care Plan which was partly typed up, partly handwritten on the side, it looked really unprofessional. We knew ■■■ was going to request a copy, so my colleague/we had had a problem we didn't have a computer for a while and a printer so my colleague just retyped the document, the additional bit onto it and in a moment of stupidity I tore it up and put it in the rubbish bin/shredder. I don't know why I did it. I hold my hands up, but it was a moment of total stupidity..."*** (Page 18).
- The ward staff in the recording state:

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

- **Voice 1:** ' We've done it because we knew this was coming so we've POVA'd ourselves' (all Page 4)
- **Voice 1:** 'We know it's going to come, we know there's going to be a massive complaint again, so that's why we POVA'd ourselves for the second time.' (Page 7)
- **Voice 1:** 'What they'll do is, the POVA **we've put in against ourselves is to cover our backs to say that it's not a restraint; it's for a comfort thing for him.** It's a reassurance measure. because where the chair was ■ still has ability to get out of bed, if it was restraint then we'd have been using cot sides or we'd have tied him in whatever....' (Page 10)
- **Voice?:** ■ said that ■ spoken to this Health Inspectorate Wales and Ombudsman person and they said it was abuse..' (Page 11)

At the beginning of this investigation the information regarding the 'properties' of the Care Plan (from the screen shot) was passed immediately to the Deputy Director of Nursing who passed this information to the BCUHB IT department. This information was also passed to the internal HR enquiry within BCUHB and it is expected that an outcome to this issue will form part of that report.

The theme of the use of restraint on Tawel Fan ward is further seen in a recent POVA that was reopened following the emergence of additional evidence. Three allegations namely that:

- Staff member 10 (support worker) used inappropriate language,
- The staff member described as B used inappropriate restraint ,
- The staff member known as M gave the patient ■ M ■ when ■ was distressed and uncooperative were found by the POVA panel to be likely on the balance of probability.

Key to the difference in outcome in this second POVA concerning this case was the ■ Staff Member 6 who said that when the patient declined ■ Staff Member 10:

- **■ went round the back of ■ and bent like that and put ■ face to ■ face, so presume ■ felt intimidated so ■ spat in ■ r face, so like a swarm**

56

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

*of seagulls the other chap came along, [redacted] pinned [redacted] down by [redacted] arms, bearing in mind to me that's why I asked if it was right because if the [redacted] is paralysed, [redacted] can't move anyway, so the chap's pinned [redacted] down by [redacted] arms while the [redacted] has grabbed [redacted] by the face [redacted]' (Page 3)*

- Staff Member 6 continued:- *'I didn't like it, that's why I went to [redacted] and the [redacted] to ask ..... if that was what sort/I know what restraint is, was that alright as a restraint, were they supposed to do it like that, because I was just questioning myself because ..... you can't be pinned down if you're not on a Section and if it is just for [redacted]' (Page 3)*

- Staff Member 6 was asked at interview – *'Looking at it and remember it as you do, to you did it seem as though the amount of force that was used was ..... too much?'*

Staff Member 6 responded *'Oh it was.'* (Page3)

- Three Members of Staff, Staff Member 6, Staff Member 16, [redacted] and Staff Member 27 [redacted] all had experience of this particular patient [redacted] (The transfer to Tawel Fan had been for operational / bed issues not for the clinical care of this patient.)
- Staff Member 6 described how [redacted] had seen staff on Tegid ward deal with this patient who sometimes declined [redacted] medication. [redacted] said *'Because I had seen [redacted] on Tegid before now and I had seen myself with the other staff they would leave [redacted], they will go back to [redacted] room, they will leave [redacted] they will go back when [redacted] has calmed down a bit and then [redacted] accept [redacted] medication....'* (Page 4). Staff Member 6 described the Members of Staff behaving *'like seagulls in a McDonald's when you're having a McDonald's when you're having a burger, it was just / no need'.* (Page 4)
- Staff Member 27 verifies the account above of how staff on Tegid ward dealt with the issue of this patient declining [redacted] medication. [redacted] stated:- *'Sometimes we would go in and [redacted] would tell us to go away and shout at us and swear at us a lot, so sometimes we would go away and then go back in ten minutes and then [redacted] would be more cooperative. [redacted] was quite changeable in [redacted] moods obviously due to [redacted] illness as well'* (page 2)
- Staff Member 27 also described how other methods were employed to persuade [redacted] M to accept [redacted] [redacted] if [redacted] were reluctant. *'Well sometimes we would get different staff to go to [redacted] because [redacted] got on better with*

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

*certain staff sometimes so we found that worked sometimes and then other times just go back about ten minutes later'.*

- Staff Member 27 describes how surprised ■■■ was that restraint had ever needed to be used in the case of ■■■ M as it had never been used at all in the preceding months in Tegid ward:- *'I was surprised because we had never had to do it in the whole/I think ■■■ had been with us probably four or five months by then, so I was quite surprised because we had never had to do it and we hadn't even considered needing to do it, because I know ■■■ was challenging at times, but it never ever came to that and like I said with people with behaviour like that you've just got to work around them and that's what we found to work so we never had to even consider it.'* (Page 3)
- Staff Member 27 also confirmed that following return from Tawel Fan ward to Tegid ward that restraint was again never considered which rules out the possibility that ■■■ M had undergone a significant change or deterioration in ■■■ behaviour in Tawel fan ward necessitating the use of restraint. What seems much more likely taking the previous accounts of the use of restraint in Tawel Fan ward by a number of relatives, colleagues and former colleagues is that behaviour by a number of members of the Tawel Fan team was unacceptable and seemed to go unchecked and unchallenged despite the fact that the ■■■ (staff member 9) and the ■■■ (Staff Member 16) both claimed to be present on Tawel Fan ward every day.
- This description of never previously having needed to use restraint was also verified by Staff Member 16 in ■■■ capacity as ■■■. Staff Member 16 said of ■■■ (Page 13) *'But soon after transferring ■■■ there (Tawel Fan) and ■■■ became almost mute and ■■■ stopped responding and ■■■ didn't eat and drink and ■■■ was doing this and ■■■ had been alright on Tegid ward and I was really upset what was happening with ■■■ .... I asked the staff and I was told that ■■■ needed restraining and that kind of thing and I was a bit surprised that ■■■ never needed restraining in Tegid ward.'* (Page 12)
- Staff Member 16 continue *that 'After being there (Tawel Fan) for a couple of days I was told that ■■■ DST needed to be redone because ■■■ needs are completely different now...'* (Page 13)
- Staff Member 16 continued *' My worry about Tawel Fan particularly after that tape is that one thing I was deliberating I said that this is a locked ward where we are admitting people who cannot kind of have a conversation or express their own needs and they are depending totally on the care staff and*

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

*if the staff members are talking about those patients this way, there is a problem.'* (Page 14)

- [REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED] In terms of [REDACTED] availability to observe practice and behaviours on the ward Staff Number 16 appears to be in a similar position as the [REDACTED] since [REDACTED] confirms: *'As an [REDACTED] and I provided almost daily input to Tawel Fan ward and [REDACTED]*  
*[REDACTED] All the 5 [REDACTED] admitted to Tawel Fan ward, I was available for the ward mostly there, almost every day.'* (Page 1)
- However, despite these apparently daily visits and [REDACTED] concern and surprise that [REDACTED] own patient [REDACTED] M required restraint within a short time of transfer from Tegid to Tawel Fan ward it takes the emergence of a secretly recorded tape of a nursing handover to raise concerns about Tawel Fan ward since neither the [REDACTED] or the [REDACTED] ever do so as a result of their daily visits.
- In addition to the likely use of restrain on the ward Family B noted the complete lack of care shown towards patients by Tawel Fan staff on their frequent visits to the ward. *'There was definitely a build- up of frustration amongst the patients at the lack of activity and that frustrations increased as they all continually walked around and around the ward.'* (Page 2)
- Family C note that [REDACTED] was admitted to a double room with two beds within Tawel Fan ward. Despite the fact that the second bed was not in use during this time none of the staff thought to move it. [REDACTED] Family C recalled *'And at that time my [REDACTED] was very frightened and [REDACTED] thought [REDACTED] was in an asylum and [REDACTED] thought that the other bed in the room was where they did electric shock treatment so [REDACTED] was very frightened.'* (Page 4.) The family do not recall that anything was ever done by the Tawel Fan ward staff to reduce or remove [REDACTED] fear of being in 'an asylum' and having the bed next to [REDACTED] 'where they did electric shock treatment..'
- In agreement with Family B and others Family C recall the daily routine in Tawel Fan ward which again the ward team did nothing to improve upon or

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

mitigate. [REDACTED] C said '*And it was like when you go in a zoo and see animals that have been captured there for a long time and that's all they've got to do is walk around and around...*' (Page 6)

**13. Conclusions**

Donna Ockenden was required to advise the following:

**13.1 Whether the concerns as set out in the Terms of Reference are proven.**

**13.1.1** This report finds that the concerns as set out in the Terms of Reference are **proven** and therefore **fully upheld and supported**.

**13.1.2** The report concludes and advises the Health Board that the Terms of Reference underpinning this report are all linked closely to multiple breaches of both the NMC Code of Conduct, Performance and Ethics. (NMC 2010) and the GMC's 'General Medical Practice - Good Practice Guidance' (2013)

**13.1.3** The report therefore concludes and advises the Health Board that in addition to the concerns in the Terms of Reference being fully upheld and supported they also constitute **serious and comprehensive breaches** of the standards required of registered nurses as set out in the NMC Code of Conduct Performance and Ethics. (NMC 2010) and **serious and comprehensive breaches** of the standards required of medical practitioners as set out in the GMC's 'General Medical Practice - Good Practice Guidance' (2013)

**13.2 Underlying issues contributing to any proven allegations.**

This final report finds that the following underlying issues contribute to the allegations and concerns found upheld within this external review.

**13.2.1** **There was a lack of action by the senior leadership team on previous reports highlighting specific concerns with the service provided by the CPG.**

In March 2012 a report (see Appendix 12) by Professor Robert Poole concluded that there were 'marked limitations in the current SUI surveillance system...' within the Mental Health and Learning Disabilities CPG. The report also described this as a problem affecting the whole of Wales which this report is not able to comment on. However taking into account that more than two years have passed since the publication of this report I have not seen any evidence to date that the CPG has taken on board any of the concerns

60

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

within the report. It is of particular concern that Professor Poole has noted that there was 'difficulty in making sense of the information (which) illustrates a real problem with the SUI reporting system in general.' (Page 13) Throughout this external review the author repeatedly asked senior staff within the CPG for information on adverse incident reporting including trends, numbers and severity of incidents. Despite multiple requests and reminders over a period of time in excess of six months this information has yet to be provided.

**13.2.2 There was a lack of systematic review and little evidence of timely actions put in place by the senior leadership team within the CPG to address known and current risks within their service across North Wales.**

The CPG has provided a series of Minutes for key meetings within the CPG spanning the period of time prior and after the closure of Tawel Fan. (See Appendices 14, 15 and 16 for examples.) The following points are of note and seem to indicate **an inability of the senior leadership team to assess accurately and take action to reduce the risks found within the service the leadership team was accountable for.** In Appendix 14 Minutes of the Senior Management (14/4/14) - the first meeting for 3 months as the last meeting appeared to be 17th January 2014. It is noted regarding Healthcare Standards 'We are currently scoring 1- 38%. The action to be undertaken was ' 1. **Ops manager to supply detail; 2. Somebody to pick it up..**' (Pages 1 and 2) The actions outlined were neither specific, or measureable and therefore not achievable in a timely manner. There also followed discussion about falls in the same non-specific way **trying to get some evidence to send to Flynn Team and let them get guidance on whether we have a problem with falls or not...**' There are further multiple other examples around admissions: **'We don't have a pathway, we should have a pathway around admissions, we have a problem because we don't have a pathway.....we have had a few problems.'** (Page 2)

In the next meeting (See Appendix 14 minutes dated 19th May 2014) there is discussion around SUIs **to look at SUI themes with today.**' What is being 'looked at' and what the output would be (and when) is not specified. Of greater concern is the following section where SUI's are placed in a section called **'Miscellaneous Imperatives.'** I have never encountered such a heading in the notes/ minutes of a Senior Team Meeting before this. Clearly SUI investigation cannot be considered 'Miscellaneous' and to put together the words **'Miscellaneous Imperatives'** makes no sense. Again even five months after the temporary closure of Tawel Fan ward and more than two years after the publication of the Poole report there is no sense of urgency from the Senior Team regarding the need to resolve the many issues regarding the

61

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

reporting, investigating and learning from serious incidents in the CPG. The actions are vague. [REDACTED] **project - SUI's, [REDACTED] invited to Operational Group to discuss. [REDACTED] to write to [REDACTED]? To invite to future SMT..** Again there is no date identified when the letter should be written and what its output is intended to be; neither is there a plan as to **when** [REDACTED] should be invited to either the Operational Group and whether it is [REDACTED] or [REDACTED] or both) who are to be invited to a 'future SMT.' There is similar disorganisation found within the 'Infection Control' Minutes dated 10th April 2014. The heading **states 'extra meeting as the last 2 meetings cancelled - therefore the meeting planned for the 22nd April will be cancelled.'** Similarly in Appendix 1 (Safeguarding Children and Vulnerable Adults Group.' dated 15 April 2014 there is a note of the target for compliance with safeguarding training being 80-100%. It is noted that current staff compliance was circa 50%. Other than the action **'this requires a big push from all'** (Page 1) there was no detail regarding the steps the CPG intended to take to improve upon this inadequate position. In addition (see pages 1 to 4 of the minutes for details) all action columns were blank with no one attributed to taking forward (and therefore no timescale confirmed) for the many actions required.

**13.3.3 It is likely there was significant under reporting of Serious Incidents (known as SUI's within the clinical areas led by the CPG.**

Interviews with relatives and staff (for example Staff Number 14 and Appendix 35). In Appendix 35 note a concern received 1<sup>st</sup> March 2013 graded as minor Grade II despite the fact that the summary of concern is "Patient suffered fall on the ward and broke hip – how did this happen? The outcome is described as "Closed with explanation" and dated 15<sup>th</sup> May 2013. The CPG have been unable to produce any investigation report showing that this incident which appears (on the face of it at least) to be very serious such under reporting of clinical risk is a constant theme throughout this investigation. Staff Member 39 refers in [REDACTED] interview to a further example of under reporting of clinical risk/ complaints. [REDACTED] describes discussing a serious complaint with Staff Number 16 in circa 2010. Staff Number 16 is described by Staff Number 39 as going "Nuts" and is alleged to have said to Staff Member 39 "I don't want any more complaints landing on the desk of [REDACTED] ([REDACTED]) "No you don't understand me, I don't want anymore complaints landing on [REDACTED] [REDACTED], you know what I mean". Staff Member 39 then described that there followed a heated discussion with Staff Number 16 where [REDACTED] said to [REDACTED] "You are telling me not to be open with complaints such as this - as all serious complaints of this nature would need to be scrutinised by [REDACTED]. Staff Number 16 kept repeating "I don't want anymore complaints landing on [REDACTED] desk". Staff Number 39 recalls that [REDACTED] then sought advice from a number of Senior

62

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

Members of the CPG Team and described the situation where Staff Number 16 had told [REDACTED] that no more complaints were to effectively be sent to [REDACTED] from the CPG. [REDACTED] was told by [REDACTED] senior colleagues that [REDACTED] was over reacting to [REDACTED] remark. No action was taken by the senior team including [REDACTED]

All of this seems to indicate a fundamental problem with under reporting of clinical risks and incidents on the ward. [REDACTED] (Family E) described an incident where [REDACTED] found [REDACTED] in obvious pain with a badly bruised arm. The response from the [REDACTED] was 'Oh [REDACTED] did complain of a painful arm but we didn't take much notice really.' Due to staffing issues the [REDACTED] had to take [REDACTED] to A and E. A fractured wrist was diagnosed. The fracture was described as typical of 'Fall on outstretched hand.' The time of fall and fracture remains unknown as the [REDACTED] was unable to provide a history and the ward staff had not witnessed the fall and seemed unaware of the injury. I have been unable to locate a Datix for this incident. The [REDACTED] described in [REDACTED] interview [REDACTED] considerable distress at the pain [REDACTED] suffered and also questioned how much longer the ward staff would have left [REDACTED] in pain had [REDACTED] not visited Tawel Fan ward that afternoon. (Family E)

- 13.3.4 It is likely that there was no (or very limited) oversight by the Senior Leadership Team of any of the activities within Tawel Fan ward. The Team on Tawel Fan ward (it appears) were just 'left alone' to behave in an unacceptable way unchecked by senior leaders within the organisation. It is unknown how long their behaviour had persisted but it is likely to greatly exceed the time frame for this report which is approximately the last two years.**

None of the senior staff from within the CPG could describe adequately how they gained for themselves and then provided assurance upwards to the Executive Team regarding the safety and quality of care on Tawel Fan ward. Some Senior Managers/ Leaders stated in interview that they never (or rarely) visited the ward. Staff member 11, [REDACTED] described visiting the ward 'once a year, not frequently anyway; and stated that any information or intelligence [REDACTED] required [REDACTED] would expect it to come via the nursing route. [REDACTED]

In addition, Staff Member 23 [REDACTED] was at interview unable to recall when [REDACTED] had last visited Tawel Fan ward, neither could Staff Member 13 the [REDACTED]. Others stated they visited regularly – sometimes daily several times a week ( e.g. Staff Members 9, [REDACTED] 16

63

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

██████████ and 40 ██████████ Their visits were clearly ineffectual since they appeared not to know what was occurring on the ward on a daily basis for a prolonged period of time. If not ineffectual the other alternative is that members of staff.

The other alternative is that they did witness what was going on and chose to ignore it. In the case of Staff Member 40 ██████████ initially ██████████ stated ██████████ had never been aware of patient / relative complaints but with a little prompting was then easily able to remember three. In the case of Staff Member 16 one of ██████████ own patients (it appears) suffered from unnecessary restraint during a very short stay on Tawel Fan ward when restraint had never been used on Tegid ward in the four or five months before the Tawel Fan incident and never subsequently to that Tawel Fan episode of restraint. However there has been no evidence provided to me that Staff Member 16 ever raised concerns regarding this episode with other senior medical colleagues (eg Chief of Staff or Medical Director) even though it would have been expected that ██████████ would have ██████████  
██████████

**13.3 Did the culture on the ward lead to the restriction or curtailment of the dignity, privacy, choice, independence or fulfilment of individuals who are or could be deemed vulnerable, and could this result in 'institutional abuse' as described in Section 6.6.2 All Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse. (Appendix 2).**

This report finds (and therefore informs the Health Board) that the culture on Tawel Fan ward **did** lead to the restriction or curtailment of the dignity, privacy, choice, independence or fulfilment of individuals who are or could be deemed vulnerable, and that this **has** resulted in 'institutional abuse' as described in section 6.6.2 All Wales Interim Policy & Procedures for the Protection of Vulnerable Adults from Abuse\*.

**13.4 Advise on any immediate or long term remedial steps considered to be required.**

The interim report advised the following immediate steps:

1. Tawel Fan ward should not be considered for re-opening until the final report from this investigation is received alongside a detailed review and understanding of any lessons to be learnt from the currently ongoing Tawel Fan mortality review.
2. Any new ward or department that may be opened in or around the area that is the currently closed Tawel Fan ward should adopt/ be given a new name.

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**External Investigation into concerns raised regarding the care and treatment of patients  
Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

3. There should be a clear set of measureable standards set for the care of frail older people with dementia across BCUHB. There are excellent examples of practice seen elsewhere across Wales and the wider UK including London and Brighton. However from the evidence seen to date Tawel Fan ward and the CPG it was part of, somehow became disconnected from this programme of renewal and change. Whilst many documents and action plans were churned out on a regular basis little (if anything) materialised from the vast amount of paper produced that made any difference to the patients and their families cared for in Tawel Fan.
4. The Board should consider a full public apology to the patients and families who were admitted to Tawel Fan ward once this final report is received.
5. The Board should consider how they will engage with the remaining families
6. Or patients / relatives who have not yet been given an opportunity to share their experiences of Tawel Fan ward.
7. There should be a complete overhaul of the concerns/ complaints/ serious incident reporting structure and an overhaul of the system of learning from these issues.
8. The Board should ensure that there is a fully operational 24/7 access to services such as diagnostics, medical cover and pharmacy across elderly mental health care in North Wales
9. Immediate work should start on a Ward to Board communication strategy across all CPGs. This should include easy access to an NHS Wales email account since a significant number of staff interviewed do not have this facility.
10. Where they exist 'shared log in' for IT services must be stopped
11. There should be an immediate review of the scale, (breadth, depth and size) of all operational, clinical and managerial roles across the CPG with a realistic assessment of the ability of the current individuals in post to perform in their roles.
12. There should be a clearly articulated message from the Executive Directors that all clinical leaders (medical and nursing) should spend a defined portion of their working week within the clinical area alongside and listening to patient and relative feedback. Evidence should be provided at monthly performance reviews with the executive team that CPG leaders have made

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

changes in practice/ care / operational service delivery as a direct result of this time within the clinical areas.

13. The BCUHB should implement an extensive and intensive skills and knowledge package around care of patients with dementia and support of their families
14. There should be an overarching review of all estates providing care of the elderly to assess its fitness to provide care.

The final report makes the following additional recommendations in addition to those recommendations above which are still considered to be valid recommendations in the presence of the further evidence considered:

15. The Board should consider the multiple very serious breaches of the NMC Standards of conduct, performance and ethics for nurses (NMC 2010) and Good Medical Practice (GMC 2013) and take appropriate steps with the two regulatory bodies to safeguard the best interests of patients utilising elderly mental health services across the catchment area of the BCUHB.
16. The Board should consider very seriously the unacceptably low standards of leadership and management exhibited and seen within the CPG during this external review and the events leading up to it. These unacceptably low standards were found within all medical and nursing leadership roles from the top of the CPG to ward manager level. The families whose relatives have suffered great harm and distress will require assurance from the Health Board that such levels of performance are regarded as unacceptable within the NHS in Wales. They will also require assurance that appropriate action will be taken in a timely manner.
17. The Board should interrogate further and in detail the information from the currently interim Tawel Fan mortality review being undertaken. Whilst it remains interim at the time of submitting this external report it originated from concerns around the potential death rate on/ associated with Tawel Fan as expressed by relatives in interviews. Feedback on the findings once completed therefore should be made public.
18. The Board needs to assess (whilst the above mortality review is ongoing) whether other similar reviews may have taken place in the past. There needs to be an urgent review of the Datix system undertaken to assess whether potential 'clues' to a possibly longer term problem around the number of deaths within/ associated with Tawel Fan ward have been 'missed'.

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

19. At the earliest opportunity the Health Board should liaise with the local Coroner and North Wales Police around the findings of the interim mortality review and take their advice as to whether further steps should be taken from each of their individual perspectives.
20. There should be a review of the training, support and supervision of junior doctors by consultant colleagues in mental health services for the elderly in North Wales. Feedback from families appears to indicate that where medical care was provided for their relatives it was often provided by inexperienced doctors who did not appear to have had consultant support and supervision whilst providing that care.
21. According to families medical care/ provision in Tawel Fan ward was largely on an 'as and when called' basis rather than in a planned systematic way. Much medical care appears to have been provided by the on call doctor rather than as a routine and planned approach to medical care. There needs to be an urgent review of medical care/ provision across elderly mental health services in North Wales to ascertain if this is / was the case and action taken in a timely way to improve upon the standards of medical care for elderly patients using mental health services if the concerns of families are proven.
22. There needs to be clear standards and expectations articulated across North Wales as to the duties of Consultant colleagues. Families have articulated that their role was often unclear and that their involvement when it happened was of secondary importance. There was no evidence of consultant leadership or clinical standard setting in the care of any of the patients that families discussed in depth as part of this external review.
23. There needs to be clarity and expectations set regarding the role of the Pharmacist/ Pharmacy services in the care of the elderly patient using mental health services in North Wales. This clarity needs to be followed up urgently by the introduction of an appropriate infrastructure to ensure the role of the Pharmacist is central to the delivery of elderly mental health care in North Wales. Families report in some cases concerns regarding overmedication of their relatives and what is referred to by some families as a 'lucky dip' approach to medicines management. Some colleagues referred to the use of 'old fashioned' medications in Tawel Fan ward that had long fallen out of use elsewhere.
24. There was limited if any evidence of Speech and Language Team (SALT) assessment, review/ involvement in the care of some of the patients who formed part of this external review. This was the case even where relatives asked ward staff for such support on a number of occasions. There needs to

67

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Tawel Fan Ward, Ablett Acute Mental Health Unit Glan Clwyd Hospital.**

**Final Report September 2014**

**CONFIDENTIAL**

be clarity and expectations set regarding the role of speech and language services in the care of the elderly patient using mental health services in North Wales. This clarity needs to be followed up urgently by the introduction of an appropriate infrastructure (and resources) to ensure the role of the SALT Team is central to the delivery of elderly mental health care in North Wales.

25. There was limited if any evidence of physiotherapy, occupational therapy and dietetic assessment, review/ involvement in the care of some of the patients who formed part of this external review. This was the case even where relatives asked ward staff for such support on a number of occasions. There needs to be clarity and expectations set regarding the role of physiotherapy, occupational therapy and dietetic assessment, in the care of the elderly patient using mental health services in North Wales. This clarity needs to be followed up urgently by the introduction of an appropriate infrastructure (and resources) to ensure the role of these colleagues are central to the delivery of Elderly Mental Health care in North Wales.
26. There should be a review of the risk assessment systems in place for elderly patients who are or become violent / aggressive as part of their conditions. Feedback from relatives seems to indicate that there was either limited or no evidence of risk assessment and no consistent standards of care/ treatment/ practice where these issues/ episodes arose.
27. There should be a review of standards for 1:1 supervision of patients. Feedback from families indicates an inconsistency in the application of 1:1 supervision (i.e. several instances where despite documented evidence of violence / aggression/ harm to other patients, self or staff expected standards of 1:1 supervision was not applied. There were also instances from family statements where even with the documentation of 1:1 care other patients were injured, which questions the quality/ accuracy of this.
28. From evidence obtained in relatives interviews it is clear that on Tawel Fan ward there was inconsistent use of risk assessments for falls and no evidence of protective measures (to reduce harm) in patients who may fall despite the fact that the Tawel Fan patient population were a group at high risk of falling. In a number of cases there was poor / limited/ no evidence of documentation of injuries or information provided to relatives/ reporting using the Datix system and referral to/ review by medical staff. Whilst there have been reviews of falls in elderly mental health services across the CPG these appear to have taken as their starting point that the numbers of falls reported were accurate which is unlikely to be the case. There needs to be the early and timely introduction of a sustained campaign of best practice examples in Falls reduction/ prevention across Elderly Mental Health Care in North Wales.

68

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29. In a number of cases relatives reported failure by ward staff to recognise and respond to a deterioration in physical condition. This included either a lack of routine ward observations or in some cases over recording of routine ward observations and failure to recognise or prioritise those patients who needed an enhanced level of observation. There was also a failure to monitor appropriately and act upon problems with fluid intake / output. It was accepted seemingly that 'Psychiatric nurses were not good at providing physical care' and there was no evidence from the perspective of relatives that there was any medical leadership ensuring that patients physical and medical needs were attended to. The Board needs to ensure that there is early introduction of the All Wales systems in 'recognition of the deteriorating patient' across elderly mental health services in North Wales.
30. Evidence from former colleagues seems to suggest a lack of DVT risk assessment or use of appropriate prophylaxis in Tawel Fan ward. This issue needs to be considered by the Board and acted upon in a timely manner.
14. **Final words from some of the families and friends who have acted as witness to the standards of care within Tawel Fan ward.**
- Close friend of Patient B *'When I was walking out I used to say to myself, I am glad it's not me, I wish I could have taken [REDACTED] out of there. They didn't take the care I would have liked them to....'*
  - The [REDACTED] family C said *'And it was like when you go in a zoo and see animals that have been captured there for a long time and that's all they've got to do is walk around and around...'*
  - [REDACTED] relative H: *'I feel this has been happening to lots of others and I have never dealt with this system before .I have a [REDACTED] who needed help from Tawel Fan Doctors and staff and hope that this ward and staff are never allowed to work together again. There has been a total miscarriage of justice to my [REDACTED] and me. I believed they would help my [REDACTED] get some sort of life back at home. Instead they took away the last few years from [REDACTED].'*
  - The [REDACTED] Family D said *'I didn't want my [REDACTED] to end [REDACTED] days in Ablett, I know that, that's not what I wanted for him, I just felt as if I was fighting all the time, all the time and it was just snide comments....'* (Page 26)

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- [REDACTED] Relative H: *'This is a terribly sad case and I want people to be accountable.'* (Page 2)
- The [REDACTED] family D concluded *'I visited my [REDACTED] regularly.... But there were patients on the ward where I never saw anybody go to visit and I feel that the people who have come forward to make....complaints or... concerns their families might get some peace from this, but for those people who had nobody and people in the future who might have nobody, if you've got a mental illness you can't speak for yourself and you're in a position where you might as well be a dog because to be quite honest you've got no thoughts, nobody's listening to you because you've got no one to speak up for you.'*
- The [REDACTED] Family F said *'I used to come out of there and it used to break my heart. Every time I went in there I used to cry...'* (Page 25)
- The [REDACTED] Family F said *'I used to cry, because I used to get very angry....Would you allow that your [REDACTED] to be treated like this, would you do this to your [REDACTED].'* [REDACTED] added *'They'd just look at you.'* (Page 51)

END

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# DONNA OCKENDEN LTD





## External review of Concerns Raised About Tawel-Fan Ward







### APPENDICES





No	Author	Date	Item
			<p><u>All hyperlinks and embedded documents are available to access via :</u></p> <p><a href="http://www.wales.nhs.uk/sitesplus/861/page/81273">http://www.wales.nhs.uk/sitesplus/861/page/81273</a></p>
1	BCUHB	January 2012	<p>Concerns Policy (No. PTR01)</p> <p></p> <p>PTR01_concerns_policy_redacted.pdf</p>
2	Commissioned by the four Adult Protection Fora	January 2013	<p>Wales interim Policy and Procedures for the Protection of Vulnerable Adults from Abuse</p> <p><a href="http://www.wales.nhs.uk/sitesplus/documents/972/QS%2010%20Pova%20Policy.pdf">http://www.wales.nhs.uk/sitesplus/documents/972/QS%2010%20Pova%20Policy.pdf</a></p>
3	BCUHB	December 2013	<p>Transcripts of covert recording of nursing handover</p> <p>Excluded – Person identifiable information</p>
4	BCUHB	2014	<p>Terms of Reference</p> <p></p> <p>Appendix 4-Terms of Reference_redacted.</p>
5	General Medical Council (GMC)	2014	<p>General Medical Practice Good Guidance</p> <p><a href="http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0914.pdf">http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0914.pdf</a></p>
6	Nursing & Midwifery Council (NMC)	2010	<p>The Code</p> <p><a href="http://www.nmc.org.uk/globalassets/sitedocuments/standards/the-code-a4-20100406.pdf">http://www.nmc.org.uk/globalassets/sitedocuments/standards/the-code-a4-20100406.pdf</a></p>
7	Abbott Davies I	October 2013	<p>Report of Dementia Care Mapping Tawel Fan Ward, YGC</p> <p></p> <p>Appendix 7-Dementia Care Map</p>
8	Royal College of Nursing – Alzheimer's Society	No Date	<p>Document Dyma fi – This is Me</p> <p><a href="http://www.rcn.org.uk/_data/assets/pdf_file/0010/546751/Dyma_fi_-_This_is_me_booklet_bilingual.pdf">http://www.rcn.org.uk/_data/assets/pdf_file/0010/546751/Dyma_fi_-_This_is_me_booklet_bilingual.pdf</a></p>

9	Kindly provide by Family A		Photograph  Appendix 9_Photo.pdf
10	Page S / Ockenden D	February 2014	Photographic evidence including photographs of Tawel Fan Ward at YGC  Appendix 10_Photos_redacted.
11	Provided by BCUHB	February 2014	Facebook excerpts – Excluded – Person identifiable information
12	Poole R	March 2012	Investigation of Serious Untoward Incidents  Appendix 12_RP Report_Redacted.pdf
13	BCUHB	July 2014	POVA Summary Tawel Fan Ward 2011-2014 Excluded – Person identifiable information
14	BCUHB	14 <sup>th</sup> April & 19 <sup>th</sup> May 2014	Senior Management Team minutes MH&LD CPG  Appendix 14_mins_redacted.pc
15	BCUHB	22 <sup>nd</sup> January & 10th	Infection Control minutes MH&LD CPG  Appendix 15_mins_Redacted.p
16	BCUHB	31 <sup>st</sup> January & 15 <sup>th</sup> April 2014	Safeguarding Children & Vulnerable Adults Group minutes – MH&LD CPG  Appendix 16_mins_Redacted.p
17	Professor Andrews J and Butler M	2014	Trusted to Care Report <a href="http://www.wales.nhs.uk/sitesplus/861/opendoc/242868">http://www.wales.nhs.uk/sitesplus/861/opendoc/242868</a>
18	Welsh Government	2014	Welsh Government response to the above <a href="http://gov.wales/about/cabinet/cabinetstatements/2014/abmuindependentreport/?lang=en">http://gov.wales/about/cabinet/cabinetstatements/2014/abmuindependentreport/?lang=en</a>



19	HIW	(dated 10 <sup>th</sup> October 2013 re Visit to Tawel Fan Ward July 2013)	Letter to BCUHB from Health Inspectorate Wales  Appendix 19 - Letter to BCUHB from HIW.†
20	Page S (BCUHB)	March 2013 to March 2014 dated 17 <sup>th</sup> April	An analysis of in-patient falls within OPMH Wards  Appendix 20_In patient falls_Redacted
21	The Royal College of Psychiatrists	2003	The Rowan Report : Implications and Advice Guidance Note to Members  <a href="http://www.rcpsych.ac.uk/pdf/Rowan.pdf">http://www.rcpsych.ac.uk/pdf/Rowan.pdf</a>
22	Commission for Health Improvement	September 2003	Investigation into Rowan Ward, Manchester  <a href="http://www.elderabuse.org.uk/Documents/Other%20Orgs/Abuse%20Report%20CHI%20Rowan%20Ward.pdf">http://www.elderabuse.org.uk/Documents/Other%20Orgs/Abuse%20Report%20CHI%20Rowan%20Ward.pdf</a>
23	Royal College Psychiatrists	June 2000	Institutional abuse of older adults (CR84)  <a href="http://www.ibrarian.net/navon/paper/Institutional_abuse_of_older_adults.pdf?paperid=4825803">http://www.ibrarian.net/navon/paper/Institutional_abuse_of_older_adults.pdf?paperid=4825803</a>
24	Joint Review undertaken by Health Inspectorate Wales and the Wales Audit Office	June 2013	An Overview of Governance Arrangements Betsi Cadwaladr University Health Board  <a href="http://www.hiw.org.uk/sitesplus/documents/1047/364A2013%20HiW%20joint%20report%20Final%20%282%29.pdf">http://www.hiw.org.uk/sitesplus/documents/1047/364A2013%20HiW%20joint%20report%20Final%20%282%29.pdf</a>
25	BCUHB	May 2013	Acute Care Programme – Bryn Hesketh Report Action Plan  Appendix 25 action plan_redacted.pdf
26	Page S (BCUHB)	October 2013	Report concerning the quality and appropriateness of the care and treatment plan of an individual  Excluded – Person identifiable information
27	Robins R (BCUHB)	October 2013	Dignity and Essential Care Peer Review of Tawel Fan  Appendix 27 Care Review_Redacted.pd

28	BCUHB	July and August 2013	Summary of Datix and concerns for Tawel Fan ward  Appendix 28_Datix stats_redacted.pdf
29	Provided by Family A	Dated 21 <sup>st</sup> September 2013	Care and treatment plan of an individual Excluded – Person identifiable information
29a	Provided by Family A	October 2013	Care plan Excluded – Person identifiable information
30	BCUHB	January 2013	Clinical Programme Group/Reporting Structures  Appendix 30 - MH&LD CPG Reportin
30a	BCUHB	May 2014	Draft of above – Revised May 2014 MH&LD CPG  Appendix 30a - MH&LD CPG Manager
31	BCUHB	February 2014	Door sign found within Tawel Fan Ward during site visit  Appendix 31_Door sign_redacted.pdf
32	Provided by staff Member	Supplied at interview	Information from personal mobile phone of staff member Excluded – Person identifiable information
33	Donna Ockenden	2014	Anonymised detail of family members interviewed  Appendix 33_Anonymised famil
34	Donna Ockenden	2014	Anonymised detail of staff interviewed  Appendix 34 staff_redacted.pdf
35	BCUHB	Nov 2012 – Jan 2014	Examples of concerns Excluded – Person identifiable information

36	BCUHB	Final draft 26 <sup>th</sup> January 2012 reviewing draft in 2014	Mental Health & Learning Disabilities CPG process for the reporting and investigation of SUI  Appendix 36_MH&LD Process for reporting
37	Page S (BCUHB)	2014	Developing Older Peoples Mental Health In-patient services  Appendix 37_OPMH inpatient services_re
38	Page S (BCUHB)	March 2013	Dementia Intelligent Targets – Progress Report  Appendix 38_Dementia intelliger
39	BCUHB	2011-2012 (Dated 22 <sup>nd</sup> February 2011)	MH&LD CPG Governance and Business Committee Structure (appears to be unfinished) sent to external reviewer July 2014  Appendix 39_MH&LD Governance & Commi
40	Pictures of Tawel Fan patients	Various dates	Excluded – Person identifiable information