

Dr Chris Overton  
Chairman SWAT  
7<sup>th</sup> September 2017  
Your Ref P-05-768

Mr David John Rowlands AM  
Chair – Petitions Committee  
National Assembly for Wales  
Ty Hywel  
Cardiff Bay  
Cardiff  
CF99 1NA

Dear Mr Rowlands

I am writing in response to the letter from the Health Minister, Vaughan Gething, dated 6 July 2017. I will respond to each paragraph in order.

In paragraph 1 there is a typo, 764 instead of 768.

In paragraph 2 not only have these issues been raised with him but with the First Minister also. On 13 June 2017 our local AM, Paul Davies, raised a question relating to the new data we had released on 1<sup>st</sup> May which you already have a copy of. It was disappointing that the minister chose to try and deflect from these issues by suggesting that it had not been shared prior to its public release. I have attached a letter which was sent on 25<sup>th</sup> May 2017 to Steve Moore, CEO Hywel Dda HB, detailing the fact that he had known the state of the problem for many months. Vaughan Gething was a recipient of that letter and thereby the Welsh Government.

In paragraph 3 it is suggested that there is full commitment to Withybush playing an important role in the future. I would like to point out at this juncture that there are a number of ongoing consultations which propose significant reductions in the role Withybush will play in the provision of all types of acute care including mental health which appears to be heading to Llanelli, at least an hour away for most Pembrokeshire people so long as they have access to a car.

In paragraph 4 the national studies relied on are not current, they have a time lag. The figures that are being relied on are predominantly from before the changes! This is why the audit was done locally because it is possible to have current data now and not next year.

In paragraph 5 the equality impact assessments showed quite clearly that every vulnerable group in Pembrokeshire would be disadvantaged. They still are because the Health Board does not have to find solutions, they only have to recognise the problems and work towards possible remedies. The clinical standards mentioned are nothing to do with patient care but with junior doctor rota standards which are arbitrarily chosen and which were claimed to be a precursor to Glangwili providing level 2 neonatal care. Even this was deceitful as can be seen from the RCPCH

representative's report to the Board meeting earlier this year, following their second visit at the end of 2016, stating that Glangwili will never achieve level 2 status.

In paragraph 6 we return to the standards which are mostly related to arbitrary rota compliance rather than patient care. The remits given to the RCPCH on both occasions they visited were very tight and to suit the question masters, Hywel Dda and the previous health minister, Mark Drakeford. Maternity care was only really added at the last minute for the first and excluded totally for the second visit. The claim that services were/are safe and sustainable and have led to improved patient outcomes is unfortunately not evidence based.

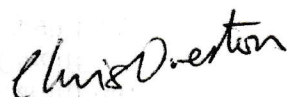
In paragraph 7 once again the 2015 review was relying on old data, predominantly from before the changes. Recently I have been informed of two further serious cases within the last 3 months where perinatal outcome was very sadly extremely poor. I have no details about these cases as they were after my dismissal for whistle blowing.

In paragraph 8 we can no longer dispute that the rules of the consultation were unlawful however those rules were changed significantly between 2006 and 2012 in favour of ministers and health boards in order to obtain the desired preordained result. The rules may have been followed but the outcome was not just or safe for the people of Pembrokeshire as has now been confirmed by the current dataset and should be reversed immediately.

In paragraph 9 the minister affirms what the Health board should be doing however I informed the risk management midwife about my findings in October 2016 and it was my understanding until I was dismissed in May 2017 that no report had been collated or presented. I had chosen to inform the risk management midwife because in early 2016 serious concerns had been raised by the neonatal consultants in Swansea in regard to the high numbers of HIE(Hypoxic Ischaemic Encephalopathy) cases they were being sent from Hywel Dda for cooling. This had resulted in a flurry of activity in the Maternity management section and a full scale investigation ensued. Nothing appears to have happened following my revelations in October 2016 and likewise now it seems the most important aim for Welsh Government ministers and Hywel Dda management is to discredit the current data rather than address the very real problems these service changes have caused the people of Pembrokeshire.

On behalf of SWAT and the people of Pembrokeshire I would be grateful if you would consider this letter in the next committee meeting and please act quickly if you want to save lives.

Yours sincerely



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Consultant Obstetrician (retired)