Reference: IC-47257-J4K8

Freedom of Information Act 2000 (FOIA)

Decision notice

Date: **4 January 2021**

Public Authority: **Betsi Cadwaladr University Health Board**
Address: **bcu.foi@wales.nhs.uk**

Decision (including any steps ordered)

1. The complainant requested information relating to a previous request he had made in respect of the 'Robin Holden report'. Betsi Cadwaladr University Health Board refused the request on the basis that it does not have to respond to questions if it would mean creating new information or giving an opinion or judgement that is not already recorded. Following the Commissioner's investigation, it did provide information in response.

2. The Commissioner's decision is that Betsi Cadwaladr University Health Board has now complied with its obligations in respect of section 1 of the FOIA, however in failing to provide its response within the timescales specified under the FOIA, has breached section 10 of the FOIA.

3. As the Health Board has now complied with its obligations under section 1 of the FOIA, the Commissioner does not require the public authority to take any steps.

Request and response

4. On 4 July 2019, the complainant wrote to the Health Board and requested the following information:

   "Q.1. The Board had a general duty of care to these patients, so why were no steps taken to identify the number of patients affected and the nature of the neglect they suffered.

Q.2. Given the clear evidence of patient neglect and probable abuse, what steps did the Health Board take to identify the individual patients to whom the generalised testimonies related, so as to ensure that any neglect or abuse ceased?

The generalised nature of the patient neglect identified in the Report falls squarely within the definition of predisposing factors which may lead to abuse, as itemised in the All Wales Policy and Procedures for POVA. The POVA guidelines make abundantly clear what action the Health Board was duty bound to take when confronted with evidence of the kind contained in the Holden Report.

Q.3. Why did the Board not trigger the consideration of an adult protection referral?

Q.4. Why did the Health Board not disclose the Holden Report to other agencies with which it shared POVA responsibilities? Was this because it made a distinction between 'neglect' and 'abuse' or for some other reason?

I find it shockingly disingenuous that you describe the POVA process as "owned and led" by the Local Authority. Given the shared nature of the Health Board's responsibilities for POVA and given that we are talking about the neglect and probable abuse of vulnerable patients in the care of the Health Board, I am amazed that you distance yourself from this responsibility by suggesting that any action on abuse would lie with the Local Authority.

Q.5. If I am wrong in this assessment, would you please confirm that the Board did, in fact, formally refer the evidence in the Holden Report to the other POVA agencies?

Q.6. You say that the Report is set out in such a way as to protect the identity of individual patients. Are you implying that this form of confidentiality prevented the Health Board from identifying the patients concerned and therefore prevented the Board from safeguarding these individuals?

You say that the whistleblowers "will have had an expectation" that their statements would be kept in strict confidence and you set this as a higher duty than the public interest or, indeed, the interest of patients. It seems to me a supreme irony that you failed to investigate the direct impact of neglect on individual vulnerable patients by invoking the right to confidentiality of the very people who wanted to expose such neglect and abuse.

Q.7. If I am wrong or have misunderstood your response, can you please tell me what your investigations discovered?

I do not believe your stance on confidentiality is justified under the Freedom of Information Act and I think you should get a ruling from the Information Commissioner. It is also clear that the POVA guidelines deliberately set the interests of vulnerable patients above other considerations, stating that confidentiality must not be guaranteed to anyone who discloses abuse.

Q.8. Given the Board is still using this interpretation of the FOI Act, are you prepared to ask the Information Commissioner for a ruling?

Q.9. Do you accept that your decision to safeguard the confidentiality of the witnesses who have disclosed abuse does not comply with POVA Guidelines?

Q.10. Have I correctly understood from what you say that the Health Board did not receive any reports on progress in implementing the recommendations of the Holden Report? Does this mean there is no record of any action taken or did another Committee or responsible Lead manager receive such reports?

5. The Health Board responded on 6 August 2019. It stated that: *"…an authority does not have to respond to questions if this would mean creating new information or giving an opinion or judgement that is not already recorded."*

6. The complainant was further informed that the Board had no further information relating to the Robin Holden Report which it could supply and confirmed that it would be unable to process any further requests relating to this subject.

7. Following an internal review, the Health Board wrote to the complainant on 11 September 2019. It confirmed that it was upholding its original decision, but further informed the complainant that his concerns had been shared with the Director of Mental Health and Learning Disabilities.

8. Following receipt of the Board's internal review, the complainant contacted the Health Board asking it to respond to his questions about its handling of his FOIA request in general as he felt these were more appropriately addressed by the FOI unit than the Director of Mental Health. He also asked if the aforementioned Director planned to reply to him.

Scope of the case

9. The complainant contacted the Commissioner on 13 October 2019 to complain about the way his request for information had been handled.

10. In addition to his concerns about the Health Board's handling of his follow on request, the complaint included concerns about the Health Board's response to his original request for a copy of the Holden Report which was determined separately by the Commissioner in decision notice FS50882004.

11. The Commissioner considers that the scope of her investigation is solely in respect of the complainant's follow-on request and therefore to determine whether the Health Board has complied with its obligations under section 1(1) of the FOIA.

Reasons for decision

Section 1 – General right of access to information held

12. Under section 1(1) of the FOIA, in response to a request for information a public authority is only required to provide recorded information it holds and is not therefore required to create new information in order to respond to a request.

13. In scenarios where there is some dispute between the amount of information located by a public authority and the amount of information that a complainant believes may be held, the Commissioner, following the lead of a number of Information Tribunal decisions, applies the civil standard of the balance of probabilities.

14. The Commissioner's judgement in such cases is based on the complainant's arguments and the public authority's submissions and where relevant, details of any searches undertaken. The Commissioner expects the public authority to conduct a reasonable and proportionate search in all cases.

15. In this particular case, the Health Board initially concluded that the request was not a valid request for information under the FOIA. However, following the intervention of the Commissioner, the Health Board subsequently provided a response to the complainant.

16. The complainant considered that the response misrepresented the contents of the Holden Report and the testimonies which inform it, adding that it describes the report as having been commissioned in response to working practices and its 'indirect' impact on patient care. However, he argued that the Health Board's response ignored the findings of the report itself citing descriptions from the report which conveyed a very real and 'direct' impact on patient care.

17. The complainant also disagreed with the Health Board's description of the report referring to the 'potential and/or perceived impact on patient care as opposed to specific cases, stating that his understanding of the report is that it does actually highlight specific cases of neglect.

18. The complainant further argued that because the response failed to acknowledge the direct evidence of neglect, it ignores his questions about POVA (Protection of Vulnerable Adults).

19. The complainant expressed concern with the Health Board's reference to the Holden Report as having been triangulated with the reports from the Health Inspectorate Wales (HIW) and the Royal College of Psychiatrists (RCP) adding that it went into considerable detail about the reporting of updates and action taken. However, he argued that having read the first update provided to the quality and safety committee on 5 June 2014, that whilst there is considerable detail about the HIW and RCP recommendations, the Holden Report is not even mentioned in passing. The Commissioner can confirm that the complainant's observations regarding this are indeed correct.

20. The complainant continued that similarly, the reports made to the full Board in June and July 2014 make no reference at all to the Robin Holden Report or to any of its recommendations, expressing concern that he found it difficult to believe that the omission was accidental as the author of the update was deeply involved in all the issues surrounding the Holden Report.

21. The complainant further stated that there was no evidence that the authors of the HIW and RCP reports had either read the Holden Report or even knew of its existence.

22. The complainant did not therefore accept the Health Board's comments that the Holden Report was triangulated with the HIW and RCP reports.

23. Having considered both the complainant's concerns and the Health Board's response, the Commissioner considers that the latter was general in nature as opposed to specifically addressing many of the complainant's questions. She therefore contacted the Health Board to establish if any further information which might directly answer some, or all of the complainant's questions was held, and for details of the search undertaken when preparing the response to the complainant.

24. In reply, the Health Board confirmed that the four individuals who were forwarded the 10 questions at the time of the request did not respond as shortly afterwards the Health Board's Information Governance team determined that the questions did not constitute valid requests for information under the FOIA. The Health Board further informed the

Commissioner that no other individuals were contacted at the time of the request.

25. The Health Board did however state that in the process of drafting its amended response (11 August 2020) to the complainant, that the following staff members were consulted:

- Acting Board Secretary
- Associate Director of Nursing
- Associate Director of Workforce
- Acting Associate Director of Quality Assurance
- Head of Office for the Nurse Executive
- Head of Governance for Mental Health

26. The Health Board further informed the Commissioner that during the above referenced consultation, and as part of other work in relation to the Hergest unit, a thorough manual search and review was conducted and presented to the Acting Associate Director of Quality Assurance, of all electronic Board and Committee meeting papers from December 2013 to March 2016, and a chronology produced.

27. Additionally, a manual search and review was conducted of any associated or linked reports such as those provided through the Health and Social Care Advisory Service (HASCAS) and Ockenden group. The Health Board informed the Commissioner that the search was solely of electronic information as this type of corporate information is only processed electronically, and the search criteria used was anything related to the "Holden Report" or the "Hergest Unit".

28. The Health Board confirmed that local drives were not searched as it is against Health Board policy to store any business or personal information on local drives. It further informed the Commissioner that when staff members leave the Health Board, as is the case of all senior staff members involved at the time in the Holden Report, all computing equipment is wiped before passing it on to other staff members, therefore any information stored locally would have been deleted.

29. The Commissioner was also informed that following the searches detailed above, it became apparent that although the Board were made aware of the review undertaken by Robin Holden, specific Holden Report updates were not actually taken to the Board, although the Health Board did receive other external reviews of the unit around that time, including Healthcare Inspectorate Wales (HIW) inspections, the Royal College of

Psychiatry (RCP), Accreditation for Inpatient Mental Health Services, (AIMS) and the NHS Wales Delivery Unit.

30. The findings of these reviews were considered collectively and reported to the Board through mental health update reports. Ultimately therefore, the Health Board informed the Commissioner that there is not a specific track back to the Holden Report, which is why it has been difficult to provide any further information specifically in relation to the Holden Report to the complainant.

31. The Health Board informed the Commissioner that the Executive Medical Director and Executive Director of Nursing and Midwifery / Deputy CEO have therefore commissioned a piece of work to validate that the Holden Report recommendations have been implemented and remain in place at this current time. The Acting Associate Director of Quality Assurance is leading this work, supported by the Acting Divisional Director of Nursing for Mental Health and Learning Disabilities, with the aim of ensuring both a corporate objectivity to the work, and a degree of impartiality, given that they have no prior involvement in the unit, division or report, and both only joined the Health Board within the last year.

32. The Health Board further confirmed that this work will be submitted for executive scrutiny, and then reported to the Quality and Safety Executive (QSE) Committee when completed. The Health Board further stated that the QSE papers will be publicly available via the Health Board's internet site.

33. Having considered the concerns outlined by the complainant, the details and evidence of the Health Board's search in addition to its explanation, the Commissioner considers that whilst it might appear a reasonable assumption that more specific information would be held at least in respect of some of the complainant's questions, on the balance of probabilities, the Health Board has provided all information falling within the scope of the request and has now therefore complied with its obligations under section 1(1) of the FOIA.

Section 10(1) – time for compliance with request

34. Section 10 of the FOIA states that, subject to subsections (2) and (3), a public authority must comply with section 1(1) promptly and in any event not later than the twentieth working day following the date of receipt.

35. The Commissioner notes that the complainant submitted his request on 4 July 2019 and did not receive a response until August 2020 and only after the Commissioner's intervention. The Health Board therefore breached section 10(1) of the FOIA in its handling of this request for information.

Right of appeal

36. Either party has the right to appeal against this decision notice to the First-tier Tribunal (Information Rights). Information about the appeals process may be obtained from:

    First-tier Tribunal (Information Rights)
    GRC & GRP Tribunals,
    PO Box 9300,
    LEICESTER,
    LE1 8DJ

    Tel: 0300 1234504
    Fax: 0870 739 5836
    Email: grc@justice.gov.uk
    Website: www.justice.gov.uk/tribunals/general-regulatory-chamber

37. If you wish to appeal against a decision notice, you can obtain information on how to appeal along with the relevant forms from the Information Tribunal website.

38. Any Notice of Appeal should be served on the Tribunal within 28 (calendar) days of the date on which this decision notice is sent.

Signed ……

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