Naciones Unidas A/HRC/22/NI/7

Asamblea General

Distr. general
1 de marzo de 2013
Español
Original: inglés

Consejo de Derechos Humanos
22º período de sesiones
Tema 3 de la agenda
Promoción y protección de todos los derechos humanos, civiles, políticos, económicos, sociales y culturales, incluido el derecho al desarrollo

Información presentada por la Comisión para la Igualdad y los Derechos Humanos de Gran Bretaña*

Nota de la Secretaría

La Secretaría del Consejo de Derechos Humanos transmite adjunta la comunicación presentada por la Comisión para la Igualdad y los Derechos Humanos de Gran Bretaña**, que se reproduce a continuación de conformidad con el artículo 7 b) del reglamento que figura en el anexo de la resolución 5/1 del Consejo, según el cual la participación de las instituciones nacionales de derechos humanos se basará en las disposiciones y prácticas convenidas por la Comisión de Derechos Humanos, incluida la resolución 2005/74, de 20 de abril de 2005.

* La institución nacional de derechos humanos tiene la acreditación de la categoría "A" ante el Comité Internacional de Coordinación de las Instituciones Nacionales para la Promoción y la Protección de los Derechos Humanos.

** Se reproduce en el anexo como se recibió, en el idioma en que se presentó únicamente.

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Anexo

[Inlgés únicamente]

Contribution of the Equality and Human Rights Commission of the Great Britain to the report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment

Title: Abuses in health-care settings that may cross a threshold of mistreatment that is tantamount to torture or cruel, inhuman or degrading treatment or punishment

The Equality and Human Rights Commission (EHRC) welcomes the Special Rapporteur's report focussing on this issue which has not been recently at the forefront of domestic or international attention in this context.

The Special Rapporteur's analysis of abuse in health care settings through the lens of the torture and ill-treatment framework is particularly prescient in the UK because of findings about patient experiences published on 6th February 2013 in the final report of the Mid Staffordshire NHS Foundation Trust Public Inquiry chaired by Robert Francis QC[1] ('the Francis Inquiry Report'). The Francis Inquiry Report follows an earlier report written at the request of the then Secretary of State for Health on care provided at the Mid Staffordshire NHS Foundation Trust between 2005 and 2009 and published in February 2010[2].

The Francis Inquiry Report details 'a story of terrible and unnecessary suffering of hundreds of people who were failed by a system which ignored the warning signs of poor care and put corporate self-interest and cost control ahead of patients and their safety.'[3]. Responsibility for this suffering is given not just to the Mid Staffordshire NHS Foundation Trust but to the health system, including the Department of Health and regulators, as a whole who failed in their duty to protect patients from unacceptable risks of harm and in some cases from inhumane treatment. It records serious failures by the Trust to listen to patients and staff; their failure to address an 'insidious' culture of tolerating poor care standards; and ill functioning management and leadership.

The Francis Inquiry Report and 2010 report detailed cases where patients - particularly those who were old, frail and confused - were left in their own excrement and soiled bed clothes for lengthy periods, in one case at least three hours and another was found by relatives in bed totally naked, caked in excrement in full view of everyone. Patients were systematically ignored by nurses when they needed help with toileting and in one case a male patient was left sobbing loudly having soiled his bed because no help arrived despite him shouting and ringing an alarm bell. Others were left on bed-pans and commodes for up to an hour causing pain and distress. Assistance was not provided with help for patients who needed it to eat and drink causing de-hydration and weight loss. Some wards and toilets were left in a filthy condition and patients were subjected to rough and painful handling. In some cases, bodies of recently deceased people were left in side rooms for several days when they should have been moved to the mortuary and in one instance a

[1] http://www.midstaffspublicinquiry.com/report
[2] http://www.midstaffsinquiry.com/documents.html
[3] http://www.midstaffspublicinquiry.com/sites/default/files/uploads/press_release_-_final_report.pdf

former member of staff gave evidence about a deceased person being found in a room she was about to let other relatives into. The deceased had been there for at least 24 hours and it took several hours to establish who the deceased patient was.

The EHRC will work with Monitor and the Care Quality Commission (CQC) who are health care regulators the Francis Inquiry Report identified as having failed in their duty to protect patient safety. We are already engaged with both to drive forward their performance on human rights and equality. Although the report acknowledges recent improvements in CQC's regulatory structures and standards it also criticises their defensiveness and lack of transparency. Through EHRC's memorandum of understanding with CQC we will build on our jointly published human rights guidance for their inspectors to incorporate the report's recommendations for CQC in a human rights and equality context.

The report is very critical of Monitor's delay in taking action in response to concerns about patient care at Mid-Staffordshire Hospital and its over attention to the hospital finances at the expense of patient safety stating that *'It is clear from the evidence that the Trust would not have been in a position to be authorised as an Foundation Trust in early 2008*[4] *if:....A thorough assessment of the Trust's compliance with minimum patient safety and quality standards had been performed, rather than the focus of Monitor's assessment being on finance and corporate governance*[5]*'*. In 2012 EHRC stepped up regulatory oversight of Monitor because of some apparent failures to embrace a proactive approach when discharging their human rights and equality obligations when implementing their functions. This work continues and will dovetail with our CQC work to ensure the development of better human rights protection for care service users, taking into account the Francis Inquiry Report recommendations.

To the extent that the Francis Inquiry Report makes recommendations for Department of Health, EHRC will capitalise on existing high level relationships and our recently signed framework of understanding with them to ensure swift steps are taken by Government to safeguard the human rights of patients - particularly those who are vulnerable. We do not rule out using EHRC enforcement powers with any of these and other public authorities in the NHS system should they become necessary.

The Commission has endeavoured to progress the Parliamentary Health Service Ombudsman's Six Lives report (2009)[6] which recommended collaboration between the EHRC, Monitor and CQC to prevent poor practice in the provision of health care. As well as seeking to strengthen regulatory practice, the Commission agreed a Memorandum of Co-operation with the Department of Health in November 2012, to help support system leadership in mainstreaming equality and human rights principles across the health and social care sector.

In our August 2012 report to the Committee Against Torture in regard to the Committee's list of issues for the forthcoming examination of the United Kingdom on the UK's 5th periodic report to CAT we raised several instances of cruel, inhuman or degrading treatment in the context of health and social care. We noted with concern the absence of any reference to some of these well publicised events in the state report.

[4] Giving it more control over its own finances and other benefits.

[5] http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf%20p52-53

[6] Six Lives: the provision of public services to people with learning disabilities. Parliamentary and Health Service Ombudsman/Local Government Ombudsman. 2009. http://www.ombudsman.org.uk/__data/assets/pdf_file/0013/1408/six-lives-part1-overview.pdf

Article 16 UNCAT and Article 3 ECHR should protect people from severe mistreatment. However even prior to the Francis Inquiry Report there was evidence that some people who use health and social care services are at risk of abusive treatment by care workers. They may also be subject to abusive treatment by other residents or service users.

People living in residential care settings are particularly vulnerable. For example, in May 2011 a BBC Panorama programme exposed through secret filming how disabled residents of Winterbourne View hospital near Bristol were routinely slapped, kicked, teased and taunted by members of staff. One particularly harrowing example captured on film was that of an eighteen year old woman being verbally abused and doused with cold water while fully clothed, as a 'punishment'. The privately owned purpose built hospital was home to 24 adults with learning disabilities and autism, whose places had been commissioned by local authorities and NHS trusts. As a result of the scandal, four people were arrested, several more staff were suspended and shortly afterwards the hospital was closed down. The scandal prompted the CQC to undertake 150 unannounced inspections of similar services in England.

In February 2011, the Parliamentary and Health Services Ombudsman (PHSO) reported on 10 investigations into the care of older people by NHS institutions in England, of which several revealed ill-treatment possibly serious enough to breach Article 16 UNCAT.[7] Eighteen per cent of the 9,000 complaints made to the PHSO in 2010 were about the care of people over 65 and the organisation accepted 226 cases about older people for investigation, twice as many as all other age groups put together in 2011.[8]

In November 2011, the EHRC published the report of its formal inquiry into older people and human rights in home care. The inquiry found some evidence of good practice in the commissioning and delivery of home care services, with many care workers providing excellent care under challenging circumstances. However, there were also worrying examples of poor treatment. In a few cases this treatment appears to have been serious enough to approach or exceed the threshold for a breach of UNCAT. For example, many concerns were raised about older people not being given support they needed to eat and drink. In one case, an older woman with Huntingdon's disease suffered dramatic weight loss because care workers simply left food and drink next to her, even though she was physically unable to feed herself. In another case, an older man with dementia lost so much weight due to not being given support to eat by home care workers that he was admitted to hospital and died three days later.[9]

[7] Parliamentary and Health Service Ombudsman, 2011. *Care and compassion? Report of the Health Service Ombudsman on ten investigations into NHS care of older people*. Available at: http://www.ombudsman.org.uk/__data/assets/pdf_file/0016/7216/Care-and-Compassion-PHSO-0114web.pdf. One example in the PHSO report is that of Mrs H, 88, who was deaf and partially sighted. After a fall at home, she was hospitalised for four months suffering from acute confusion. While in hospital, she experienced poor standards of care and had several further falls, one of which broke her collarbone. She was transferred to a care home by ambulance while strapped to a stretcher in a state of agitation and distress. On her arrival the manager noticed that she had numerous unexplained injuries, was soaked with urine and was dressed in clothing held up with large paper clips. She was bruised, dishevelled and confused. The following day she had to be readmitted to a local hospital. She died before the PHSO could conclude its investigation.

[8] Ibid.

[9] Equality and Human Rights Commission, 2011. *Close to home: An inquiry into older people and human rights in home care*. Available at: http://www.equalityhumanrights.com/legal-and-policy/inquiries-and-assessments/inquiry-into-home-care-of-older-people/. See page 28.

The EHRC therefore endorses the conclusions and recommendations of the Special Rapporteur in particular that "examining abuses in health-care settings from a torture protection framework provides the opportunity to solidify an understanding of these violations and to highlight the positive obligations that States have to prevent, prosecute and redress such violations."

The Equality and Human Rights Commission
February 2013