In Search of Accountability

A review of the neglect of older people living in care homes investigated as Operation Jasmine

A Review by Margaret Flynn

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Dedication

A great deal of thanks is owed to members of Justice for Jasmine – Loraine Brannan, Catherine Cawte, Hayley Cook, Pam Cook, Val Downs, Gaynor Evans, David Jenkins, Marilyn Jenkins, Elaine Jones, Gail Morris, Kelvyn Morris, Vivien Thomas, David Walters, Marina Walters, Elizabeth Williams, Gaynor Williams, Alan York, Freda York and Geraint York. I have profited greatly from discussions with them individually and in groups, most particularly as they continue to search for effective responses to the neglect of older people with compromised mental capacity. Although the criminal justice system denied them the restorative power of speaking about the suffering endured by their relatives and other older people ill-served within care homes, it is hoped that this Review – which is dedicated to them, to their relatives and to all of those who suffered in the homes within south east Wales – including C's mother 'Alice' and Julia Matthews' father, Daniel Rowlands – is a testimony to their immense determination – as well as to their ideas about the creation of more compassionate futures for all of us.

You show me the way it is, to lose, to keep

the light of your life in the lens of a line,

syllables of grief, the world

more luminous seen through tears.

From *Honesty* by Gillian Clarke[1]

[1] Gillian Clarke (2012) *Ice* Manchester: Carcanet Press

Acknowledgements

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Shirley Williams and Sarah Rochira, the Older People's Commissioner for Wales, have been important sources of support throughout the Review. Their work, *Learning Review of Incidents of Significant Harm at Hillcroft Slyne with Hest Care (Nursing) Home* (in north Lancashire) and *A Place to Call Home: Care Home Review Report* (based on fact finding throughout Wales) has provided a useful backdrop to this Review. Similarly, *John Kennedy's Care Home Inquiry* has been a valuable reference.

Whistle-blowers have been indispensable to my learning and I am grateful to those who generously came forward. It follows that some sources are not cited.

I have been able to count on Gwyneth Roberts for her assistance and valuable commentary in reading drafts of the report; on Ruth Eley for her encouragement, proof reading and reflections on emergent findings; and on Vic Citarella of CPEA Ltd for his supervision, wise advice and careful oversight.

Finally, a special note of appreciation is due to Rhian Thompson who has provided more than the promised administrative support to this Review. She has sought out information, facilitated meetings and provided a grounded civil servant's perspective on how some of the Review's obstacles might be lowered or removed.

Notwithstanding all the assistance and support I have benefited from in preparing this Review I am solely responsible for its contents and any views or opinions expressed therein.

Margaret Flynn, Ynys Môn, May 2015

Contents

Foreword

"We need for there to be accountability, for there to be somebody who is responsible for enforcing standards and holding people's feet to the fire"

Jennifer Granholm, former Michigan Attorney General

This Review is an examination of a series of events and allegations of abuse at care homes and nursing homes in south east Wales at the beginning of the twenty-first century. These events were the subject of a seven year investigation by Gwent Police, which was known as Operation Jasmine. There had been, however, ten years prior to the Operation Jasmine, expressions of concern about allegations of neglect at a number of residential and nursing homes in the south east Wales area, as witnessed by two television programmes in 1995.

Silence about what was actually said and done and what was not revealed has escaped the public scrutiny and condemnation that such neglect deserves. The situation could be described as the silence of denial which risks insulting those who suffered by closing off the possibility of imagining a more compassionate and valued future.

The questions asked by the group, Justice for Jasmine (which consists of the relatives of some of the older people who were harmed), are important:

- Why has no one been held accountable for the violations endured by these older people?
- Why does it appear easier to prosecute for cruelty to animals than for the neglect of frail older people in care homes?
- In the light of Operation Jasmine, what does it mean for the Crown Prosecution Service to assert: *The greater the vulnerability of the victim, the more likely it is that prosecution is required…..Neglect tends to have a negative impact. The development of pressure sores should be considered a primary indicator of poor care practice, but by* ***no means a conclusive indicator***[2]? [emphasis added]
- And in terms of public scrutiny, why is historic child abuse awarded greater priority than the historic abuse cases of older people?

There is a broader backdrop to this Review as stated by Michael Mandelstam (2011) [3] who confirms that concern about the harms endured by older people in care settings throughout the UK is neither rare nor occasional.

As a number of criminal indictments remain extant following the halted trial in March 2013, this Review is based only on the evidence that a number of relevant agencies and involved individuals were prepared to submit, and allow to be placed in the public domain.

[2] Crown Prosecution Service, *Prosecuting Crimes against Older People* Undated – but published during the Gwent Police investigation

[3] Mandelstam, M. (2011) *How we treat the sick: Neglect and abuse in our health services* London: Jessica Kingsley Publishers; and Mandelstam, M. (2013) *Safeguarding Adults and the Law* 2nd Edition, London: Jessica Kingsley Publishers

Consequently, the Review is limited to what these agencies and individuals believe they are able to reveal. Additional information was supplied by whistle-blowers - people who were willing to disclose what they perceived as the illegal or unscrupulous practices of employers. The fact that they were not alone in this is shown by the experiences of other employees who featured in the two television programmes broadcast 20 years ago.

To the person in the street, inspection and regulation are perceived as straightforward matters. Their natural understanding would be that nursing homes for older people employ experienced and competent nurses and staff and that, if they do not, the regulator would step in to help, rescue or protect the residents. This Review points to a different reality, most particularly to the tension that exists between Inspectors using enforcement judiciously and the expectation that Inspectors should be available to assist failing providers to improve. Additionally, the Review prompts such questions as what arrangements are there for:

- undertaking a criminal investigation in parallel with enforcement action?
- a succession of repetitive *improvement notices*?
- evidence of *ritualistic* or minimalistic compliance with standards (which are not enforceable) and regulations which are enforceable?
- home owners who deny that there is anything wrong with their homes and seek legal assistance to prove their position?
- an independent care sector with apparently limited accountability or reference to local needs assessment?
- honestly pooling the concerns of residents, people's relatives and visiting health and social care professionals, including contract compliance monitors, without fear of litigation?

This Review points to a disquieting dynamic arising from General Practitioners (GPs) and their partners also becoming owners of residential homes. It confirms that the ownership of residential and nursing homes by GPs operating in this way is no guarantee that residents and patients will receive the health care they require. There is no doubt that having GPs associated with the ownership of residential and nursing homes creates a conflict of interest, most particularly where they are directly sourcing residents from their patient lists and/or providing healthcare to the residents and patients at such homes. Although there are guidelines in relation to GPs and conflict of interest, this Review confirms that the guidelines are a single element only in decision-making about their businesses, quite apart from any clinical concerns, and may be overruled by other considerations such as profit and any perceived tax advantages.

About the contents

This Review is organised into sections and sections 3-13 open with a summary. It begins with:

1. An **Introduction** which sets out the Terms of Reference of the Review and the origins of the Gwent Police investigation: Operation Jasmine
2. The second section entitled **Methodology** describes the process of fact finding, including obstacles, and the following sections succeed roughly according to the chronology of the Review's fact finding.
3. The section, ***They made us who we are*** discusses the experiences of the relatives of older people who were harmed in the residential homes reviewed here and it begins with autobiographical fragments. It goes on to identify the similar experiences which led to families seeking nursing home placements and then *noticing that things were not right.* Accounts of the various stages of their relatives' end of life experiences hint at the search of Justice for Jasmine relatives and friends for more tangible solutions than promises of reform or even claims that *things are better now*.
4. This is followed by a section with an account of **two families** whose older relatives were in homes which did not feature in the Gwent Police investigation, but which further testifies to the ways in which families sought to understand wrong and indifferent practice.
5. Thereafter are sections which consist of a series of chronologies. They deal with critical events which took place in **the companies owned by two GPs**. This couple owned two of the six homes investigated by Gwent Police.
6. The next section sets out **the parameters of, and key events in, the Gwent Police investigation** in south east Wales.
7. This section outlines what is known about the decision-making of the **Crown Prosecution Service**.
8. The role of the **Care Standards Inspectorate for Wales** and its successor, the **Care and Social Services Inspectorate Wales**, in relation to six homes is explored in this section and key events in these homes (until 2009).
9. **Caerphilly CBC** (where three of the six homes were located) as a service commissioner and the lead role of local authorities in terms of **adult protection** are considered in this section.
10. Key events in the role of the **Health and Safety Executive** are outlined here.
11. This section deals with **the role of the NHS** in addressing the clinical needs of older people in care homes and in secondary care as well as in commissioning care.
12. This consists of the first part of the Review's analysis and it considers the **legal context of residential care and corporate governance** which has been written by Aled Griffiths, Chaynee Hodgetts and Rois Ni Thuama.
13. The second part of the analysis explores **the role of the media**; the **governance of the police investigation**; the **use of expertise**; the **limits of local authorities' adult protection procedures**; the contrast between **known outcomes** and **the expected**

outcomes; the **challenges for inspection and regulation**; the **workforce culture**; and questions about **GPs and/or company directors** of homes for older people and how the care of residents might be improved.

14. The **Conclusions and Lessons** include reflections on what has emerged during the Review process.
15. Lastly there are the **Recommendations** from the Review

The **Appendices** include:

- Summaries of TV broadcasts and a radio broadcast about the homes known to Operation Jasmine
- Summaries of inspection reports from the six Operation Jasmine homes
- A table providing a summary overview of the companies owned by Dr P Das and Dr N Das
- Correspondence to and from the Crown Prosecution Service and their notes arising from the meeting between Keir Starmer, the former Director of Public Prosecutions, and relatives of older people harmed in six of the homes investigated by Gwent Police
- Caerphilly Adult Protection Committee's *Protection of Vulnerable Adults Practice Improvement* document dated, *2002-current day.* [This document is also known as the '106 lessons' from Operation Jasmine]
- Photographs of deep pressure ulcers prefaced with an explanation by Professor Keith Harding, Medical Director of the Welsh Wound Innovation Centre
- A letter to the First Minister and the Deputy Minister for Social Services in relation to the Regulation and Inspection of Care and Support (Wales) Bill

In an attempt to make the Review as reader-friendly as possible, a number of conventions have been adopted. First, for readers with little time to read the whole report there is an executive summary, which is also available in Welsh, and second most sections begin with a summary.

Throughout the Review, the use of italics indicates direct quotations – most of which indicate their source. However, contributors were assured that they would not be identifiable, most particularly those who did not wish to be acknowledged. Unless explicitly stated, there were no obligations of confidentiality arising from information shared with the Review. Unless families wanted their relatives to be named, older people are not identified. Bold font is generally used to differentiate the names of individuals, agencies, residential homes and dates and to emphasise specific points.

Section one: Introduction

On **4 December 2013**, the **Rt Hon Carwyn Jones AM, First Minister of Wales** announced in the Welsh Assembly that he was setting up a Review of Operation Jasmine (and the events associated with it) *in order that we may learn for the future*.[4] The purpose of the Review was to investigate a series of questions which arose from Operation Jasmine but which remain unresolved. Operation Jasmine was a major investigation by Gwent Police into historical events and alleged abuses in care homes and nursing homes for older people in south east Wales. It began in 2005 and ended with a halted trail in 2013. The First Minister explained to the Assembly that it had always been intended that a Review would follow the conclusion of the criminal investigation. However the *unusual circumstances* surrounding the efforts to prosecute **Dr Prana Das**,[5] **Paul Black**[6] and **Puretruce Health Care Ltd** prompted concern that there has been no account of, for example:

- the ways in which older people experienced their care
- their alleged abuse and
- the grief that has accompanied the efforts of the families' campaign group, Justice for Jasmine.

In relation to the scope of the Review, the First Minister referred to the importance of speaking with the relatives of those involved, *the local authorities, the police, the professionals and the regulators*. There was a *need for a full and independent review of these events to understand whether there is anything else the social care sector and policy makers need to learn…to quickly and effectively look at the major issues raised by the events surrounding Operation Jasmine*.

Purpose

The purpose of this Review is to:

1. Set out the experiences of those people and their families in residential care homes in Gwent that came to be known as Operation Jasmine.
2. Set out the key events.
3. Consider and set out actions that have been taken by the various parties involved in the interim, and
4. Set out key lessons for the future alongside recommendations regarding policy or legislation, regulation and operational practice, for the various parties involved.

In particular, the Review will examine:

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[4] http://www.bbc.co.uk/news/uk-wales-25218006 (accessed 28 December 2013)

[5] A GP Director (with his wife, Dr N Das) of Puretruce Health Care Ltd

[6] The Chief Executive of Puretruce Health Care Ltd whose background was *in sales and marketing. He worked for textile companies and, latterly, for distributors of medical products.* He was *responsible for the commercial management of all of the…companies homes and his duties* included *the procurement of supplies and the structuring of staff training* (*Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006)

- The experiences of the people receiving services and the wider impact on their families.
- The policies, procedures, governance and practices of the owners of the care homes involved.
- The policies and procedures of the relevant parties involved including (but not necessarily exclusively) the local authority and NHS, various professionals and the workforce, police, regulators and Welsh Government.
- The regulatory regime including the powers available to relevant parties.
- The voice of those living in care homes, as well as that of their families and friends

The Review is not expected to detail individual cases, but will seek to draw out thematic, broader lessons for the future.

The Origins of Operation Jasmine

Operation Jasmine was established during **October 2005** when **Gladys Elvira Thomas**, an 84 year old resident of **Bryngwyn Mountleigh** nursing home[7] in Newbridge, was admitted to Newport's Royal Gwent Hospital after being given incorrect doses of medication. She later died. Gwent Police were called since she had severe and extensive bruising, a cracked collar bone and broken rib and a ligature mark. None of these injuries, or their causes, had been documented by the home. On investigation, the police established that a pattern of concerns could be linked to deaths in other homes in south east Wales.

It was in **October 2005**, that the Terms of Reference of Gwent Police's investigation: Operation Jasmine were identified, that is, *to fully investigate the death of Gladys Thomas whilst in Bryngwyn Care Home; to fully investigate concerns regarding care/neglect issues in relation to present/past residents of* Bryngwyn *or Mountleigh Care Homes; to conduct a professional and thorough multi-agency investigation and explore fully any criminal liability of care staff or management of Bryngwyn Mountleigh Care Homes who are employed, have been employed or who had responsibility for care in these premises.* By the following month, the scope of Operation Jasmine *widened to include Brithdir* [a nursing home] at a time when *care* at *Brithdir* was *deteriorating.* The parameters of the police investigation were:

- *To investigate the circumstances of all the deaths where there are or have been concerns*
- *To investigate all allegations or suspicions of abuse*
- *To investigate all allegations where neglect has led to potential criminal offences.*[8]

Media coverage during **2013** gave some indication of the reach of Operation Jasmine, such as the significant deployment of Gwent Police resources in that 75 officers and members of

[7] One of two homes on the same site - also known as Mountleigh Bryngwyn and Millview House and Millview Lodge after 2007

[8] Gwent Police's Terms of Reference and the parameters of their investigation are set out in the *Review of Operation Jasmine: the North Wales Police Review into the Gwent Police Care Home Manslaughter Inquiry – Victim Evelyn Jones born 28.11.1917* (2009)

police staff were involved in taking 4216 statements and amassing over 10,000 exhibits. There were over 100 alleged victims, many of whom have since died. In all, Operation Jasmine was said to cost over £11m.[9]

Gwent Police were, however, unable to prosecute for either gross negligence manslaughter or wilful neglect since, during **2010**, the Crown Prosecution Service (CPS) decided that there was insufficient evidence to support a reasonable prospect of success on this basis as it was believed that it could not be shown that the injuries sustained were the cause of the deaths. It was maintained by the CPS that it was also difficult to prove neglect – such as failure to provide sustenance, hydration and medical attention, although a causal link need not be established. Individual examples of malpractice did not of themselves amount to corporate liability/responsibility for people's deaths.

As a result, the anticipated trial of Dr P Das, Paul Black and Puretruce Health Care Ltd in **March 2013** hinged on charges of fraud and breaches of Health and Safety legislation. Had a trial proceeded, it would have considered the circumstances of a small number of former Brithdir residents. However, the trial was halted because it was deemed that Dr P Das was unfit to plead because of the brain injury he suffered as the result of an assault in **September 2012**.[10] The charges were placed 'on file' on the basis that the case might be revived should Dr P Das recover sufficiently to stand trial at some future date.

This meant that it is only since the trial date, **1 March 2013**, that families have been able to talk about their own experience. Some had provided statements to Gwent Police eight years previously and were advised to remain silent so as not to compromise the criminal justice process. They had not been able to establish contact with other relatives who were similarly potential witnesses. Their perception of fairness and accountability were undermined by the slow pace of the legal responses which led to the trial and the fact that account could not be taken of the totality of residents' suffering. The restorative power of speaking about their relatives' falls, accidents, penetrating and infected pressure ulcers and unattended pain, for example, in six residential and nursing homes was denied them both before and on **1 March 2013**. The fact that the excessive, and apparently lethal, incidence of such harms did not meet the threshold tests of the Crown Prosecution Service fuelled their sense of injustice.

Poor and neglectful care is not the sole preserve of the homes and localities associated with Operation Jasmine. The material gathered through this Review provides a compelling rationale for different and improved responses to the support needs of older people and their families.

[9] http://www.caerphillyobserver.co.uk/news/938919/first-minister-announces-review-of-care-home-abuse-investigation-operation-jasmine/ (accessed 28 December 2013); in addition the Health and Safety investigation cost around £3m

[10] http://www.bbc.co.uk/news/uk-wales-21685428 (accessed 1 February 2014)

Section two: Methodology

According to the Terms of Reference for this Review, its primary function was to examine information which individuals and their agencies were prepared to put in the public domain without being legally obliged to do so. What had happened to the residents of the homes which were investigated was a sensitive and potentially threatening subject, since it involved questioning the decision-making and actions of senior professionals, their agencies and their reputations. This was an issue which became clear during the process of interviewing families and the corresponding desk-top research concerning local and national media coverage.

Contact was established at an early stage of the Review with representatives of **Justice for Jasmine** (which consisted of family members and friends of residents in the six homes which were ultimately the focus of the Gwent Police investigation). This confirmed that, in addition to the Review's role in setting out the pivotal events, their implications and consequences, it was important to explore ways of displacing their experience of harmful residential provision for older people with a humane legacy for all older people. Such meetings also confirmed the importance of providing a constructive role for the group, and giving the participants the opportunity to tell their individual stories, to contribute to meetings with agencies, to ask questions and to share ideas.

A number of the families who were known to Justice for Jasmine agreed to be individually interviewed. These open-ended interviews lasted from an hour to two hours. Notes were taken during the meeting and subsequently shared to ensure that they were factually correct. However, some families withdrew completely from the process since they had already experienced an interminable wait for what was, for them, a key event which, ultimately, never occurred: that is, the trial of those responsible for the running and management of one of the homes. Furthermore, there was disappointment that the call for a Public Inquiry was not heeded. Some families whose contact details were shared by Gwent Police explained that it would be too painful to revisit their experiences; for others, their health was too compromised, and a number of potential witnesses had also died.

In addition, in **March 2014**, an advertisement was placed in the free-press in south east Wales, inviting individuals who might wish to contribute information and experience to get in touch. During **August 2014**,[11] BBC Wales invited people with an interest in the Review to make contact. Monthly briefings were circulated by email to all those involved in the expectation that they would be distributed beyond their immediate recipients.

Since the Review also considered criminal justice processes, various kinds of investigation, regulating, service reviewing, clinical practice, contract compliance monitoring, social service management, the management of residential homes and the legislation concerning companies, a number of people were invited to assist in the fact-finding, checking and analysis. These included:

[11] At the time within four months of the end of the Review

Richard Barker, former Lecturer in Social Work at Bangor University and independent social work/care consultant

Vic Citarella, former Director of Social Services and Director of CPEA Ltd

Ruth Eley, former Deputy Director of Social Services and former National Programme Lead: Older People and Dementia, Department of Health

Aled Griffiths, Research Fellow, School of Law, Bangor University

Joanna Griffiths, Justice of the Peace and former Director of Social Services

Chaynee Hodgetts, Lecturer in Law and PhD law student, Bangor University

Paul Hodgkin, former Director of Patient Opinion and former GP

Janet M Hughes, local authority solicitor, Conway CBC

Rois Ni Thuama, PhD law student, Bangor University

In addition, the Review benefited from a **Reference Group** of health and social care professionals, practitioners and researchers with whom emergent lessons were shared.

The assistance of key agencies and the perspectives of a range of individuals (see Acknowledgments) were sought. In looking back as well as looking forward it was envisaged that professionals would share their own agency's self-scrutiny, as well as bring matters of general concern about the care of older people to the attention of the Review, not least by reflecting on what might have made a distinctive and positive difference.

Gwent Police, the **Care and Social Services Inspectorate Wales**, **Caerphilly CBC's Social Services** and the **Aneurin Bevan University Health Board** were invited to participate in timetabled events, in sharing material relevant to the Review, identifying critical alliances and preparing written accounts of their actions. These events were introduced by families recalling their experience. Meetings were also held with the **Older People's Commissioner**, the senior managers of **Merthyr Tydfil Social Services**, **Torfaen Social Services, Health and Safety Executive** and the **Coroners** of Gwent and Rhondda Cynon Taf for example.

However, the **First Minister**'s expectation that agencies would be *keen to be involved* was not realised. Concerns with the Review's governance and *procedural safeguards* (e.g. *We should be grateful for clarity around the holding of any information shared or provided and the data protection safeguards that will be put in place*); that a future trial should not be compromised (e.g. *I needed some assurance to be satisfied that it would be legally appropriate for Gwent Police to participate in the* [two day] *event*[12] *and that to leave myself or officers attending, open to legal challenge, criticism or potentially contempt of court proceedings, would be untenable*) resulted in slow and intermittent progress. Gwent Police declined to participate in

[12] During the first day the agency was invited to tell their story and describe the processes and contexts in which they worked. On the second day it was invited to reflect on what would have made a distinctive and positive difference i.e. the future orientation of the second day considered the *unfinished business* – the (a) powers and (b) actions professionals wish they might have had and taken had contexts, circumstances, policies and legislation been different

the timetabled event held during **May 2014**. Eventually, they themselves hosted an event during **October 2014** and began to share documentation during **November 2014**.

It was only during **November 2014** that a detailed written submission was received from the Health and Safety Executive (HSE). The cover-page of the HSE's *factual summary for the assistance of the Operation Jasmine Review* states:

This document is provided by HSE solely for the assistance of the Operation Jasmine Review in accordance with the principles of the correct retention and control of material so as not to adversely affect any potential judicial proceedings. It has been adapted from material which relates to commenced (albeit currently "stayed") criminal proceedings. As such, HSE, to whom this document belongs, wishes to restrict onward disclosure to any persons and provide it on the understanding that it will not be further disclosed and that, if any such action is contemplated, HSE will be consulted in advance in order not to prejudice any potential legal proceedings.[13]

The **Crown Prosecution Service** (CPS) declined to meet and outlined their position in correspondence.[14]

The absence of any legal determination did not dissuade the **Care and Social Services Inspectorate Wales** (CSSIW) from sharing the inspection reports concerning the six homes with associated chronologies concerning the actions of Inspectors. In addition, the CSSIW shared its reflections on its own actions and those of its predecessor, the **Care Standards Inspectorate for Wales** (CSIW). Similarly, the **Welsh Government**'s lawyers (who advised the CSIW and the CSSIW) shared valuable contextual material.

During the course of the Review, notes were prepared from two HTV's *Wales this Week* programmes broadcast during **1995** – one of which focused solely on Dr P Das and his homes; a BBC Wales' *Week In Week Out: Taking Care?* broadcast (of **28 June 2005**); a *Week In Week Out: Wales' Nursing Home Scandal* broadcast (of **4 June 2013**); and BBC's *File on Four- Elderly Care: Neglected Questions* broadcast (of **4 June 2013**).[15]

It appeared that as more and more material emerged a kaleidoscope effect was created with the smallest addition altering the entire image. One such movement concerned the **Nursing and Midwifery Council**'s Conduct and Competence Committee hearings which began in Cardiff during **September 2014**. These addressed the allegations of poor nursing care of residents at two homes, **Grosvenor House** and **Brithdir**.[16] Another significant movement concerned information from the HSE and Gwent Police which was forwarded within only weeks of the due date of the end of **December 2014**. It was agreed with the First Minister

[13] The contents of the HSE document are not disclosed in this Review

[14] See Appendix 4

[15] See Appendix 1

[16] In May 2015 the BBC stated that there had been *89 failings by six nurses* at Brithdir http://www.bbc.co.uk/news/uk-wales-south-east-wales-32930423 (accessed 29 May 2015)

that the publication of the Review could extend into 2015 to take account of this information. This matter was also discussed with the Justice for Jasmine families.

Finally, during **April 2015** the chronologies (spanning Sections 5-11 only) were sent to the relevant individuals and agencies with the request that they should be checked for factual accuracy. The chronologies were largely drawn from agencies' own written submissions as well as material in the public domain. The resulting corrections have been made to the chronologies. Additional clarifications feature in the footnotes of each chronology.


Megan Downs
Evelyn Jones
Dorothea Hale
Megan Downs
Stan Bradford

Section three: *'they made us who we are'*

A Glimpse of People's Biographies

In this section…

> *…some of the themes covered by this Review are introduced. The relatives of older people who are known to have been harmed in care homes describe their experience. There was a wide discrepancy between the hopes of families and the experience of their relatives following their admission into homes. The organisational practices they witnessed were inadequate in attending to people's frailty, chronic illnesses, deteriorating health, mental distress and pain. The businesses responsible for the homes in question appeared impervious to the needs of residents or the concern of relatives. They considered the values underpinning such businesses and they raised questions about accountability. You will learn a little about their relatives' lives and their humane values, which as the title suggests, reflects their desire to be effective in the face of injustice.*

During interviews and meetings the relatives and friends of older people who had been in the Operation Jasmine homes reminisced about the lives of the people they had lost. This often meant sharing photographs from family albums – mute testimony to a person's place in their family and communities, before calamitously being placed in a home where they were harmed. They affirmed that the life of a loved one mattered a great deal both before and after they had succumbed to dementia, with many having relationships with spouses, siblings, children, nieces and grandchildren over many years. It was clear that these relationships had helped to protect them from feeling diminished by their failing memories and compromised capacity.

The most immediate means of conveying the vitality of people's lives is to introduce something of eight people's histories. Their families and relationships had exerted enduring emotional forces in their lives. They were essential to their well-being and identities.

As was said by a relative in referring to the experience of taking someone into a residential home: *When you leave them you know they* [the staff] *don't have your knowledge of the person you love.*

Stanley Bradford had been a miner. He was a cheerful man who would help anyone – even giving coal to those who had none, as well as chopping up firewood for them. He enjoyed long walks and, because children enjoyed his company, he was *like the Pied Piper* with his children and their friends in his wake. He made dolls' houses and furniture. He made castles and garages. He took orders and would not take any money if families could not afford it. He bought bones from the butchers for local dogs so even they were pleased to see him! His granddaughter recalls that he would buy her a drink – just before her 18th birthday – and

advise her not to tell anyone. Although mental illness had led to the break-up of his marriage he remained in daily contact with his wife and family who continued to care for and about him.

Megan Downs had volunteered for the Women's Royal Air Force when war broke out and had stayed in the service throughout the war. She had five children, two of whom were disabled, and one of whom had died as a child, in a marriage that had lasted up to her death. She had successfully challenged the exclusion from the local school of her youngest child. Because he had to wear callipers the school would not accept any responsibility for him. Megan Downs had recognised and demonstrated, however, the importance for her son of growing up and being educated with his siblings and local children. So she took him daily, collected him at lunch time, returned him after lunch and collected him again after school. He died as a young man. Megan Downs had complemented her love of music with dancing and socialising. She and her husband had many friends but they particularly enjoyed family parties.

Edith Evans and her husband had no children but her nieces enjoyed many happy times and holidays with them. They recalled piling into the car and enjoying the fun of picnics by the roadside with tins of peaches and milk. Edith Evans was a sociable person who loved dancing and travelling in the UK and abroad.

Dorothea Hale had been a housewife and mother. Her husband worked for the National Coal Board. After the birth of a son, and because she could no longer have children, they adopted a daughter who recalled *a very loving family*, which had set down clear boundaries and values: *The values and restrictions she placed on me I have passed on to my own children.* The family did things together, from shopping on Saturdays to visiting places of interest on Sundays. Fascinated by history, Dorothea Hale was a knowledgeable woman who attended archaeology and history classes and favoured active holidays to places of historical interest. Although she wrote stories she refused to have any published because of her concern that they were not good enough. She had a generous nature and would buy birthday presents for local children, the friends of her children when they had children as well as for her grandchildren. Her daughter recalled that when her parents looked after her children: *They would leave with a small bag and return with a suitcase full of stuff they'd been given!*

Evelyn Jones was a seamstress. She was popular and loved partying. She was a thoughtful neighbour, for example, taking their washing off the line for them and checking if any shopping needed doing. She was a member of the Women's Guild and the over 55s club. She was often out of the house five times a week.

Evelyn Jones was a caring daughter, mother and friend. After remarrying as a young woman, she remained in regular contact with her 12 year old daughter who had decided to live with her grandparents in order to stay close to her friends. Evelyn Jones used to take her daughter to *the pictures* every Friday night and would also visit her and her parents three times a week, often catching an early bus to their house, getting the coal in, setting and lighting the fires for

them. These visits continued into her daughter's adulthood – first visiting her parents and then her daughter after she herself had become a mother. *As she came through the door she would have my washing on and* [then] *on the line before she caught the bus home. When it snowed I have known my mother walk two miles down the Deri old railway track to light the fires and look after* [her parents] *to help save me doing it. It is hard to believe she was in leg irons until she was seven."*

Ronald Jones had been a steel worker until he sustained a head injury in a car collision. He had a young wife and family for whom the consequences were considerable, because *it was as though he became two different people.* Having been a family man who liked to provide for them, he had the frustration of transferring to an office-based, administrative job. Over time his body became progressively contorted. Before and throughout these potentially isolating experiences he was known as *a man who would help anybody…He was a trooper – a really good man.*

Hilda Scase was German and had married a Welshman. After being widowed she was befriended by neighbours who had German connections and became their *adopted Nan.* She had no contact with her German relatives or those of her late husband. She was a good friend to her adopted "family," most particularly to one who became almost *the daughter she once lost.*

Pearl Cavell York was a gentle and lovable person. She had worked in a biscuit factory, a factory making candlewick bedspreads and as a school cleaner. She liked to sew and was good at it. Pearl Cavell York met her husband at the school where she worked. She had always lived close to her family and they, her neighbours and local children enjoyed her company. She was a member of the local ladies' choir. She had been a driver and owned her own car and had even done a mechanics course.

Some Shared Phases

Within the recesses of people's memories were unique experiences and recollections of definable phases not all of which were chronological. The first phase was to do with **noticing and suspecting that something was wrong**.

This phase marked the beginning of a challenging time for families and friends when it was difficult to determine where familiar and typical behaviour ended, and concerning behaviour began. Some spouses put off acknowledging their suspicions, even to their families, being naturally reluctant to acknowledge their partners' growing dependency.

She couldn't get to her own toilet and she became fearful of using her stairs [which resulted in her moving] *to a council run, warden controlled bedsit. It was there that her forgetfulness became noticeable…* [Ultimately] *she became confused about which tablets she had taken…*

There are memories that are not good…

As she was getting older the symptoms of Alzheimer's were becoming more difficult…

Even before [her husband's death, we] *thought of it as old age and forgetfulness. But there were events which suggested that something wasn't right such as the time she threw her purse into a bin…*[then there was the occasion when] *she was cooking egg and chips for herself and she explained that she had a cooked dinner that was in the oven…*[she] *knocked over a Calor gas heater and burned herself trying to put the fire out…she was always losing her box of savings then she lost her keys and put a brick through the window…*[then] *there was a day when she rang 12 times…*

My brother and his family lived upstairs and mum and dad occupied the downstairs… [Following major surgery] *she had a stroke and she would suffer episodes of confusion. In hospital, even though her speech was affected, she said "I need to get better."*

She always had an open door. However, as she got older she was perhaps a bit too friendly…she had rung at 2.45 in the morning and on some occasions when she looked at mirrors she observed "There's a man in there." It is believed that she was taken advantage of by unscrupulous visitors and may have endured sexual and physical assaults.

Another phase concerned **the recognition of people's changing support needs and explicit involvement in assisting with caring**. For some this was when a clinical diagnosis of Alzheimer's or dementia was made, which had confirmed their suspicions and prompted them to consider the need for both immediate and longer term support. Others became immersed in the world of GPs, hospitals, psychiatrists, community services and entry into residential homes, sometimes via acute hospital care:

One person, who was herself the deputy manager of a residential home, applied for a placement at the home: *I'd committed myself to caring for her. I knew every aspect of her care…I did my work with conscience and couldn't envisage someone else not doing the same.*

When Alzheimer's was diagnosed, *the family decided…that she would not go into a nursing home and they would all help to look after her…this continued for five years…*

They opted to move to a bungalow but then she *developed arthritis and Dad was becoming more limited…*

The warden encouraged her to join in – not in a bullying way, but it worked…she visited her family most Sundays and her family were frequent visitors. [Her daughter in law] *arranged for her medication to be put in secure boxes with the date of their administration clearly marked and the staff supporting her knew to offer her the correct tablets for a single day…*

It was when he started having falls…they were probably mini-strokes…he had a stroke and then a bigger stroke and [we knew we] *couldn't manage…*

[In hospital] *she received excellent care. Her communication got better. There were lapses in her memory but this was not comprehensive. She liked to reminisce with Dad about places*

they had been and seen together…Dad went every day…Mum couldn't stay [in hospital] *indefinitely* [and neither] *could she live at home...it was decided that we should find a suitable home for her to receive that appropriate level of care…*

For some elderly husbands and wives, the decision was primarily made by professionals:

Her condition deteriorated badly. She did not know the difference between night and day and did not recognise family members. Her physical health was becoming poor and the doctor stressed to our father that a nursing home should be found to give her the care he was not qualified to administer…

Decisions about supporting her were taken out of the hands of the family. [We] *were advised by social services to move her into a council run home with a day centre* [where she lived for two years. The family] *regretted that she could not stay longer* [at this home] *as there were a lot of local carers who knew her…*

It was heart-breaking telling her [that she had to move] *"It's because you hit people." She said "I'll go home" and I reminded her that she couldn't because she had sold her house.*

The phase of **identifying a suitable home** was familiar to all families. There was lack of choice – and for some it was a case of *take it or leave it* - but there was trust in what was available and convenient. The GP and social workers did not question people's choices. If some employees at a home and residents were known to families, these were experienced as encouraging signs. Families were under the impression that if something went wrong, for example, then the Inspectors would pick it up. This trust proved to be misplaced since residents were not *happy shoppers* who could choose alternative suppliers. Their dementia was too advanced, they were physically very frail, some had chronic health needs and proximity to their families was a paramount consideration.

With two exceptions, families were not aware of the poor reputations of some owners and managers or of the homes which repeatedly breached regulations.

The home belonged to her GP. This was not considered a plus point because she had little faith in him as a doctor…

There was a matron and a deputy matron who were good and it was staffed by local people…

She was assessed as EMI [Elderly Mentally Infirm] *and then transferred to the Home* – [this] *required an 18 mile round trip* [and] *it made daily visits difficult…*

The decision was taken with great sadness…Dad wanted to carry on caring for her and it was nearby… [After a POVA meeting] *we tried to have her moved but this was not possible…*

It was near…

People's admission to care homes was a further, distinctive phase and a distressing milestone for families and friends. Neither Registered Managers nor staff took account of the detailed knowledge of older people's relatives and friends, even though their caregiving experience prior to admission had often been extensive. It was as though staff did not appreciate the heartache which accompanied the placement decision and all that had happened in advance of the separation. Without exception, people's entry into care homes did not reduce the responsibilities felt by spouses, families and friends, irrespective of their first impressions. Ultimately their perception of what was acceptable was tested by their experience, for example:

When she went into the Home, she looked so well and was so chatty that other visitors thought that she was visiting! We were satisfied because she had a beautiful bedroom…she had to move [homes] *and her room was dreadful. It was dark and dowdy and she had old blankets.* [We] *asked for another room and she was moved…*

We'd take him out and he often said "I want to go home." We said, "No Dad, you have to go back. You know we love you."

Her behaviour resulted in some staff getting hurt. It was when she was toileted that she hit out…

An especially painful and protracted phase was that of **becoming aware of the suffering, unhappiness and inattentive care** which occurred in certain homes. Relatives and friends who were themselves trained nurses and carers were anxious not to appear as asserting their professional authority, even though they were appalled by what they saw. Some events stood out because they drew attention to the shameful practices within these homes. These experiences raised serious questions about a business sector which generously rewarded the few at the expense of many. As one relative asked: *We don't mind people making money and running a business – but making a pile of money when the business is causing old people to suffer, how is that right?*

The phase of **noticing and knowing that *things weren't right*** heralded a confusing and distressing time for families and friends with several recalling their anguish about the potential backlash if they over-reacted and/or complained, not least since their relatives could no longer communicate. Having to revise their expectations of what specialist provision/nursing homes would be like took its toll on families. It undermined their trust in the care sector and in "nursing homes" in particular. As one relative reflected: *We assumed – stupid really – that they knew what they were doing.*

It was when [senior staff] *started to leave and they weren't replaced, and local girls started to leave, and then agency staff were in and out that it stopped being a good home. All activities stopped. They just had children's TV on all day…*

There was no entertainment – no one to read to them, sing familiar songs…he was living a dog's life…Mum used to put the snooker on the TV for him…

When she was at the Home she was sedated all day and every day. It was explained that since there were not enough staff it made handling and managing her easier. We didn't want this. It appeared that they were treating her as though she was without significance, without a history…

There was no hoist in his bedroom…

The day after she moved in…she was sitting in a high backed winged chair. She looked very old and was crying out that she needed the toilet…she was being ignored…

We showed them how to care for her wig and yet they didn't pay any attention to it, even though it mattered to her and to us…

We could never understand why her nails were so dirty and why she never looked spruce...she used to have her hair done every week but it wasn't done at the Home. She wore glasses all her life and yet we don't remember seeing them there…The PEG feeding tube was always dirty [and] *she was often wearing other people's clothes…*

She had a single tooth and they rang to say that because it was rotten could they get it removed…it was not removed and it must have been painful…

I asked for a doctor's assessment to see if her physical condition outweighed her mental state. I wanted more choices of placements, nursing or EMI. I took time off work so that I could be present. I was dismayed to receive a call from the Home's doctor stating that her needs had changed and she could be moved to a nursing home but she "may need morphine…"

A lot happened to his health and he lost his sparkle. On an occasion that he went into hospital from the Home, he cheered up. We accompanied him back in the ambulance and he said, "Don't take me there" and later "Why have you put me in here? Don't you love me?"

She was only there for ten weeks. During this time her hair was unwashed and her hearing aid was not working. I told them but was troubled that they didn't keep batteries for hearing aids even though these were freely available at the hospital. I had to show staff how to insert the batteries …she was a different woman when she could hear – a light would go on in her eyes…

Another family recalled the aftermath of questioning the practice of a nurse. Their frail father was advised to take their mother to the Health Centre for a blood test since no one at the home was qualified to take blood. Since this was too much for him to manage, his daughters helped. Their mother was very confused and frightened. She had a lucid moment as their car passed the end of the street where they once lived. She sobbed and begged to go home. It was hard for her husband and family to witness her distress. Because of her distress the blood sample could not be taken. The phlebotomist was so appalled by what had taken place that she gave the family her contact details in case they decided to challenge the home. On their

return to the home they asked why their mother had been subject to this experience and the nurse replied: *That's what you get for complaining.*

Such depersonalising exchanges occurred in the broader landscape of inattention to what relatives and friends described as *the little things* - ensuring that hair was brushed in the way it always had been; ensuring that residents were wearing their own clothes and that their nails were clean; and making sure that people had their dentures, and were wearing their glasses and functioning hearing aids for example. These assumed greater significance because they were not known or ignored and so not attended to.

Being in a nursing home or EMI care was not synonymous with receiving uninterrupted nursing attention – which led families to **question the responsiveness of staff to people's frailty, health status and mental distress**. Residents' admissions to acute hospitals resulted from failures to administer essential medication, to secure medical assistance, to promote people's mobility, or to address nutritional deficiencies, for example. These were critical events which affected how families viewed the care being provided to their relatives.

She went into hospital on three occasions. On the first occasion she had swollen feet. It wasn't clear what the cause was…on the second occasion she had a blood sugar level of 1. She had swollen feet and awful bed sores… [We] *discovered that she had bruises over much of her left side, upper torso and an arm. They had not been hoisting her properly…*

When she had been in the Home she had not wanted to go into hospital because she didn't want to be on drips and it seemed cruel to put her through this…[Ultimately her daughter accepted that a GP wanted her mother to go into hospital where she was met by her granddaughter]. She recalled that: *The smell was terrible. I thought that she had dirtied herself. The pressure ulcer was so deep, extensive and infected that her bowel was* [visible], *irreparably damaged and there was nothing that could be done…At the Home,* she *had been sleeping on a hard mattress. On admission to hospital there was no evidence that she even had any dressings on her back. There were no signs of any kind of dressings in her bedroom.* [Home staff had explained] *that they had sent for the Tissue Viability Nurse but this nurse was away for two weeks…*

He had diabetes…then he had a heart attack and a stroke and he could not communicate…he didn't get his medication…

We couldn't understand his screaming. It was terrible to hear…

I never saw any pressure relieving aids…

One day I visited and she had a plaster over her eyebrow. One explanation was that she had bumped her head on the side of the door. Another was that she had hit it on the bedside cabinet. I knew that it would be painful removing the plaster and I asked if they would ring up so that I could be with her when it was removed. No one telephoned until after it had been removed…

These examples underline the significance of *how* care was provided to very frail people without any apparent acknowledgement of their pre-existing medical conditions. Relatives who sought to complement the work of nursing staff, sharing their knowledge of the most effective ways of encouraging cooperation, for example, were emphatically excluded from practice which may be characterised as unsupervised trial and error.

Inattention to people's nutrition, hydration and infection control: people's families were concerned about the food and fluids provided to their relatives not least because most of them lost a great deal of weight and were often very thirsty. Families did not believe that nutritional requirements were met, or even that attention was paid to people's physical comfort, dental and mouth care, difficulties with swallowing, loss of skills to feed themselves, drugs impairing the desire to eat and even unappetising food in terms of its smell and appearance.

It was a standing family joke that she loved her food. Any buffet and she was always the first to go! However, she lost her appetite and they'd say "She's not eating" and just leave the meal beside her…I visited to help to feed her…

I had to hold her up to enable her to drink and it was evident that she was very thirsty. Her mouth was terrible and I had to get all the mucus out of her mouth before I could quench her thirst…

We had reservations about the frequency with which he was offered fluids. We didn't think he was getting enough because when we visited and offered him drinks with a straw he would drink four or five glasses straight back…

Dad raised concern that she was losing weight…food was placed in front of her but she was not able to feed herself…

The food was unappetising with soup like water and dry bread sandwiches. We never saw a proper cooked meal…

[The GP owner] *liked cheap food for residents…there was a terrible smell of kippers… repetitive menus and the worst of school dinners, e.g. cheap diced swede…*

I was concerned she was not eating enough and was bringing in treats…Dad would try to coax her to eat…Shortly after her admission her bottom set of dentures were lost [and] *Mum had difficulty consuming food.*[17]

Her granddaughter's a nurse and she noticed that her grandmother's eyes were infected. She was appalled by what she witnessed…the level of hygiene was very poor…

Our father signed for her to have a PEG feeding tube…she went into hospital because of her poor swallow but now we wonder if she'd been fed appropriately…we know that some

[17] The family contacted the community dentist and was informed that community dentists visit *very infrequently* and it would be quicker to get new teeth privately. The family dentist was unaware of any dental practitioners who visited nursing homes

people's relatives were starved but that wasn't our experience. She blossomed because she was overfed. She put weight on when she shouldn't have because she had a PEG feeding tube…She developed septicaemia from the infection around her feeding tube. In hospital she screamed when she had morphine injections around the site of the tube. A photograph was taken of the site and a nurse said that she would willingly be a witness because her condition was disgusting…

I visited at different times and her pad had not been changed…

Ultimately families became attuned to the **tolerance of unacceptable standards**.

You notice things initially – like what needs painting, whether or not it's dirty or grimy – but then you don't notice it. You get used to it…

It was difficult communicating with staff with a very limited knowledge of English…why were they allowed to distribute medicines to patients who could not understand them?

She shared a room and would occasionally express concern that "There's a man in my room."

She was in a room with a woman who sang hymns all the time…

I took a dirty looking garment out of the bottom of her wardrobe and showed it to the manager. He asked what it was and I replied that it used to be my mother's cardigan. These things add up…things like that matter…she was often dressed in other people's clothes…

When her teeth were lost staff searched in cupboards and rooms and in their own pockets and finally found them in a member of staff's pocket…

Over time the staffing [numbers] *became very low…One Christmas I visited and I couldn't find any carers downstairs…*

Her glasses were lost and had to be replaced…

The review occurred at six weeks because her social worker was part time and on holiday. Concerns were expressed about, [inter alia] *dehydration. The outcome was an undertaking to keep a fluid balance chart…*

Why didn't [The GP owner] *ensure the availability of useable equipment and staff trained to use it?*

Some families witnessed the **callous treatment** of other residents. They were hesitant about challenging staff practice and uncertain how to respond to staffs' explanations:

I walked by one room and noticed that there was a mattress on the floor. The member of staff explained that it was because the resident kept falling out of bed…

There was quite a vocal lady there and one of the carers put her in a big chair and pushed it against the wall so she was facing the wall. I said, "You can't do that!" only to be told that she was being "too loud"…

There was a woman who had been moved upstairs. I went up to see her and was shocked to see the state she was in…lying back on a chair. Her face was black and blue and blood running from her nose…the staff assured me a doctor had been called…when I revisited the home I was told that she had died…

There was a resident who used to wander around with just a napkin on and sometimes he was naked, without a pad…

The wheelchairs had no foot-rests and we saw staff yanking residents to their feet from wheelchairs and tilting them back to manoeuvre them. Even though the manoeuvres were precarious there were no straps to secure people in…

Families became attuned to the processes of exclusion and the shrinking worlds of older people who develop dementia. The families of EMI residents learned about the geographical **boundaries within homes** which separated the EMI from other residents and from staff. The families of the EMI residents became accustomed to requesting the assistance of staff from other parts of the home. Typically their relatives were *upstairs* and out of sight i.e. the designation EMI both labelled and isolated people:

At first he used to sit downstairs. He liked to be around people and he used to sit in the eating areas…over time however, he gradually spent more time in the EMI unit upstairs where on two or three occasions I learned that he had [implausibly] *fallen out of bed. He was always in bed…When we visited his eyes lit up. You had to read his eyes. He loved his granddaughter and he was able to hold her…It was so hard seeing him…*

The foyer was always tidy and it had a fish tank but it wasn't for the residents because they couldn't access the foyer…

The bad ones went on the top floor…

We rarely saw carers – even on 2-3 hour visits and yet he should have been turned every two hours…

I visited on a warm sunny day. She wasn't in the small sitting room. She was in her room alone, with the curtains closed…

She was in the same chair, in the same position, day in, day out…I never saw any pressure relief aids….there was a concert arranged downstairs for all the residents and mum was asked if she wanted to go downstairs and watch it…she said she would. When the care assistant returned she said that Mum could not go because there was no room…

There were even nets at the windows so they couldn't see out…

She used to walk around the Home, pushing doors open. It was mostly up and down the corridor because there were no grounds that she could walk around and the Home had no garden. We never saw any residents outside the home…

The entrance to the Home had a keypad with the code taped onto the door! It meant that anyone could get in…

From the perspective of families, being separated from the main areas within the home had damaging consequences for residents' health and wellbeing. It contributed to a sense that they were being marginalised. Although there seemed to be no clear processes towards a placement *upstairs*, the end result was often anxiety on behalf of their relatives.

In terms of the **disquieting behaviour of owners, managers and staff**, families did not realise that they were relinquishing the care of their relatives to homes in which there was no ostensible evidence of achieving valued outcomes for older people. The outcomes they experienced were grotesque. The apparent *fitness* of owners and managers became a charade when undermined by the recruitment and appointment of unsupervised and inadequately trained staff – for whom there is no registration requirement. A source of continuing distress for families hinges on the failure of staff to alert them to the harm endured by their relatives plus the failure to secure essential medical treatment, especially pain relief, which often resulted in people's accelerated deterioration. One relative recalled how a former friend who had worked in the home where a member of her family suffered *can no longer look me in the eye.* Some professionals, outwith the care homes, offered to *be a witness* if families wanted to secure redress, while others in, for example, Accident and Emergency Departments, had themselves contacted the police and social services directly.

I met a former employee who expressed condolences…and explained that she gave her notice in because she could not stick the awful conditions of the residents and she didn't want to work in such a setting…

They asked us to provide some new bras and I offered to do this. I got a variety of sizes as I was unable to measure her due to her awkward posture…I had noticed a lot of sticky substances around her eyes [and eventually] *I spoke to Mum's designated nurse about her eyes and asked if they could check which bras fitted mum. She replied "I wish I was an octopus. I pray to God I become an octopus so I can do everything that you want me to do for your mother." I found a quiet spot and burst into tears…*

[On one occasion when her granddaughter and great granddaughter visited] *there were three members of staff in the same room* [who were] *playing cards. They used to paint their nails there too. Nana was crying and we pulled her up the chair to make her comfy. The staff must have seen this but they didn't offer to help.* [Neither did the staff inform her family that their Nana had deep pressure ulcers on her back]…*she endured pain and isolation without the family knowing anything about the condition of her back…It is hard for* [us] *to acknowledge that as we sought to better position* [their mother and Nana] *we were unknowingly causing*

her pain. There was a nurse… [Who when the family asked about our relative's distress would turn and ask loudly of their relative]: *"Why are you crying?"*

The staff were so nice to me and yet so neglectful of her…

I was told that she had a pressure sore and I asked to see it. It was small and excoriated. I trusted the staff to give the appropriate treatment. [Almost two months later] *she was complaining of her bottom being sore…*[and another month later] *she had a pressure sore on her ear* [and] *I believed they would provide the appropriate treatment…*[Days later] *she was being nursed in bed …there was a horrendous smell in her room. A fan had been put on, the windows were fully open and an air freshener had been sprayed and placed in her room* [*which now I believe originated from untreated pressure ulcers*]…

I regret that I didn't ask searching questions of the matron who stated that the pressure ulcer was being dressed appropriately and that the reported "sores" and a "blister" were not pressure ulcers…

She had visits from her husband, brother, daughters and grandchildren and many friends and no one said anything about her pressure ulcers or the fact that she had had five falls…

In hospital a nurse asked us "Why have you let him go like that?" [He was emaciated.] *We explained that the staff in the Home had said that there was nothing they could do – to which the nurse said that there was lots that could have been done…*

Sometimes however, hospitals also failed their relatives: *On an occasion when she went into hospital her teeth were accidently broken by staff and they were replaced at my Dad's expense…*

The [home] *manager fobbed us off and used to talk about his own mother…*

She lost the top off one of her fingers – it looked as though it had been torn off - and required hospital treatment and yet we were not told – even though she contracted MRSA as a result…

The staff would always have an answer if you questioned things…we knew things weren't right and yet we didn't know who to go to…

There was a meeting when [The GP owner] *complained that* [the local authority] *wasn't sending enough people and he wasn't making enough money. I took the opportunity to ask why* [my relative] *had to be admitted to hospital…he didn't try to explain. He wanted more residents…*

[The GP owner] *wanted us to sign a form saying that we were satisfied with the care our relatives received. We didn't sign it…*

They told lies, including lies about the fluids she had drunk. The Home's staff, including its GP had a duty to act and yet they didn't and all the while friends and families were being lied to and left to believe that the staff were doing the right thing…

Our father tried on many occasions to speak to [the GP owner] *but was unsuccessful…He believed that* [the GP owner] *was like the old school of doctors and would be respectful…*

One person described how a matron showed how she dealt with a person who was agitated, restless and hitting out. She said: *Shhh…* with an accompanying finger in front of the lips gesture which could be construed as intimidating. It was clear that neither her status nor her years of employment had given her the skill or knowledge to understand that such an individual's behaviour might result from, for example, not being fed or being left on a soiled incontinence pad.

Two families knew that nursing home provision could be attentive and even supportive of rehabilitation. They regret that such provision was not routinely available:

Having witnessed the Home going downhill [we] *were clear we did not want her to return after her last stay in hospital. She was admitted to a small home…There, she always had a glass of water or juice beside her and staff encouraged her to drink.* [Her family] *had never witnessed anything like that at* [the previous] *Home…*

When Dad transferred from the Home, staff got him sitting in a chair once again which confirmed that he didn't need to be in bed all the time…This photo was taken when Dad was in the second home where he was dressed, sitting up, clean, better cared for and able to be part of the home – not stuck upstairs in a part designated EMI…

One person acknowledged the difficulties of *battling against ignorance about what to do* which they associated with such attitudes as: *She's wet anyway so there's no need to toilet her.* It appeared that managers and staff had internalised a negative stereotype of frail older people which left out of the equation people's subjective experience, the conditions and ways in which relationships with people's spouses, relatives and friends sustain their relationships and continue to express their love.

People's experience of the period preceding the death of a relative does not reflect what valued palliative care and hospice care can provide. Typically there was a lack of benign attention, respectful and tender acts of care at **the end of people's lives**.

When the hospital to which one woman had been transferred called to explain that her mother had been moved, a nurse explained that a message to this effect had been left on the answering machine. Then she was told *"your mother is dead." I just fell back in the chair shocked.* Subsequently, she visited when she was assured that: *We were all with her when she died* [to which] *I replied that I wasn't there with her, was I?* [This experience was so shocking that the daughter required immediate medical attention herself.]

He was very poorly and yet he was on a mattress which had broken and [the failed mechanism] *was three times louder than a lawn mower. After two hours Mum couldn't bear the noise and yet Dad endured it for four days. Mum didn't like to make a fuss but we asked a member of staff "How would you like to see your father like this?"*

Her breathing was laboured…she had an increased respiratory rate and increased pulse rate. I told her nurse and suggested that Mum had perhaps aspirated. Two hours later this nurse said that Mum was fine – yet she was unchanged – so I confronted her. I said I wanted a doctor to be called…She replied "It's not so easy to get a doctor in the community. I don't think your mother needs a doctor." Many hours later I learned that "the GP had decided not to come out." At the next visit Mum was unresponsive, cold and clammy and I thought she was going to die. [The following day] *I rang her GP who said that Mum would have to be admitted to hospital.* [There] *a staff nurse said "I cannot believe the state of your mother. She has five pressure sores and her PEG tube is blocked and filthy."* [The consultant said that] *the pressures sores were the worst he had ever seen. He was concerned about the care she had received because she was "so dehydrated and malnourished." The excellent care she received in hospital unexpectedly prolonged her life for seven weeks…*

In hospital staff had used swabs to clean his mouth but in the Home his mouth wasn't swabbed…once when we visited he was struggling to breathe…we asked them to get oxygen. They wiped his mouth and drew out a jelly like mould, black crust…we had used sponges to moisten his mouth and he would hold onto the sponge in his mouth because he was so thirsty…his catheter bag was full and bloody…We should not have had to put him in there. He deserved good care at the end of his life…

When we visited she was on some kind of reclining chair. I asked what was wrong and was told that the staff considered that she would be more comfortable…Her husband had been taken into hospital with a heart attack. I visited my mother the next morning and was told that they had telephoned for a doctor…the manager suggested ringing for an ambulance which I did. She went to the same hospital where her husband was a patient. The staff were able to bring him down to be with her and all the family were with her when she passed away. No one said anything about a pressure sore…

Relatives were sometimes exposed to the implied criticism of hospital clinicians when it was pointed out to them that a person was dehydrated or had infected pressure wounds. Because some relatives wore uniforms themselves, hospital clinicians believed they were addressing nursing home staff. This served to deepen people's sense of personal responsibility and left them feeling far from consoled.

In terms of **ethical obligations, legal requirements and organisational practices**, some families secured photographic evidence of the infected, deep pressure ulcers of their relatives. They know that *the basics* of attention to people's hydration and nutrition, to people's underlying medical conditions, to toileting, physical comfort and personal hygiene, for example, were not adequately addressed. They regard these as systemic lapses suggestive of the abandonment of common humanity, for which – remarkably - there has been no apology. They are interested in the circumstances which leave staff apparently devoid of empathic and introspective capacity. Although they acknowledge that this is not typical of all

care homes in Wales, since some have positive experience of others, they do not believe that Operation Jasmine is a rare scandal. However, the existence of good homes does not explain away the homes which ignore people's emotional lives, their physical wellbeing and their relationships. They are fearful for all ageing citizens, including those for whom some are currently caring.

I had a holiday and didn't see her for two weeks. When I left she was fine but on return I couldn't believe the change in her…She was lying in a chair and she couldn't talk. I asked staff if she was unwell and was told that "Old people do deteriorate quickly when they start going." We were kept in the dark…

I did my best for my parents. If you love someone you stick by them…There's a sense of – they're only old people so it doesn't matter much…

I looked at her body and wept. I had to be calmed down by staff. What had been described as blisters and cracked skin were deep pressure ulcers. She had not been given pressure relief by day or by night. She needed a maggot culture to cleanse the wound and a machine to clean the deep sacral wound…

There was the time she went into hospital by ambulance and the paramedics were annoyed that there was no one to travel with her…

A nurse at the Home told me that he had been trying unsuccessfully to persuade the matron to get my relative admitted to hospital for the last two weeks…The nurse had threatened to go to the authorities unless she was admitted. My relative was in a chair without pressure relief i.e. she was on an air flow cushion without a machine to power it. Staff had to search the home for one…

I had to walk out and cry. It was hard on Mum, seeing him there…they just didn't do what was necessary…

Mum is petrified because having seen our father deteriorate she fears admission to a neglectful home herself…

After she died we went to get her wedding ring because she wanted to be buried wearing it. Because she had lost so much weight her ring would slip off and we were told it was put somewhere safe. In the home's office a member of staff fumbled around in a plastic bowl and among bits of jewellery and plastic rings from Christmas crackers was a wedding ring. We checked it against photos but we still don't know if she was buried wearing her own ring…

Why isn't there any scrutiny of the money that owners take out of a service because this impacts on staffing levels and pressures on staff? Why does no one see the grave injustice of my relative paying to be harmed? She had sold her home and was paying to be left to develop extensive pressure ulcers which went with her to her grave…

There is a good deal of overlap in the above accounts but also clarity about what people need if they are to live well with dementia. It has prompted a hunger not only for justice but for a

more grounded consideration of what good care is. Of all the competing possibilities, the definition advanced by Tom Kitwood[18] confirms why intervention is needed and to what end:

…to care for others means to value who they are; to honour what they do; to respect their unique qualities and needs; to help protect them from harm and danger; and - above all – to take thoughtful and committed action that will help to nourish their personal being. (p3)

In the light of the neglect experienced by their loved ones, relatives and friends are haunted by such questions as:

- Didn't they even count as human?
- Don't human rights and meeting basic needs go together?
- Weren't they worthy of compassion and attentive care during their final illnesses?

[18] Kitwood, T. (1997) The concept of personhood and its relevance for a new culture of dementia care. In Bere M.L. Miesen and Gemma M.M. Jones *Care-giving in Dementia: Research and Applications* Vol 2 London: Routledge


Evelyn Jones
Edith Evans
Daniel A Rowlands
Hilda Scase
Ronald Jones

Section four: An account of two families

In this section…

> …is an account from two families whose older relatives were in homes which **did not feature** in the Gwent Police Operation Jasmine investigation. It does describe the circumstances of two people who were living in residential homes at the time. Their families came forward in response to an invitation published in the local press and broadcast by BBC Wales.[19] Both families asked whether or not events in the lives of their relatives could shed further light on the more general care and support of frail older people in south east Wales.

'**Alice**' was the mother of C who is a registered and qualified Social Worker with many years of experience in local authority and independent social care provision. Although retired, C continues to work in fostering and adoption.

During **March 2005** it became noticeable that Alice, who was then 81, was becoming forgetful. At the time, neither C nor her four siblings took too much notice since she was keeping home as ably as she always had. However, within two years her deterioration had become more evident, not least because C's father 'Ed' was deteriorating physically: he had fallen and damaged his back, he was registered as partially sighted and he was aspirating food. As a result he was losing weight and becoming physically very frail. Although Ed's family rallied to help, Ed was reluctant to accept the assistance of help outside his close family.

Ultimately, Alice became *very, very confused*. Her husband and adult children found it increasingly difficult to look after her. She became nocturnal, dressing in the early hours and wanting to go to the shops. When she ceased to recognise her husband and occasionally became aggressive the family acknowledged that Ed would require a lot of encouragement to accept help. The adult children understood that respite care was necessary but had to address their father's reluctance to seek a longer term solution and enduring concern that he was *giving up on* his wife. Ultimately, Alice received respite care at an excellent local authority home. However, on another occasion when respite was needed, there were no vacancies at this *wonderful* home and she was admitted to a private sector home.

The path to securing assistance for Alice and Ed was an uneven one, as is seen in two complaints brought by the family against the social services authority. The first occurred during October 2005, when a sitting service arranged via social services did not materialise. The providers of the sitting service were under the impression that it was to commence a week later than on the date the family had been given. Since it took a great deal to persuade Ed to accept assistance for his wife, as the complainant noted, *it caused a great deal of anxiety for both my parents…my father has now decided that he wants no further contact with* [either

[19] http://www.bbc.co.uk/news/uk-wales-28599217 (accessed 17 February 2015)

the provider service] *or social services…any changes to my mother's daily routine takes a lot of time and hours of reassurance and repeating information hoping that my mother will understand what is going to happen…*[My father] *is my mother's main carer and the fact that he has eventually agreed to accept help from outside the family indicates to us that he is finding it difficult being with my mother 24 hours a day. It took a lot of persuading to have a stranger come into his home but he felt that my mother would have someone to spend some time with her he could have some respite for two hours twice per week…the impact of such mistakes on people with this dreadful condition is magnified. It also leaves the already exhausted carer to deal with the confusion.*

The second complaint concerned the private home where Alice received respite care for a week. It was a former chapel with rooms on three floors and accommodated 31 people. Although the CSIW's Inspection Report for **2006-2007** was broadly complimentary, it did specify *requirements* such as*,* for example,

- *The registered person must ensure that where a service user is being accommodated under arrangements made with a local authority, the service user's plan is consistent with any plan of care prepared by the local authority*
- *Certificate to be provided to CSIW to evidence servicing and inspection of central heating boiler and gas appliances*
- *Assistance with catheter care must be detailed on service user care plan, with evidence available of staff training to undertake the task*
- *The registered person must ensure no person commences work at the home until fitness checks as detailed in the Regulations are completed.*

Two *Good practice recommendations stated: Staff should ask the GPs to give full instructions for all prescribed medicines, including where necessary a maximum daily dose;* and *a programme of routine maintenance and renewal of the fabric and decoration of the premises should be produced and implemented with records kept (National Minimal Standard 33.2).*

Alice's admission to the home was not auspicious. C noted there was no signing-in book and her family were shown a room with a broken window, rubbish in the wardrobe and in her bathroom, a toilet seat wet and smelling of urine. The family asked to see a second room which was *still of a poor quality* and a third room they were shown was *full of furniture.* The room in which Alice eventually stayed had a broken bedside cabinet (C and her sister brought a different bedside cabinet from another empty room), the carpet had *numerous cigarette burns covered with a stained rug* and contained a broken clock (this was removed five days after the family pointed it out to staff). The staff did not understand that a clock telling the same time all day may disorientate an already confused person. In addition to concerns regarding inadequate staffing levels, her family were concerned to note during daily visits that Alice was wearing other people's clothes; she wore her own trousers inside-out; she had dirty hands and nails; and the toilet in her bathroom was used by other residents and was not cleaned often enough; she lost her handbag containing her inhaler and glasses and a small

amount of money. Staff were seen smoking on the landing in the home; and C was informed by staff that there was no management cover during weekends. After seven days at this home, Alice urgently required a bath. The family organised for Alice to move in with C's sibling, who lived nearby, until respite care in the residential home of choice could once again offer a placement. Whilst this was the only option at the time it only added to Alice's confusion as she soon came to think as her daughter's home as her home and when she was taken to spend time with her husband she had no memory of their former family home.

The family were concerned that (i) their complaint which was addressed to the Care Standards Inspectorate for Wales (CSIW) was investigated by the Registered Person since the complaint was concerned with the management of the home and (ii) that the findings of the home's investigation missed the point i.e. *a no smoking policy has been started…refurbishment has been taking place…we try to avoid* (people's clothes being lost in the laundry) *but unfortunately mistakes can be made…Management are on call* during *weekends…resident rooms can be changed in any way…the visitors' book is located next to the door.*

After this experience Alice had respite at the local authority home which was so much more attentive to her. It was clean and comfortable and the family believe that staff did their best to care for Alice. The family was invited to celebrate their parents' Diamond Wedding at the home. Although Alice did not recognise her husband she enjoyed the event. While negotiating her respite, the adult children were also supporting Ed and a sibling who was diagnosed with a serious illness.

Alice's support was negotiated by her family and included stays at the local authority home, and as Ed's health deteriorated she spent longer periods of time there receiving respite care. As her husband lay dying, their son went to get his mother. She was prompted to hold Ed's hand and she asked: *Who is it?* When she was told she remarked: *Well I never!* Later, when she was informed of his death she made a reference to the sea, apparently alluding to the death of her first husband who had died during the war after only six weeks of marriage.

During the times Alice was receiving respite care there was not a day went by without one, or often two, of her family visiting her. Ed was adamant that his wife's status as a mother should still be recognised and she deserved to have her family around her, in spite of not being able to live in her home. She enjoyed the visits of her husband, sons, daughters, grandchildren, sisters in law and friends. Ed died in April **2007**.

Shortly afterwards it was explained to C and her family that Alice's agreed permanent place had been given *to someone who had no relatives*. Unfortunately, in May **2007** Alice broke her hip whilst receiving respite and in the unfamiliar hospital environment, because she became *more and more aggressive* she was moved to the hospital's EMI unit - without negotiation with her family. C recalls this as a time when, yet again she had to negotiate hospital bureaucracy at the same time as watching her mother's deterioration. Following the operation on her hip Alice never walked again. The staff on the medical ward did not have time to feed her and she lost weight. On one occasion the family found her trying to eat a

dessert covered in cling film which she could not see. The family said that they were told not to bring food from home onto the ward. When in the EMI Unit the family were informed that Alice had fallen out of bed or had been *sort of caught in a blanket.* C had to negotiate with staff that Alice's bed be re-positioned since above her head there was a large television on a tilted holder. The fact that Alice could not see her television did not seem to concern the staff. Once again, her family noted that she was wearing other patients' clothes, despite Alice's own clothes being labelled. They saw one patient wearing their mother's slippers. They took her washing home to reduce the likelihood of such mistakes. However, on the last occasion they sought to do so they were told that they should not *because your mother has got E.coli.* Alice died at the EMI unit during August 2007.

The nature of the support offered to Alice was distressing for her family since it was not family-orientated. It was also at a time when they had other painful family concerns in addition to their mother's Alzheimer's, such as the deterioration of Ed's condition and their sibling's serious ill health. Their experience was remote from the values inculcated in them by their parents - who had been a former factory worker, homemaker, singer and Women's Guild organiser, and a miner/full time union official: *your family is important…you do your best…treat everyone with respect…be kind to people…don't put others in a corner.* Alice and Ed were part of a mining community where families helped each other, families were important, children were cared for by parents and grandparents alike and older people were treated with love and respect. Ed survived a colliery explosion where several of his friends died and many others received treatment for their extensive burns. He was instrumental in setting up donations for the families of dead and injured miners, anonymous donations were put through their letter box and their parents kept a ledger and took money to the bank daily. Prior to a celebration for the surviving miners and their families when most had returned from hospital, their father told them that they should be kind to everyone they met at the party, they should not react to people who were facially scarred and they should remember that *inside they are like all of us.* C and her family have told their story *in order that those who do not have family to speak and fight on their behalf are not ignored.*

Mr Daniel Rowlands was born in March 1923 and he died during **November 2009**. Prior to his death he was a resident at a nursing home owned by Southern Cross. His admission to the nursing home was the result of a number of detrimental events.

Mr Rowlands was treated at the University Hospital of Wales for a broken femur and was then transferred to Ystrad Mynach Hospital where he began physiotherapy. This was discontinued initially because of the physiotherapist's holiday and then because it was *against his wishes and his human rights*, that is, because he found the process uncomfortable he could not be compelled to participate. He was able to walk with a Zimmer frame but tremors in both arms compromised his mobility. Within six months he was using a wheelchair…*he simply gave up walking.* Then, during Mr Rowlands' stay at Ystrad Mynach he was catheterised even though he was able to use a bottle to urinate. His daughter, Julia Matthews, perceived this

unnecessary intervention to have been driven by convenience; the *temporary* intervention became permanent. He was transferred to Caerphilly Miner's Hospital since his bed at Ystrad Mynach was *needed.* Mr Rowlands acquired MRSA during his hospitalisation (it is not known at which hospital) for which he was prescribed a barrier cream with antibiotics.

Mr Rowlands was also insulin dependent and his daughter was concerned about his considerable weight loss during hospitalisation, not least since he had once had a *tremendous appetite*. His tremors meant that he required assistance to eat and drink and his weight loss confirmed that he had not been helped to eat.

Although *Social Services became involved* towards the end of Mr Rowlands' stay at Caerphilly Miners Hospital, his daughter has no recollection of any assessment process. In **February 2006**, Mr Rowlands became a self-funding resident at the Southern Cross home where he *lost interest* and *slowly, he began to deteriorate.* During his three and half years of residence at this home *there were at least four different managers.*

Mr Rowlands' residence at the home was marred by painful pressure ulcers. Although he had been mobile at the point of admission his daughter believes that *it was easier for them to manage patients who weren't walking around by themselves.* Initially he developed pressure ulcers on his heels *because of the types of chairs he was being put in during the day.* These *had a fixed, raised foot rest and my father's feet were constantly left up on the foot rest without being checked.* Mr Rowlands also developed a *serious* sacral pressure ulcer.

The sores on Mr Rowlands' head *worsened and started to weep…causing significant scarring…Every time he caught an infection at the home he would be kept in his room…this meant that he was isolated.*

Mr Rowlands had wanted the catheter to be removed before his admission to the Southern Cross home *but this did not happen.* His daughter asked staff at the home to remove it and it was explained that since he had *an infection,* the removal of the catheter would result in *a worse infection.* However, the catheter remained in-dwelling even when Mr Rowlands' infection had cleared up. *Eventually they began to use pads and incontinence style nappies…for* their *convenience* and *my father suffered infection after infection* after being catheterised. He was *constantly on antibiotics due to infections.* Within three months of being admitted to the home, his blocked catheter was not noticed by staff. He developed septicaemia and was taken to the Royal Gwent Hospital. This was the first of several *serious penile infections…he was not being given sufficient fluids…Doctors were not called to look at the catheter…a nurse would take it out and another member of staff would reintroduce the catheter…one two occasions my father suffered penile trauma and ended up in hospital…and was given the Last Rites after one serious incident. A nurse* who had not been trained in the UK was identified as *the person* responsible. A second incident was as distressing. This occurred within months of Mr Rowlands' death. He was admitted to the Royal Gwent Hospital in the early hours and his daughter went directly to A&E. She recalled that he was *in a dreadful state. His teeth had not been brought in with him, he had no glasses and he was dressed in a*

hospital gown with no other clothes. He was very disorientated and *extremely frightened.* Penile swabs confirmed that he had MRSA and *it was suspected that he had septicaemia* – for the second time. *He had low blood pressure, his urine was an extremely bad colour and…his catheter was not draining…*also, *he had E.coli.*

Very few staff [in the home] *were appropriately trained to look after elderly patients. The staff did not speak English fluently. They would find it difficult to understand the patients' requests and patients were unable to communicate with them properly. Very often patients would not understand what was being said by the nursing staff.* Mrs Matthews noted that *one or two of the nursing staff were very good, however, a lot of them* [were] *very poor, including a few who could not converse in English.*

My father suffered with numerous bruises all over his body from being bumped…against the hoist. During December 2008, *he had a swelling to his left leg and a haematoma on his left shin…the staff were not careful when using the hoist or perhaps were not properly trained to use it. They should have taken more care of him as he had paper thin skin.*

Mr Rowlands was offered a poor diet at the home. *He didn't have regular foods which would keep his blood sugar levels at an appropriate level for the sake of his diabetes but equally would have bowel problems. He ended up being given* laxatives*…this would not have happened if he had not been left at the table to try and feed himself…*he would *complain to me that the food was now cold and* staff *had told him they could not heat it up. More often than not…most of it dropped on the floor…*he would *regularly complain that he was hungry or thirsty. He was a gentleman and sometimes would find it difficult to ask for more, particularly as nursing staff would say they were busy. I used to make easy to eat food such as cottage pie…and father would eat all of it as though he had not eaten at all. The same would happen with drinks.*

I had to purchase a wheelchair for my father early on, and over a period of time, it *was never cleaned…my husband took it outside and cleaned it…food, spillages, toothpaste and all sorts of other unidentifiable dirt. When it had been done, another patient asked my husband if he could clean their wheelchair as well.* This was at a time when *my father was suffering with open wounds…on his legs.* Yet there were *many occasions I would arrive and my father's shirt would be stuck to him with food. The shirt would not be changed. His clothes were only changed once a day and not necessarily when they were soiled. The laundry facilities were also disorganised…the linen would be thrown on the floor…all mixed in together and taken away.* Given that *patients might have infections this was a way that infection could be spread.*

There would always be an odour in my father's room and the windows were never opened. The carpet wasn't cleaned…on one occasion I found my father's hearing aid in bits in the bin…his teeth were never cleaned regularly. I would always have to help him brush his teeth. I observed nursing staff in outer clothes and yet undertaking procedures which required them to be in uniforms.

In the last two years of my father's life my father *remained in his own room isolated from others…this caused a great deal of his mental deterioration as previously he enjoyed socialising with others…*isolation *caused him to deteriorate on a mental level.*

I reported lots of things…eventually a POVA was undertaken (in September 2009 by which time, Mr Rowlands' care was being funded by Caerphilly CBC). The POVA concerned Mr Rowlands' *neglect* as evidenced by *pressure sores.* The home did not act on the advice of the health board. The police considered Mr Rowlands' circumstances and *advised that it did not meet the criminal threshold.* The POVA investigation determined that:

- There was no Tissue Viability Nurse available to the home
- Although Mr Rowlands had two pressure areas – his heels and sacrum, there was a single care plan for wound care
- His grade 4 pressure wound did not result in a notification to the CSSIW or a POVA referral
- There were questions concerning the appropriateness of Mr Rowlands' care
- His records were inadequately completed, unsigned and undated
- The home did not have a wound policy or procedures
- Pressure audits were not being undertaken.

Minutes of the POVA case conference of September 2009 noted that *the Tissue Viability Nurse does not attend to patients within care homes but requests that if the patient is well enough they are taken to the hospital…it would be a good idea for staff to spend time with a wound specialist in order to gain knowledge.* The POVA Case Conference resulted in *a unanimous multi-agency decision…the outcome of the allegation* [of neglect] *was proved.*

Mrs Matthews successfully sued for clinical negligence: *It wasn't for the money – it was to do justice because no one is accountable. They paint a rosy picture but don't tell you what's happening behind the scenes…They'd give him his insulin, for example, but they wouldn't feed him. He went downhill. These nursing homes just want your money. On one occasion I found my father screaming in his room. He said that no one came in when he had been calling. The cot sides were up, his legs were hanging over the edge of the rails, and there were mattresses on the floor and pillows under the bed. He had become disorientated and disillusioned…My complaint was noted at the time* [**December 2008**].

Although Mr Rowlands had open wounds on his head, staff would *spray cheap air fresheners on him. There were no staff to accompany him to hospital. My hands were blue because he held them so tight because the flesh was falling off his feet. He cried like a baby. It wasn't Dad. Dad was tough…* [The staff used to] *pull his buzzer out of the wall at night so they weren't disturbed.*

This was the end of life of a man who went to Lourdes every year to look after the sick. There was an occasion when he greeted a woman with the claim "I know your face" and it turned out it was the Duchess of Kent! He showed her around the ward. He didn't receive care. I'd like

to say I could draw a line under it but it will be with me for the rest of my life. That this could happen to a good man who had loved jazz from an early age, who played the piano, the church organ. It was a terrible time and until social services took over, he was paying for a terrible service which was unaffected by his distress and my complaints. He didn't have individual care. He lived with the consequence of greed.

Section five: Relating to Dr Prana Ballava Das and Dr Nishebita Das and their companies

In this section…

> *…the business interests of two GPs are considered. Although concern about inattentive care in the homes this couple owned, as well as concern about their business practices, had featured in TV programmes during 1995, at least two of their homes featured in Operation Jasmine. You will learn about the couple's track record as sole directors and shareholders of their companies and the disquieting evidence made public during two Care Standards Tribunal hearings and two television programmes broadcast in 2005 and 2013. Fifteen of their homes went into receivership and the registration of five homes was cancelled. Although there was long-standing professional concern over a considerable period, it was only during 2011 that charges were brought against one of these individuals, as well as against their company and its chief executive. However, the trial was halted in 2013 because of an assault which took place at the couple's home and which resulted in injury to Dr P Das who was to have been prosecuted.*

This narrative highlights several critical events in the history of the companies owned by Dr P Das and Dr N Das, two General Practitioners. This couple's ownership of a number of nursing homes began in the mid-1980s onwards, initially in the Islwyn area then more widely in Gwent as well as Mid Glamorgan. They eventually owned 24 homes in an area which extended from Blaenau Gwent to Carmarthenshire. Shedding light on a particular home, that is **Brithdir** Nursing Home, which was purchased by one of their companies, requires reference to other areas of their business. The home was owned by **Puretruce Health Care Ltd**, one of several of the Das' companies.

A **1995** television programme, *Wales this Week,* expressed concern about three of the eight homes then owned by Dr P Das and Dr N Das: **Silverdale**, **Hengoed Hall** and **Holly House**. Criticisms included the *serious neglect of patients, acute understaffing and penny pinching.* People's relatives and former employees described:

(i) Inattentive and harmful services and concern that nursing home patients were sourced from the Das' general practice list; and

(ii) medically frail patients suffering from rationing, for example from an instruction to *cut down* on such necessities as food and incontinence pads.

The programme stated that the **Community Health Council** had received complaints from relatives, former staff *and local doctors who* had *spoken privately about the acute state of some of their patients* in these homes. Dr P Das denied all allegations**. Mid Glamorgan Health Authority** *declined to release their inspectors' reports.* A former employee expressed concern

that there were no obstacles to the growth in their nursing home business, irrespective of the harms sustained by residents.

It was during **March 1995** that **Puretruce Health Care Ltd** was set up as a limited company. In due course it became responsible for the operation of: **Brithdir**, **Holly House**,[20] **The Beeches**, **Brynheulog**, **Valley Manor** and **The Village**. Irrespective of the considerable assets held by the company in the form of nursing homes, according to Dr P Das, **Puretruce Health Care Ltd** experienced *cash flow difficulties*.[21]

A further *Wales this Week* programme, also in **1995**, revisited the nursing homes owned by Dr P Das and Dr N Das and discussed issues which were to become relevant to Gwent Police's investigation - **Operation Jasmine:**

- **(i)** A claim that changing dressings because of pressure ulcers was *an everyday event in Welsh private nursing homes*
- **(ii)** The conflict of interest inherent in medical doctors (and/or their spouses) owning nursing homes given their potential to influence referral processes
- **(iii)** Harmful service provision associated with unknown profits for nursing home owners and shareholders
- **(iv)** Health authority Inspectors' awareness of concern in relation, for example, to *the severe shortage of equipment and materials*
- **(v)** The nature and independence of health authority inspections
- **(vi)** Denial that problems existed[22]

By **1995**, there were 13,000 beds in private nursing homes in Wales – more than double the 6,000 beds in **1989**.[23]

In **November 1996**, **Puretruce Care Ltd** was set up.

In **March 1998**, another company, **Puretruce Care (Developments) Ltd**, was set up.

Six homes in Wales were deregistered between **2001 and 2005**; three of these belonged to Dr P Das and Dr N Das.[24] They were fined £3,000 during **2001** on the grounds that **Aberpennar Court** in Mountain Ash, which was one of the homes they owned, had no one in charge of it.[25]

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[20] Holly House was owned by Puretruce Pension Fund, of which Dr P Das and Dr N Das were the sole beneficiaries. Puretruce Health Care Ltd paid £40k rent to the Fund per annum. Puretruce Health Care Ltd sold Holly House to Puretruce Pension Fund for £450k in the year ending 31 October 2003. In the same year, the company made contributions to Puretruce Pension Fund (£102k) to enable Puretruce Pension Fund to make the purchase

[21] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

[22] See Appendix 1

[23] *Wales this Week* 1995

[24] *Week In Week Out, Taking Care?* 2005

[25] See Appendix 1, *Week In Week Out: Taking Care* 28 June 2005 and lexisweb.co.uk/cases/2002/.../puretruce-ltd-v-bro-taf-health-authority (accessed 29 May 2015)

In **February 2001**, another company, **L-Giri** was set up. The following year, this was the company registered with the **Care Standards Inspectorate for Wales** (**CSIW**).[26] It owned 100% of the shares of **Puretruce Health Care Ltd**. The Directors and shareholders of both companies were Dr P Das and Dr N Das.

During **2002**, the registration of another of the Das' homes, **Merthyr Tydfil Nursing Home**, was cancelled; that is, the provider could no longer legally operate a residential care service from these premises.

On 30 **April 2002**, Dr P Das informed the **CSIW** that their company **Puretruce Health Care Ltd** was taking over the management of **Brithdir Nursing Home** on 2 **May 2002.**

Business planning was premised on the purchase of residential care sector homes at low cost. For example, **Puretruce Health Care Ltd** purchased **Brithdir** for only £150,000.

In **May 2002**, the leader of **Caerphilly County Borough Council** *demanded an inquiry into how a disgraced GP* (that is, a former colleague of Dr P Das) became employed by **Puretruce Care Ltd**.[27] Media coverage stated that **Puretruce** *has nearly 1,000 places for old people at its 22 registered nursing and residential homes and employs hundreds of staff.* Dr P Das said of the disgraced GP that *he did not participate in the day-to-day running of the care homes, particularly not on the clinical side…his duties were business and procurement and to ensure the best value for money.*

During **2003**, the registration of **Bay Bridge** home in Cardiff was cancelled. This also belonged to Dr P Das and Dr N Das.

In **June 2003**, Dr P Das met with the **CSIW**. At this meeting he complained about *harassment* by the Inspectors. They walked out of the meeting on the grounds that they felt threatened by Dr P Das' behaviour.

During **July 2003**, Dr P Das confirmed with the **CSIW** that he was the *Responsible Individual* for **Brithdir**.

In **September 2003**, **Paul Black** was appointed as **Puretruce Health Care Ltd**'s deputy Chief Executive. His background was in the sales and marketing of medical products. The Review was informed that within weeks of his arriving he had achieved *savings of over £100,000.*

During **October 2003**, **Puretruce Care Ltd** ran into financial difficulty and since it ceased to pay rents on 15 homes it was placed in receivership.[28] Paul Black wrote to the **CSIW** stating that *with immediate effect we have ceased operating.* Also during October 2003, a meeting

[26] The regulator responsible for registering and inspecting care homes and enforcing standards

[27] http://www.thefreelibrary.com/SEX-FOR__CASH+DOCTOR+IN+HOMES+JOB+STORM%3B+Inquiry+call+over+shamed...-a085917693 (accessed 16 October 2014)

[28] NHP Plc was the freehold owner of 14 of the Das' homes and one belonged to a separate landlord. It took action to recover back-rent from Puretruce Care Ltd. Over £1m was outstanding and Puretruce Care Ltd confirmed that it could not meet this debt. However, Puretruce Care Ltd continued to be legally responsible for the operation of these homes since they were registered to Puretruce Care Ltd

between Dr P Das and the **CSIW** underlined the concerns of the inspectorate about the adequacy of support within **Puretruce Health Care Ltd**'s remaining homes. Urgent remedial action was required, not least in terms of pressure ulcer prevention and treatment.

In **November 2003**, Paul Black met with the **CSIW**, **Caerphilly CBC** and the **Caerphilly Local Health Board** to discuss the concerns of an agency nurse about the poor standards of care at **Brithdir**, particularly during the night, and inadequate pressure ulcer prevention and treatment. Paul Black was told about the inadequate response of **Brithdir** staff and the company to **CSIW** inspections and timetables for improvements and to the necessary recruitment of nurses who were suitably qualified to supervise and train staff.

In **January 2004**, Dr P Das wrote to the Regional Director of the **CSIW** to complain about an Inspector, that is, visits that were *too frequent*…the *random referral of incidents to* **Protection of Vulnerable Adults** (**POVA**)...the contact with *the police, local authority and health and safety organisations without our knowledge*…and *nit-picking.* Furthermore, Dr P Das alleged that the death of a resident was attributable to this particular Inspector who also was *affecting our staff, our residents and our business* since she *provided no support.* Dr P Das and Paul Black met with the **CSIW**'s Regional Director who subsequently wrote to Dr P Das defending the Inspector's approach as *necessary* when *providers have been requested to address serious shortcomings but appear to have made little progress. Where homes are not meeting the requirements, Inspectors are required to monitor the home on a more frequent basis…were you to resolve the issues identified in the notices and improve the quality of provision to meet the Regulations and National Minimum Standards,* the Inspector's visits *would reduce.*

During **February 2004**, Dr P Das accused the Inspector of *racism…she doesn't like so many agency nurses in our home. Her statement has been viewed as 'racial' because almost all the nurses that come to us from the agency are 'black African.'* Seeking a response to his complaint of **January 2004**, he was advised to concentrate his efforts on attending to *the very serious shortfalls within the home.*

During **April 2004**, **Puretruce Health Care Ltd** appointed a Clinical Nurse Manager who, it was envisaged, would *supervise* six care home managers. (The second Care Standards Tribunal hearing observed that her job description was unrealistic given the documented history of concern about the homes.)

During **June 2004**, the **CSIW** Inspector informed Paul Black and Dr P Das that since two nurses were required at **Holly House**, two **Brithdir** nurses were sent there which left **Brithdir** with a single nurse on duty. The Inspector reported that she had insisted that a particularly poorly resident was transferred to hospital. The home's acting manager resigned *because of ongoing staffing problems.*

At a **POVA** meeting during **July 2004**, Paul Black acknowledged that there were staffing shortfalls.

During **October 2004**, Dr P Das informed the **CSIW** that he was *not* the Responsible Individual for any of the **Puretruce Health Care Ltd**'s homes.

In or about October 2004 Dr [P] *Das decided that, in order to ease the "cash flow difficulties" of* Puretruce Health Care Ltd, *he would stop paying to the HM Inland Revenue the monthly amounts due from the company in respect of its employees' income tax and National Insurance contributions. Dr Das did not disclose this information to* [Paul Black, the Chief Executive] *or to others working for or advising the company*.[29]

Also in October 2004, a team of District Nurses from **Caerphilly Local Health Board** assessed the 28 Brithdir residents, 10 of whom had pressure ulcers, and identified concern relating to *skin damage, nutrition, lack of equipment and assessments.* As a result, **Caerphilly CBC** placed an embargo on further placements. Lawyers acting for **Puretruce Health Care Ltd** undertook to challenge the decision.

At the Inspector's visit during **November 2004**, staff were *agitated* because they had not been paid. Dr P Das wrote to **Caerphilly CBC** claiming that the embargo was damaging the company.

In **December 2004**, the embargo was lifted with three conditions,

- **(i)** Only two residents per month were to be admitted (Dr P Das challenged this as *seriously insufficient as old people on average in any nursing home die about 3-4 a month, maybe more in the winter…*)
- **(ii)** Monthly visits by a **Caerphilly CBC** employee were to continue
- **(iii)** A senior nurse would review the position during **March 2005**.

During **January 2005**, the **CSIW** rejected the nomination by **Puretruce Health Care Ltd** of its Operations Manager as the Responsible Individual for three of its homes, including **Brithdir**. The Inspectorate did not consider the nominee to be a 'fit person'. The Operations Manager subsequently left the company.

In **May 2005 –** the **Care Standards Tribunal** heard the appeal of **Puretruce Health Care Ltd** against the cancellation of Registration of **Holly House Nursing Home**. It stated *we were unimpressed by the evidence of the senior management team at Puretruce Healthcare Ltd…and we concluded that we could not rely on the factual correctness of all of their evidence.* Although it was acknowledged that *the attitude of Dr* [P] *Das has been a major stumbling block to the improvement of standards* at **Holly House**, the home was given a *last chance* even though the conclusion was reached *on the finest of margins.* The Care Standards Tribunal did *not accept* Dr P Das' criticism of the Inspector. The Tribunal imposed conditions on the running of the home. Yet, only four months later, the CSIW issued a further Notice of Proposal to cancel **Holly House**'s registration.

In **June 2005**, Puretruce Health Care Ltd *and its holding company had failed to pay* [CSIW registration] *fees amounting in total to £27,760.00 in respect of five homes (Valley Manor, The Village, Holly House, The Beeches and Brithdir) from 2002-3 to date…*These amounts were

[29] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

still outstanding and remained in default at the date of the hearing[30] (that is, during May-July 2006).

Also in June 2005, Dr P Das sought *to extract "cheap money" from Caerphilly County Borough Council. Within a very short time of the publication of the Tribunal's decision…Dr* [P] *Das wrote to the Director of Finance of his company's main customer and revealed that it had pressing debts totalling £49,360.00 that it could not pay. Dr Das in effect threatened Caerphilly that if they did not help him financially he would be forced to leave them without a home in which to place the vulnerable adults for whom they had responsibility.*[31]

On 28 June **2005**, the BBC Wales broadcast *Week In Week Out: Taking Care* opened with the question, *If frail, elderly people were abused in a nursing home it would be stopped wouldn't it? You'd expect vulnerable residents to be safe in the hands of those paid to care for them, wouldn't you? Would a doctor fail elderly patients time and time again? This GP, Dr Prana Ballava Das, owns a string of nursing homes…we expose how he has been doing it for years.*

The families of **Holly House** residents were unaware of the nature and scale of failings at the home. **The Care Standards Inspectorate for Wales** undertook 20 announced and unannounced visits to **Holly House** when 2-3 per annum were the norm. Dr P Das dismissed the evidence and the complaints chronicled by the Inspectors. Dr Jonathan Richards, a GP and Professor of Primary Care who had patients at the **Merthyr Tydfil Nursing Home** - also owned by Dr P Das and Dr N Das – stated that patients there had *infected ulcers* and were *malnourished and dehydrated.* He reported Dr P Das to the **Health Authority** and an investigation began. The TV presenter explained that although the **Care Standards Inspectorate for Wales** had cancelled **Holly House**'s registration, the **Care Standards Tribunal** had upheld the appeal. Joe Howsam, the Director of Social Services at **Caerphilly County Borough Council**, commissioned an independent report into **Holly House**. The council's dilemma was that the poor and neglectful care of some residents did not necessarily mean that other residents and their relatives wished for them to be moved. He confirmed in the television programme that he would not place one of his relatives in **Holly House** since it did not meet minimum standards *in all respects.*

During **July 2005**, Puretruce Health Care Ltd *belatedly filed its accounts for the year ended 31 October 2003 with Companies House in Cardiff. These accounts showed that the company made a loss of £513,475 in that year. In the previous two years the company had made losses of £633,677 and £1,599,570.00 and the deficit in the shareholder's funds had increased from £754,857 in 2001 to £2,868,302.00 in 2003. But for the profit on the sale of Holly House to Puretruce Pension Fund, the loss in 2002-3 would have been £878,673.00 (adjusted for the pension contribution). The accounts also showed that Dr* [P] *Das owed the company*

[30] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

[31] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

£235,157.00 as at 31 October 2003 on his director's loan account (increased from £177,370.00 on 31 October 2002) and that the company owed its bankers £2,829,131.00.[32]

In **September 2005**, the **National Assembly** *formally requested production (under regulation 28) of documents* [concerning] *the financial viability of care homes owned by L-Giri and* [Puretruce Health Care Ltd], *including management accounts,* [information from] *the companies' bankers and a business plan for the next 3-5 years showing how* [Puretruce Health Care Ltd] *and its related companies intended to improve their financial positions.* [Puretruce Health Care Ltd] *did not provide the requested documents, notwithstanding that management accounts, held on the company's computer system, were readily available.*[33]

In **October 2005**, Dr P Das wrote to the **CSIW** to explain that he had asked **Caerphilly CBC** for *compensation for loss of business* and when this was refused he sought an interest free loan, blaming the **CBC** and **CSIW** for the depletion of **Puretruce Health Care Ltd**'s funds. Dr P Das filed an affidavit exhibiting a letter from the company accountant which indicated that **L-Giri** did not trade.

Also in October, Puretruce Health Care Ltd *filed its accounts for the year ended 31 October 2004 with Companies House in Cardiff. Those accounts showed that* [Puretruce Health Care Ltd] *made a profit of £35,455.00 for the year but only after exceptional gain £465,837.00 arising from the writing off of amounts due to another company in the group. Without the exceptional gain the company would have suffered a loss of £430,382.00. The auditors placed caveats on the accounts because of the absence of invoices to support repairs and additions to* [**Holly House**] *amounting in total to £258,986.00 and their inability to obtain all of the necessary information for the purposes of the audit. The notes to the accounts revealed that the company paid directors' emoluments to Dr Das and his wife (of £50,000.00) and made contributions to the directors' pension schemes (of £9,400.00). Bank borrowings amounted to £2,900,572.00 (an increase of £71,441.00 on the previous year)…On 27 October 2005 HM Revenue and Customs issued a winding up petition against* [**Puretruce Health Care Ltd**] *in respect of unpaid taxes amounting in total to £303,634.*[34]

During **November 2005**, **Caerphilly CBC** and **Caerphilly Local Health Board (LHB)** gave **Puretruce Health Care Ltd** six months' notice of termination of its contract.

Dr P Das disputed **CSIW**'s inspection report and via solicitors, advised that a new management team was to run **Brithdir** which involved Dr N Das. Once again, **Brithdir** received external assistance, that is, senior district nurses providing additional support in respect of wound care,[35] for example, not least because of (i) a police investigation arising from the death of a resident, Evelyn Jones and (ii) a series of **POVA** meetings.

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[32] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

[33] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

[34] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

[35] Aneurin Bevan *Health Board summarized timeline of pivotal events: Jasmine Review,* August 21 2014

Brithdir was the focus of further **POVA** meetings at the beginning of **2006**. Dr P Das did not agree that there was inadequate staffing at the home. Not even attendance at a **POVA** meeting concerning a resident's pressure ulcer damage persuaded him that there were problems at the home.

During **January 2006**, Corona Energy (a gas supplier) *notified the CSIW that they were again planning for the isolation of the gas supply to The Beeches and other homes because of non-payment of bills. A hearing was fixed for 27 March 2006 at which Corona Energy would have sought authority to cut off the supply but on 26 March 2006 Dr Nishebita Das paid the outstanding amount due to Corona Energy using her personal credit card.*[36]

The last resident was removed from **Brithdir** during **April 2006** when the home was sold.

Following the closure of Holly House, six members of staff became entitled to redundancy and accumulated holiday payments…awards were made by the Employment Tribunal on 20 ***May 2006.***[37]

During **June 2006**, the **Village Nursing Home** *closed and in July 2006* [Puretruce Health Care Ltd] *sold the property for £1,425,000.00.*

In **July 2006**, Puretruce Health Care *entered into negotiations for the sale of Brithdir Nursing Home (for £900,000.00); Bedwelty Nursing Home (for £383,000.00); Bryncoed Nursing Home (also for £383,000.00) and Merthyr Nursing Home (also for £383,000.00).* [38]

During **July 2006**, a second **Care Standards Tribunal** hearing determined that *the persistent breaches proved were more than sufficient to merit the closure of* **Holly House** and **The Beeches**. Of the former, it was stated that *Dr* [P] *Das was the person in ultimate control. His financial management was unprincipled and ill-considered and in some instances, disastrous.* Further, it stated that *Dr Das and his wife have benefitted considerably* from their businesses. *Dr* [P] *Das extracted funds from the applicant company and the other companies in the group in a manner which if not illegal was certainly unethical. On the advice of accountants, and presumably to avoid taxes, the companies, including the Applicant company, granted Dr Das massive loans instead of paying him emoluments or dividends. The increase in his director's loan account with the Applicant company from* ***31 October 2002*** *to* ***31 October 2003*** *(£57,787) during a period when the company made a very substantial loss and failed to pay its bills was truly remarkable and indefensible. At that time, the company plainly needed to recover the debts owed to it, not to extend further credit to its directors. In the following year, as soon as the company made the semblance of a profit, it paid directors' emoluments to Dr Das and his wife of £50,000 and made contributions to their pension schemes of £9,400…Dr* [P] *Das has developed a predisposition…called "brinkmanship"…that term may be insufficient to describe his preparedness to approach a chasm before stepping back from it. He certainly confronts*

[36] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

[37] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

[38] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

*problems only at the last possible moment but he sometimes reacts only after that moment has passed…*He *allowed at least seven judgements to be entered against the company in respect of money owed…*He *only released funds to pay Powergen and Corona Energy when they obtained dates for court hearings of their applications to cut off the supplies of electricity and gas…The Tribunal was satisfied by the evidence that the changes required to make* ***Holly House*** *and* ***The Beeches*** *satisfactory care homes are beyond the management capabilities of the Applicant company and that the problems that will be created by…closure…are not insuperable.*

Holly House and The Beeches were deregistered during **September 2006**.

In **November 2006**, the **Care Standards Inspectorate for Wales** informed the **General Medical Council** (GMC) of the outcome of the Care Standards Tribunal. The GMC *placed* the case *on hold pending completion of the criminal investigation.*[39]

In **December 2006**, the **General Medical Council** imposed an interim order on Dr P Das. One condition banned him from having any involvement in the clinical care of patients at any nursing or care home in which he had a financial interest.

During **May 2008**, the **General Medical Council**'s restrictions placed on Dr P Das' clinical practice were extended.[40] GMC lawyers argued that it was *in the public interest* to do so since they were *proportionate to the serious nature of the allegations facing Dr Das.* Mr Justice Blair noted that: *It is unsatisfactory that Dr Das finds himself in the position he does. The police inquiries have not resulted in charges, let alone a date for a trial, or anything of the sort.*

During **October 2011**, the **Health and Safety Executive** and the **Crown Prosecution Service** sought to bring charges against **Puretruce Health Care Ltd**, Dr P Das and the Chief Executive Paul Black.

There were two proposed charges against **Puretruce Health Care Ltd** under S3 (1) of the Health and Safety at Work Act 1974 (the Act), relating to the treatment of residents on dates between 2002 and 2006.

There were a further two proposed charges against Dr P Das and Paul Black under S37 (1) of the Act; and two charges against Paul Black under S7 (a) of the Act.

There were four proposed charges against Dr P Das (under S1 and S17 (1) (a) of the Theft Act 1968), listing a theft of £23,080.65 committed during 2002, and a total misappropriation from company funds of £337,737.30 between **March 2002** and **October 2005**.

During September **2012**, Dr P Das was attacked at home and sustained severe head injuries.

During March **2013**, Cardiff Crown Court was told that Dr P Das was unlikely ever to recover sufficiently to stand trial, and consequently no further action was taken to progress a trial.

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[39] Chief Executive and Registrar, GMC

[40] http://www.southwalesargus.co.uk/news/2259711.blackwood_gps_practice_restrictions_extended/ (accessed 16th October 2014)

In relation to the homes in which Dr P Das and Dr N Das were involved:

- A number have been the subject of adverse TV programmes during 1995, 2005 and 2013
- 15 of the homes went into receivership
- the registration of five of the homes was cancelled
- Holly House was the subject of two Care Standards Tribunals
- Their business practice was criticised by Wayne David MP in the House of Commons during June **2005**[41]
- In **March 2013,** Nick Smith MP contributed to a Westminster Hall debate concerning Operation Jasmine: *All the evidence collected in this long running case must be brought to the public's attention, so that it is open and available for them and they can form their own views about what happened*[42]
- There was professional concern over a considerable period based on allegations of inattention to standards of care at the homes, the neglect of residents and specific failures in terms of pressure ulcer prevention and pressure ulcer treatment.

[41] http://www.theyworkforyou.com/debates/?id=2005-06-23a.995.0 (accessed 16 October 2014)

[42] http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130313/halltext/130313h0002.htm#13031349000002 (accessed 16 October 2014)

Section six: Gwent Police

In this section…

> *…you will read about the Gwent Police investigation – and some of Gwent Police's comments resulting from its reading of this section. It relies principally on a peer review of Operation Jasmine by North Wales Police which was published during 2009. Operation Jasmine developed from an examination of the injuries which led to the death of one nursing home resident during 2005 to an operation which deployed 75 officers at a cost of £15m – including the Health and Safety Executive's investigation. The section considers the involvement of Gwent Police in Protection of Vulnerable Adults meetings and also refers to Operation Vermont. The parameters and priorities of Operation Jasmine are set out, as well as the setbacks, and the observations of the North Wales Police reviewers. The section concludes with Gwent Police's consideration of the outcomes arising from Operation Jasmine.*

The purpose of this chronology is to set out the parameters of Operation Jasmine, an investigation by Gwent Police into incidents of neglect and unexplained deaths at an unknown number of homes[43] in south east Wales. It is not to be regarded as a detailed account of the process by which Gwent Police moved from one phase of the investigation to another; nor of the way in which decisions were reached on what was in need of investigation since such information was not shared with the Review. Rather, it is an attempt to set out the key events, abstracted primarily from documentation originating with Gwent Police but relating to other agencies,[44] North Wales Police,[45] the Care and Social Services Inspectorate Wales (CSSIW) and Caerphilly CBC. The residential care of older people, the processes of contracting with homes, care planning with residents and relatives, reviewing the adequacy of individual care plans and monitoring the standards within the homes were foreign worlds to Gwent Police (as with

[43] Feedback from Gwent Police on 5 May 2015 confirmed *six care homes* (p1). However, the same communication stated: *and for Brithdir, read also any other home owned by Das/Puretruce* (p7)

[44] Gwent Police (2014) *Operation Jasmine Briefing to Dr Flynn March 2014*. On 10 November 2014, Gwent Police emailed letters x2 from Puretruce to the CSIW in August 2005 and March 2005; a letter from Puretruce to Caerphilly CBC in January 2004; witness statements x2 concerning Edith Evans from a Professor of Geriatric Medicine, June 2009 and August 2010; reports x2 of a consultant nurse adviser concerning Evelyn Jones and Edith Evans, April 2009 and May 2009; a *conjoined expert report re Alan Sayers*; reports concerning Dorothea Hale by (i) a nursing expert, July 2009; (ii) a retired consultant physician, March 2010; and (iii) an undated witness statement/medical report by a forensic pathologist

[45] On 18 November 2014, Gwent Police emailed the North Wales Police (2009) *Review of Operation Jasmine: The North Wales Police Review into the Gwent Police Care Home Manslaughter Inquiry – Victim Evelyn Jones born 28. 11. 1917.* The review team comprised five serving police officers of various ranks, an analyst, a scientific support performance manager, and four retired police officers. Feedback from Gwent Police on 5 May 2015 stated that the process of a review, such as that undertaken by the North Wales Police, *is…subjective…and strategies and leadership differ…based on knowledge and experience of the issues at hand. Peer review recommendations are not mandatory…the weight given to the* [North Wales Police review] *in this* [section] *is disproportionate and at odds with the importance…attached to it at the time* (p7)

most police forces at the time). It therefore sought the assistance of an expert panel - professionals with a broad experience of medical, nursing and social work reviews and the inspection of homes, to assist their investigation.

The immediate trigger for Operation Jasmine was the hospitalisation and subsequent death of **Gladys Elvira Thomas**[46] during **October 2005.** She had been a resident at **Bryngwyn Mountleigh**, then in ownership of Apta Healthcare. However, Operation Jasmine's Terms of Reference as set out in the North Wales Police Review (p16-17), were broader: that is, *to fully investigate the death of Gladys Thomas whilst in **Bryngwyn Care Home**; to fully investigate concerns regarding care/neglect issues in relation to present/past residents of **Bryngwyn** or **Mountleigh Care Homes**; to conduct a professional and thorough multi-agency investigation and explore fully any criminal liability of care staff or management of **Bryngwyn Mountleigh Care Homes** who are employed, have been employed or who had responsibility for care in these premises.*[47] The circumstances surrounding her injuries and death were considered by the expert panel.

Gwent Police noted that, *In due course…the investigation also encompassed the care of another resident…Alan Sayers who had died in 2004.*[48]

There were two sets of associated activities which might have been perceived as relevant to, and foreshadowing, an extended Operation Jasmine investigation but which were not treated as part of a pattern of events.

Firstly, police officers took part in an unknown number of **Protection of Vulnerable Adults** (POVA) meetings hosted by local authorities; during these meetings facts about the concerning circumstances of older people were available but were draped in the ambiguity of *adult protection.* With the exception of **Hilda Scase** [who was a resident prior to the ownership of the home by Dr P Das and Dr N Das],[49] it is not known whether the criminal offences of manslaughter, wilful neglect or ill-treatment and assault were explicitly considered or whether discussion was limited, in most instances, to the specific consideration of POVA procedures. According to Gwent Police:[50]

It *did take action as a result of POVA referrals, albeit in a limited number of cases, prior to the commencement of Operation Jasmine. However, when the POVA documentation that was*

[46] http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/04_06_13_fo4_elderlycare.pdf (accessed 7 July 2014)

[47] Feedback from Gwent Police on 5 May 2015 stated: *by Christmas 2005 the number of deaths being investigated totalled 19. It was a feature of policy and parameters that it was necessary to regularly review and amend decisions whilst deaths and concerns would grow over time to 63.* (p5)

[48] Feedback from Gwent Police on 5 May 2015

[49] A self-funding resident of Brithir for 10 weeks during 2002. Feedback from Gwent Police on 5 May 2015 stated: *At least two matters were referred to the CPS but no prosecution took place. It is also the case that a number of matters were never referred to the Police i.e. Alan Sayers,* [and another man], *Edith Evans and Stanley Bradford* (p6)

[50] Email from Gwent Police dated 12 December 2014. Feedback from Gwent Police on 5 May 2015 stated: *These meetings pre-dated Operation Jasmine…It was also the case that Operation Jasmine referred Gwent Police Officers who were involved in some of these early cases to its Professional Standards Department where matters appeared to involve sub-optimal decision-making and practice* (p6)

recovered during the investigation was examined by the Operation Jasmine team, it was identified that there were shortcomings in the police response in a number of the cases reported through this process. Officers that attended the meetings in order to discuss these cases were being asked to comment on matters that they were unfamiliar with. These were not routine referrals to the police and clearly the police are not a regulator in this sector, as a result investigations were either not commenced or were conducted in isolation, thereby failing to examine the totality of the available evidence in order to make informed decisions based on all of the information available. [51]

Secondly, **Operation Vermont** concerned the *investigation into the death of Dorothea Hale and the subsequent wider investigation into the standards of care at Grosvenor Nursing Home.*[52] In relation to Dorothea Hale's death,

…the hospital pathologist refused to carry out a post mortem examination because of the ongoing POVA investigation. The subsequent post mortem was then carried out by a Home Office pathologist who was unable to provide a cause of death…as the investigation progressed…a decision was made to transfer this case to the Operation Jasmine investigation. The rationale…being that whilst this investigation was focussed at a separate care setting and located in a separate local authority area….the established investigation team had established the expertise and command structures to properly direct and supervise this particular investigation…The CPS determined that there was insufficient evidence to support a prosecution.[53]

In carrying out its task, Operation Jasmine was overseen[54] by a *Strategic Management Board (SMB)* which initially included **Gwent Police**, the **Crown Prosecution Service**, **Caerphilly Local Health Board**, **Caerphilly County Borough Council**, **Newport City Council**, **Torfaen County Borough Council**, the **Health and Safety Executive** and the **Care Standards Inspectorate for Wales**. An undated draft document outlined the purpose and functions of the Strategic Management Board:

To take ownership of the strategic leadership of the investigation…with an overarching responsibility to ensure that the investigation is adequately co-ordinated, resourced and funded…to ensure that the welfare of vulnerable adults takes primacy within their organisations and within the investigation…to ensure that all agencies work together effectively…to agree that in the criminal investigation Heddlu Gwent Police retain primacy [there is a line through this and the substituted suggestion that] *each participating agency*

[51] At the relevant time, Gwent Police was a signatory to the South East Wales Executive Group for the Protection of Vulnerable Adults (2003) *Protecting Vulnerable Adults: Interagency policy, procedures and practice guidance for responding to alleged abuse and inappropriate care of vulnerable adults in the South East Wales Area*

[52] One of the six homes

[53] Email from Gwent Police dated 3 December 2014

[54] Feedback from Gwent Police on 5 May 2015 stated: *the SMB was subsequently replaced by a GOLD structure comprising of only the investigative agencies due to recognised conflict of interests and potential culpability by partner agencies*

has primacy in the areas for which it has statutory responsibility. The objectives included to *ensure that current risks to vulnerable adults emerging during the investigation are acted upon immediately and ensuring a robust risk management process; to ensure standards are in place to guarantee the integrity of the investigation and rigorously scrutinise the gathering of collaborative and additional evidence to the investigation; to ensure all agencies commit sufficient trained resources and that prompt, appropriate support is offered to victims and their families during the investigations and throughout and following any court processes; to ensure that the investigation has access to appropriate legal support; to consider at the appropriate time how the lessons of this investigation can be learnt and promoted.*

An *Investigation Management Board* was also set up at this time. An undated draft document outlined the envisaged purpose and functions:

The Investigation Management Board is the forum where the range of professionals can meet and agree how the investigation is delivered on a day by day basis and is responsible for ensuring that the progress of the investigation is in line with the partners' policies and procedures…The Investigation Management Board will be responsible for formulating policy/ procedure and tactics on a day to day basis in the following areas: victim and witness support; the professional handling of all exhibits and safe storage of records seized in connection with this enquiry…to ensure careful consideration is given to the health and social care needs of victims; to ensure that the victim and offender interviews are conducted by trained personnel…the Senior Investigating Officer…will be responsible for maintaining a policy decision book detailing policies guiding the conduct of the enquiry…to keep the Strategic Management Board informed of any resource shortages experienced by professionals…to ensure a consistent and appropriate inter-agency approach to practical and emotional support for victims and their families and personnel working on the enquiry…to coordinate interagency response to service users, families and provide consistent information; to ensure that issues which need to be shared by other agencies…are communicated…and addressed; to ensure that all staff…are clear about the parameters of shared information, data protection and confidentiality…and observe the terms of the information sharing protocol agreed by the Strategic Management Board…to ensure the relevant intelligence and information has passed between agencies and to the Police Major Incident Room…The Senior Investigating Officer…should chair the Investigation Management Board and membership should include representatives from the social services, CSIW [Care Standards Inspectorate for Wales]*, Local Health Board and the local authority.*[55]

According to the North Wales Police reviewers:

The number of deaths within Operation Jasmine grew rapidly in the early weeks of the investigation. Then throughout the enquiry further cases came to light. This caused the Senior

[55] Feedback from Gwent Police on 5 May 2015 stated *The IMB Terms of ref. changed twice. Final change took place in June 2007. They were adapted due to expert criticism being received which identified that the levels of neglect were more wide ranging* (p10)

Investigating Officer to adjust the focus of the investigation. There have also been significant peaks in workload caused by events such as the Gladys [Elvira] *Thomas and Alan Sayers trials[56]. Other delays include obtaining expert reports and changes in legal advice on the status of suspects and witnesses. These issues have made it difficult for the investigation to maintain an overall strategy around arrest and interview. The result is a situation where some suspects have been arrested whilst others in the same case have not. Many individuals have been on bail and/or reported for summons for a significant time.[57]*

In **October 2005**, Gwent Police began an investigation at Bryngwyn Mountleigh.

During **November 2005**, there were 20 police officers/staff[58] working on Operation Jasmine. Minutes of the first three meetings of the *Strategic Management Board* have been made available to this Review by other agencies. The first meeting *stressed that this was a joint investigation (multi-agency).* Attendees were briefed about **Gladys Elvira Thomas**' injuries and were informed that the neglect of others at **Bryngwyn Mountleigh** *will require investigation,* for example, *an incident where a member of morning staff found a patient tied to a bed. This incident was not investigated by the police* [at that time].[59] The minutes of the meeting are unclear as to whether (i) the police were informed of this incident and decided not to investigate or (ii) the police were *not informed* of the incident and were therefore unable to investigate. During the meeting it was determined that three members of staff at the home should be suspended; that an inspection by the **CSIW** should be postponed (this was subsequently amended, *postponing the visit was agreed by the POVA strategy meeting*); that *body mapping* and reviews of all residents should be undertaken; meetings arranged with Apta Healthcare (the owners of the home); and a press statement prepared and agreed.

At the second *Strategic Management Board* it was reported that two more residents of **Bryngwyn Mountleigh** had been admitted to hospital. One patient was *grossly dehydrated* and the other had not received any medication since the home had *run out.* Further, officers inspecting **Gladys Elvira Thomas**' room reported that it was *very sparse* and contained a broken table. It was noted that *historic investigations will also take place as there are concerns over one gentleman who died and was left for 3 hours on his own.* The Detective Inspector *asked that all new referrals to the hospital were to be reported straight to the police.[60]* The police were *looking to increase the strength of officers/staff working on the*

[56] http://news.bbc.co.uk/1/hi/wales/south_east/8404240.stm (accessed 19 July 2014)

[57] Feedback from Gwent Police on 5 May 2015 stated: *There are frequently issues associated with managing multiple suspects in any investigation* (p10)

[58] It is not known when Operation Jasmine was at its peak in terms of deploying 75 detectives (as told to *Week In Week Out* on 4 June 2013 – (See Appendix 1**).** Feedback from Gwent Police on 5 May 2015 stated: *Whilst there were not 75 detectives working on the investigation throughout the maximum resource levels were reached in 2008 to 2009* (p11)

[59] Feedback from Gwent Police on 5 May 2015 stated that this incident related to: *a 1997 matter which was not raised until 2002 during a [POVA] strategy meeting. It hinged on claims made by a whistle-blower…Operation Jasmine reinvestigated it for relevance…The evidence amounted to uncorroborated hearsay only. As a result the CPS advised that no further action would be taken in respect of the allegations* (p11)

[60] It is not known if these individuals were then referred to other agencies for their attention and potential action

investigation…Caerphilly Social Services have allocated 4 persons full time for a period of 6-12 months. It was confirmed that (i) there was an embargo on **Bryngwyn**, that is, no new residents would be admitted and that (ii) there were no plans to lift the embargo *until Caerphilly Social Services are satisfied.*

On 4 **November 2005**, the home was taken over by **Southern Cross.**[61] It was noted that residents were to have risk assessments and *new care plans* and that **Southern Cross** planned to *release all current staff.*

At the third meeting of the *SMB*[62], *it was agreed that the terms of reference for Bryngwyn/ Mountleigh would also apply to Brithdir.*[63] It was noted that *there have been significant concerns with Brithdir over a number of years with regard to regulatory breaches. Caerphilly County Borough Council completed an audit with specific timescales, some of which have not been achieved* [resulting in] *an immediate embargo on the home* [and the intention] *to issue a termination of contract…CSIW's legal department* was also addressing concerns regarding **Brithdir**. The **CSIW** was asked if it *could provide a member of staff permanently to the investigation team…a request for additional police staff has been made…the aim for the completion of the investigation is 31* ***January 2006*** *provided the relevant monetary/staff resources are found.*[64] The police undertook to *inform the General Medical Council.*

Two members of **Caerphilly CBC** and a (retired) **CSIW** employee were initially co-located with Gwent Police *to provide support around individual service user cases and files…*the *police made significant requests for information…and wished to interview staff and take statements. This resulted in potential disruption to the running of the service and unnecessary anxiety for staff…contacted 'out of the blue' as staff were not aware of the extent of the police investigation. Therefore a process of a point of contact was developed.* At the beginning, *agencies worked together through the multi-agency POVA process.* Over time however, *the usual POVA process of individual strategy meetings appears to have been replaced by 'overarching meetings' where both multiple referrals and systems failures in Mount Leigh Bryngwyn and Brithdir nursing homes were discussed.*[65]

During **November 2005**, Operation Jasmine *widened to include* ***Brithdir*** at a time when *care* at ***Brithdir*** was *deteriorating.* The parameters of the police investigation were:

- *To investigate the circumstances of all the deaths where there are or have been concerns*

[61] A Darlington based care home operator which ceased operating during 2011 when it was unable to pay rent to its landlords http://www.bbc.co.uk/news/business-14102750 (accessed 29 January 2015)

[62] Only three sets of minutes were shared with the review

[63] Ultimately, the Gwent Police investigation focused solely on Brithdir

[64] Feedback from Gwent Police on 5 May 2015 stated: *this comment was made in November 2005…Clearly this view changed in early 2006 when additional resources joined the operation and the true extent of the matters under investigation became apparent* (p13)

[65] Caerphilly County Borough Council Improvement Journey: Report for Jasmine Review, p7

- *To investigate all allegations or suspicions of abuse*
- *To investigate all allegations where neglect has led to potential criminal offences*

On **30 November 2005**, the death occurred of **Evelyn Jones** – she had been a resident of **Brithdir**. The North Wales Police reviewers are questioning of Gwent Police's response to **Evelyn Jones**' hospitalisation, that is, although she died on **30 November 2005**, *there is no entry in the* [police] *policy book that day despite her being a priority line of investigation three days earlier. The next mention of Evelyn Jones within the policy books is on **3 January 2006**…*The police did not attend her post mortem – *this is a significant omission.*[66] *Understanding the mechanism of death is a key feature in this investigation*[67] - and *forensic opportunities…appear to have been missed. For example, there was no attempt to locate and examine the mattress she had been sleeping on at **Brithdir Nursing Home***[68]*…there was no examination of the deceased by an expert in tissue viability until **24 December 2005**, by which time the body was deteriorating and the expert was unable to form an opinion.*[69] Further, the Home Office Pathologist noted, *The presence of Clobazam*[70] *in the hair is of concern and is not accounted for by any of her prescribed medicines…[Clobazam has been found in a number of samples taken from both the victims of suspected abuse and other residents of the home, despite the drug not being prescribed to them.]* The North Wales Police reviewers recommended that this line of enquiry should be *revisited* and that *further investigative work* was required *to establish if a cause of death for **Evelyn Jones** can be agreed by all the relevant experts.*[71]

Concern about Gwent Police's responses to the hospitalisation and death of **Evelyn Jones** led the North Wales Police reviewers to recommend that, *Gwent Police create a contingency plan to be implemented in the event of death of a living victim within the Operation Jasmine database. This plan would ensure the level of response provided was in accordance with the current Murder Investigation Manual and in particular that a comprehensive Forensic Strategy*

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[66] There was no senior officer present at the PM for Gladys Thomas which took place in October 2005

[67] That is, the police were operating outwith the Murder Investigation Manual which states: *In the majority of cases the SIO will wish to be present at the PM examination. This will ensure the SIO is always involved where there are interpretational issues or findings that could significantly alter the course of the investigation*. Feedback from Gwent Police on 5 May 2015 stated: *The Murder Manual is not a Code of Practice or legally binding* (p6)

[68] No action was taken to recover a pre-transfusion blood sample on Evelyn Jones' admission to hospital - this was destroyed; and *head hair samples had to be re-taken from care home residents due to insufficient quantity being obtained initially…blood samples taken early in the investigation were stored in different ways.* Feedback from Gwent Police on 5 May 2015 stated: *The timing of the referral of Evelyn Jones to Gwent Police initially, and then Operation Jasmine formally were outside the windows of opportunity to forensically intervene* (p17)

[69] North Wales Police Review of Operation Jasmine

[70] A Forensic Scientist was quoted in the North Wales Police Review: *Clobazam is a benzodiazepine type drug that has limited use in the UK. It is licenced for the treatment of epilepsy but its use is relatively rare. Side effects attributed to its use include drowsiness and sedation. When dispensed it should bear a label warning of the potential for drowsiness to be experienced.*

[71] Feedback from Gwent Police on 5 May 2015 stated: *A report dealing with the Clobazam line of inquiry was completed for the information of Prosecution Counsel prior to the HSE trial process*

was in place to secure and preserve evidence.[72] The police reviewers noted that *there is evidence that the investigation had not fully considered or pursued all forensic lines of enquiry.*

In **January 2006**, *the* Operation Jasmine *priorities were identified as 18 deaths across* **Bryngwyn Mountleigh** and **Brithdir**…*Seven identified action teams will be assigned to fully investigate the intention of compiling a file of evidence…*An *Investigation Overview Report* stated *that there is no link between the Bryngwyn Mountleigh and Brithdir Nursing Homes in respect of either the management or the owners. As there was no commonality between the two enquiries, in hindsight, the management of the investigation may have been better served by opening a second HOLMES*[73] *account. This may have prevented the parameters between the two investigations becoming blurred…This process has been adopted with the creation of a second data base in relation to the Belmont Home investigation.*[74]

During **March 2006**, and *following a conference with Counsel,* it was determined that *the enquiry would be undertaken in four phases.*[75] By **April 2006**, the investigation had identified 13 cases and Phase 1 (that is, the priority) included **Evelyn Jones, Edith Evans**, **Gladys Thomas** and **Alan Sayers**.

During **April 2006**, *a briefing was held where it was decided to seek the advice of Counsel regarding the crossover of subjects from the status of suspect to victim…QC's advice is clear, this can only be decided on a case by case basis…added to which must be the expert panel's view of culpability and continuum of culpability.*[76]

In **July 2006**, Dr P Das *became a suspect for money laundering and neglect offences.*[77] Also during July, *it was decided to structure the investigation beginning with carers then dealing with qualified members of staff…this decision was later reversed.*[78]

By **August 2006**, Operation Jasmine's *priorities were revised…the investigation was now looking at 22 cases, split over six phases…suspects were placed on long term police bail pending the completion of reports* and **Evelyn Jones** was re-located to Phase 3.

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[72] Feedback from Gwent Police on 5 May 2015 stated: that in response to this recommendation, *the investigative team will look to examine current systems and set in place process to ensure deaths are appropriately responded to. For new deaths at other homes the existing force resources will deal. With regard to the historic victims of Operation Jasmine a contingency plan was initially developed but will be reviewed in light of this recommendation* (p16)

[73] Home Office Large Major Enquiry System

[74] Feedback from Gwent Police on 5 May 2015 stated: *This was a decision taken by Gwent Police senior managers at the commencement of the Brithdir investigation when the extent and complexity of the investigation was unknown* (p16)…*During the early investigative stages…it quickly became apparent that the quantity and severity of neglect issues at Brithdir exceeded those at Bryngwyn/Mountleigh. In order to manage both investigations a phased prosecution approach was commenced following consultation with QC and the CPS* (p29)

[75] North Wales Police Review of Operation Jasmine

[76] North Wales Police Review of Operation Jasmine

[77] North Wales Police Review of Operation Jasmine. It is not clear to which circumstances these allegations relate and whether or not they were allegations which led to charges

[78] North Wales Police Review of Operation Jasmine

During **2005-2007**, Gwent Police had been contacting the relatives of people who had been in particular homes and alerting them to the fact that some of the deaths of former care home residents were associated with neglect. Some of these contacts occurred over many years after these deaths. Since this was *devastating for families,* contact was made with **Victim Support** which was advised by Gwent Police that this was *a massive case*. This led to the preparation of a business case for £20K of funding to: recruit volunteers; provide training for volunteers; and training for the witness service team to support families in court. Gwent Police officers and a member of Victim Support visited Greater Manchester Police and Victim Support personnel who had worked on the Harold Shipman investigation to learn about how they had approached the task of supporting an escalating number of victims' families. Initially Victim Support offered face to face support but because not everyone wanted this, telephone contact was offered at key times. This was what the majority wanted. Early glimpses of how difficult it was for some families concerned were given expression in turning down the assistance offered by Victim Support, typically with the claim: *It's too late now. We wanted help at the time*. After the first three months, Victims Support's calls involved checking that people were OK and reporting that there was *no news*. However, as the investigation extended people got fed up of being told that there was *no news*.

In **January 2007**, **Gwent Police** revised the priorities once again.[79] Arrests were postponed in relation to the deaths of **Evelyn Jones and Edith Evans** since there were outstanding arrests and enquiries concerning **Gladys Elvira Thomas** and **Alan Sayers**. The North Wales Police reviewers stated that since the investigations into the deaths of Gladys Thomas and Alan Sayers *took precedence…a delay resulted…due to a lack of resources*.

The North Wales police reviewers noted that *the focus* of Operation Jasmine was *adjusted…on a number of occasions…decisions had been made to address new information in the investigation that uncovered many new concerns. There were also ongoing issues about the volume of work and the limited resources available…The Review Team found there was inadequate explanation recorded…as to why the previous priorities had been superseded.*

The circumstances of an unknown number of home residents were made known to the expert panel.[80] However, it is known that they included **Stanley Bradford**, **Megan Downs**, **Edith Evans** and **Evelyn Jones, Ronald Jones**, and **Hilda Scase**.[81] There was an embargo at **Holly House**[82] which spanned **November 2003** to **February 2004**, during which time there were

[79] Feedback from Gwent Police on 5 May 2015 stated: *OJ was simultaneously trying to manage the EE, EJ, [and another woman] investigations (still at an early stage) whilst trying to conclude GT & AS and secure a charging decision from CPS & QC. The GT charging decision was complicated by experts opening up the window of opportunity for when the unaccounted injury could have occurred (just one of the contributory causes of death) and so further arrests were necessary and interviews undertaken (more than reasonably anticipated) and this interfered in timetables of those other investigations* (p24)

[80] Feedback from Gwent Police on 5 May 2015 stated: *In total Police submitted fourteen cases for expert opinion. These submissions however were made to different groups of experts when additional care home enquiries arose. Experts were instructed differently for HSE matters* (p25)

[81] These are the names of people whose families have contributed to the Review

[82] Owned by Dr P Das and Dr N Das

POVA strategy meetings; there were additional POVA strategy meetings before the **Care Standards Tribunal** hearing in **May 2005,**[83] which granted an appeal against de-registration. The **Care Standards Inspectorate for Wales** secured an emergency closure of the home just three months after the Care Standards Tribunal. In **May 2006**, a second Care Standards Tribunal hearing[84] established that regulations had been breached seriously and extensively and **Holly House** was closed.

Brithdir was subject to an embargo between **March 2002** and **June 2002**, during which time the home was purchased by the company belonging to Dr P Das and Dr N Das. There had been a POVA meeting in **February 2002** concerning **Hilda Scase.**[85] There were more deaths before an embargo was imposed in **October 2004** (which was lifted in **December 2004)**. Although **Caerphilly Social Services**' monitoring revealed lack of improvement at the home, in **August 2005**, eight **Holly House** residents and some Holly House staff were transferred to **Brithdir**. A total of 24 people transferred to the home after **December 2004**. Before another embargo was imposed in **November 2005**, there were more POVA meetings and more resident deaths.

Gwent Police asserted that there were *24 "suspicious" deaths* at **Brithdir**, one at **Grosvenor House** (that is the death of **Dorothea Hale**) and another at **Bank House**. However, Gwent Police indicated that there were many others, stating: *a total of 63 deaths currently subject of investigation*.[86]

Gerard Elias QC was brought into Operation Jasmine *as the case was developing*. The superficial evidence concerning **Brithdir** was that pressure ulcers were the substantive cause of deaths in company with lack of care. There was a strong case based on the numbers of older people with pressure ulcer damage. Gerard Elias put his opinions in writing to Gwent Police.[87] The criminal offences investigated were threefold:

- Manslaughter by gross negligence
- Offences Against the Person Act 1861
- Ill treatment – S127 Mental Health Act 1983

In **June 2006**, the expert panel was instructed *following consultation with the **CPS*** [Crown Prosecution Service] *and Counsel*. They were asked to:

[83] *Puretruce Health Care Ltd v National Assembly for Wales* [2004] 0371 (EA-W) 15 May 2005

[84] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

[85] Following her death in **March 2003** a manslaughter prosecution was considered against employees of the home at that time. No action was taken

[86] Gwent Police briefing of March 2014

[87] Feedback from Gwent Police on 5 May 2015 stated: *His earliest advice was not Brithdir specific but also applied to Bryngwyn/Mountleigh. His subsequent advice… was based on the prevalence of pressure sores & wound care; their apparent nexus to death; and over a relatively constrained time frame* (p26)

- *Examine the medical records and other evidence of the care and treatment provided to individual residents*
- *Comment upon the standard of care and treatment afforded to those individual residents*
- *Determine whether there is any evidence of physical abuse or other ill treatment (including drug misuse) to any individual resident*
- *Determine whether there is any evidence of negligence in relation to any individual resident*
- *Determine (in the event that any finding of negligence is made) where possible and from a medical/care standpoint, which person or persons bears professional responsibility for such negligence*
- *Determine whether in any individual case where death has occurred, physical abuse and/or negligence has caused death or contributed to the cause of death*

The North Wales Police reviewers stated: *Twenty-six people were identified as suspects in relation to **Evelyn Jones**. The first two were interviewed in June 2006 followed by a third in July. The last three were interviewed in September and October 2007. The majority were not seen until early 2008.*[88]

In **July 2006**, the expert panel was in possession of case papers concerning **Gladys Thomas** and **Alan Sayers** and during **November 2006**, *draft combined reports were received.*

In **January 2007**, the final report concerning **Gladys Thomas** was produced, that is, it was delivered within approximately six months. The North Wales Police reviewers noted that *the backlog of* [police investigation] *work had reached an almost critical level* and by **March 2007** *no additional staff had been appointed and the backlog of work remained at a critical level.* It was noted that *a considerable backlog within the document flow and action management was created by insufficient resources being allocated.*[89]

In **April 2007**, the expert panel was given the case papers concerning **Evelyn Jones**, **Edith Evans** and another woman (this was 16 months after the death of **Evelyn Jones**)…*it was confirmed that combined reports were the best way of producing the evidence from experts.*[90]

In **July 2007**, the expert panel wrote to the Chief Constable to draw his attention to concern about nursing home residents. They stated that since the residents were unable to speak for themselves *those responsible for their wellbeing had a high level duty of care, for example, to*

[88] It is difficult to discern the precise details of who was interviewed and when from this account

[89] Feedback from Gwent Police on 5 May 2015 stated: *Operation Jasmine placed an unprecedented demand on Gwent Police and crucially affected force wide performance. Accordingly Gwent Police sought Home Office Special Grant funding in early 2007 in order to recruit additional staff and secure suitable premises* (p27)

[90] The North Wales Police Review. Feedback from Gwent Police on 5 May 2015 stated: *This was a Gerard Elias QC decision…He would later reverse that view based on his own experience in the Gladys Thomas case and the increasing difficulties the experts faced in being specific, timely and in reaching consensus* (p27)

recognise pain and distress and to address problems such as dementia, incontinence, immobility, weight loss, dehydration and potentially harmful behaviour…

- *Persistent and wide-ranging failure of nursing homes to meet statutory standards of care*
- *Failure of regulatory bodies, including the Care Standards Inspectorate for Wales (CSIW), Local Health Board and Social Services, to monitor care being provided, enforce national standards and safeguard vulnerable adults*
- *Failure of care home owners and responsible staff to respond appropriately to concerns raised by regulatory authorities*
- *Failure of Protection of Vulnerable Adults (POVA) procedures to safeguard residents*
- *Failure of care home owners to ensure the safety and wellbeing of residents*
- *Where the care home owner is a registered medical practitioner, failure to comply with additional professional responsibilities to ensure the safety and wellbeing of patients*
- *Failure of nursing home staff to request assistance from NHS services when it was necessary*
- *Failure of general practitioners to review or monitor residents' medical conditions and medication*
- *Failures of specialist psychiatric services for residents including failure to follow the Care Programme Approach (CPA) procedures*
- *Failures of other health care professionals to provide adequate specialist services*
- *Failure of primary and secondary care practitioners to recognise the possibility of elder abuse and initiate vulnerable adult procedures*
- *Failures in the prevention and treatment of pressure ulcers including failures in the education and training of staff*
- *Absence or failure of clinical governance procedures to ensure adequate clinical care of residents*
- *Failure of Coroners and Coroners' officers to consider the possibility that deaths of vulnerable people were not due to natural causes.*[91]

We note that these problems have arisen within systems of professional regulation that have failed to ensure consistently safe professional performance.

Gwent Police shared this letter with the Health Minister and provided two briefings to Ministers during 2007.

[91] This conflates two concerns (i) no post mortem resulted from **Edith Evans**' death in **2005** and (ii) there was no inquest. After consideration of the circumstances, the coroner decided that a post-mortem was unnecessary because the (natural) cause of death was evident. Effectively the decision was, and is, administrative insofar as it typically results from discussion or correspondence between a doctor (who may be newly qualified/ inexperienced) and the coroner's officer

In **November 2007**, the *Senior Investigating Officer sought **CPS** advice on a proposal to report suspects for summons due to problems encountered in the management of large numbers of suspects.*[92]

On 11 **December 2007,** the **Welsh Government** wrote to Gwent Police *Re: **Operation Vermont***[93] stating that the **Care and Social Services Inspectorate Wales** (CSSIW) intended to continue its investigation into **Belmont Care Home** and that *its investigation is with a view to a potential prosecution…In investigating, I confirm that CSSIW does not wish to take steps which will compromise the police investigation. CSSIW hopes to be able to agree a way forward which enables CSSIW and the police to co-operate with each other and to run parallel investigations. If Welsh Ministers are to initiate any prosecution against Mr and Mrs Bentley*[94] *information will need to be laid with the court by 11 March 2008…would be grateful if you could write to confirm whether Gwent Police is content for CSSIW to arrange to interview witnesses in December/January with a view to PACE* [Police and Criminal Evidence Act] *interviews in early February. It would be most helpful if you could reply by 17 December.*[95]

Caerphilly CBC stated: *The police actions remained unclear while* [**Belmont Care Home**] *was being considered by Operation Jasmine officers. Caerphilly CBC continued to coordinate update meetings until April 2010 when a decision was made by Caerphilly CBC (with the agreement of Health and CSSIW) that, due to these extraordinary circumstances, the POVA processes would be closed and left open only to the Operation Jasmine investigation. Due to the police investigation these cases had not been managed in line with the usual POVA processes and there had been considerable delay, Caerphilly CBC wanted to give families an individual outcome and so, following consultation with Police, CSSIW and Health, every family was offered between **June** and **August 2010**, an individual case conference with all agencies present to discuss the findings…Gwent Police formally closed **Belmont** investigations in **November 2010**.*

Also during **2007**, the North Wales Police reviewers [96] stated that, *it became necessary to re-evaluate the make-up and use of the expert panel.*

The North Wales Police reviewers noted that: *As Operation Jasmine progressed further serious allegations of neglect were identified in other care homes. These other cases came to light from police sources and partner agencies. Although cases were investigated as individual offences, there was growing evidence that significant negligent practices and abuse may have been widespread in a number of establishments.*

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[92] Feedback from Gwent Police on 5 May 2015 stated: that advice was also sought *from the National Policing Improvement Agency, National Interview Adviser and the Home Office, Police and Criminal Evidence Act Review Team* (p29)

[93] See earlier reference to Operation Vermont in this section

[94] The owners of Belmont Care Home

[95] A six month timeframe was in situ until April 2009

[96] June 2009 Review of Operation Jasmine

The North Wales Police reviewers note that *from October 2005 to January 2008 the MIR* [Major Incident Room] *was significantly under-resourced, at times to the detriment of the investigation and those staff involved.*

From **February 2008**, *the Health and Safety Executive had a team of investigators working alongside the Police and looked at health and safety issues around pressure ulcer management.*[97]

During **March 2008**, the death of **Dorothea Hale**, a resident of **Grosvenor House**, was deemed *suspicious.*

The expert panel delivered reports concerning **Evelyn Jones**, **Edith Evans** and another resident. However, the North Wales Police reviewers noted that *these reports were incomplete and had some shortcomings so were not accepted.* Also, the expert panel wrote a follow-up letter to the then Chief Constable.

During **April 2008**, the trial began of eight care workers charged with the ill-treatment and neglect of **Gladys Elvira Thomas** – who died in **October 2005**.

During **May 2008**, Mr Justice Blair extended the **General Medical Council**'s restrictions on Dr P Das' clinical practice and noted that: *It is unsatisfactory that Dr Das finds himself in the position he does. The police inquiries have not resulted in charges, let alone a date for a trial.*

Also during May, eight members of **Bryngwyn Mountleigh** staff were acquitted of the wilful neglect of Gladys Elvira Thomas.[98] A qualified nurse at **Bryngwyn Mountleigh**, who had pleaded guilty to neglect, was given a conditional discharge.[99] It was acknowledged during the trial that this nurse had neither physically harmed nor neglected Gladys Elvira Thomas and noted that others were *equally culpable* for failing to comply with her hospital discharge arrangements.

The **CPS** noted: *We should make it clear that…evidence has only been available since **April 2008** and as such the medical issues have changed considerably and could not have been foreseen before the start of the trial.*

During **July 2008**, the North Wales Police reviewers noted that *partner agencies withdrew from the multi-agency oversight board. This was due to conflicts of interest as it emerged that some agencies may have been culpable.*

Also during **July**, *for reasons which included the results of the Gladys Thomas trials, it was decided that the combined approach to the reports from the panel of experts was to cease. Experts were then requested to submit individual reports in respect of Evelyn Jones, Edith Evans* and another resident. *This strategy change came about some fifteen months after the*

[97] Letter from the HSE and Gwent Police to relatives 26 February 2013. Feedback from Gwent Police on 5 May 2015 stated: *HSE were involved from the outset of the investigation but due to the fact that the initial investigation related to* [a potential] *assault they took the view that they had no basis to investigate. They returned in 2008 at the request of Gwent Police* (p31)

[98] http://news.bbc.co.uk/1/hi/wales/south_east/7396289.stm (accessed 27 January 2015)

[99] http://news.bbc.co.uk/1/hi/wales/south_east/7414850.stm (accessed on 16 October 2014)

original requests for combined reports. Eventually a target date was set for March 2009 for the delivery of the final reports. This was not achieved but even if it had been, it would have taken experts over 22 months to fulfil their obligations in respect of the reports.[100]

Also in July 2008, the North Wales Police reviewers noted that the Senior Investigating Officer *recorded a policy decision to take no further action in the cases of carers unless there was clear evidence of significant neglect.*[101] *Three of those reported for summons had already been in police bail for 22 months. At the time of the review* [that is, 2009] *they were still under the threat of prosecution. The* [North Wales Police reviewers] *have concerns about the length of time these individuals have been waiting for this matter to be finalised.*

The North Wales Police reviewers recommended that a *second analyst* should be appointed to Operation Jasmine since *Operation Jasmine is servicing two investigations involving deaths in care homes – the Operation Jasmine Inquiry and a separate Major Incident Room investigating deaths at* ***Belmont House*** *and* ***Grosvenor Nursing Home****.*

The North Wales Police reviewers stated that in the early stages of the investigation *agreement was reached with Forensic Science Service for the urgent and premium submissions of some forensic examinations.* Although *delays then occurred* there was no management intervention.

In **August 2008**, the North Wales Police reviewers stated that although 20 *further potential victims had been identified at* ***Brithdir****…*it was decided that *no further enquiries would be conducted until existing investigative priorities had been completed. In addition there are more than 20 other cases described as 'questioned' deaths. The Review Team agree that* Gwent Police *must continue with current priorities,* however, concern was expressed that *potentially evidence is being lost* in terms of the other cases. The police reviewers stated that *Gwent Police should give further consideration to these other cases…there is a further risk that a suspect or offender already identified by information already held, but not yet acted upon, remains in a position of trust.* The reviewers proposed that Gwent Police *could consider utilising an 'operational expert advisor'* to *assist in focusing on cases where health practice appeared suspect. The operation of this filter could reduce or negate referrals to the panel of experts.*

In **November 2008**, Enda Evans, **Bryngwyn's** Manager, and Dr Sushma Ohja were convicted of criminal offences surrounding the death of **Alan Sayers**, that is, wilful neglect and, respectively, making a false representation for a cremation. His death was sudden and unexpected.

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[100] North Wales Police Review

[101] Feedback from Gwent Police on 5 May 2015 stated: *Based on QC advice…Rationale for treating a carer/nurse as a witness/suspect that had been used in the Gladys Thomas and Alan Sayers cases could not be readily transferred to BCH and so GE QC was heavily involved in unpicking this issue. The rationale for the decision being that because there were potentially so many nurses involved in each of the cases under investigation and because the management of wounds was a medical intervention to be undertaken by qualified staff, that care staff would not be prosecuted in these cases unless specific evidence existed* (p34)

Also during November 2008, *a police search was carried out at Grosvenor Nursing Home,* that is, almost two years after the death of **Dorothea Hale**. *During this search a significant amount of documentation was recovered and was assessed in order to identify whether evidence of additional suspicious deaths had occurred at this nursing home.*[102]

During *the early interviews* at the outset of Operation Jasmine, delays were occurring *during interviews as officers needed to seek assistance in understanding medical terminology.*[103] Although over time they acquired *sufficient experience in medical matters to enable them to undertake further interviews without such delays,* the North Wales Police reviewers advised against this.[104] *Generally interviews were conducted over two or three days, the suspects were not kept in custody but bailed each day…Full accounts were taken in relation to the employment history of the suspects in order to identify their expertise and qualifications, some of which are thought to be forged. This made for lengthy interviews but was deemed necessary.*

The interviewing officers informed the North Wales Police reviewers that *they felt the investigation was now in a better position to cope with the next phase of the enquiry. They believed that the interviewers were better equipped, not only due to their enhanced interview training but also due to the knowledge gained previously, particularly in the medical field. The intention is therefore to use only seasoned Operation Jasmine officers for the next phase.*

During **February 2009**, the death of a **Bank House** resident during **2008**, was deemed *suspicious.*

In **June 2009**, North Wales Police reviewers submitted their ***Review of Operation Jasmine*** which focused on the death of **Evelyn Jones**, their review also considered six other deaths, including that of **Edith Evans**. It is noted that within the database there are *40 other victims and 44 other 'questioned' deaths…*[and further that] *The scale of the enquiry had grown to make it a very large investigation employing some 66 staff at the time of the* [North Wales Police] *review,* that is, from **November 2005** to **February 2009**. The Review stated that it had *not found any significant negative outcome arising from the restricted resources other than the length of time the enquiry has taken.*

The North Wales Police reviewers stated that on **1 June 2009**, *of the 1,165 actions for allocation, 15 were of a high priority, 13 of those had been waiting for allocation for14 days or more…Of the total number of actions in the For Allocation queue, 88 had been ready for allocation over 12 months and had not been allocated at any stage during the course of the investigation. Four actions have been in that queue for between 663 and 740 days…One action*

[102] Email from Gwent Police dated 3 December 2014

[103] Feedback from Gwent Police on 5 May 2015 stated: that *between January 2006 and May 2006 officers understanding of these matters significantly improved and the delays that were initially evident were no longer a concern. Interviewing officers sought advice from the nursing advisers working on the investigation and were integral members of the investigative team* (p37)

[104] They advised, *that a medical professional should be available to the interviewing officers, at the time of the interviews to assist when medical terms and procedures were covered…it is not appropriate to rely on officers' experience in this area.*

was allocated to an Enquiry Officer on 16 March 2006. The next transaction on the action log is dated 15 January 2009, some three years later…it is not best practice for actions to be allocated for an excessive period of time. The North Wales Police reviewers recommended *that a review of the For Action, Allocated and Pended Action queues is conducted.*

In **December 2009**, the **Court of Appeal** quashed the convictions of Enda Evans, **Bryngwyn**'s Care Manager and Dr Sushma Ojha, Alan Sayers' GP.[105] He had died unattended, in **September 2004**. This was contrary to his care plan which stated that he required attention 24 hours a day. Eight defendants in total were prosecuted – four care assistants, a staff nurse, the manager and the care manager. Convictions were obtained against a care assistant, the staff nurse and the care manager. Although the assistant did not appeal against the conviction, the staff nurse and care manager did so. The Court of Appeal upheld the staff nurse's conviction since he had not briefed night staff at the outset of the shift to ensure that Alan Sayers was accompanied throughout the night. Although the staff nurse stated that he had carried out hourly checks, the evidence relating to rigor mortis suggested that he had not done so. The care manager's conviction was overturned[106] because although she was on holiday at the time of Alan Sayers' death, she had not deliberately set up a care regime and rota system which was wanting.

Dr Ojha had been found guilty of making a false representation for a cremation and her conviction was overturned. The certificate had made incorrect statements about the time of Alan Sayers' death and the last time Dr Ohja had seen him. Although the prosecution had alleged that she had been deliberately dishonest in completing the form with a view to covering up her own failings, there was no evidence that this was the case. Eventually, five years after Alan Sayers' death, a staff nurse and carer were convicted for his ill treatment and neglect.[107]

In **January 2010**, **CPS** advice was formally delivered to the police that there was insufficient evidence. At a meeting with the police in **April 2010**, the **CPS** with the assistance of the Specialist Crime Directorate repeated the written advice indicating that on four of the cases a relevant cause of death could not be identified. Additionally, on the other two cases (**Evelyn Jones** and **Edith Evans**), that although there was a relevant cause of death, there was no individual identified as being responsible and therefore there was no causation.

The then Chief Constable of **Gwent Police** was not satisfied with the advice of the **CPS** and met with the **Director of Public Prosecutions** (DPP). It is understood that the DPP reiterated

[105] Convictions of care manager and GP quashed on appeal, http://news.bbc.co.uk/1/hi/wales/south_east/8404240.stm (accessed 27 March 2014)

[106] *R v Salisu* [2009] EWCA 2702

[107] Feedback from Gwent Police on 5 May 2015 stated: *The neglect which contributed to his death was not reported until a Whistle-blower from Bryngwyn/Mountleigh came forward to Operation Jasmine in December 2005* (p41)

the advice that despite thorough investigation, the cases had not reached the evidential threshold for prosecution, given the difficulties of proving wilful neglect.[108]

In **February 2010**, the *Review of In Safe Hands*[109] listed the *general lessons* arising from Operation Jasmine *that have already been identified and shared with other agencies by Gwent Police.* These are principally drawn from Caerphilly Area Adult Protection Committee's *Protection of Vulnerable Adults – Practice Improvement 2002-current day.*[110] An additional lesson was submitted by Gwent Police to the review of *In Safe Hands:*

The use of health and social care staff to support failing care homes require critical risk assessment and should be subject to legal advice to ensure they are not in danger of colluding (either actively or inadvertently) in the provision of unacceptably poor practice (p135).

On **23 April 2010**, the CPS informed Gwent Police that *they did not believe the evidence was sufficient to prosecute for gross negligence manslaughter* [at Brithdir] *and they did not believe that Counsel should be engaged or instructed.* [111]

During **August 2010**, the *CPS sent Gwent Police formal notification that no suspect would be prosecuted for Wilful Neglect*.[112] **Gwent Police** briefed Welsh Government officials. This confirmed that Operation Jasmine investigations were based *on examination of 63 cases in two Gwent care homes in 2004-05* with evidence gathered for *six test cases,* two of which concerned gross negligence or manslaughter and four concerned wilful neglect. It was described as *a major investigation, unprecedented in the UK and with compelling evidence from expert opinion.* It was anticipated that the **CPS** and **HSE** decisions *about proceeding to trial* would be known by **January 2011**,[113] with the trial beginning during the summer of **2011**.

During **July 2011**, *primacy for the investigation was transferred to the Health and Safety Executive.*

In **January 2012**, **Gwent Police** and the **Health and Safety Executive** briefed the **Welsh Government**. The **HSE** were leading the prosecutions rather than the **Gwent Police**. *Both the HSE and CPS cases had been merged into one case that had been introduced into Magistrates Court in November* [2011] *and would be heard in the Crown Court in early **February**. It was likely that the defendants would make an "abuse of process" challenge on the grounds of delay in bringing the cases to trial. If a trial is granted it is likely to be held in **October** or **November***

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[108] Feedback from Gwent Police on 5 May 2015 stated: *The CPS advice was contrary to what the experts had described. The CPS action in ignoring expert opinion was contrary to their earlier stance that they would be guided by the experts*

[109] Magill, J., Yeates, V. and Longley, M. (2010) *Review of In Safe Hands: A review of the Welsh Assembly Government's Guidance on the protection of vulnerable adults in Wales* University of Glamorgan: Welsh Institute for Health and Social Care

[110] See Appendix 5**.** Feedback from Gwent Police on 5 May 2015 stated: *This was a document that was designed by Operation Jasmine and shared with the Adult Protection Committee. It was authored by Operation Jasmine and with the assistance of seconded members of staff from partner agencies* (p42)

[111] Email from Gwent Police 30 June 2014

[112] Email from Gwent Police 30 June 2014

[113] Feedback from Gwent Police on 5 May 2015 stated: *The actual advices were received by the Operation Jasmine team in January 2011, however, some had been dated August 2010* (p43)

*and last at least eight weeks with conclusions possible in early **2013**.* Following an earlier interim **General Medical Council** Order, the GMC would await the outcome of the new prosecutions relating to the Health and Safety at Work Act 1974, brought by the **HSE**, and the Theft Act 1968 before deciding whether or not to undertake a new investigation of Dr P Das.

During **March 2013**, the trial was halted before a jury was sworn.[114]

In the **March 2014** briefing provided to this Review, it was stated that *In addition to the cases of **Evelyn Jones** and **Dorothea Hale**, both Gwent Police and HSE decided that all deaths where expert opinion existed that suggested that neglect played a part in the death were to be referred to the respective Coroner…*[115]*The cases referred from Brithdir Nursing home are **Ronald Jones*** and four others, *all from **2003; Megan Downs*** and three others *from **2004; Stanley Bradford,** plus **Edith Evans** (non HSE case) from 2005;* and four people from **2006.**

The deaths of **Edith Evans**, **Evelyn Jones** and one other *were examined by in excess of 10 experts including a Forensic Pathologist; the deaths of **Dorothea Hale*** and three others *were examined by five experts, including a Forensic Pathologist.*

Gwent Police identified six *positive internal outcomes* arising from Operation Jasmine:

i. *Professional misconduct referral protocol identified as national good practice*
ii. *An enhanced working relationship between the police and the governing bodies*
iii. *A family liaison and interview strategy complimented by National Adviser, NPIA* [National Policing Improvement Agency][116]
iv. *Enhanced working relationships between Police, HSE and Victim Support*
v. *The awareness of the issues identified has been presented to the force senior detectives, the regional senior detectives and the National SIO* [Senior Investigation Officer] *Conference*
vi. *Development of 'Lessons Identified' document, detailing 106 recommendations for enhancing adult protection*

Gwent Police also identified eight *positive external outcomes:*

i. *Reviews of adult protection across all 22 unitary authorities in Wales*
ii. *Identical protection procedures adopted by the four Welsh audit forums*
iii. *The 'Escalating Concerns' guidance document from the All Wales Project Group*
iv. *Feedback to the national review team of 'No Secrets' the English guidance document through the ACPO* [Association of Chief Police Officers] *lead*

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[114] http://www.publications.parliament.uk/pa/cm201213/cmhansrd/cm130313/halltext/130313h0002.htm (accessed 27 January 2015) and feedback from Gwent Police on 5 May 2015

[115] Gwent Police (2014) *Operation Jasmine Briefing to Dr Flynn*

[116] Phased out in October 2013

v. *Participation in the Welsh Government and Welsh Institute for Health and Social Care review of 'In Safe Hands' guidance*

vi. *Health Authority guidance document on pressure sores that now links to neglect and POVA referrals*

vii. *Improved POVA strategy within Caerphilly County Borough Council and Gwent NHS Trust*

viii. *Welsh Government recognition of benefit to Welsh Government Police Review, All Wales [Protection of Vulnerable Adults] Police and Commissioning Guidance*

With reference to Gwent Police's contribution to discussions concerning POVA:

Where Police shortcomings were identified an investigative policy decision was made to refer the individuals concerned for internal investigation. Also having identified a lack of awareness by Police to the issues that were apparent following examination of the minutes of the POVA meetings, staff from Operation Jasmine carried out briefing sessions with front line uniform and CID colleagues and Community Support Officers, both in force and at national conferences in order to identify the potential criminal offences that may be reported through the POVA process and provide guidance to staff when investigating criminal offences in a care home setting.[117]

[117] Email from Gwent Police, 12 December 2014

Section seven: the Crown Prosecution Service overview chronology

In this section…

> *…you will glimpse some of the decision-making of the Crown Prosecution Service lawyers as expressed in correspondence - and in revisions to the same correspondence. You will learn that there were insufficient resources deployed at the outset of the investigation and that the case was transferred from Cardiff to York. It was during 2010 that the CPS decided that their case was weak in terms of establishing the cause of people's deaths.*

Correspondence from the **Crown Prosecution Service** (**CPS**) in **February 2015** stated that:

The disclosure of CPS advice has been raised with the Chief Operating Officer and he has taken the view that there is no reason to depart from the usual rule that advices between police and the CPS remain confidential.

This chronology is therefore restricted to two letters and the minutes of a CPS meeting[118] in response to several requests for information and to additional information received indirectly from non-CPS sources. Yet from the outset of Operation Jasmine in **November 2005**, the **CPS** was represented at two of the three meetings of the Operation Jasmine *Strategic Management Board* and **Gwent Police** had clearly *sought early advice from the **CPS** because of the emerging scale of the cases.*[119]

The **CPS** correspondence states that:

The police investigation into deaths linked to poor care…focused on the prospect of prosecutions of 6 gross negligence manslaughter cases at the Brithdir Care Home. These 6 cases were selected as the provisional view of the police was that they provided the strongest evidence of GNM [Gross Negligence Manslaughter] *and wilful neglect – although this was not based on any dedicated expert evidence. Expert medical witnesses were instructed. Their clear terms of reference were to identify if there was evidence against <u>any individuals</u> who may have committed acts/omitted to act which caused the death.*

The CPS accepts there were insufficient resources deployed from the start of the investigation. If CPS advice were sought in similar circumstances now, the matter would be referred immediately to our Special Crime and Counter Terrorism Division (formerly known as Special Crime Division) which deals with cases involving corporate manslaughter and gross negligence manslaughter involving members of the medical profession.

*In **April 2009**, Operation Jasmine was transferred to the Cymru/Wales Complex Casework Unit (CCU). The CCU was responsible for reviewing the evidence and making the charging decisions.*

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[118] See Appendix 4

[119] Notes of **July 2013**, Operation Jasmine meeting at Cardiff City Hall - shared by the **CPS** in **October 2014** – see Appendix 4

The Special Crime Division (SCD) conducted a quality assurance of the review notes and charging decisions made by the CCU. It is accepted that due to the size and complexity of the case, referral to the CCU should have taken place at an earlier stage and local senior management should have addressed that issue.

*In **June 2009**, a very experienced lawyer, Helen Allen from the SCD assisted the CCU by giving a presentation to the police concerning the legal necessities and difficulties in establishing GNM and also identified the potential for the HSE to bring criminal proceedings. By this stage the HSE had a team dedicated to this case and were engaged by[120] the police.*

The police continued with the investigation and submission of files to the CCU for offences of GNM and wilful neglect in relation to 6 patients at the Brithdir Nursing Home. The CCU concluded, with SCD providing quality assurance of the review notes and advice, that there was insufficient evidence to bring proceedings. It was not possible to establish individual responsibility, following a review particularly of the expert evidence.

The minutes of a meeting supplied by the CPS[121] stated that *the case had been transferred to the Complex Case Unit based in Cardiff and the CCU would look at individual cases and would be then reviewed by Special Crime lawyers in York.*

The **CPS** correspondence states:

…in January 2010…advice was formally delivered to the police that there was insufficient evidence.[122] *The advice was not accepted by the police. At a meeting with the police in **April 2010**, the CPS with the assistance of SCD repeated the written advice indicating that on 4 of the cases a relevant cause of death could not be identified. Additionally, on the other two cases (Evelyn Jones and Edith Evans), that although there was a relevant cause of death, there was no individual identified as being responsible and therefore there was no causation…[123] Nevertheless the police sought the further opinion of the experts relating to all 6 patients.*

The **CPS** correspondence states:

A Director's Case Management Panel (DCMP) was conducted in ***June 2010**, by the former Director, Keir Starmer. It was agreed that Counsel would not be engaged and that the Advices were correct. The police also sought the opinion of experts on the responsibility of senior management…for offences of GNM and wilful neglect. If there was insufficient evidence to establish individual responsibility for those who had direct contact with patients then it is more*

[120] Feedback from the CPS dated 28 April 2015 states that *the HSE…were engaged with the police*

[121] See Appendix 4

[122] Feedback from the CPS dated 28 April 2015 proposes that this line should be removed and replaced with , *The advice was formally delivered to the police in January 2010 although the CCU preliminary views (which were repeated in the formal advice) were expressed to the police in October 2009*

[123] Feedback from the CPS dated 28 April 2015 adds, *It was agreed by the CPS that there may be some purpose in seeking reports from the experts concerning particular behaviour by individuals in relation to the deaths of Evelyn Jones and Edith Evans if it has been unclear to the experts that their terms of reference included consideration of individual responsibility*

difficult to establish responsibility by those with little or no direct contact…There was insufficient evidence to bring proceedings for these offences.

The **CPS** correspondence states that:

Dr Benshuita[124] Das was charged with Health and Safety offences.[125] When the decision was made that the trial could not proceed against Dr P Das *due to ill health it was decided that the prosecution would not pursue the allegations against her alone. This decision was made in conjunction with the Health and Safety Executive upon advice received from Andrew Langdon QC.*

In **February 2013**, relatives were sent *an update on the Operation Jasmine Investigation* from the **Health and Safety Executive** and **Gwent Police** and an invitation to attend a meeting on **1 March 2013**. It stated that the purpose of the meeting was: *to offer you as families the opportunity to meet with the other families involved in the investigation in order that you may share your experiences and question. This opportunity has not been possible previously due to the constraints of the investigation…to offer you the opportunity to hear about the investigation from the senior officers who guided the inquiry; To hear from the CPS the rationale behind their decision-making (their attendance is not confirmed, however it is hoped they will be represented); to hear from the Prosecution Counsel the legal reasoning as to why the case cannot move forward.*

The CPS confirmed in the 28 **June 2013** broadcast of *Week In Week Out: Wales' Nursing Home Scandal* that it should have offered fuller explanations to the police and to the families.[126]

In **July 2013**, the Direct of Public Prosecutions met with the relatives of older people who had died at **Brithdir** and **Grosvenor**.[127] The meeting concluded with an undertaking since this was *the beginning of dialogue and not the end…the next step would be individual meetings with families and then there would be general dialogue with everyone as this was not something the CPS would walk away from.[128]* The relatives had no further contact from the CPS.[129]

[124] All other documentation seen by the Review identifies her as Dr Nishebita Das

[125] This is incorrect. Dr N Das was not charged with Health and Safety offences. Feedback from the CPS dated 28 April 2015 proposed that this sentence and the following two should be deleted. The CPS noted that *Enquiries have been made with the reviewing lawyer who believes that HSE charges were considered…unable to clarify further and suggest that HSE will have a definitive answer*

[126] Feedback from the CPS dated 28 April 2015 states…*unable to provide any comment in relation to this information*

[127] Anna Buchanan, Director of Prosecution, Scrutiny and Human Rights, Older People's Commissioner for Wales, prepared "Brief notes" from this meeting. These stated that *RA asked whether the public interest test had been considered. The DPP responded that it had not because the cases did not meet the threshold for prosecution.*

[128] See Appendix 4

[129] Feedback from the CPS dated 28 April 2015 proposed that this paragraph should be removed and replaced with *The CPS held a meeting on 5 July 2013 with former DPP Keir Starmer and all family members when full explanation of the CPS decision was provided…During the meeting in July 2013, an offer was made to the family members present that they could seek a further meeting with the CPS. No one took up the offer of a meeting*

In **October 2014**, this Review received a letter from the Chief Crown Prosecutor of the **CPS Wales Area**.[130] This explained that *all of our lawyers who have been involved in the case from Wales have retired* and set out the *reasoning in broad terms* why *the charges of gross negligence manslaughter could never be proved on the evidence available.*[131]

[130] See Appendix 4

[131] Feedback from the CPS dated 28 April 2015 removed this paragraph

Section eight: the overview chronology of CSIW/CSSIW

In this section…

> *….you will learn about the Care Standards Inspectorate for Wales, its successor, the Care and Social Services Inspectorate Wales and the registration and inspection of six homes within the purview of the Operation Jasmine. In 2002, the Care Standards Inspectorate for Wales was set up as the single inspection and regulatory body. Of particular relevance is the fact that the inspectorate was required to demonstrate that reasons for deciding to close a home remained compelling at the point of closure – most particularly where health and social care agencies had already 'stepped in' to shore up failing practice since this masked the failures of the registered provider. This section and the accounts which follow on as to what happened at the six homes throw into stark relief the accumulating pressures on the regulator.*

It was in **1995** that a HTV Wales broadcast, *Wales this Week,* first brought to the public's attention certain concerns about three of eight homes then owned by Dr P Das and Dr N Das, that is, **Silverdale**, **Hengoed Hall** and **Holly House**.[132] This was at a time when homes were specified as either care homes or nursing homes. Care homes were regulated and inspected by local authorities, whereas nursing homes were regulated and inspected by the health services. This meant that, at that time, both the local authorities and the local health services were responsible for the oversight of the Das' homes, as well as other homes known to Operation Jasmine.

During **April 2002**, two significant events occurred in terms of regulation and inspection. The **Care Standards Inspectorate for Wales** (**CSIW**) was established as a division of the Welsh Assembly Government, with delegated authority for its regulatory decisions. (However, the regulator does not have the power to prosecute – this rests with Welsh Government Ministers). The creation of the CSIW brought every home under the purview of a single registration and inspection body. The CSIW became responsible for ensuring that all registered social care establishments[133] in Wales complied with the **Care Standards Act 2000**[134] (which also came into force in April 2002) and its associated regulations. The CSIW inspected services against the requirements of the Act, the national minimum standards[135] and relevant regulations. For example, the regulations required the registered person to

[132] See Appendix 1

[133] The purpose of registration is to ascertain that the premises are suitable for the proposed use and that the registered person/body is suitable

[134] This provides for the administration of a variety of establishments and agencies providing care or health services including residential care homes, children's homes, independent hospitals and domiciliary care agencies

[135] http://www.csiw.wales.gov.uk/docs/nmscarehomes_oldpeople_revised_e.pdf (accessed on 27 December 2014)

notify the CSIW of such events as deaths, illnesses, accidents and injuries[136] which might result in investigations by the CSIW or other regulatory bodies, including the **Health and Safety Executive** (**HSE**) and the environmental health departments of local authorities.

In **2007**, the **CSIW** and the **Social Services Inspectorate Wales** (**SSIW**) became merged into the **Care and Social Services Inspectorate Wales** (**CSSIW**). The CSSIW carries out its functions on behalf of Welsh Ministers, albeit with safeguards to ensure its operational independence. The CSIW and (after April 2007, the CSSIW) had power when issuing a certificate of registration to impose conditions, including the categories of person a home could accommodate e.g. whether it was suitable for residents needing nursing care. The regulations made under the Care Standards Act 2000 also imposed requirements on care homes. Under the Act, an individual or organisation running more than one care home is separately registered in relation to each home, and the manager of each home is also separately registered. The legal advice to the CSIW was that if there was concern about two homes in a group of homes owned by a single business, the Inspectors were to take action on a home by home basis. This meant that the new Inspectorate had to prioritise action against the homes which showed the greatest number of breaches of standards and regulations.[137]

In **September 2003**, the South East Wales Executive Group for the Protection of Vulnerable Adults published, *Protecting Vulnerable Adults: Interagency policy, procedures and practice guidance for responding to alleged abuse and inappropriate care of vulnerable adults in the South East Wales area.* The CSIW, local authorities and Gwent Police were signatories to the document. It stated that:

Social Services covering the area where the vulnerable adult is living are responsible for co-ordinating the process of planning, investigation and case conferencing. This is regardless of where the vulnerable adult came from or who is responsible for funding…Social services will inform the Care Standards Inspectorate for Wales if a referral has been taken about an adult protection issue in a regulated setting (p28)

*If an allegation of crime is made, **the police must lead the investigation in partnership with other agencies.** The police **must** keep other agencies informed as appropriate of the progress of their investigation e.g. regulators (who may need to take steps to ensure regulatory compliance)* (p72)

From **2002** to **2005**, **Holly House** (which belonged to the Das' but was not one of the six homes associated with Operation Jasmine) became a source of particular concern to the CSIW Inspectors. They made six visits to the home in **2002**, eleven visits in **2003**, and nineteen visits in the first seven months of **2004** – all with a view to addressing concern about temporary managers, inadequate staff supervision and inadequate staff training, the lack of suitable nursing aids and equipment and inadequate attention to hygiene at the home. Repeated non-

[136] Regulation 38 of *The Care Homes (Wales) Regulations (2002)*

[137] This point was endorsed by *Puretruce Health Care Ltd v National Assembly for Wales* [2004] 0371 (EA-W) 15 May 2005

compliance with the required standards led to a *Notice of Proposal to Cancel Registration* during **August 2004.** Dr P Das appealed the decision.

During **May 2005**, the **Care Standards Tribunal**[138] hearing overturned the decision to cancel **Holly House**'s registration. It rejected most of the Inspectorate's grounds for cancellation, including the ground that Das' companies were not financially viable. The Tribunal's Chair explained that the burden of proof was on the Inspectorate to show that cancelling the home's registration remained appropriate **at the date of the hearing** [emphasis added]. The Inspectorate could not do so since **Caerphilly County Borough Council** and **Caerphilly Local Health Board** had placed staff at the home in order to limit the harm to which residents were exposed, and in order to reduce the risk of residents moving to alternative provision. The Tribunal imposed two conditions: the appointment of a full time manager and an independent consultant to advise the CSIW of progress made against targets every two months.

In **August 2005**, an emergency cancellation of **Holly House**'s registration was issued because of the unsafe gas supply to the home and by **September 2006**, the cancellation of registration was upheld by a second **Care Standards Tribunal** hearing.[139]

The regulator undertook to brief Ministers and senior Welsh Government staff throughout the duration of Operation Jasmine.

Providers are given opportunities to ensure that their services are safe and compliant with the detailed regulations. It is then necessary for the Inspectors and their legal advisors to ensure that the evidence gathered shows that attempts to improve have failed, and that the situation warrants enforcement action, not least since the power to cancel registration is matched by a great responsibility to see that it is not exercised unjustifiably.[140] A notice of the decision to cancel **Holly House**'s registration was issued in **2004**. **The Beeches** and **Brithdir** (two of the six homes associated with Operation Jasmine) were also owned by Dr P Das and Dr N Das. There were similar challenges to the regulatory reasonableness of the CSIW in relation to these homes. On occasion, the homes were threatened with a disconnection of the gas and electricity supply because of the non-payment of bills. Concern about inattentive and harmful practices required the **CSIW** to prepare three extensive and independent sets of evidence within the same timeframe. That is, the **CSIW** could not deal with concern about the company's performance over the long term, nor with potential corporate failure, poor risk management and weak internal control across the company.

Frequent inspections confirmed major failings at **Brithdir**. However, in the light of the first Care Standards Tribunal decision concerning **Holly House**, the legal advice was that the efforts of the social services and Local Health Board to raise standards could still be a barrier to the issuing of an order for the cancellation of the home's registration. Nevertheless, the CSIW

[138] *Puretruce Health Care Ltd v National Assembly for Wales* [2004] 0371 (EA-W) 15 May 2005

[139] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

[140] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

decided, in March **2006,** to issue a Notice of Proposal to Cancel Registration. As a result, Brithdir was closed in the following month.

Inspection, regulatory and enforcement activities at the six Operation Jasmine homes feature in the following sections. While each of the descriptions distils the significant events, it should be noted that care homes are complex places in terms of:

- responding to the physical frailty of residents
- the competence of staff at all levels
- the nature of their relationships with residents
- the ways in which their work is organised, and
- the terms and conditions of their employment, including preparation for their role and the physical condition of the home itself. Nursing and care staff may engage in such diverse tasks as acting as gatekeepers to primary health care, helping to maintain the identity of individual residents by knowing something of their biography and providing end of life care.

The Chief Inspector commissioned an in-depth review of the CSSIW's response to Operation Jasmine and this resulted in a more resource-efficient approach to ensuring standards compliance and enforcement action. A further level of enforcement has been adopted for addressing the failings of corporate organisations. Crucially, the regulator no longer investigates complaints in favour of *responding to concerns*; it has separated the functions of inspecting from the taking of enforcement action; and it has increased its use of interviews and observational methods.

Currently, the CSSIW undertakes two forms of inspections of registered services:

- *Baseline inspections,* that is, long and *less frequent inspections used to provide a greater assurance about services*
- *Focused inspections,* that is, *short inspections…used to explore the experience of people receiving care, specific aspect of the service concerned or to respond to incoming concerns.*[141]

The CSSIW's response to non-compliance is shaped by five principles,

(i) *Provider responsibility…Unless urgent action is required, providers will be given opportunities to rectify failings*

(ii) *Proportionality: when action is taken…this will be proportionate to the outcomes for people receiving services, the risk to their health and wellbeing and the readiness of the provider to achieve compliance*

(iii) *Efficiency and effectiveness: action…will be clear, consistent, timely, fair and transparent*

(iv) *Progressive action: providers who progressively fail to comply with regulations will face escalated enforcement action*

[141] http://cssiw.org.uk/docs/cssiw/general/140730baselineinspectionguideen.pdf (accessed 11 November 2014)

(v) *Coordinated action: CSSIW will work with commissioners and other regulators to ensure that any action is coordinated and information and concerns are shared. This is particularly so when there are safeguarding concerns or health and safety issues overseen by other regulators. We also work closely with the Nursing and Midwifery Council and Care Council for Wales sharing concerns about the professional conduct of staff and managers of services*

In contrast, the early regulatory history of **Brithdir**, **The Beeches**, **Belmont**, **Grosvenor**, **Bank** and **Mountleigh Bryngwyn** was disadvantaged by a disproportionate focus on non-compliance with standards and time limits in taking enforcement action.

Since the Gwent Police's *prosecution and investigation vision*[142] at Brithdir spanned 2002-2006, and the CPS had determined during 2009 that there was *insufficient evidence,* the chronologies of **Brithdir** and **The Beeches** conclude in **2006**, **Mountleigh Bryngwyn**, **Grosvenor**, **Belmont** and **Bank** conclude in **2009**.

[142] Gwent Police (2014) *Operation Jasmine Briefing to Dr Flynn,* March

Brithdir

Brithdir Nursing Home was opened during **1991** as a 40 bed Nursing Home for Elderly Mentally Infirm (EMI) people. Information about events which occurred at this particular home was drawn from information provided by the CSSIW (and the records of its predecessor CSIW), from information provided by the **Aneurin Bevan University Health Board**, the **Health and Safety Executive**, and from Justice for Jasmine relatives. The chronology reflects a long-term battle to secure compliance with acceptable standards of care, not only at this home but at the five other homes which feature in this Review. Although this cannot aspire to be a fully comprehensive account, it nevertheless sets out all the available facts and in doing so, attempts to honour the memories of those who lived through this torrid period in their lives.

Initially the home was in the ownership of **Davyani Patel**, **Joyce Lal** and **Harjinder Gill**[143] of Middlesex until April **2002**,[144] when it was sold to Dr Prana Das and Dr Nishebita Das.

From the date of its registration with **Gwent Health Authority** in **1991** to its closure in **2006**, there was lack of consistent management and a high turnover of staff. The emphasis and approach from the professionals whose concern was with the standards of care at the home were similarly inconsistent.

The Registered Homes Act 1984 Part II required Brithdir to meet the standards set by Gwent Health Authority. These *standards of care and* [the] *quality of life* of patients were monitored during two inspection visits per year. The aim of the visits was to commend *good practice* and *recommend improvements* where necessary. There had to be *adequate arrangements* for the recording, safekeeping, handling and disposal of drugs. A sample of pharmaceutical inspections during **1999** and two undertaken during **2001** contained a number of repeated recommendations e.g. *written procedures should be available…controlled drugs should be recorded.* The extent to which the administration[145] of medication was improved as a result of such inspections is not obvious from this sample.

A sample of Gwent Health Authority's Inspection Reports concerning Brithdir (during **1999** and including two during **2000**) highlighted *actions still required* in terms of *Staffing levels, Nursing/Clinical Care, Records, Fire Safety, Environment of Care, Kitchen, Laundry* and *Quality of Life.* It appears that these relied on persuasion since the section *Action still required following previous report* contained such repeated themes as, *moving and handling assessments for all patients* (**1999**), *moving and handling trainer to undertake updating training* (2000), [all] *staff must attend movement and handling instruction,* and [all] *staff must attend moving and handling instruction within a period of four weeks* (**2000**).

[143] The Review was informed that at least one of these owners was a GP

[144] Coinciding with the enactment of the Care Standards Act 2000, and the changeover from the United Kingdom Central Council for Nursing, Midwifery and Health Visiting to the Nursing and Midwifery Council

[145] That is, in terms of the right resident, right medication, right dose, right route, and the right time (see for example http://www.nationalcareforum.org.uk/medsafetyresources.asp accessed 7 July 2014)

These Inspection Reports also identified *requirements* for Brithdir, some of which had featured in previous inspections e.g. *Fire drill to be undertaken every three months* and *a fire drill must be undertaken within the next four weeks* **(2000);** Personal Identification Number (PIN) not recorded… *Expiry dates of qualified staff* and *PIN to be checked with UKCC* (United Kingdom Central Council for Nursing, Midwifery and Health Visiting)…and *expiry dates recorded* **(2000).** These inspections appeared to have had little impact on the regime at Brithdir – a theme that appears and reappears again and again throughout the nursing home's inspection history (that is, as known to this Review).

Some of the *actions* required of Brithdir during **1999** included: *completion of performance reviews for all staff; obtaining of a life history reflecting patients' personhood; completion of all assessments in respect of all patients accommodated; and assessment in respect of each patient must be recorded; reporting of appropriate accidents to Health and Safety Executive; Auditing of accidents on a regular basis; a fire lecture must be given to staff every six months; vanity units in a number of rooms…required repair; a review of all pillows must be undertaken as many were very lumpy; rooms 1 and 2 had strong incontinence odour; provision of lidded bins in each toilet area; temperature control valve required regulating…redecoration required…flooring around toilet required resealing* (in bathrooms and toilets)and *appointment of laundry personnel to relieve care staff from laundry duties.*

Before the creation of the **Care Standards Inspectorate for Wales** (CSIW), Brithdir was subject to a police investigation arising from the life-threatening pressure ulcers of **Hilda Scase**.[146] Her admission to Brithdir pre-dated the sale of the home. Her admission to hospital had been delayed for two weeks because the Matron of the home did not believe it was necessary. This was despite the fact that her GP had advised that *she may need morphine because of the sacral area*. Hilda Scase had been in Brithdir for only ten weeks but during this time her deterioration was rapid. There was a **Protection of Vulnerable Adults** (POVA) strategy meeting, and since she needed in-hospital treatment and care for almost six months for the treatment of extensive and penetrating pressure ulcers, District Nurses visited to assess other residents. She died shortly after being discharged to a different nursing home. The penetrating wound to the sacral area did not heal. The home from which she had been transferred to Brithdir was confident that Hilda Scase did not have pressure ulcers when she left (and neither did any of the other residents). A review carried out only four weeks after her admission to Brithdir highlighted concern on this issue as well as concern about her dehydration, her (non-functioning) hearing aid and her hair – which had not been washed during the whole of her time at Brithdir. Crucially, Hilda Scase was given no pressure relief. Subsequently, her friend recalled hearing her screams as nurses sought to dress her wounds.[147] Hilda Scase was a 'self-funder.'

[146] Residents whose names have not featured in the public domain, or have not been shared by relatives and friends, are identified by gender, the home's initials and number

[147] A nurse was referred to the NMC and although possible manslaughter charges were considered, there was no further police action

Inspections confirmed that three other patients at Brithdir had *undocumented* wounds; this included **Man Br7** who *suffered intermittent pressure sores to his buttocks and feet;* there were three Protection of Vulnerable Adults (POVA) Strategy Meetings[148] spanning February to April 2002[149]; an embargo on admissions was imposed during **March 2002** (but was lifted in **June 2002**); and a nurse, was referred to the **Nursing and Midwifery Council** (NMC) - which concluded four years later that there was insufficient evidence to prove allegations of misconduct).[150] Ultimately Gwent Police took no action although they were party to the POVA meetings.

During **April 2002**, Brithdir was sold to the Dr Das', whose companies (**Puretruce Health Care Ltd** and **Puretruce Ltd**) were already managing six homes. **Davyani Patel** retained legal responsibility for Brithdir. **Peter Smith**, who had been the Manager of **Holly House** (which is another home which features in this Review and belonged to the Das'[151]) applied to be the Manager of Brithdir. The legal advice received by the CSIW indicated that there was *no reason to refuse his application.* The registration process occupied 16 months since Dr Das failed to complete the registration forms; during **November 2002**, he requested that Brithdir should be registered in the name of **L-Giri Ltd** and new registration forms were dispatched (the majority of correspondence with CSIW was on Puretruce Health Care Ltd letterheads);[152] Dr P Das delayed supplying financial information concerning L-Giri Ltd; he complained that the level of staffing required by the **Care Standards Inspectorate for Wales** was higher than that required by Gwent Health Authority and that of other authorities in which his homes were located;[153] and establishing his fitness to be the Responsible Individual[154] was compromised since his referees were either not contactable or declined and he had insufficient understanding of his role as the Responsible Individual.[155] During **2002**, and prior to the home

[148] Guidance concerning professional responses to adult protection/safeguarding concerns was relatively new – *In Safe Hands* was published in **July 2000**. Typically a local authority employee would be appointed to act as an adult protection coordinator, to address adult protection matters at individual and institutional levels. During **October 2003**, the South East Wales Adult Protection Protocol was adopted in order to better manage information sharing and to take action on adult protection matters.

[149] At this time the home was struggling financially with 50% occupancy

[150] For nursing home employers, it is not clear how they are to deal with nurse employees when scrutiny of a nurse's practice takes so long. For an adult protection coordinator, "waiting" for the outcome of a police investigation may create a sense of being in limbo since the overarching concern and expectation is that a potential criminal investigation should not be compromised. Furthermore, the investigation of potentially negligent *nursing care*, is outwith the expertise of *social workers/*council employees

[151] Holly House was owned by Puretruce Pension Fund, of which Dr P Das and Dr N Das were the sole beneficiaries.

[152] There were registration anomalies which led to QC advice that a successful prosecution was *unlikely*

[153] They had owned 24 homes extending from Blaenau Gwent to Carmarthenshire. As a result, the homes were subject to a number of different registration and inspection authorities

[154] The role of the Responsible Individual is not a registered position under the Care Standards Act 2000. However, the Responsible Individual is required to be representative of the Registered Provider and of sufficient seniority to ensure that resources are available to the home to meet required (albeit minimum) standards. If the CSIW had believed Dr P Das was unfit, the only potential regulatory action that they could take would be to consider the fitness of the provider in putting forward such an applicant.

[155] Two years later, Dr P Das denied that he had ever been the Responsible Individual even though his name featured on the original application by L'Giri for Brithdir's registration

being registered,[156] seven inspection visits were made and a complaint was investigated concerning the inadequate levels of care provided to **Woman Br1.** This was upheld and recommendations were made.

During **June 2002**, Peter Smith wrote to Caerphilly CBC *as the prospective registered person in charge at Brithdir Nursing Home, to advise you of the action I have already taken and those which I would take to prevent a recurrence of that which happened to…Mrs Scase. I have discussed these matters fully with the directors of Puretruce Healthcare[157]...to ensure that action taken meets all the areas of concern.* These were, *allocation of key workers to provide specific day to day care to a group of residents of 6 maximum by specific care staff; Nursing Care Dependency Assessments have been completed and will be reviewed at least monthly; Waterlow Pressure Damage Risk Assessments have been completed and will be reviewed at least monthly; residents requiring regular positional change by key workers have been identified…residents requiring pressure relief mattresses have been identified and these are in place…nutritional assessments are also under review…care plans are also under review; a system of thorough checks of skin and tissue condition is in place to coincide with the minimum twice weekly bathing for residents; should the skin or tissue of any resident give cause for concern the Nurse in Charge would insist upon a visit by the General Practitioner to prescribe treatment; if considered appropriate the Nurse in Charge would insist upon the services of a Tissue Viability Specialist. Should the above measures fail to prevent tissue deterioration, then the Nurse in Charge would insist upon the resident being referred to hospital by recourse to the emergency 999…I trust that the above plan of action will prove satisfactory to prevent any similar situation arising in the future as happened to Mrs Scase…Peter Smith, RMN, for and on behalf of Puretruce Healthcare Ltd.*

During **November 2002**, there were two POVA strategy meetings which hinged on residents' pressure ulcers; inadequate record keeping and *effective management* at Brithdir. It was agreed that district nurses should *continue to offer support,* that there should be *joint reviews by health and social services* and that ***as previous action plan not being met a new one required*** [emphasis added]. A further action plan was developed following a CSIW inspection.

In **December 2002**, the CSIW partially upheld a complaint about the inadequate care and loss of clothing of a resident.

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[156] The registered provider was L-Giri, a company which was incorporated in 2001, and registered during January 2003. Prior to this, it had been managed by Puretruce Health Care Ltd under a management agreement with the previous owners. L-Giri was the parent company of a group of companies including Puretruce Health Care Ltd. Dr P Das would assert that this fact was known by a CSIW nurse Inspector. However, L-Giri and Puretruce Health Care were connected since they had the same directors – Dr P Das and Dr N Das – who were also the owners of all the issued shares in L-Giri. During October 2005, Dr P Das would inform the CSIW that L-Giri Ltd *does not trade* and (later) that L-Giri was *a holding company and always had been…*operating through Puretruce Health Care as its agent. Since the CSIW was sending notifications to the three companies it had effectively condoned the complex registration arrangements, including that of the Responsible Individual - Davyani Patel - who was not part of L-Giri and subsequently, Dr Das himself

[157] The letter was headed *Puretruce Care Limited* and underneath this, *Puretruce Healthcare Limited,* with the address of the *Head Office: Valley Manor Nursing Home*

During **January 2003**, there was a further POVA strategy meeting at which a new action plan was agreed. Also, an inspection visit resulted in the issue of six written notices of action required. However, because this was the first report under the Care Standards Act 2000 and Regulations, the owners were given time to address the new requirements. At this point, Davyani Patel was the Responsible Individual and **L-Giri** was managing the home on her behalf since L-Giri had not completed its registration.[158]

Woman Br18 died in **February 2003**. She had suffered with grade 1 and 2 pressure ulcers[159] to her buttocks.

During **March 2003**, **Ronald Jones** was admitted to hospital from Brithdir. He had had a heart attack and a stroke and his ability to communicate was limited. His family was concerned that he was not getting enough fluids because he was always *so thirsty* when they offered him drinks. The nursing home claimed that, on more than one occasion, he had *fallen out of bed.* This did not make sense to his family because his body was contorted and he had little voluntary movement. When Brithdir contacted his family to report that he had a high temperature and was very sweaty they attended immediately. They noted that the *urine* (in his catheter bag) *was like sludge.* On hospital admission he was found to be malnourished and had three pressure ulcers and dangerously high blood sugar levels, that is, his diabetes had been neglected. Since his family did not wish to make a formal complaint they simply informed **Caerphilly County Borough Council**'s social services department of these facts. A social work investigation concluded that no action was needed because the home had called the GP and dressings were applied as directed by the District Nurse. A POVA strategy meeting discussed the *lack of progress* concerning the action plan

Woman Br19 returned to Brithdir following a hospital admission triggered by a fall and fractured femur. Over a 14 month period at Brithdir she had sustained many injuries to her arms and legs. Pressure ulcer damage was noted by a District Nurse, including a grade 3 sacral ulcer. She had no care plan. She transferred to another home the following month.

Four inspection visits resulted in the issue of *written notice of actions required*.

During **May 2003**, **Woman Br20** was seen by her GP since her sacral ulcer had deteriorated to a grade 4 wound. **Caerphilly Local Health Board** wrote to the CSIW stating that although some progress had been made, there were still concerns about the management of Brithdir.

Man Br7 died in **August 2003**. At the time of his death he had *grade 4 sores to buttock and heel.*

During **September 2003**, a woman resident was reported to have been *left to wet herself and put down hard in a chair by a young, strong, male carer.* She was moved from Brithdir. Eight *written notices of actions required* were issued.

[158] The purpose of registration is to ascertain that the premises are suitable for the proposed use and that the registered person/body is suitable

[159] A grading system to describe the severity of pressure ulcers

An anonymous expression of concern about *poor manual handling* was raised by an employee. There were *insufficient numbers of hoists* and staff were experiencing *backache.* Although Brithdir's manager, Peter Smith had responded to staff with a promise that hoists were *coming,* they had not materialised. A monitoring visit was carried out by the CSIW and a *written notice of actions required* was issued.

Brithdir was finally registered during **September 2003,** but not before Dr P Das had expressed dissatisfaction with the protracted registration process, threatened to make a complaint and subsequently threatened to bring the matter to the attention of the inspectorate's *superiors*.

During **October 2003**, an agency nurse raised concern about a woman resident, **Woman Br2.** Having been recently discharged from hospital, she had returned there because of pressure ulcers on her ankles and buttocks, unexplained bruising on her back and extremely high blood sugar levels. She also appeared to be hot and dehydrated. There was *a lack of appropriate pressure relieving equipment.* A POVA Strategy Meeting was convened by **Caerphilly CBC** and a police-led investigation began. Ultimately however, no action was taken. (The person who had brought this to the CSIW's attention received an apology at the end of **December 2003** for the *delay in outcome of concern investigation.*)

An inspection resulted in the issue of three *written notices of actions required*.

Two meetings in October 2003 resulted in contradictory findings about Brithdir. A strategy group (which had been meeting for 12 months) listed concerns such as inadequate care plans, lack of suitable equipment, missing staff CRB checks and poor food. However, it was noted that other homes had similar problems and a senior nurse with **Gwent Health Care NHS Trust**, reported that the Trust was *impressed* with improvements at Brithdir.[160]

Also in October, **Grant Thornton** was appointed as the administrative receiver to Puretruce Care Ltd. – a sister company to Puretruce Health Care Ltd and L-Giri Ltd – and also owned by Dr P Das and Dr N Das. Puretruce Care Ltd's 15 homes were taken over by the (two) landlords of the homes. Puretruce Care Ltd had failed to pay any rent and the landlords reclaimed its property thus placing another company in charge of frail residents' support and care. This period coincided with food being delivered to the remaining Puretruce Health Care Ltd and L-Giri homes on a *cash on delivery basis.* The CSIW sought confirmation of the financial viability of the Das' remaining companies – which was not forthcoming since Dr P Das and colleagues argued that the inspectorate had no right to request this information.

The CSIW drafted a briefing note for the Minister for Health and Social Services. At the end of **October 2003**, CSIW received confirmation that in **November 2003, Daphne Richards** would become the registered manager of Brithdir.

[160] Within two years the Trust acknowledged that the home did not recruit nurses with the appropriate skills for the level of care required and that Brithdir staff did not seek help *before a case became serious*

Meanwhile, Dr P Das sought to change the company's name to *Celtic Health Care Ltd*[161] (a request which was withdrawn within weeks). The number of residents receiving *nursing and personal care* at Brithdir appeared to fluctuate i.e. *37 nursing [dementia] and 3 older people* during **June 2003**, whereas during **August 2003** there were *36 nursing and four older people*.

By **November 2003**, **Paul Black**, the Chief Executive of Puretruce Health Care Ltd had applied to the CSIW *to provide 30 nursing places and 10 personal care.* Earlier correspondence had made reference to *27 nursing and 13 residential places.* Dr P Das was informed by CSIW that he was required *to comply with his staffing notice* and Paul Black informed the CSIW that he was to be *the Responsible Individual for all Puretruce homes.*

Concern was raised about **Woman Br3** during **December 2003** and was referred to POVA. It was alleged that her medication had not been administered and that she was dehydrated and constipated. She had lost 12.5 Kgs in 10 months, had received only ten days out of 22 days' worth of medication for her high blood pressure, and had not had a bowel movement for nine days. She displayed agitated behaviour and refused to eat and drink. It was alleged that Peter Smith, Brithdir's manager, was *responsible for most omissions,* and a police-led investigation began.

Three CSIW inspections resulted in 13 written notices of actions required.

During **January 2004**, Paul Black confirmed that Daphne Richards was Brithdir's manager; although Peter Smith resigned as the manager he remained at Brithdir *as a staff nurse* and **Anthony Yelland** was nominated as the Responsible Individual. Dr P Das complained about a CSIW Inspector stating that (i) [the Inspector's] *mishandling of an alleged incident may have led to the death of* a resident at another of the Das' homes – Holly House) and (ii) that the Inspector had disclosed to a visitor that a member of staff *had been suspended* (while subject to a police investigation concerning a resident.) Furthermore, Paul Black alleged that the CSIW inspector had encouraged a [Brithdir] employee *to work somewhere better*.

The CSIW was alerted to further concern about the *financial viability* of the Das' homes in that Dr P Das had received threats to disconnect gas supplies. Paul Black provided assurance that gas bills had been paid. The CSIW also received complaints from Brithdir employees concerning management practices and the failure *inter alia* to replace broken equipment.

An inspection resulted in three *written notices of actions re*quired.[162]

[161] A change in business details – such as a name – has implications for information held by Companies House, Corporation Tax and Company Law. Although these were not within the sight of health or social care regulators during 2003, the financial viability of companies responsible for frail older people was an enduring concern of the CSIW (and the **Care and Social Services Inspectorate Wales** (CSSIW) after April 2007)

[162] Throughout **2004**, there were regulatory actions at other homes belonging to Puretruce Health Care Ltd i.e. ongoing concerns about Holly House led to the decision to cancel its registration. Puretruce Health Care Ltd appealed to the Care Standards Tribunal. Similarly, the Beeches (also owned by the Das') was known to have inadequate staffing. These homes became the main focus of the CSIW attention.

During mid - **February 2004**, a CSIW inspection made 134 requirements and wrote to the company *requiring proof of financial viability.*[163] The **Welsh Assembly Government's Legal Services** advised the CSIW to follow through Enforcement Protocol procedures. The **Health and Safety Executive** (HSE) visited Brithdir (and served four improvement notices on L-Giri Ltd between **February** and **August 2004**). In response to a challenge concerning the employment of so many agency staff, Dr P Das made a further complaint about the CSIW Inspector, suggesting that there was a *racial* element to her inspections in that most of the agency staff working at Brithdir were *black African.* This was in response to a challenge concerning *so many agency staff.* Subsequently, the inspectorate's Regional Director advised that Dr P Das' efforts would be better focused on improving Brithdir.

An inspection resulted in the issue of six written notices of actions required.

Daphne Richards applied to become the Brithdir manager at the beginning of **March 2004**, and a POVA meeting hinged on *the quality of food…shortage of equipment* and *concerns about the experience and Criminal Record Bureau checks of staff* at Brithdir. Paul Black provided documentation concerning the accounts and the insurance certificate. The CSIW chased up the responses to the written notices of actions required and received Brithdir's Action Plan.

During **March 2004**, the husband of **Megan Downs** spoke to POVA staff at **Caerphilly CBC** about his concerns: *the staffing levels are inadequate and the staff do not have enough time for all the residents…he does not know who is in charge…has asked on a number of occasions for a meeting with Dr* [P] *Das but has had no response…He visits daily…his wife has lost weight and is not eating enough…*He described the use of medication which was not prescribed for her and an unhygienic nursing procedure during which she became distressed, not least because the nurse did not speak to her. The procedure was witnessed by his granddaughter (also a nurse) and Mr Downs said that *he would like his wife moved.* Their concerns were reiterated by his daughters and, subsequently, the manager who arranged a review. At the review the Matron reported that the nurse concerned denied that she had undertaken an unhygienic procedure and apologised to the family (i) that the nurse had failed to address Mrs Downs, explaining that she was *a new agency nurse from South Africa and* (ii) that it was not acceptable for Mrs Downs to be treated with another resident's prescription. Mr Downs explained that he had sought to meet with Dr P Das on three occasions but had received no response and the Matron said that she *would try and arrange* this. She acknowledged that Megan Downs had lost almost 10 kgs and explained that her GP had requested blood tests…*family feels Mrs Downs requires help to eat…Matron agreed…also agreed to refer to dietician when blood test results are available…care plan amended.* It was suggested that the matter of having to take Mrs Downs to see a phlebotomist because there were *no nursing staff able/trained to do this,* was *a training issue and* the Matron *would ask the GP to visit to do bloods…The family…were satisfied with the responses* and *were made aware of complaints*

[163] The company was warned that failure to provide proof would constitute an offence

procedure and CSIW role. However, this failed to address the fact that Mr Downs had been surprised to receive a telephone call from Brithdir asking him to take his wife to the health centre for a blood test. Four days later, the family contacted POVA personnel. They wanted to pursue the matter since *Mr Downs did not meet Dr* [P] *Das as* the Matron had promised. This discourtesy *upset the family.* The family were given the CSIW contact details and they requested *a review in a month's time which I have agreed to do.*[164]

During **April 2004**, rumblings of disquiet continued. Dr P Das persisted in his efforts to have the Inspector removed; Daphne Richards (Brithdir's acting manager) withdrew her application to be the Registered Manager; the CSIW requested (i) that their internal finance advisors audit the records provided and (ii) legal advice concerning the management of two employees, one of whom was alleged to have abused a resident and another for the alleged sexual assault of a child visiting Brithdir. **Caerphilly CBC** agreed an action plan to run for six months, supported by monthly reviews by one of their staff and extra visits were made by the District Nurses.

Puretruce Health Care Ltd appointed **Rachel Pritchard** as the Clinical Nurse Manager (based at Holly House).

At the beginning of **May 2004**, a man who worked for the Das'[165] applied to register as Brithdir's manager. During **May-June 2004**, **Caerphilly Local Health Board** was alerted to the *POVA concerns* which *began to increase in respect of Brithdir…*concerning *poor care resulting in pressure damage and about the professional conduct of a GP visiting the home.*

During **June 2004**, **Marion Barnes**,[166] a Brithdir resident, was the subject of a POVA investigation. Her family alleged that she had been neglected. She had sustained a complete break to her femur and a dislodged patella. It was alleged that she had fallen from her bed but her family was not informed for over four hours. Marian Barnes alleged that she had been told to use her pad to urinate. A young carer initiated a call for an ambulance. There were not enough staff on duty; there was a delay in calling an ambulance; and the accident report was altered. Findings from CSIW inspection were reflected in an annual report with requirements issued and the contract was terminated for Marion Barnes - she did not return to Brithdir.

When **Woman Br5**[167] was admitted to hospital she was very dehydrated with a penetrating pressure ulcer which was *very odorous* and *covered in faeces*. The manager had informed the Inspector that *repeated requests for Woman Br5's GP* – to visit yielded a prescription for antibiotics and hospital admission for re-hydration and debridement of dead skin. A District Nurse had advised by telephone, *to rub barrier cream onto the sore.* Woman Br5's care notes made no reference to her wound or a turning regime. The Inspector insisted that the GP was

[164] From POVA case notes

[165] He had been appointed as the Acting Manager at Holly House during April 2004. He resigned from this role during August 2004

[166] See Appendix 1, Summary of *Week In Week Out* 2013

[167] Woman Br5 was one of the five residents whose death was investigated by the HSE

called immediately and Woman Br5 went directly into hospital. She was dehydrated and had a necrotic sacral pressure ulcer. The wound still existed at the time of her death. **Caerphilly Local Health Board** and CSIW undertook a *joint investigation* and the police sought advice from the **Crown Prosecution Service** as to whether or not this required a criminal investigation. A POVA strategy meeting agreed that there would be a joint investigation by *health and the CSIW.*

Caerphilly Local Health Board dispatched District Nurses to undertake (i) assessments of all residents in respect of pressure damage and (ii) reviews of record keeping. A formal investigation into the conduct of Woman Br5's GP was sought.

Peter Smith returned to work at Brithdir during **June 2004**.

During **July 2004**, Daphne Richards, the acting manager resigned because of persistent *staffing problems*. The CSIW instigated enforcement action concerning 19 National Minimum Standards in their inspection report. **Caerphilly CBC** noted no major progress at Brithdir, irrespective of support by a number of agencies. The CSIW had discussions with the Welsh Government's Legal Services about taking action. The advice was that alleged breaches would have to be precise and evidenced if they were to succeed.

Megan Downs died in hospital, the day after being admitted from Brithdir.

During **August 2004**, **Woman Br6**[168] was admitted to hospital with an infected and penetrating pressure ulcer measuring 14x12 cm. It was believed to have been caused by prolonged contact with urine, faeces and incontinence pads. She had lost 20kg. She died eight days later and a police-led investigation began. There was a POVA strategy meeting.

During **September 2004**, **Man Br1**[169] was admitted to hospital with *numerous pressure ulcers*, a high temperature and pneumonia. He was recorded as having 16 sites of pressure ulcers - he *was unresponsive and responded only to pain* and had been *unable to communicate*, *was immobile and needed full nursing support.* He died a week later. In Brithdir's records there were *several references to* ManBr1 *being in pain and shouting out or screaming.* Although the syringes used to flush his PEG feed were designed for single use only, they had been used more than once. The CSIW continued monitoring and discussing options for further action with government lawyers. Dr P Das was advised to produce an *action/improvement plan* in the light of the volume of POVA referrals and the absence of a registered manager. **Caerphilly CBC** considered an embargo[170] on future placements. Additional POVA meetings concerned continuing inattention to residents' health care.

[168] Woman Br6 was one of the five residents whose death was investigated by the HSE

[169] Man Br1 was one of the five residents whose death was investigated by the HSE

[170] Embargoes are not imposed lightly since they can and do compromise the financial viability of a home. However embargoes imposed, embargoes lifted and embargoes with conditions speak of the unprecedented pressures facing regulators, commissioners and those seeking to identify homes for older people – at a time when the relatives of older people, who had not sustained physical harm, made clear their hope that Brithdir would remain open

Caerphilly LHB shared the concerns of **Caerphilly CBC** about Brithdir. The Social Services Directorate produced a chronology of POVA Strategy Meetings from *2002-September 2004 as a result of which contract monitoring was increased.* District Nurses were requested to undertake an assessment of 28 residents over three days. *They subsequently reported issues in respect of pressure damage; weight loss; smell of urine; and care plans not being updated. Additional NHS nursing support was identified.*

The CSIW received an anonymous complaint from the relative of a resident regarding the effects on residents of the non-payment of bills and the shortage of staff. Milk and bread deliveries had ceased on 27 August and, for the same reason, incontinence pads and wipes were not delivered on 10 September. The phone line to Brithdir had been disconnected and the new nurses were *difficult to understand and do not understand what is being asked of them. Clothes are being shrunk, bleached and lost.* The CSIW wrote to Dr P Das on two occasions requesting an immediate improvement plan since there had been no response to July's inspection report. He was warned of the potential cancellation of registration for Brithdir.

Financial considerations were increasingly important to the CSIW since Dr P Das had not disclosed confirmation of their companies' financial viability – repeatedly stating that they were *in preparation.*[171] Monies were apparently owed to a nursing agency and on occasions, staff in the care homes were paid in cash because payments through the banks had been delayed.

During **October 2004**, the gas supplier once again threatened to disconnect the gas supply if payment was not received in full. Paul Black paid the bill. A CSIW *enforcement meeting* highlighted *concerns regarding ongoing non-compliance.* Dr P Das had resisted taking part in this meeting and claimed that he was not and had never been the Responsible Individual. An inspection visit detailed 79 requirements. **Caerphilly CBC** placed an embargo on further placements at Brithdir.

A multi-agency group, convened to consider a number of POVAs at Brithdir resulted in an allegation of 'institutional abuse.' It was noted that all residents had been assessed by District Nurses for a third time over a period of time as a result of concerns and a pressure relief audit had been undertaken…CSIW were in discussions with the police.[172]

During **November** and **December 2004**, Dr P Das requested that the CSIW Inspector should be disciplined for *offensive behaviour* and sought an apology. Also, he alleged that the Inspector had been *sniffing residents' incontinence pads*[173]*…had forced the handyman to*

[171] During the Care Standards Tribunal's hearing about Holly House, an employee of Companies House confirmed that *enforcement proceedings were being contemplated because no accounts had been filed for the company for 2002-2004*

[172] Aneurin Bevan *Health Board summarized timeline of pivotal events: Jasmine Review* August 21 2014

[173] The Inspector was concerned that Dr P Das would not pay for disposable pads to be removed and he expected staff to put them into ordinary bin bags for the Council's refuse collection. She recalled that *the stench from the bins outside the home was overwhelming*, rendering "sniffing" unnecessary

*paint…a floor area…*resulting in *a cook* falling; and since the Inspector's POVA referrals…*had not been found valid* he requested a *medical certificate* confirming the Inspector's physical and mental fitness to undertake inspections in his homes.

The CSIW wrote to Dr P Das, again detailing the deteriorating standards.

An *overarching POVA meeting* was held which drew together the concerns of **Caerphilly CBC**, the CSIW and **Caerphilly Local Health Board**: there were no proper assessments or assessment tools, there was a lack of skilled staff and the management did not request help, irrespective of the LBH's presence in Brithdir, the presence of District Nurses and others.[174] It was agreed that the LHB and Caerphilly CBC would place an embargo on further placements at Brithdir and they recommended that Caerphilly CBC should give six months' notice of the termination of its contract with the home. This was confirmed in a meeting with Dr P Das.

In mid-**December**, **Woman Br7**'s family raised a concern about bruising to her wrist. Although she explained that she had been *roughly led out of the lift* her GP said that *it looked as if she had banged her arm.* The police noted that *this incident would be difficult to investigate.* Woman Br7 was moved to another home.

Antony Yelland had a *Fit Person Interview* with the CSIW inspectors.

During **January** and **February 2005**, Peter Smith applied to be Brithdir's Manager and was appointed once again. Paul Black requested that another Inspector should undertake the annual announced inspection because L-Giri and CSIW were involved in the forthcoming Care Standards Tribunal (concerning Holly House). The Inspector continued with her unannounced inspections.

During **March 2005**, Dr P Das advised the CSIW that since Anthony Yelland was unwell, he was nominating Paul Black as the Responsible Individual with immediate effect.

A review of Brithdir by the Health Board concluded that it had made *considerable improvements to the standard of care, particularly in respect of tissue damage, nutrition and care plans* with evidence that the home was delivering on improvement recommendations.

A visit to Brithdir by bailiffs during **March 2005** resulted in several pieces of equipment being labelled in lieu of debt recovery. It emerged that the labelled equipment could not be removed since it was owned by L-Giri Ltd and not Puretruce Health Care Ltd (both of which were the Das' companies).

[174] The involvement of external nurses could not halt the rates at which residents developed pressure ulcers i.e. the compression of soft tissue between a bony prominence and an external surface for a prolonged period, since the risk factors which contribute to the susceptibility to pressure ulcers were largely beyond their control: malnutrition; dehydration; prolonged periods of immobility, including sitting; absence of meticulous preventive measures, including training; a consistent regime of pressure relief, including re-positioning, most particularly at night; incontinence; taking multiple medications for a prolonged period – which may alter the skin tolerance to the effects of pressure; poor supervision of care planning; inadequate infection control; and poor recording of the condition of skin when repositioned (see Appendix 6)

During **April 2005**, **Caerphilly LHB** received reports prepared by a Consultant Psycho-geriatrician, made at the request of Puretruce Health Care Ltd for the prospective Care Standards Tribunal (appealing against the cancellation of Holly House's registration). These presented evidence that transferring *vulnerable older people (particularly those with cognitive impairment)* [makes them] *potentially at risk of increased morbidity and mortality* and accordingly, *the decision to deregister should be informed by the need to balance the associated risks and benefits…the risks associated with relocation can only be considered as potential and must be weighed against the risks associated with individuals remaining in an environment where there can be serious concerns regarding the ability of the organisation and care team to appropriately assess and meet the complex care needs of the resident group.*

By **May 2005**, a warrant for the disconnection of Brithdir's gas supply was raised, once again.

An inspection resulted in a written notice of action required.

During **June 2005**, Dr P Das wrote to **Caerphilly CBC** requesting almost £50K *emergency assistance to pay creditors.* He explained that the funding was to *cover the costs* to Puretruce of the CSIW's application to close Holly House and the successful appeal to the Care Standards Tribunal against the closure notice.

Caerphilly CBC contacted the CSIW to raise concerns about the financial viability of Puretruce Health Care Ltd.

Ten months after her death, **Woman Br6's** family expressed concern about her pressure ulcer which penetrated *to the bone, about* the *mismanagement of* her Urinary Tract Infections (UTIs) and inadequate *oral care.* She had also developed a disease requiring dental intervention.

Wayne David MP made a statement in the House of Commons about Dr P Das' successful appeal against the CSIW's decision to cancel the registration of Holly House. He listed incidents and concerns[175] and proposed that the Care Standards Tribunal *should be obliged to examine the full background to a case rather than simply the events immediately preceding the withdrawal of a licence…The determination should be based on whether the CSIW acted correctly not on whether the so-called improvements are sufficient to make the situation better in future…It is wrong that someone can continue to operate a care home after all the professional agencies have concluded that there has been institutional abuse there.*

Stanley Bradford was admitted to Brithdir during **June 2005**. His family became concerned that he became withdrawn and had *lost his sparkle.* They were also concerned that he was losing weight and his catheter bag was *often full and bloody*…*He never looked clean and his nails were often dirty*. He had Parkinson's, a swallowing difficulty and poor mobility. On one

[175] These included allegations of a resident leaving the home unsupervised; a resident with diabetes being admitted to hospital as an emergency and the hospital reporting concerns about their physical state (the resident died three months later); a resident without a risk assessment or a care plan who was prone to falls and had extensive facial bruising; a member of staff restraining and striking a resident (resulting in a police investigation); a resident being admitted to hospital suffering from hypothermia; and during an unannounced CSIW inspection, a resident being found on the floor of the lounge

occasion when he was admitted to hospital *he cheered up* and returned to his familiar self. When his daughters accompanied him back to Brithdir in an ambulance he said: *Don't take me back there* and later: *Why have you put me here? Don't you love me?* His hospital admissions arose from chest infections and UTIs, and on another occasion when he was admitted to hospital, his daughter was distressed to see his emaciated body. It was as distressing to be asked by a hospital nurse: *Why have you let him go like that?*

Also in **June**, BBC Wales' *Week In Week Out* about the Das' homes was broadcast.

During **July 2005**, a neighbour complained about the noise of two residents who were shouting at each other.

Paul Black resigned as the Deputy Chief Executive.

Caerphilly CBC continued their contract monitoring at Brithdir.

During **August 2005**, **Sue Greening** - who had been appointed to work at Holly House - resigned. Dr P Das sought a meeting with Rob Pickford, the Chief Inspector to express his concerns about two CSIW Inspectors.

Also during August, the registration of **Holly House** was cancelled and eight of 18 residents of Holly House were transferred to Brithdir. The transfer added to the pressures on Brithdir. The transferred residents were accommodated together and supported by some of the staff who had transferred from Holly House.

There were two POVA referrals relating to *poor care and neglect* at Brithdir. It was noted that *the owner was moving patients from one home to another without consultation.*

During **September 2005**, concerns arose about gas safety at Brithdir – the oven and a vent were *borderline dangerous* and other appliances required remedial attention. Later in the month it was established that the remedial work to the gas appliances was substandard and a further five requirements were made.

Woman Br8 had transferred to Brithdir from **Mountleigh Bryngwyn** (which also features in this Review). Her family raised concerns when she was admitted to hospital with dehydration, pneumonia and diabetic complications. A CSIW investigation concluded that there were concerns about the delay in diabetes management at Brithdir. The family *were adamant that they did not want Brithdir to be the subject of* an *investigation.*[176] Five requirements were made arising from Woman Br8's unattended health needs.

Edith Evans was admitted to hospital from Brithdir. She had been at the home since 1999 and had ceased to speak after a year. At the beginning her family *didn't think the place was too bad.* She *used to walk around the home, pushing doors open. It was mostly up and down because there were no grounds that she could walk around and Brithdir had no garden.* Later,

[176] A reluctance to initiate an investigation and the reluctance of families to complain are commonly associated with fear of the consequences for their relatives.

her family reflected that they could *never understand why her nails were so dirty and why she never looked spruce* and why *she was often wearing other people's clothes.* Although she used to have her hair done every week, her appearance at Brithdir was not prioritised. She had worn glasses all her life and yet her family could not recall seeing her wearing them while she was in the home. Also, her *PEG feeding tube was always dirty.* During **August 2005**, her PEG site *looked sore* and a swab confirmed that the site tested positive for MRSA and Candida. By mid-**September 2005**, she had a grossly inflamed PEG site, penetrating pressure ulcers on her back and buttocks, her hip was scratched, her heel was hot and inflamed, her tongue was swollen and her mouth dry. In addition, when admitted to hospital she was in a very poor condition – she was unwashed and her hair was dirty and matted. One of the ambulance paramedics noted that the PEG site *smelled gangrenous.* Her family recalled that *she screamed when she had morphine injections around the site of the PEG.* She died at the end of **September**, her death being certificated as due to *1a: septicaemia; 1b: infected PEG site; 2: dementia.* The CSIW wrote to Dr Das issuing three requirements, including an investigation of the circumstances of Edith Evans' admission to hospital. The police led the investigation.

The CSIW detailed urgent concerns regarding deterioration in care standards which required Dr P Das to ensure greater supervision and an immediate action plan. He did not respond.

Funded Nursing Care assessors were involved in further nursing assessments of residents. They identified such concerns as the *poor skills and knowledge of staff relating to physical care, catheter care, use of pressure relieving equipment and insulin administration.* Agencies met to consider responses, that is, re-establishing the embargo, re-drafting action plans and cancelling the contract.

Stanley Bradford died during **September 2005**. On the last occasion on which he had been discharged from hospital he was placed in an upright chair at Brithdir. His family questioned this because, in hospital, he had been turned every two hours. Also, hospital staff had used swabs to clean his mouth. The Manager suggested to his family that it was *best* not to keep taking their father into hospital, but rather *keep him comfortable at Brithdir,* adding that they could *give him morphine if it was required to make his last days comfortable.* This did not happen: he was on a mattress for four days which was *three times louder than a lawn mower.* (A towel was placed over the mechanism to reduce the noise.) On one occasion when he was struggling to breathe, his family requested that he be given oxygen. As a member of staff wiped his mouth, a dark mucus crust in the mould of the roof of his mouth was removed. His family recalled that when staff moved him they could *hear his screams of agony.* They had no knowledge of the fact or extent of his pressure ulcers.

During **October 2005**, Gwent police commenced the Operation Jasmine investigation.

Woman Br10's family raised a concern about the possibility of physical abuse. She had bruises on her hands and arms, she had been found sitting in urine which was running down her chair,

she had no choice of food and she was admitted to hospital in terrible pain. She was diagnosed as having a twisted bowel. This was investigated by the police under Operation Jasmine.[177]

During **November 2005**, concerns were raised about **Evelyn Jones**'[178] pressure ulcers. She was one of the residents who had been transferred from Holly House. Within a two week timeframe (when her family were on holiday) her deterioration was rapid. On their return, they asked staff if she was unwell and were told, *Old people do deteriorate quickly when they start going.* They were concerned that on one visit Evelyn Jones' *mouth was terrible* and before giving her a drink they had to *get all the mucus out of her mouth.* The family was led to believe that she was becoming more physically compromised because of her age. *She was always upset when they sought to move her so that she could drink. There was a Jamaican nurse…*and the family *would ask her about Evelyn Jones' distress and she would turn to Evelyn Jones and ask loudly, "Evelyn, why are you crying?"* Evelyn Jones had told her family that she *didn't want to go into hospital.* However, when a GP said that she ought to be admitted, her family decided to override Evelyn Jones' wishes. On admission, it became clear that the severity of her pressure ulcers had been underestimated by Brithdir nurses. At Brithdir she had been sleeping on an ordinary, hard mattress. Furthermore, there was no evidence that she had even had any dressings on her back. Although her 18x14 cm wound was too septic to be fully assessed, it was clear that the prognosis was poor. She was *dehydrated, unresponsive and emitting an offensive smell* which was *so invasive she had to be moved to a private cubicle to protect her dignity and for the comfort of other patients on the ward.* Her low serum levels on admission to hospital were consistent with marked malnutrition. The following day she was *unconscious, profoundly dehydrated and only responding to painful stimuli.* The cause of her death was noted as *sepsis due to infected pressure ulceration on her back consequent upon immobility and dehydration. Ischemic heart disease was listed as a contributory cause.* She was the subject of two POVA meetings and a police investigation.

The CSIW inspector raised concern about **Woman Br12**.[179] She had noticed *a number of pressure areas, broken areas and inadequate dressings.* From **September 2005**, her pressure ulcers became progressively worse. A POVA meeting was held and in the light of unabated concerns, an embargo was placed on Brithdir by **Caerphilly CBC** and a notice to terminate the contract with Brithdir was planned. The police were to investigate and CSIW continued to monitor and consult regarding further enforcement action. An inspection resulted in the issuing of four written notices of actions required.

A CSIW Inspector visited Brithdir with two Gwent Police officers *to assist with information gathering.* They met the relatives of a resident who had moved from **Holly House** to **Brygwyn Mountleigh** and finally to Brithdir. The relatives were described as *extremely hostile* (most

[177] It was not clear to the CSIW how the launch and conduct of Gwent Police's Operation Jasmine would indicate substantially different police responses to those which had prevailed during Brithdir's history when the police had been involved in POVA strategy meetings

[178] Evelyn Jones was one of the five residents whose death was investigated by the HSE

[179] Woman Br12 was one of the five residents whose death was investigated by the HSE

particularly towards the CSIW Inspector). One shouted: *You can't close this home down as well*. They were advised that the care that their relative had received at Bryngwyn Mountleigh *would form part of the police investigation.*

The Minister for Health and Social Services and the Chief Inspector were briefed about the police investigation *following allegations of neglect surrounding the deaths of two female residents*.

During **December 2005**, the report of the announced inspection was made and 79 requirements issued, most of which were outstanding from the previous inspection report. Dr [P] Das requested a meeting to discuss the report's *factual inaccuracies*.

The acting manager contacted the CSIW in distress because she was having difficulty covering the shift since: *staff were leaving or sick and Dr* [P] *Das was reluctant to pay for agency staff.* Within two weeks she was asked to provide reassurance that all shifts were being covered at Brithdir.

Concern was raised by **Prince Charles Hospital** about **Woman Br12**. On admission she had pressure ulcers on a buttock, one on her sacrum and a bruised scapula. She died in hospital.

A CSIW inspector raised concerns about **Man Br2**. He had been admitted to Brithdir from hospital during **October 2005** when he already had pre-existing pressure ulcers. These deteriorated during his five months of residence at Brithdir. It was noted that he appeared to be unwell and chesty and had an injured shin. There had been three occasions when Man Br2 had sustained injuries and yet Brithdir had undertaken no credible investigations. The police investigated his circumstances *under Operation Jasmine.*

The CSIW met with the Government's Legal Services during December. There was concern that **Caerphilly CBC**'s decision to terminate its contract would mean that its case for cancelling Brithdir's registration would be weakened. However, senior staff decided that there were sufficient grounds to issue a proposal to cancel registration. **Caerphilly LHB** received legal advice which noted their obligation to provide nursing care for residents in registered care homes and recommended 12 weeks' notice of termination of contract rather than immediate termination. Notice to cease funding placements from May 2006 was issued.

During **January 2006**, Sue Greening, Brithdir's manager, reported that two nurses had found **Man Br3** *naked in a bathroom next to a full bath of cool water.* The two carers who should have attended to him refused to do so. They were suspended from duty. Man Br3 had developed pressure ulcers which deteriorated.

Solicitors notified the CSIW that Dr N Das was *taking over the running of the home from Dr* [P] *Das.*

A solicitor acting for the CSIW provided Counsel's advice concerning a potential prosecution. CSIW was not satisfied that Paul Black was suitable as the Responsible Individual. By the end of the month, 51 requirements were still outstanding and 49 new ones had been issued. Two inspection visits resulted in five *written notices of actions required*.

Renewed concern about **Man Br2** focused on inadequate nursing care. The inspector found that although he had a PEG feed, his regime was not being followed. A GP had asked staff to monitor and record his temperature and yet this had not been done. Also, care staff rather than the nurses were setting up the PEG feed and *flushing* the tubes.

The CSIW Inspector also raised concerns about **Man Br4** regarding dehydration and suprapubic catheter care. He had had no drink for 14 hours and his mouth and skin were dry. His urine bag was full and attached to a night bag which dragged because it was not on a stand. He had a bruise on his abdomen and dressings on his forearm and hand. His bedroom was malodourous. His incontinence pad and catheter had been attended to by a staff member who did not wash her hands, wear gloves or an apron. The bedrails did not fit **Man Br4's** bed and his legs were between the mattress and the bedrails.

Woman Br13 had transferred from **Holly House** to Brithdir and she had some pressure ulcers on admission. She developed pressure ulcers on her heels and sacrum, the latter developing into a grade 4 ulcer. She died during January 2006. Traditional nursing tasks had been allocated to carers i.e. a carer had changed the dressing on **Woman Br13**'s penetrating pressure ulcer, claiming that it had come off and the wound was much better. This was not the view of the District Nurse since the wound was complex. The Manager observed that the home could not be managed with the existing complement of staff.

The CSIW inspector raised concern about **Woman Br14** who was found by the Inspector staggering in the laundry area in what appeared to be a toxic state. A written notice of action required was issued.

Finally, the CSIW inspector raised concern about **Woman Br15** who was noted to have a shin injury sustained whilst being moved. She had oedematous legs, with *paper thin skin,* a large skin flap in her shin and she was lethargic. She had lost 3 kgs in a month. A referral was made to the HSE to investigate. **Woman Br15** was moved to Valley View Care Home – which was also owned by the Das'.

At the end of **January 2006**, there was a **Caerphilly CBC** multi-agency meeting *to discuss concerns and lack of progress.* It was decided to terminate all contracts with Puretruce Health Care Ltd.

During **February 2006**, a District Nurse raised a concern about **Woman Br16**. She had developed a pressure ulcer on a buttock and was using a mattress which had *been incorrectly set on the highest setting.* (This was during a period when the involvement of external agencies was intense.) Also, concern was raised by **Valley View Care Home** when **Woman Br15** was admitted there. It was found that she had a deep wound behind a knee which, in Brithdir's documentation, had been described as *chafing*, yellow bruising to a breast, several *quite deep* broken areas on a shin and a lump and bruising to her face. Brithdir claimed that this was caused by banging her face into a bedrail whilst in bed. The **HSE** was asked to investigate the bedrail injury and the LHB was asked to investigate the pressure damage.

The CSIW Inspector raised a concern about **Man Br5** who had developed a gangrenous foot/toe. The documentation *reflected* the fact *that he did not have adequate care; he had pressure ulcers and pneumonia* arising from aspiration. There was also concern regarding financial irregularities. Such irregularities were noted in the personal monies of **Man Br2**, **Woman Br16** and **Man Br6**. The Inspector also raised concern about **Woman Br17** who alleged that she had been pushed by a carer. She was moved from Brithdir. The inspector raised further concerns about the unsafe moving and handling of two women and two male residents: **Woman Br18**, **Man Br6**, **Woman Br16**, and **Man Br2**.

An inspection resulted in a written notice of action required.

The HSE also visited during **February 2006**. A particular focus of the visit was bedrail safety.

During **March 2006**, Brithdir's Manager outlined the actions taken arising from the 52 *outstanding requirements* and the *49 new requirements issued,* as well as those arising from recent inspections. Dr N Das inquired of the CSIW whether or not the actions taken would be evidenced in a prospective inspection report. CSIW took legal advice concerning the Notice of Proposal to cancel the registration of Brithdir.

Dr P Das wrote to state that he neither agreed nor accepted the *allegations* concerning Brithdir. He made a separate complaint about another CSIW Inspector.

Towards the end of **March 2006**, there was an outbreak of vomiting and diarrhoea at Brithdir.

The CSIW received notification that **Man Br6** had been physically assaulted by a male employee. He did not want the police to investigate and moved to another home. The details of the alleged assault were passed to Operation Jasmine.

Man Br4's family raised a concern about lack of attention to his medication. On admission to hospital *his anti-convulsant levels (which should have been in the range of 4-10) were 2.*

District Nurses were at Brithdir twice a day. They described the care home staff as *hostile and resentful.*

By **April 2006**, **Caerphilly CBC** and **Caerphilly LHB** had removed all residents from Brithdir. Dr N Das added her concern to that of her husband about the alleged conduct of the second CSIW Inspector.

An inspection resulted in a *written notice of action required*.

During **May 2006**, Dr P Das contacted the CSIW stating that since Brithdir was still registered, he intended to remain open for business, that is, he intended to admit non-Caerphilly CBC people and self-funding residents. A day later he confirmed that another local home owner would be purchasing the home.

Caerphilly CBC's POVA personnel advised the CSIW of the criminal investigation into the care of residents at Brithdir *and of the advised suspension of four nurses*. However, Paul Black had confirmed in correspondence to the Council that he was not prepared to suspend the nurses.

Paul Black notified the CSIW of the suspension of Sue Greening, who withdrew her application to register as Manager.

The CSIW requested information about the ongoing management of Brithdir, the names of employees and potential residents and confirmation that the latter were informed of the enforcement action.

The CSIW issued a Notice of Decision to cancel Brithdir's registration.

L-Giri Ltd applied for a Judicial Review opposing the cancellation of contracts by **Caerphilly CBC**. The Judge dismissed the application on the grounds that it was *totally without merit.* The CSIW sought advice concerning a possible prosecution for *carrying on a care home without being registered in respect of it.*

During **June** 2006, the solicitor acting for the provider lodged an appeal but this was subsequently withdrawn.

The CSIW was notified that the potential purchaser was not buying Brithdir and a new buyer had been identified as Apsley Park Ltd, which had approached Catherine Steadman to manage the home. Catherine Steadman sought to register as the Manager.

During **July 2006**, it was confirmed that Aspsley Park Ltd was no longer buying Brithdir but that his original purchaser intended to do so. Puretruce Health Care *entered into negotiations for the sale of Brithdir for £900,000.*

During **September 2006**, the **Care Standards Tribunal** heard evidence of non-compliance with Regulations and the escalating financial concerns about the Das' companies which had tangible impacts on the residents of their homes. However, the hearing also highlighted the complex legal tests which had to be met, that is,

…the registration authority and on appeal, the Tribunal must be satisfied that the registered person has breached either the Act or the Regulations made under it or some other relevant statutory provision…There is no legal requirement to comply with the minimum standards but compliance with the regulations is enforceable subject to the national minimum standards being taken into account.

The Tribunal's hearing concluded that *the Applicant company was operating both Holly House and The Beeches in breach of many regulations…the nature and extent of the breaches were hotly disputed…the Applicant company persistently failed to deal properly with appointments of managers…The applicant company was manifestly in breach of its obligation under regulation 10 to carry on both Holly House and The Beeches with sufficient care, competence and skill…Dr*[P] *Das was the person in ultimate control. His financial management was unprincipled and ill-considered and in some instances disastrous.*[180]

CSIW received confirmation that Paul Black was no longer the Responsible Individual.

[180] *Puretruce Health Care Limited (Holly House) v National Assembly for Wales* [2005] 544 (EA-W) JP

Brithdir was deregistered during **October 2006**.

Finally, reference to the **CSIW**'s **2002** – **2006** lengthy inspection reports concerning **Brithdir** (as summarised in Appendix 2) play down the reach of Inspectors' activities but not the build-up of concerns, most particularly concerning the adequacy of the home's equipment and the residents' food. There were at least four meetings held with **Dr P Das** to explore improvement and warn of the consequences of sustained non-compliance. *Written notices of actions required* were issued on at least 23 occasions and more than 437 requirements were made. Between **January 2002** and **April 2006**, Inspectors made at least 67 visits to the home.

In addition, the **CSIW** contributed to multi-agency meetings with **Gwent Police**, **Caerphilly CBC**, **Gwent NHS** Trust, the **Caerphilly teaching Local Health Board** the **Health and Safety Executive**, the **Public Health Officer** and independent gas safety engineers for example.

The Beeches Nursing Home

The Beeches was registered from **1997** with **Gwent Health Authority**. In **March 2002** it was registered under the Care Standards Act 2000 to provide 29 nursing and 10 older persons' beds. Dr P Das, a Director of **Puretruce Health Care Ltd**, was the Responsible Individual. The Beeches was a listed building and former general hospital in Blaenavon, Torfaen.

During **May 2002**, an anonymous complaint from a member of staff expressed concern about staffing levels and the home's practice of getting residents up and breakfasted by 7.30am and putting them to bed at 6.30-6.45pm, that is, before the arrival of the night staff. The **Care Standards Inspectorate for Wales** (CSIW) made a *complaint visit* during **May 2002** and a *follow-up visit* during **July 2002.** An announced inspection during **October 2002** (see Appendix 2) cited 25 *outstanding requirements and 109 new requirements.* A structural survey revealed problems with the building, confirmed by the **Health and Safety Executive** (HSE). Paul Black[181], the Chief Executive who became the designated Responsible Individual, *proposed actions in response.*

During **November 2002**, **South Wales Fire Service** issued Puretruce Health Care Ltd with an enforcement notice.

During **January 2003**, the CSIW received a Notice of Proposal to Vary Conditions at the Beeches: Care Home (Nursing), 21 places: and Care Home (Older people), 18 places.

An unannounced CSIW inspection during **March 2003** resulted in four notices of action required. (From **March 2003** until **March 2006**, Puretruce Health Care Ltd failed to pay registration fees in respect of The Beeches – amounting to £5,574.00). During **June 2003**, **South Wales Fire and Rescue Service** issued a new notice for work outstanding. An unannounced visited during **October 2003[182]** (see Appendix 2) sought a *compliance plan* by **December 2003**. The CSIW's Regional Director wrote to Dr P Das about *difficulties in some homes* concerning *required staffing levels, food stocks…*and *CRB checks.* Dr P Das provided verbal assurances and there was an acknowledgement of the *financial investment needed in respect of refurbishment and upgrade of The Beeches*.[183]

During **November 2003**, the CSIW wrote to Dr P Das expressing concern that *to reduce the staffing level requirements that was stipulated at registration had not been agreed because…of the dependency needs of residents.*

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[181] Whose background was *in sales and marketing. He worked for textile companies and, latterly, for distributors of medical products.* He was *responsible for the commercial management of all of the…companies homes and his duties* included *the procurement of supplies and the structuring of staff training* (*Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006)

[182] During October 2003 the CSSIW was informed that NHP plc – the freehold owners of 15 of the Das' care homes - intended taking action to recover back-rent from Puretruce Care Ltd

[183] Dr P Das attributed the home's deterioration to **Cadw** - the guardian of the built heritage of Wales. Dr P Das claimed that he was applying for Cadw grants, that Cadw would not let him undertake maintenance and/or that Cadw was responsible for the slow progress

During **December 2003**, the CSIW was informed of a *Change of Company name…to Celtic Healthcare Ltd.* It would appear that this change was temporary since the name does not appear on subsequent documentation.

At the beginning of **2004**, **Anthony Yelland** was the Responsible Individual for, *inter alia,* the Beeches Nursing Home, **Holly House** Nursing Home and **Brithdir** Nursing Home and **Diane Grohmann** was the Registered Manager. Evidence of concern about the financial viability of Puretruce Health Care Ltd was reflected in the failure to attend to the internal and external fabric of The Beeches.

During **April 2004**, Paul Black informed CSIW that **Rachel Pritchard**, the former manager of **Baybridge** Nursing Home in Cardiff, was the *clinical nurse lead for their whole group of homes.* Her role included *clinical administration procedures, resident diet programmes, training needs of staff and overseeing matters relating to CSIW notices and reports.* At the end of April, and in response *to anonymous concerns raised by staff*, the CSIW wrote to Paul Black concerning the lack of agency staff cover at the weekend and Bank Holiday. Confirmation of staffing arrangements was requested as a matter of urgency.

During **June 2004**, a payment of £1,890.00 was made towards The Beeches registration fee for 2004-05.

During **September – October 2004**, the gas supplier to the Das' homes, **Corona Energy**, took steps to recover payment for a debt of over £20K. Puretruce Health Care Ltd made a payment on account, promising a further payment of £10K. After sending a "disconnection letter," a further payment of £5,279.00 was paid, leaving a balance outstanding of £6,770.00.

During **October 2004**, The Beeches' manager and Matron, Diane Grohmann, resigned and *the nurse in charge at The Beeches (Mrs **Marilyn Jolley**) told* the CSIW Inspector *that she was very concerned about the lack of staff at the home.*[184] Between **November 2004** and **March 2005**, the CSIW were unsuccessful in establishing the steps Puretruce Health Care Ltd was taking to replace the manager.

During a CSIW monitoring visit in late October, the Inspector saw that there was water coming through the ceiling of the main lounge and onto a light fitting. It was explained that staff were using a bath to wash commodes and Paul Black stated that this *was never their practice* [that is, it was not a routine]*. The drainage pipe from the bath was leaking.* Although an undertaking was given that the damage would be rectified, at a visit in early **December 2004**, the damage had still not been repaired. Paul Black explained that *he thought the work had been done and he would make inquiries.*

During **November 2004**, Paul Black sent a memorandum to all staff, entitled *Staff Wages,* which stated that wages would be paid *when the residents' fees have been cleared through the bank from social services.*

[184] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

During **December 2004**, the CSIW published their annual inspection report which noted that although some repair work had been undertaken, there were over 270 requirements to the physical environment, most of which were outstanding from the previous report.

At the beginning of **2005**, CSIW wrote to Dr P Das expressing reservations about the ability of the Responsible Individual, Anthony Yelland *to appropriately supervise the management of the care homes.* During **March 2005**, Paul Black informed CSIW that since the manager's resignation, **Lynn Pennells** had *acted up*.

During **April 2005**, two anonymous complaints from relatives of residents highlighted concerns about staffing levels; residents *never seem to have regular medication;* residents were not being bathed; dressings were not being changed; there were no hoists; one resident had black eyes having fallen; The Beeches was dirty – with mice and ants; the deputy manager was heard shouting and swearing; and the Clinical Nursing Director *didn't want to know.* A *complaint visit* confirmed that *there had been and would be insufficient staff on duty to comply with the regulations.* The Responsible Individual said that he would *sort it out.*

During a follow-up inspection, 13 breaches of regulation were identified and four written notices of action issued.

During **May 2005**, CSIW wrote to Dr P Das requesting assurance that there were *adequate numbers* of *appropriately qualified staff on duty.*

Puretruce Health Care Ltd paid £10,275.00 to Corona Energy, leaving a balance of £29,015.00 in respect of all of the company's homes. The gas supplier then notified all concerned of their intention to disconnect supply to the homes. At the end of the month **Torfaen CBC** held a POVA Strategy meeting at which the CSIW were represented. This focused on the threatened disconnection of the gas supply. The gas bill for The Beeches was £11,391.00. In addition, there were long-standing matters concerning investment in the fabric of the home, equipment, staffing and training. Torfaen CBC undertook to obtain evidence of payment of the gas bill before the recommencement of any placements at The Beeches. Following Torfaen CBC's embargo, The Beeches had only 22 or fewer residents.[185]

Although a payment of £22,000.00 was made to Corona Energy, Puretruce Health Care Ltd failed to make payments in respect of current supplies from **May** to **August 2005**. This resulted in further debts accruing and the reinstatement of the energy company's intention to disconnect the gas supplies.

At the end of May, a CSIW inspection with colleagues from **Torfaen LHB** and **Torfaen CBC** reviewed the personnel files and found that three newly appointed staff did not have enhanced Criminal Records Bureau Disclosures and had not fully completed their job application forms. A review of six residents' files identified significant deficiencies in the risk assessments and care plans e.g. one resident who had been at The Beeches for nine years had

[185] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

no care plan. There was *a failure in the very basic nursing processes* with *repercussions for individual patients.*[186] For example, there was no evidence that residents who required blood pressure checks before having their medication had had any checks.

During **June 2005**, Puretruce Health Care Ltd confirmed that Anthony Yelland was leaving and that Paul Black would be the Responsible Individual.

Another anonymous complaint was received from a relative, once again raising concerns about staffing levels at The Beeches.

When CSIW inspectors met with the *acting manager,* Lynn Pennells, she confirmed that she did not want to be the manager. This claim was contradicted by Rachel Pritchard, the Clinical Nursing Director.

A Torfaen CBC's POVA strategy meeting of **21 June** considered the home's unpaid gas bills; the difficulties that had arisen because two South African members of staff were living in a flat at The Beeches; the deficient recruitment files; the absence of a training audit; and the fact that *the fundamental elements of nursing and personal care* had not been undertaken since the departure of the registered manager.

During **July 2005**, the acting manager confirmed to the CSIW inspector that she did not wish to be the manager. During the visit The Beeches was noted to be *dirty and untidy.* Fire doors were wedged open. The acting manager confirmed that the home was short of *domestic cover…she was not permitted to employ any agency staff* and *the agency had not been paid.* Further, the contents of the *personnel file of a member of staff…had been removed because they would have disclosed an insufficient Criminal Records Bureau disclosure and a possible…DHSS fraud.* CSIW sought urgent action and clarification concerning the management of The Beeches – not least since Paul Black was the Responsible Individual.

In early July, **Torfaen CBC** held a POVA strategy meeting as a result of allegations about the physical and psychological abuse of **Woman Be1**. The meeting also considered complaints made *in respect of eight other residents.* A local GP – **Dr Wayne Lewis** – submitted a report expressing concern about the *general deterioration in the care of residents* at The Beeches. Although **Woman Be1** had sustained bruising to her arms and chin and a cut to her finger, *it was decided that there was insufficient evidence to pursue the allegation of physical assault…but the allegation of verbal abuse was sufficiently proved…the police were not keen to pursue claims of verbal assault.* A joint investigation by CSIW and Torfaen CBC was agreed.

Puretruce Health Care Ltd's Clinical Nurse Manager informed the CSIW that The Beeches was *left unsupported by the company…no supervisions or appraisals of staff were being undertaken* and she acknowledged that *there were insufficient numbers of staff to cope with the high dependency of service users.*

[186] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

It was noted that a *police investigation was to commence* concerning: an allegation that **Woman Be2** was told that *if she did not stop calling for the toilet (member of staff* Z *) would kill her budgies;* **Man Be1**, was sworn at (by staff Z); **Man Be2** was subjected to swearing by staff Z and unsafe manual handling practice – *dragged regularly…not hoisted resulting in sore heels…had legs bent by staff Z causing him to scream out in pain*; **Woman Be3**, was subject to staff Z's swearing and abuse; **Man Be3**, was *taunted* by staff Z, calling him a '*perve'* and *making rude comments about his incontinence;* and **Woman Be4**, was *slapped* and subjected to verbal abuse (*police indicated that* although the *'slap' was* witnessed by a staff member *there was no evidence to pursue allegations of physical assault…not keen to take further allegations of verbal assault).* Following suspension, Puretruce Health Care Ltd dismissed staff Z in **September 2005**.

The Beeches' acting manager started to work night shifts.

Paul Black resigned as the Chief Executive (but subsequently worked on a month by month contractual basis) and the CSIW asked Dr P Das who was the nominated Responsible Individual.

Towards the end of **July 2005**, a relative complained about staffing levels which resulted in (i) **Man Be4**, waiting for an hour and forty-five minutes to have his incontinence pad changed (ii) residents *still at the breakfast table* after midday and (iii) carers still getting residents up after midday.

A meeting with **Torfaen Advocacy Service** was attended by two residents and 13 relatives confirmed how compromised The Beeches was as a home: *staff lacked proper training…were working excessively long shifts. They were bickering…protesting about not being paid…*they were *failing to provide proper care…displaying unacceptable attitudes* and the management of the home was *inadequate.*

South Wales Fire and Rescue Service made recommendations to Puretruce Health Care Ltd *in respect of fire risk assessment.*

During early **August 2005**, the acting manager left The Beeches and Torfaen CBC held a POVA strategy meeting *to discuss information held and prepare an action plan to identify how to manage the situation.*

A relative made an anonymous complaint about woeful staffing levels. When the CSIW visited, The Beeches *appeared to be in chaos.* The Inspectors asked how many residents were at the home and were told *26.* The CSIW Inspector asked the staff to recount and it was confirmed that there were *29 residents.* Furthermore, resident and personnel files confirmed endemic problems concerning the administration of residents' medication and unsafe staff recruitment practice (amounting to 13 breaches of regulation and four written notices of action required).The Inspector contacted Paul Black and the Clinical Nursing Director to emphasise their *grave concerns about the health and welfare of* residents. Discussions began with legal services. A visit by Torfaen LHB concluded that there remained *a number of very serious concerns.*

Paul Black reported to a **Torfaen CBC POVA** strategy meeting that *several members of staff had left The Beeches* and *there were difficulties in recruiting* staff and a manager. Also, the Clinical Nursing Director reported being *very concerned about the high levels of dependency of many of the residents* and since *the home was not geared up for this level, she asked what support could be offered to the home.*

Torfaen CBC and **Torfaen LHB** determined that *they would have to provide a support package for The Beeches for a limited period* and avoid closure.

Dr P Das wrote to the CSIW stating that senior management support was in place, i.e. *Matrons were responsible for running their own homes…no need for extra managers.*

A **Health and Safety** Officer visited The Beeches and found that gas boilers had not been serviced or safety checked. Also, tumble dryers were unsafe and two emergency fire escapes were faulty and dangerous. Repairs were undertaken at the end of August.

Gordon Cole[187] (who had been employed by **Puretruce Health Care Ltd** and **Caerphilly CBC** to address the failings at **Holly House**) visited The Beeches to undertake *an evaluation for business purposes.* He suggested *that a review should be carried out of the use of all of the accommodation and repairs, redecorations and improvements required*. This review should then, he said, be used *to prepare a phased plan to bring all areas of the home up to satisfactory standards and to ensure the most effective and efficient use of the accommodation for the future.*

At the end of **August 2005**, although Puretruce Health Care Ltd sought to transfer staff from other homes, CSIW issued a notice of proposal to cancel the registration of The Beeches; and **Powergen** demanded payment of £3,429.00 for electricity supplied to the home.

At the beginning of **September 2005**, **Corona Energy** again gave notice to The Beeches of the immanent disconnection of gas because of the non-payment of bills amounting to £6,873.00. Dr P Das disputed this figure but then accepted a *payment plan.* Between **September** and **October 2005**, Puretruce Health Care Ltd sent cheques to Corona Energy amounting to £23,818.00 but failed to discharge the debt in full.

A pharmacy inspection visit at the beginning of September made 12 recommendations.

Dr P Das hosted a meeting of residents' relatives which was also attended by members of Torfaen social services department and the Local Health Board. He explained that *because he would have to obtain the services of lawyers to pursue the appeal against cancellation of registration, there would be less money available to be spent on the home.*[188]

During the annual CSIW inspection, and irrespective of the temporary involvement of Torfaen CBC staff, residents' care plans were wanting and there was no staff supervision. The building

[187] *A policy adviser and representative for Care Forum Wales and an independent consultant providing advice to local authority and independent sector care providers,* (p2 of *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006)

[188] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

exhibited all the signs of inadequate maintenance, such as unusable wash hand basins, unrepaired sash windows, and exposed electrical wires. The South Wales Fire and Rescue Service issued an enforcement notice requiring attention to the fire alarm system *as a matter of urgency.*

When three members of a domiciliary care agency attended The Beeches at the request of Torfaen CBC to cover for staff attending manual handling training, they reported being appalled by the care practices. A member of staff disclosed that the home could not acquire necessary equipment for The Beeches because suppliers were not prepared to extend credit facilities.

Torfaen CBC held strategy meetings concerning the practice witnessed by domiciliary care staff: **Man Be5** was alleged to have suffered *neglect/physical abuse;* **Woman Be5**, was seen to fall against a toilet and her injuries were not checked; and **Woman Be6** was alleged to have been given medication which had been prescribed for another resident and was given a *digital manual evacuation.* The Local Authority and Local Health Board were to undertake a *joint investigation.* Three members of staff were suspended and then dismissed. The residents *denied that they had experienced mistreatment and the investigators felt that there was insufficient evidence to justify action against the staff. They were then reinstated.*

Torfaen CBC had a *contingency meeting re home closure* with the CSIW.

Puretruce Health Care Ltd's solicitor wrote to the CSIW identifying the *corrective measures undertaken by the company to keep it going on a long term basis.*

An anonymous complaint concerning *the unacceptable behaviour of* a *care assistant…. identified no grounds to discipline or sack.*

At the end of September, Dr P Das informed the CSIW that the Clinical Nursing Director *would be the acting manager of The Beeches with immediate effect.*

When **Man Be4** was admitted to hospital from The Beeches he was found to have *several pressure sores.* The Clinical Nursing Director disputed the suggestion that he had not received appropriate care and *a further investigation revealed that the pressure sores might have developed during an earlier stay in hospital. The problem was compounded by a lack of documentary evidence at The Beeches and was never properly resolved.*

Powergen asked Puretruce Health Care Ltd to contact them to discuss an outstanding debt of £4,443.00 and received no reply.

At the beginning of **October 2005**, Dr P Das requested a meeting with the CSIW Inspector *to discuss withdrawal of Notice of Proposal to Cancel Registration* in the light of remedial work undertaken and because *there had been an interest in the purchase of The Beeches* which was contingent on withdrawing the *cancellation notice.*

Four residents were the subjects of Torfaen CBC POVA strategy meetings; **Woman Be1** was found slumped against cot sides *and had sustained a red mark on her face…family wishes*

Woman Be1 *to remain in the home;* it was alleged that **Woman Be7** was moved by a carer and she fell, sustaining black eyes and facial bruising. Her family were *not prepared to make a statement* and reported that *the care staff look after* **Woman Be7** *well and it was just an accident;* **Man Be4** was *admitted to hospital with* a *chest infection* and *nine pressure sores* (the outcome of the investigation was that *evidence suggests that appropriate care was not given by staff at The Beeches);* and **Pearl York** was also admitted to hospital. It was her third visit. On the first *she had swollen feet. It wasn't clear what the cause was…On the second she had a blood sugar level of 1.* Pearl York had diabetes*...swollen feet and awful bedsores.* On this occasion she had *extensive bruising to* her *arms…and swelling to chest wall and back,* problems with her blood and a *black ulcer* on her foot. After her hospital treatment Pearl York's family moved her to another home. The outcome of the POVA investigation was recorded as: *evidence suggests that appropriate care was being delivered – bloods being monitored and system working well.*

Pearl York's family recalled that The Beeches was initially *brilliant.* It had *a Matron and a deputy Matron who were good and it was staffed by local people. Pearl York used to get her hair done and there were activities like tea dances. It was when the Matron and deputy left and they weren't replaced, and local girls started to leave, and then agency staff were in and out that it stopped being a good home…they just had children's TV on all day.* Pearl York's family recalled attending a meeting *where Dr* [P] *Das complained that Torfaen wasn't sending enough people and he wasn't making enough money. The family took the opportunity to ask why Pearl York had to be admitted to hospital because her blood sugar was so low, even though staff claimed that she had had tea and biscuits. He didn't try to explain. He wanted more residents. They observed that when you check a place out you don't expect standards to tumble so fast.*

A District Nurse visited The Beeches to attend to **Woman Be7** who was *suffering from necrosis of the foot and to provide advice and assistance to the nursing staff of the home…felt that the dressing…was less than optimal and that better treatment could be arranged…when* the District Nurse made another visit, *the nursing staff at The Beeches were using the same dressing as before.*[189]

A CSIW visit resulted in a written notice of action required.

Gwent Healthcare's Clinical Governance Manager reviewed residents' files at The Beeches and *found gaps and inconsistencies.*

The CSIW confirmed in writing to Dr P Das that the regulator was *not in a position to rescind the Notice of Proposal to cancel registration.*

In mid-October, the solicitor acting for Puretruce Health Care Ltd submitted a 30 page document containing *evidence in respect of matters referenced in the Notice of Proposal to cancel registration.* Ultimately these representations were not successful.

[189] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

Towards the end of **October 2005**, the relative of a resident telephoned the CSIW to express concern about *mixed messages* regarding the potential closure of The Beeches. The family *had been advised by a social worker to find an alternative placement.* Days later, letters from nine families were received *in support of The Beeches and the care provided.*

During **November 2005**, CSIW published their annual inspection report about The Beeches (see Appendix 2). This listed *200 action requirements to remedy breaches of the regulations ranging from the replacement of the lock on the* attic door *to the removal of oxygen cylinders from the area adjacent to the boiler room.*

Powergen served a *disconnection letter* and were informed that the bill would be paid within days. Although Powergen received a payment of £4,443.00 at the end of November, Puretruce Health Care Ltd *then failed to pay…further bills.*

In mid-November **Torfaen Local Health Board**'s Medicines Manager made a contract compliance visit to The Beeches and noted *no serious concerns* regarding *medicines management.*

During **December 2005**, **Lynne Neagle** AM wrote to **Rob Pickford**, the Chief Inspector of the CSIW, about the threat of The Beeches closing. By the end of the month the service remained *registered,* an inspection *identified regulatory breaches* and a written notice of action required was issued. The inspection revealed that the *unsatisfactory practice of washing commodes and pots in the bath was apparently continuing* [and]*…the fire doors did not fit properly.*

During **January 2006**, **Corona energy** notified the CSIW that they were again planning to disconnect the gas supply to *The Beeches and other homes because of the non-payment of bills.* (A hearing was fixed for **March 2006** but Dr Das' wife, Dr Nishebita Das paid the outstanding amount *using her personal credit card.)*

The CSIW wrote to Dr P Das informing him that *CSIW had concerns about Paul Black's ability to be the nominated Responsible Individual.*

The CSIW's Regional Director met with two relatives/members of *Friends of The Beeches* who sought to be *actively involved in the inspection of The Beeches.* It was explained that concerns about The Beeches had been *ongoing for years* and *there were so many breaches that the need to protect service users outweighed the reasons to keep the home open.* One member objected to reference to Dr P Das rather than Puretruce Health Care Ltd and told the Regional Director that they would hold her personally responsible *for pre-meditated manslaughter* if their mother died as a result of being moved from The Beeches.

At the end of January, **Torfaen CBC** led a food safety inspection which resulted in an improvement notice.

Dr P Das dismissed the concerns of the CSIW that Paul Black had asserted he would *continue as the valid responsible person for the company as Puretruce Health Care Ltd appointed him.*

During **February 2006**, CSIW drafted a briefing for the Minister for Health and Social Services about the *cancellation of registration.*

During a CSIW inspection the Clinical Nurse Director/acting manager made a recording of some of her conversations with an Inspector. Scrutiny of the personnel files of a nurse and care staff identified significant breaches of regulations with regard to references, CRB checks (including a failure to investigate a disclosed offence) and employment history. The Inspectors were informed that the required electrical work had not been completed *because the contractor had not been paid.* It was noted too that some sash windows remained defective and dangerous i.e. *repair requirements imposed by CSIW three years earlier therefore remained outstanding.* Furthermore, there was no *modern, electronic sluice* at The Beeches. The Chief Executive and the Clinical Nurse Manager *maintained that a manual sluice is just as well, if not better suited to the purpose of cleansing portable toilet equipment.* Gordon Cole confirmed at the hearing that *the provision of an electronic sluice at The Beeches would be appropriate.*[190]

In mid-February the Divisional Fire Safety Officer issued a further enforcement notice.

A review of the *systems of management and administration of medication at The Beeches* noted, *inter alia,* that *the previously condemned practice of borrowing medicines from the supply obtained for one user for use by another had not been entirely eliminated.* Furthermore, there was *serious failure* relating to the administration of medicines generally.

At the end of February, the CSIW's Regional Director wrote to Dr P Das stating that although there had been some improvement, this was *insufficient to justify* withdrawing the Notice of Proposal to Cancel Registration.

Torfaen CBC wrote to Dr P Das to inform him that the Council and **Torfaen LHB** were retaining their embargo on the placement of new residents because of *the financial uncertainty and instability.*

During **March 2006**, Powergen obtained an order authorising them to disconnect the electricity supply to The Beeches *for non-payment of* £2,260.00. The arrears were paid.

The two relatives/representatives of Friends of The Beeches submitted their *audit.* This asserted that the home's problems did not justify closure and proposed that the Inspectors were seeking *to get their own back for the reprimands they had relating to…Holly House.*

A POVA strategy meeting about **Woman Be3**, hinged on the non-administration of a *dose of antibiotic therapy.*

The ratio of registered nurses and care staff to residents exercised the **Health and Safety Executive**. Paul Black advised contacting the *manager at home.*

During **April 2006**, Gordon Cole visited The Beeches. The acting manager stated that she favoured supervising staff on the job. He drew her attention to the regulations and

[190] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

specifically, the *dedicated time* which should be devoted to supervision. He noted, *inter alia,* omissions concerning keys to the medicine cupboards and missing records concerning fridge temperatures. He reported that The Beeches was *a home with potential which is not being realised.*

During **May 2006**, the family of **Woman Be3** raised a concern that she had being *without dentures for three weeks* and *without glasses since Christmas…left at dining table for a long time after eating, clothes missing, not toileted regularly* and on *Mothers' Day* there was a *lack of staff with residents all congregated in staff room.* This was referred to POVA, the outcome of which was *inconclusive.*

A relative/Friend of The Beeches informed the CSIW that staff had *not been paid in full and that Paul Black had explained that this was because of late payment by Torfaen LHB….Members of staff* reported that they *were not happy with the non-payment of their wages.* They had *been told nothing by Puretruce Health Care Ltd and would not continue to work in the home indefinitely if promises to pay their wages were not honoured.* A carer left *as a result of the delayed payment.* [191]

The Care Standards Tribunal's hearing concerning Holly House and The Beeches commenced.

The hearing dates of the Care Standards Tribunal continued during **June** and **July 2006**.

During **August 2006**, the CSIW asked Dr P Das about the management arrangements for The Beeches. He replied that [a named doctor] *intends to take over The Beeches in a few months' time.*

A POVA referral was made concerning **Man Be5** *over quality of care and possible financial abuse.*

The acting manager of The Beeches withdrew her application for registration as manager.

Paul Black apologised to the CSIW inspectors who received *a slow handclap welcome from staff* and relatives when they visited at The Beeches.

The Notice of Decision to Cancel the Registration of The Beeches was upheld by the Care Standards Tribunal's hearing during **September 2006** and the transfer of residents began.

Paul Black ceased to be the Responsible Individual.

During **November** 2006, the CSIW advised the **General Medical Council** of the outcome of the Care Standards Tribunal's hearing. Dr P Das requested a copy of the CSIW's *information sharing protocol and copy of* the *letter sent to GMC.*

[191] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006

Mountleigh Bryngwyn Care Home

This 42 place home received registration approval in **1995**. It was registered to provide nursing care for *younger and older people with dementia.* During **May 2000**, the Bryngwyn Unit was de-registered.

In **2002**, the home's Registered Provider was **APTA Healthcare UK Ltd** which was a subsidiary of the **Southern Cross Healthcare Group**. The Responsible Individual was Mary Davis and the Manager was Enda Evans, whose registration remained to be determined with the **Care Standards Inspectorate for Wales** (CSIW).

During **February 2002**, concern was expressed about the neglect of **Woman M1**. Her relative complained that Woman M1 had *been left to walk unaided,* she had fallen and died. The investigation report upheld the fact that she had walked unaided. The home drafted an action plan in response to the complaint investigation.

During **April 2002**, a relative of **Woman M2** expressed concern about her continence management. The CSIW *passed* this back to the *care home for local resolution.*

An Inspection Report was published during **July 2002** (see Appendix 2) and another in **December 2002**. The latter identified *29 requirements outstanding and 22 new requirements* were issued.

During **August 2002**, the CSIW received a Notice of Proposal *to determine registration* so as to provide *39 dementia nursing* places and three *dementia personal care places for older and younger adults.*

During **November 2002**, the CSIW attended a *multi-agency strategy meeting regarding the alleged abuse of residents between 1995 and 1999…serious allegations were made by a former* employee i.e. *that residents had been assaulted* and restrained; a resident's fingers were *deliberately broken and another resident* was *punched several times.* Although **Gwent Police** investigated and *found no evidence to support the allegation…a possibility of restraint being used* was acknowledged. However, there was *insufficient evidence* to prosecute.

During **March 2003**, the relative of a woman who was a temporary resident contacted the CSIW to express concern that after three days at the home she had fallen and died two weeks later – and the family were being charged for 19 days' respite. During **June 2003**, concern was expressed to the CSIW about **Man M1** falling, the associated *risk assessments* and the *attitude of a nurse on duty.*

An Inspection Report was published during **September 2003** (see Appendix 2). The inspectorate issued 33 requirements.

In **October 2003**, Enda Evans withdrew her application to register as the home's manager.

During early **2004**, Dawn Harris applied to the CSIW to register as the Manager. An inspection resulted in a *Written Notice of Required Action* about radiator covers.

During **May 2004**, an Agency Care Assistant wrote to the CSIW about *manual handling*. The outcome of the resulting investigation is not known. Also during May, a relative of **Man M2** wrote to the CSIW about his neglect, *dramatic weight loss, delays in seeking medical advice and treatment.* **Man M2** died six days after being admitted to hospital. The Inspectorate issued three requirements.

Resident **Alan Sayers** died during **September 2004**.[192] [193] The circumstances of his death were investigated by the police.

During **November 2004**, Jennifer Heath applied to the CSIW to be the Responsible Individual. An Inspection Report was published during **December 2004** (see Appendix 2). This set out 22 requirements.

During **April 2005**, the husband of **Woman M3** alleged that his wife required close supervision since she was at risk of falling. Although he had informed staff of this risk, Woman M3 had fallen and fractured her hip. He had also brought to the carers' attention an occasion when she had been *left in the cold.* The matters were referred to **Protection of Vulnerable Adults** (POVA). In a resulting case conference, the provider offered Woman M3's husband *assurances about his wife's care.*

During **June 2005**, the home submitted a Notice of Proposal to vary the registration. It sought to register the Bryngwyn unit and confirmed that Enda Evans was to be the Manager. The CSIW issued a Notice of Determination to vary the conditions, that is, Mountleigh and Bryngwn were registered and Enda Evan's registration remained *to be determined.* An Inspection Report was published during **July 2005** (see Appendix 2). This listed 11 *outstanding requirements* and 31 new requirements.

Also during July, there were two expressions of concern. One was raised by the family of **Man M3**. It was alleged that he had lost around four stones in weight in the 11 weeks he had been at the home. This *complaint* was *not upheld* by the CSIW.[194] He had been nursed in a bed without bedrails contrary to a risk assessment. This *complaint* was *partially upheld.* On an occasion that a relative had found Man M3 *in pain and distressed,* the carers were asked if an ambulance had been called. There were two members of agency staff on duty looking after 40 residents - and their first language was not English.[195] Having been told that *it had*, two hours later the relative instructed the carers to ring 999 once again. The *agency staff couldn't open the front door* because they *did not know the key codes and they could not turn off* the *fire alarms which had been activated. When the ambulance service finally arrived, they were appalled at Man M3's condition and the chaos in the home and said that they would be*

[192] http://news.bbc.co.uk/1/hi/wales/south_east/8404240.stm (accessed on 3 November 2014)

[193] http://www.southwalesargus.co.uk/news/neglecttrial/3778005.print/ (accessed on 3 November 2014)

[194] The recorded weight entries confirmed an overall weight loss of 1st 4lbs and the investigation confirmed that Man M3's reluctance and refusal to eat resulted in three referrals to a GP. He was prescribed and given supplementary drinks

[195] It was *recommended that the home's recruitment process should place greater emphasis on staff's ability to communicate in the service user's native tongue*

reporting the home to the GP. The relative had been asked to *sit and mind* the residents. This *complaint* was *partially upheld.* Although there had been a POVA referral, since the outcome of the POVA investigation had not been shared with the family, permission was obtained from **Caerphilly CBC** to reflect the findings in the complaint investigation.

The second expression of concern was about **Woman M4**. During a morning visit a relative was informed that Woman M4 had been given medication because she *was up and down…hadn't eaten…had been sleepy.* She had been *heavily sedated* on admission to hospital that evening. The hospital was informed by the home that she had fallen that morning. Woman M4 was found to have *hip and pressure* wound *damage* and was in so much pain that morphine had been administered. There had been no one from the home to escort her to hospital. The Manager of the home was asked to investigate. This *complaint* was *proven* and *improvements in policy and practice were said to be being implemented.*

During **September 2005**, concerns were expressed about two more residents. **Man M5** was one of 10 people who had been transferred from Holly House Care Home (which itself had been subject to an emergency cancellation order). He was admitted to hospital with bronchopneumonia, dehydration and renal failure and died four days later. The allegations were investigated by a LHB consultant nurse and *systemic failings* were noted on the part of the home. The CSIW issued requirements concerning improved staff induction and training for *overseas staff; reduction of high usage of agency staff;* their deployment i.e. *agency staff to work alongside permanent staff for continuity;* and Mountleigh Unit and Bryngwyn Unit *to each have a care manager.*

During **October 2005**, a whistle-blower employed at the home emailed the CSIW to inform them of residents' poor *personal care, lack of bathing, a resident* who was *dropped when hoisted, nurses* who were *poor at dressing wounds, poor infection control, no activities* for residents, *poor staff morale* and *inadequate breakfasts* for residents who were *late risers.* The information was shared with **Gwent police**.[196]

Also during October, a concern was raised by the Royal Gwent Hospital about **Gladys Elvira Thomas**.[197] She had been admitted with breathing difficulties and *fractures to her clavicle and ribs, dislocated shoulder and extensive bruising to right side and groin*. There was a POVA strategy meeting which *determined that there was no apparent evidence to suggest that she had fallen at the home…Transfer documents from* a hospital visit at the beginning of October *indicated that she had fallen in hospital…sustaining grazing and bruising.* Her circumstances were *investigated under Operation Jasmine.*

Finally, during October 2005, concern was expressed about **Woman M3** by an employee who had witnessed her being slapped by a nurse who was also employed at the home. It was alleged also that the residents' *wound dressings* were *not changed,* there was *poor post-fall*

[196] The records do not indicate that the CSIW was informed of the outcome

[197] See summary of BBC Radio 4's *File on Four* – Appendix 1

monitoring, poor supervision of residents at night, that *two residents had been shut in a lounge* during a night shift without lights, and that *a resident had been pushed from one room to another.* The CSIW assisted the police with their investigation and *abuse was proven.*[198] The CSIW provided documents to the police about 13 Mountleigh Bryngwyn residents.

During **November 2005**, three residents came to the attention of the CSIW, **Woman M7**, **Woman M8** and **Woman M9**. A hospital expressed concern about **Woman M7**. *On admission she presented as having very severe dehydration and oral thrush to the extent that she was unable to swallow…had to receive intravenous antibiotics and fluids and had hourly oral care. She had pressure area to sacrum.* Her family confirmed that she *had become totally immobile in the eight week period she had been at the home.*

The family of **Woman M8** expressed concern that the home delayed seeking medical attention. She was hospitalised on two occasions, once for dehydration and high blood pressure and secondly for back pain. The CSIW informed the POVA strategy meeting that *there were no grounds for emergency closure* but monitoring at the home would be increased and the regulator would work with the LHB *to address pharmacy issues.* The police led an investigation.

During **December 2005**, concerns were expressed about seven residents, **Man M6**, **Man M7**, **Man M8**, **Woman M10**, **Woman M11**, **Woman M12** and **Woman M13**. The three men were admitted to hospital: Man M6 *with dehydration, kidney failure and…respiratory tract infection.* Recommendations were made in a POVA action plan*;* Man M7 was admitted *with severe dehydration, several pressure areas and several bruises on buttocks and hands.* This was investigated under Operation Jasmine; and Man M8 was admitted with *a suspected stroke and scabies*. This was investigated under Operation Jasmine.

Woman M11 was *found on her bedroom floor* with another resident in her room. The home was to conduct *an internal investigation.* Woman M12 was admitted to hospital with *possible pneumonia…dehydration…broken area noted on sacrum…no dressing in situ and no mention of broken area in transfer documents*. A relative witnessed *an agency carer slapping* Woman 13. The outcome of a referral to POVA was not known to the CSIW.

Also during December, the acting Manager resigned and the registered Manager was suspended.

At the beginning of **2006**, serious concerns about this home persisted. The circumstances resulting in **Man M9**'s admission to hospital were bizarre. A nurse claimed to have revived him *using CPR* and yet on admission to hospital he was treated for dehydration. No discharge information was provided and the case was not investigated under Operation Jasmine.

Also during **January 2006**, an employee witnessed a colleague *flicking a flannel at* **Woman M3**'s *face – to stop her spitting*. The member of staff was suspended and referred to the POVA

[198] It is not clear what *proven* means in this context nor to what alleged incidents it refers

list.[199] Also, **Woman M3**'s husband was *alleged to be giving his wife medication (Asprin).* This was reported to POVA by the manager.

In **February 2006**, the police investigated *inter alia,* the *poor personal care re bathing* experienced by **Woman M4**, and poor levels of *resident supervision* generally. Also, **Woman M13**'s sister was observed slapping her sister as she assisted her to eat. A POVA visit resulted in subsequently supervised visits.

APTA Healthcare UK informed the CSIW of the home's change of name. It was to be known as **Mill View House** and Lodge. Enda Evans was *to be determined* as the Manager.

During **May 2006**, a whistle-blower from an employment agency reported that residents were up and dressed before 5.00 in the morning; that care during the night was *poor*; and that manual handling practices were *poor.* There was a POVA strategy meeting. Also, it was alleged that an agency nurse physically assaulted **Woman M3**. A verbal warning resulted.

In **August 2006**, the CSIW received expressions of concern about a resident who was *screaming all night.* The resident was *reviewed by* a *GP* who *altered* the resident's medication. Also, **Woman M14** alleged that a male carer *struck her across the face when she asked to use the toilet.* The police investigated.[200] It is not clear whether any further action was taken. At the end of August a whistle-blower reported several concerns. Those which were investigated and *upheld* included *poor infection control…lack of staff…lack of appropriate pressure care…*inattention to residents' *hygiene…faeces caked under fingernails.* The CSIW issued 14 requirements.

By **September 2006,** the CSIW acknowledged to a *multi-agency meeting* that *standards* at the home were *declining.* A further whistle-blowing notification raised concerns about *the attitude and performance* of a senior member of staff and the *lack of action when concerns are raised.* The senior member of staff resigned.

During **October 2006**, the person who had sought to register as the home's manager was suspended since he had failed to disclose a Criminal Records Bureau conviction.

In **November 2006**, the CSIW contributed to a multi-agency meeting convened *to address the improvements needed.* Also during November a whistle-blower expressed concern about the management of **Woman M15**'s money and the fact that generally, *residents' money was being pooled to pay for a chiropodist.*

During **December 2006**, the CSIW received a Notice of Determination to Vary Conditions and provide a service to *one younger adult.* Also, the home confirmed that an acting manager was in place.

[199] A list of care workers who have harmed vulnerable adults in their care

[200] The records do not indicate that the CSIW was informed of the outcome

There were expressions of concern addressed to the CSIW about four residents during **January 2007**. These included an allegation that **Woman M16** had been pushed by another resident and had sustained a fractured pelvis; and that **Woman M17** had sustained *pressure damage to both heels* and had no pressure relieving equipment. A POVA strategy meeting was convened; **Woman M18** was slapped by an employee *on the back of her hand.* The carer was dismissed and referred to the POVA list. No action was taken by the police *on the advice of CPS;* **Woman M19** witnessed Woman M18's slap and objected to the employee who responded: *I could fucking slap you sometimes too.* The CSIW received a complaint about the acting manager concerning the *disposal of controlled drugs, wearing inappropriate clothing, swearing and shouting at staff in front of residents, 'making up' records prior to a CSIW visit, care staff being made to carry out domestic and kitchen duties,* and *being absent from the home despite being on rota.* These matters were investigated by a Southern Cross manager.

During **February 2007**, the CSIW received an action plan from the home and an Inspection Report was published during the same month (see Appendix 2).

During **March 2007**, an agency care worker raised concerns with the CSIW. Two were upheld: *the protracted* length of time it took to administer residents' night medication and the failure to inquire *how residents fell.* The *provider agreed to address* these matters *through performance management and supervision.*

During **April 2007**, the **Care and Social Services Inspectorate Wales** (CSSIW) received expressions of concern about **Man M10** and **Woman M20**. The husband of a resident had threatened to *kill* a male resident *if he entered his wife's bedroom* and he requested staff to *lock* his wife in her room. The same man slapped **Woman M20** and shouted: *Go away.* He had been observed *pushing and shoving* Woman M20 on *numerous occasions.* The staff were *monitoring the situation* and a referral was made to POVA.

In **May 2007**, CSSIW received an application from a prospective manager to register and registration checks began.

During **June 2007**, the CSSIW received expressions of concern about **Woman M21** and **Man M11**. The former had sustained bruising to an eye, she was not being given thickened fluids, her scalp was scaly, she had faeces under her nails and staff were not assisting her to uncross her legs. The CSSIW *referred to the home to resolve the issue.* Man M11's family *complained about the poor treatment* he had received. This was also referred back to the home for *local resolution.*

During **September 2007**, a whistle-blower *raised concerns about a carer who was rough with residents,* used foul language and made physically threatening gestures. This was investigated by a POVA coordinator and Southern Cross managers. The member of staff *returned to work under supervision* since *there was no apparent evidence to substantiate the allegations.*

An Inspection Report was published during **November 2007**. This was positive, listing four outstanding requirements and five new ones.

In **December 2007**, the CSSIW received expressions of concern about six of the home's residents. Staff informed a visiting Occupational Therapist that since **Woman M13** *did not like the hoist* the staff lifted her. Although this was subsequently denied by a senior member of staff, a POVA investigation *upheld* the concern. When **Man M12** became dehydrated the GP was called and a rapid response team set up subcutaneous fluids. The team gave *specific instructions* which were not followed and Man M12 died two weeks later. A nurse was dismissed and referred to the **NMC** and the **POVA list**.[201] The family of **Woman M22** believed that she had sustained bruises because when they visited she was *blue.* However, she was wearing only a short sleeved top and was very cold. Furthermore, her eyes were sore and her gums *split.* The CSSIW visited and 14 requirements were issued. It was a local authority monitoring visit that triggered similar concerns about **Woman M21**, **Woman M23**, **Woman M13** and **Man M13**. They were left without drinks, pressure relief and continence care. Since staff *falsely* recorded that these tasks had been undertaken, this was investigated *under the POVA process and all elements upheld.*

The beginning of **2008** was unpromising with expressions of concern received about three residents. Relatives of **Woman M24** noted that she had sustained heavy bruising to her face and that another resident was wearing her slippers. She had a *history of falls.* The family sought **Continuing Heath Care** funding for one-to-one supervision. There was a POVA investigation. The family of **Woman M25** wanted her to be cared for *entirely in bed.* This was investigated by the Local Health Board and the local authority. A visit by an Inspector during **February 2008** resulted in 14 regulatory requirements.

The CSSIW noted that a police inspector attending a POVA strategy meeting *determined that there was insufficient evidence for them to proceed…*but that *there* was *evidence of poor standards in the home which CSSIW* were *best suited to address.* A manager at the home resigned.

During **February 2008** the CSSIW issued 12 requirements. Towards the end of the month **Woman M27** fell and was assisted to stand by staff. The following day her foot was swollen and a GP was called. The hospital determined that she had a fractured femur. The home agreed to investigate the matter and they informed the CSSIW that they were putting a *voluntary suspension on placements to Mill View House* but not Mill View Lodge.

In **March 2008** a visiting social worker noted that **Man M14** was in an armchair in a corridor, facing the wall. He attempted to stand but was unable to do so. An employee explained that *he had put himself there when he had been aggressive.* The staff did not see this as restraint. A POVA investigation deemed that the event was suggestive of *poor practice issues* rather than *abuse.*

During **April 2008** concern was expressed to the CSSIW about six residents. **Woman M4** was *soaked in urine and* was wearing the clothes she had been wearing the previous day. This was

[201] Information provided by the CSSIW

investigated by the provider…*all elements of the allegation were upheld* and the staff concerned were disciplined. It was alleged that an employee told **Woman M28** to: *Shut up. I can't stand you anymore. You're getting on my fucking nerves.* This employee lifted Woman M28 onto her bed without using a hoist explained to a colleague that: *It's OK – she's only light.* The employee said to Woman M28: *This is what you get for being naughty.* This was investigated by POVA and *all areas of concern were upheld.* The carer was dismissed and referred to the POVA list. Manual handling was also the focus of a concern expressed by an occupational therapist. Staff were not aware that **Man M13** had Parkinson's disease. A POVA investigation determined that there were *some practice issues to be addressed.* **Man M13** was associated with a further expression of concern since he shared a room with **Man M15**. It was believed that they had had an altercation and both sustained bruising.

Also during April, concern was expressed by the family of **Woman M14** that she had lost weight. The staff explained that *she wouldn't eat anything and they didn't have time to feed her.* When she was admitted to hospital she was dehydrated and had diabetic complications. The cause of her death was *pneumonia and dementia*.

A friend of **Woman M30** raised concerns about her distress and threats to self-harm unless she was *allowed home.* Furthermore, Woman M30 was not getting the 200 cigarettes a fortnight that her friend was delivering to her. This was *not progressed to POVA* since it was *considered as a care management issue.*

During **June 2008**, it was noticed that **Woman M26** had a swollen wrist. Since it was no better 24 hours later and she was in pain a GP was called. A fractured ulna was diagnosed and she went to hospital. This was *considered under the POVA process and* was *referred to the Local Health Board to investigate.* Since the findings were *inconclusive* it was *referred back for the* home *to case manage*.

An embargo on places was *conditionally lifted,* that is, *no respite care to be offered, fortnightly monitoring* and support for the Manager in *deciding who will be admitted.* During **July 2008**, the CSSIW received a Notice of Proposal to reduce numbers at the home from 62 to 61.

During **September 2008**, the CSSIW issued a Notice of Decision to vary the registration conditions i.e. to reduce the numbers of residents to 61. There was an expression of concern about **Man M16**. He was *found tied by the arm to the bed with a sheet.* Two members of staff were implicated and the incident was referred to POVA. The outcome was not made known to the CSSIW.

An Inspection Report was published during **October 2008** (see Appendix 2). Also during October, concern was expressed about **Woman M16**. She was pushed by **Woman M13** and **Woman M16** sustained a fractured hip. This was addressed initially as a *POVA concern* and was subsequently passed back to the care home to *case manage.* The women were re-accommodated in single rooms rather than continuing to share a bedroom. An Inspection report was published. This listed an outstanding requirement and two new ones. The CSSIW registered a manager.

There were expressions of concern about five residents during **December 2008**. **Woman M31** and **Woman M34** attended hospital separately, both had severe bruising. **Woman M31** had a fractured humerus and hospital staff *reported* that **Woman M34**'s bruises *appeared to be due to unnecessary force.* Both were dealt with under POVA and the outcome for both was *inconclusive.* A similar outcome resulted from the investigation of **Woman M32**'s UTI, inactivity, unmanaged constipation, swollen nose and eyes. Her family were concerned that medical attention had not been sought for her. **Woman M33** was drag lifted by a member of staff and the same employee had *refused to give thickened fluids to* **Woman M24**. The member of staff resigned prior to a disciplinary hearing.

At the beginning of **2009**, **Man M17** fell and injured his groin. Hospital staff noted new and old bruising and raised concerns that he had bruising around his genitals which were *thought to be non-accidental.* The ambulance staff reported that the *staff at the home had been unhelpful*. The outcome of the POVA investigation was *inconclusive.*

During **May 2009**, ambulance staff expressed concern that **Woman M35** was *found flat on her back when she was in obvious respiratory distress. The nurse on duty was unable to give information as her English was so poor.*

An Inspection Report was published during **July 2009** (see Appendix 2). No requirements were made.

In **August 2009**, **Woman M36** made allegations of physical assaults by three male residents. At the suggestion of the POVA team this was *investigated by the provider.* It was concluded that the evidence was inconclusive.

Later during the year a temporary manager at the home went on secondment and the CSSIW received an application *to register as manager.*

Grosvenor House Nursing Home

Grosvenor House Nursing Home in Blaenau Gwent was registered by Gwent Health Authority to Dr and Mrs SM Uzair Subzwari and Dr and Mrs SK Narang of Lightend Ltd. It had operated since 1993 and was initially registered to provide *42 general nursing beds.* During **2001**, Gwent Health Authority issued a certificate to register Lightend Ltd *to carry on Grosvenor House in the categories of 38 general medical beds and 4 terminal care beds.* Mrs Susan Goode (later known as Susan Reynolds) was approved by Gwent Health Authority as Matron of the home. During **2002**, the home's Registered Provider was Lightend Ltd, the Registered Individual was Dr Satish Narang and the Registered Manager was Susan Goode. Attention to staffing was a condition of the **Care Standards Inspectorate for Wales**'s (CSIW) registration. An Inspection Report was published in July 2002 (see Appendix 2).

During **2003**, there was an announced inspection, a follow-up visit and an unannounced inspection.

During **2004**, a complaint was received concerning the verbal abuse of **Man G1** by a member of staff. The outcome of this is not known. An Inspection Report was also published during the year which set out 43 requirements. There were six inspection visits during the year. The CSIW wrote to the Manager on five occasions to arrange a *fit person interview* as part of the *ongoing registration process.* An Inspection Report published at the end of **2004** identified *28 new requirements.*

In **May 2005**, the wife of **Man G1** made a complaint which was *investigated under the* **Protection of Vulnerable Adult** (POVA) *process and CSIW process*. This resulted *in recommendations.*

During **August 2005**, Dr Narang wrote to inform the CSIW of the resignation of the Manager, who was not registered with the CSIW.

At the end of the year a Registered Manager application was received. A Notice of Determination was issued to vary the registration from a *total of 42 persons, including 38 nursing and 4 palliative to up to 42 older persons nursing care, up to 4 older persons with palliative care needs and up to 8 older people with personal care needs.* An Inspection Report was published (see Appendix 2).

At the beginning of **2006**, the Registered Manager applicant *declined the position* and Dr Narang informed the CSIW that Susan Reynolds would be the Manager. She was sent an *application for registration as a manager* pack.

During **January** and **February 2006** there were three CSIW inspection visits and 44 requirements were made. A report published in **April 2006** identified *29 new requirements* and *12 outstanding requirements.*

During **July 2006**, **Dorothea Hale** was admitted to Grosvenor Nursing Home.

During **November 2006**, **Woman G3** fell from her wheelchair *whilst left unattended.* The home issued *a final written warning to* a *staff member.*

Also during November, **Dorothea Hale** was admitted to hospital with severe multi-site pressure ulcer damage. A POVA alert *was raised by staff at Nevill Hall Hospital* and a police investigation began.

Dorothea Hale's daughter had been informed during September 2006 that her mother had a pressure sore in her sacrum area. Since this was small and excoriated her daughter trusted the staff to give the appropriate treatment. Shortly afterwards, she was led to believe that the sore had healed and her mother was back in her chair. Although concerned that her mother had developed a pressure sore on her ear, her daughter believed that the nursing home would provide the appropriate treatment. Days later she visited and her mother was being nursed in bed. She had diarrhoea and there was a horrendous smell in her room. There was a fan, the windows were fully open and an air freshener had been sprayed. The smell originated from the pressure wound to her sacrum. Professor John Saunders[202] examined Dorothea Hale and he described this wound as the largest, deepest and most offensive smelling wound he had seen in his career. Furthermore, she was dehydrated and malnourished, her PEG tube was blocked and filthy and she had sepsis. She had not had a pressure relieving mattress until two weeks before her admission to hospital.

The Police and the CSIW contributed to the POVA strategy meetings and further placements at the home were suspended by **Blaenau Gwent CBC**. There was an unannounced *monitoring visit* by the CSIW during **December 2006** which resulted in *14 requirements*.[203] There was only one qualified nurse on duty *which contravened the conditions of registration of the home. A letter to Dr Narang outlined the findings…and identified 14 requirements, 8 with immediate effect. An action plan was required by the end of the year.* Nurse assessors reviewed all the Grosvenor House residents' *nursing care provision.*

At the strategy meeting the CSIW fed back the concerns identified during the **February 2006** inspection, *a number of which mirrored those found by social services.*

During **January 2007**, **Dorothea Hale** died and a Home Office pathologist was appointed to undertake a post-mortem examination.

By **February 2007**, an Inspector visited, there had been five POVA strategy meetings and *progress against* the home's *action plan* was *explored with* Lightend Ltd *and the Manager.*

During **March 2007**, an Inspection Report was published (see Appendix 2). The CSIW requested access to the documentation seized by Gwent Police and Blaenau Gwent Social Services *to initiate further enforcement action.* Irrespective of *repeated requests* by CSIW for documentation necessary to prosecute, the six month timescale the CSIW required elapsed.

[202] A Consultant at Nevill Hall Hospital

[203] An initial review of documentation by the social services highlighted concerns such as tissue viability, wound care, nutrition and the management of PEG feeds

Also during March, **Man G3** was the subject of a POVA referral by the CSIW. He was suffering from *pressure* wound *damage* to both feet *and weight loss – he had lost 12 kg in one month.* Although *reddening on his feet had been noted by staff* during early February, *no wound care plan had been created until* March. The Deputy Manager was suspended. Man G3 had not been referred to a dietician and pressure relieving equipment was not used.

During **April 2007**, at the sixth strategy meeting concerning Dorothea Hale, the new body, the Care and Social Services Inspectorate Wales (CSSIW) reported their *possible intention to propose to cancel* Grosvenor's *palliative care bed category and cancel* the *registration of the manager.* This was confirmed in a meeting with Drs Subzwari and Narang during **May 2007**. Also, the Manager's registration was cancelled.

During **June 2007**, Lightend Ltd, the registered provider, was issued with a notice removing their palliative care provision, and a potential manager did not proceed through the registration process.

During **October 2007**, **Woman G4**, about whom there were allegations of *neglect/ pressure damage/ management / access of equipment* was referred to the CSSIW. No strategy meeting was held.

At the beginning of **2008**, the CSSIW determined that it could not proceed with a prosecution because of the long delay in establishing the cause of Dorothea Hale's death.

During **February 2008**, there was a POVA referral concerning a resident alleging verbal abuse by a staff member. The POVA was during **April 2008.**

An Inspection Report was published during **September 2008** (see Appendix 2).

An Inspection Report was published during **August 2009** (see Appendix 2).

Belmont Residential Home

Belmont was registered with mid-Glamorgan from **1983** but during **April 2002** it became registered with the **Care Standards Inspectorate for Wales** (CSIW). The registered providers were Mr and Mrs Bentley. The certificate of registration indicated that Belmont was to provide for *up to 17 older persons within the categories of dementia/mental infirmity or physical disability.* It was not registered to provide nursing care.

During **June 2002**, the South Wales Fire Service *identified five areas of remedial work required* concerning the fire alarm system and *fire routines.*

During **October 2002**, the conditions of registration were confirmed with Mrs Bentley as the Registered Manager. An announced inspection identified 51 regulatory requirements and five good practice recommendations.

In **March 2003**, an unannounced inspection confirmed that staff training had been booked *in first aid, moving and handling and fire safety.* An action plan was requested since *there were a number of items highlighted at the time of the announced inspection that had not been completed.*

During **June 2003**, the South Wales Fire Service made some *minor recommendations.*

During **August 2003**, an announced inspection identified 17 regulatory requirements and four good practice recommendations. The home was advised that one resident required immediate re-assessment and that out of date reviews for all residents should be remedied.

There is no additional information concerning South Wales Fire Service's correspondence with the home or the CSIW's two inspections during **2005**.

During **April 2006**, there was a **Protection of Vulnerable Adults** (POVA) referral concerning the alleged neglect of **Woman Bm1**. *It was noted that the carers were not using correct moving and handling procedures or the correct equipment when transferring residents. A carer was observed using a stand aid with a belt that was too big for Woman Bm1…wound healing was affected by poor moving and handling…risk assessments had not been updated. The District Nurse reported that other residents also experienced injuries to their shins and shear marks to their skin.*[204] The CSIW contributed to the strategy meeting and a written notice of action required was issued. There was a follow-up visit, another inspection and correspondence from the South Wales Fire Service during 2006.

During **April 2007**, the **Care and Social Services Inspectorate Wales** (CSSIW) received notification about the sale of Belmont. In **May 2007**, an application was received from (i) **Expanding Horizons** to be the provider and (ii) Timothy Jenkins to be the Responsible Individual. The registration process was then begun.

[204] A recurring theme in inspection reports between 2002-2006 was a *lack of assessment for falls and cot sides*

During **July 2007**, the CSSIW received a letter from the provider detailing *the outcome of a comprehensive review of the quality of service provided,* including an action plan.

Expanding Horizons alerted the CSSIW to the lapsed Criminal Record Bureau certificates of staff; to the 'cash in hand' payments made to staff; and to the false information given to CSSIW Inspectors and others. Subsequent scrutiny by the CSSIW identified residents whose care and support needs exceeded those which could be considered residential care being supported by staff who had become desensitised to the behaviour of troubled residents. For example, Belmont accepted responsibility to care for a resident with schizophrenia without seeking a variation in registration. In addition, there was a high volume of unexplained injuries, none of which were reported to the CSSIW. Further significant deficiencies included numerous failures to access medical advice and treatment for residents promptly; failing to revise residents' care plans taking account of diagnoses such as diabetes; ignoring the local authority's assessments of residents; administering medication covertly; giving the medication prescribed for one resident to another resident; telephone prescribing; and running out of dressings for residents with pressure ulcers.

In **August 2007**, the CSSIW received confirmation from Mrs Bentley of the cancellation of registration and a letter confirming that Belmont remained *financially viable.* **Expanding Horizons** submitted its Notice of Proposal to Register, that is, to provide a service to *up to 15 older people over 65 years with a mental infirmity or physical disability* – but reducing *to 14 older people over 65 years when one person moves on.* The home was not registered to provide nursing care. Notice of the decision to register was issued at the end of August.

Also at the end of August there was a POVA referral from a local authority Occupational Therapist concerning **Woman Bm2**. She *sustained a fracture as a result of being moved from a wheelchair by a fellow resident…professionals raised concerns re lack of footrests* on wheelchairs and the *need for urgent moving and handling risk assessment.* Subsequent inquiries revealed *more generic failings* concerning the *availability of equipment, staff training, staff CRBs* and *insufficient bathing facilities.*

In **September 2007**, a CSSIW Inspector visited in the light of the *high level of dependency of residents and lack of CRB renewals.* Referrals were made to Caerphilly CBC's safeguarding team. *Eighteen service users were initially identified as having suffered neglect/abuse* and *the home was placed under* the *provider performance protocol. A criminal investigation resulted in a prosecution of the former registered providers, Mr and Mrs Bentley.* CSSIW's Regional Director wrote to residents' families offering them a debriefing session. Caerphilly CBC reassessed all residents and the process included mental capacity assessments.

Also during September, concern was raised about **Man Bm1**'s *symptom control, lack of ongoing assessment and care planning…allegations of neglect.* A criminal investigation was undertaken.[205] Two further POVA referrals similarly made allegations of neglect. **Woman**

[205] The CSSIW has no record of the outcome

Bm1's death featured in *part of a larger POVA process and* was investigated by Gwent Police. The Manager suspended a carer for moving and handling **Woman Bm3** *inappropriately.* At the strategy meeting it was agreed that there should be an *independent OT investigation* and that *risk assessments and care plans* should be in place.

At the end of September there was a POVA referral concerning **Women Bm4**, **Bm5**, **Bm6**, **Bm7**, **Bm8**, **BM9**, **Bm10** and **Bm11**. [206]

During **October 2007**, Caerphilly CBC hosted a meeting to *look at actions and progress against the action plan…at Belmont Care Home.* Also, it was determined that Belmont should *close for refurbishment and re-open with the same categories of registration.* At the end of the month, there were POVA referrals concerning (i) **Women Bm2**, **Bm3**, **Bm4**, **Bm5**, **Bm6**, **Bm7, Bm8**, **Bm9**, **Bm10**, **Bm11**, **Bm12** and **Bm13** and (ii) **Men Bm1** and **Bm2**. The allegations concerned *neglect, physical, emotional and psychological abuse.*[207] The CSSIW gave the provider the *option of closing voluntarily with immediate effect pending notice being served.* Had this option not been accepted the regulator would consider issuing a *notice of urgent closure.* The provider agreed to give notice to close voluntarily. Caerphilly CBC hosted a provider performance meeting *to discuss the vulnerable adults residing at the home and the ongoing support needed from all agencies to support them.*

Caerphilly CBC stated: *although the home had closed, Caerphilly CBC coordinated ongoing meetings with **CSSIW** and **police** between **November 2007** and **2008** whilst CSSIW prepared for a prosecution. However, a **police** decision as to whether there would be a formal investigation remained on hold…*

By **December 2007**, the CSSIW were considering *alleged failures* occurring between **2005** and **2007** *in respect of:*

- *Promoting and making proper provision for the health and welfare of service users*
- *Promoting and making proper provision for the care and treatment of service users*
- *Making arrangements for service users to receive where necessary treatment, advice and other services from health care professionals*
- *Making arrangements for the recording, handling, safe keeping and safe administration of medicines received into the care home*
- *Making suitable arrangements to prevent infection and the spread of infection…*
- *Ensuring that unnecessary risks to the health or safety of service users are identified and insofar as possible eliminated*
- *Making suitable arrangements to provide a safe system for moving and handling service users*

[206] The CSSIW has no record of the outcome. However, this may be evidence of an accumulation of concern

[207] The GP and District Nurses were frequently present at the home *and when it comes to care and treatment for pressure sores for example, it may be difficult to prove a breach if arguably responsibility for managing pressure damage had transferred at least in part to the District Nurses…*serious concerns emanate from *deaths in the home,* the GP's *involvement in certifying deaths and clusters of deaths close together in time e.g. three deaths in one week*

- *Making suitable arrangements for staff training to prevent harm or abuse to service users*
- *Ensuring that assessments…are reviewed*
- *Reviewing and revising the service user plan*
- *Maintaining records…*
- *Ensuring…that suitably qualified, competent, skilled and experienced persons are working in the care home in sufficient numbers to meet the needs of service users and that adequate training is provided*
- *Giving notice to CSSIW of notifiable events…*
- *Ensuring that no nursing care is provided by the registered persons or their staff (as per conditions of registration).*

During **January 2008**, the CSSIW received a Regulation 38 notification[208] and information about where the former Belmont residents were being accommodated. The CSSIW invited the former registered providers to be interviewed. *They declined to be interviewed under caution*. Mr and Mrs Bentley's solicitor contacted the CSSIW during **February 2008** to request *documentation seized by the police.*

During **March 2008**, the CSSIW was informed that *the investigation into Belmont was being taken over by…Operation Jasmine.*

During **May 2008**, Gwent Healthcare Trust shared the nurse assessments of seven former Belmont residents.

In **August 2008**, the CSSIW received a Notice of Proposal to Vary Conditions from **Expanding Horizons** for up to seven younger adults with learning disabilities.

During the following months correspondence concerning the prospective prosecution of Mr and Mrs Bentley was exchanged.

During **January 2009**, a three week trial began which was the culmination of 18 months of work on the part of the CSSIW Inspectors, team manager, support staff and Welsh Government lawyers. The offences concerned employment matters, notifications to the CSSIW, the care of individual residents and general care. This focused on former residents and *a number who were deceased.* Mrs Bentley pleaded guilty to 37 offences and Mr Bentley pleaded guilty to ten offences – 22 of the offences related to the inadequate care of residents. The *total fines and costs combined was £28,833.00.* The judge described a number of the offences as *very serious breaches* and made reference to the sentencing constraints and limited penalties. The judge thanked the CSSIW for its investigation of a difficult and complex case.

In **June 2009**, **Expanding Horizons** indicated their intention to close the home and that the *one remaining service user* would *be found suitable accommodation.* By **2010** the service was *non-operational.*

[208] Notifying the CSSIW of death, illness and other events

Bank House Care Home

This 64 bed home first opened in 1993. It was registered to Mrs Syal, the wife of a GP, and Mrs Lal.[209] The Manager was Beverley Evans and the Responsible Individual was Mr Prem Lal, Mrs Lal's husband. Following registration by the **Care Standards Inspectorate for Wales** (CSIW) in **2002**, a Notice of Decision was issued authorising the provision of 64 beds, consisting of 57 nursing places and seven personal care places.

During **February 2003**, a *neglect and psychological abuse "concern"* was received about **Woman Ba1**. Since certain elements of the complaint were upheld, the CSIW issued a number of requirements.

During **April 2003**, the home sought to vary the conditions so as to *include up to four palliative care places.*

An Inspection Report was published in **September 2003** (see Appendix 2). A concern about the neglect of **Man Ba1** was also received. As a result of CSIW's complaint investigation, the home disciplined a member of staff.

A further Inspection Report was published in **November 2003** (see Appendix 2).

During **2004**, CSIW requested *evidence of progress* arising from the regulator's requirements. Towards the end of the year a Notice to Vary Conditions was submitted for an increase in the number of residents.

At the beginning of **2005**, the application to Vary Conditions was received by the CSIW *to provide dementia care…10 places. The conditions were agreed.*

An Inspection Report was published in **April 2005 (**see Appendix 2)

During **October 2005**, concern was expressed about **Woman Ba2** and **Woman Ba3. Woman Ba2**'s family *did not want* to make a complaint but they were concerned about *the standard of care* which was being provided – **Woman Ba2** was *unkempt* and staff were inattentive to her medication. **Woman Ba3** was *force-fed medication* by a nurse. The nurse was *suspended by the manager who raised the referral.*

An Inspection Report was published in **December 2005** (see Appendix 2). Although the home responded to this, that response was considered to be *incomplete…no action plan.* Also in December, concern was expressed about **Woman Ba4**. The CSIW attended a Protection of Vulnerable Adults (POVA) strategy meeting which considered whether or not she had been subject to neglect.

An Inspector visiting the home during 2005 asked about residents with Grade 3 *pressure sores.* It was asserted that there was one. She found this to be incorrect, there were others.

During **January 2006**, Mr Prem Lal, as the Responsible Individual, made an Application to Vary Conditions and specifically, *to allow a Registered General Nurse to work on* the *Meyrick Unit* i.e. a part of the home which provided for a service for people with dementia.

During **February** and **March 2006**, concerns were received about the neglect of **Woman Ba5** and **Ba6** respectively. These were *not progressed to POVA* but it was agreed that the CSIW *would inspect.* This resulted in *requirements* and an *action plan…from the home.* **Woman Ba6** was admitted to Nevill Hall Hospital with *extensive pressure* wounds *mainly around the buttocks. The wounds were necrotic and abscessed requiring surgery. The home admitted liability and issued an apology to Woman Ba6's family.* After recovering, **Woman Ba6** returned to Bank House and her family wrote a letter of support to the manager and staff.

During **August 2006**, the CSIW met with the provider and Registered Manager and informed them of the regulator's intention to *take civil action.* Furthermore, *a number of conditions to* [pressure] *wound care were imposed.* Legal advice was sought by the CSIW and a criminal investigation was considered. However, this was *not progressed on the basis this would be disproportionate.*

During early **2007**, the Responsible Individual confirmed that *wound care training* had been *arranged.*

In **May 2007**, a concern was expressed about the *physical restraint* of **Woman Ba7** which was investigated by POVA and the police. Also during May, in response to an inquiry by a Blaenau Gwent councillor the Care and Social Services Inspectorate Wales (CSSIW) analysed the number of deaths at Bank House. An Inspection Report was published in **May 2007** (see Appendix 2)

During **August 2007**, the CSSIW received an expression of *concern* about the *neglect and psychological abuse* of **Woman Ba8** and **Woman Ba9**. Also a *concern* was also raised by the family of **Woman Ba10**. The *manager's attitude* featured in two complaints during **November 2007**, one of which raised concern about *continence management, maggots found in chair* and residents' choices about food and bedtimes, for example.

During **April 2008**, an Inspection Report was published (see Appendix 2). Concern was also expressed to the CSSIW about **Woman Ba11**. She was admitted to hospital with extensive pressure wounds and she was severely dehydrated. She was described as having *Grade V infected pressure ulcers down to the bone…the wounds had extreme pus and were infected and malodorous…heels were…discoloured and necrotic. She had acute renal failure secondary to dehydration.* Also, Woman Ba11 experienced *drowsiness secondary to opiate accumulation.* The CSSIW identified failings in her care assessment and documentation and noted the *delay in seeking medical attention in relation to episodes of confusion…and vomiting.* It was 10 days before *GP advice*[210] *was sought* i.e. when Woman Ba11 *became*

[210] Her GP was the husband of Mrs Syal. He was also a member of the LHB's Clinical Governance Committee at which POVA concerns were discussed and actions recommended

unresponsive. The CSSIW consulted with legal representatives, Blaenau Gwent imposed an embargo and Gwent Police considered a criminal prosecution.

Ultimately, the CSSIW did not recommend prosecuting since the home had responded positively to the requirements made, the family of **Woman Ba11** were *keen* for her to return to Bank House and *steps were being taken to ensure there was no repetition.* Woman Ba11's circumstances were complicated since she was *difficult to place.* Furthermore, she had been in Bank House for a short period i.e. she *spent two weeks in the home, then…hospital followed by four weeks in the home, then hospital until* her death. The CSSIW was not made aware of any police action and the Local Health Board *would not share records,* citing the Data Protection Act.

It was alleged, in the records, that the home's food bill *had been halved* (bacon had been removed from the menu) and that *cleaning hours* had been *cut.* The latter endorsed previous concerns about the cleanliness of the home. Concern was noted about three men and four women residents during **2008**. This included physical assault, neglect and possible over-sedation. *All service users* were *considered under an over-arching strategy meeting* and the CSSIW required *monthly reports* from the home. One woman's GP was prescribing medication and dressings while she was in hospital (and not occupying a GP bed). Her death was investigated by the police. The embargo on placements was lifted towards the end of the year.

At the beginning of **2009**, the Responsible Individual wrote to the CSSIW with a request to *extend their dementia provision* and the CSSIW received an application for a Registered Manager.

During **March** and **April 2009**, the CSSIW received two Applications to Vary Conditions i.e. *to provide for younger adults with mental health needs* (this was subsequently withdrawn), and *to extend dementia care provision.* Also during April, Mrs Lal stepped down as a provider/owner and her husband became registered as the provider/owner. An Inspection Report was published in **April 2009** (see Appendix 2)

Concern was expressed to the CSSIW about two women residents: the *neglect* of one woman (which resulted in the suspension of a member of staff) and the *physical/ psychological* abuse of another.

During **October 2009**, Gwent Police sought registration information about Bank House and in **November 2009**, the CSSIW wrote to the Health and Safety Executive confirming that the CSSIW was *working in partnership with other agencies to inform improvements at the home and* acknowledged that the home was subject to a **Health and Safety Executive** (HSE) investigation.

Section nine: the local authorities and adult protection

In this section…

> *…you will learn about a particularly critical context, that is, the challenges arising from the creation of new authorities in 1996 and the implications for the delivery and oversight of social services. The section places a spotlight on Caerphilly CBC since this is where three of the six Operation Jasmine homes were located. A further context is also described, that is, a disproportionate focus on child protection during the late 90s and early 2000s. In relation to older people, referrals were made to Caerphilly CBC under Protection of Vulnerable Adult (POVA) processes which included inattention to pressure ulcer prevention and treatment. These resulted from the publication of the Welsh Assembly Government's framework for adult protection: In Safe Hands. An embargo on placing older people at one home, Brithdir was imposed and lifted during 2004, not least because of the contribution of District Nurses to improving practice at this home. In 2005 Caerphilly gave notice that its contract with Brithdir was to be cancelled. The section concludes by referring to certain deep-rooted issues which are of particular concern to local authorities, including the situation where developers build new homes without reference to the service requirements of the area.*

The homes within the purview of Operation Jasmine spanned three local authorities – Caerphilly CBC, Blaenau Gwent CBC and Torfaen CBC. This section focuses on Caerphilly CBC since it is where three homes were located, **Brithdir**, **Bryngwyn Mountleigh** and **Belmont**. Events at Brithdir would have been centre stage had the efforts to prosecute Dr P Das, **Puretruce Health Care Ltd** and Paul Black proceeded.

In **1996,** the eight county and 37 district councils which at the time constituted local government in Wales were replaced by 22 unitary authorities, containing a range of population numbers. These newly constituted bodies were given diverse responsibilities for a wide range of services. There was no institutional integration, however, between these authorities and the services provided by the hospital and preventive health services. These remained the responsibility of the NHS.

The process of setting up these new authorities is pertinent to this Review. It was experienced as disruptive – and, at times, even chaotic - with considerable uncertainty over job security and future roles for staff at every tier. Added to this was the loss of organisational memory and management expertise as many senior managers retired and/or sought employment elsewhere. Crucially, too, there was a temptation to place decision-making concerning, for example, the greater use of shared services and enhanced communications *on hold* until the new organisations were *bedded-in.* This period of significant change and ambiguity preceded

the widespread availability and use of the internet, electronic mailing lists and rapid communication. Thus at a time when communication within and across organisations and with the public was essential and *business as usual* was expected, information moved relatively slowly through and across the new hierarchies, including within Caerphilly.

Several of those who contributed to this Review recalled the challenges which faced the new authorities and their members as they sought to present a coherent corporate image to employees and the local population, as well as struggling to come to terms with the varying approaches and practices of the amalgamated bodies. The previous committee system, which had dealt with functions such as the provision of social services and housing, had made it possible for councillors to acquire specialist knowledge. The **Local Government Act 2000** established overview and scrutiny committees in local authorities (the legislative provisions may be found in the **Local Government (Wales) Act 2011**). These committees were intended as a counterweight to the executive structures. Their role was to develop and review policy and make recommendations to the council. The **2000** Act had obliged local authorities to adopt political management systems with a separate executive, and every council in Wales was obliged to have a mayor, or a council leader, plus a cabinet system.

Caerphilly emerged as one of the largest of the new authorities, consisting as it did of a merger of two former District Councils (Islwyn and Rhymney) and parts of two former County Councils, that is, Gwent and Mid Glamorgan. In contrast, Torfaen[211], Blaenau Gwent[212] and Merthyr Tydfil were amongst the smallest, prompting questions concerning their capacity to deliver services which were responsive to local priorities and circumstances. The effectiveness of these smaller authorities was assumed rather than demonstrated. The duplication of scarce resources within the south east Wales area, and the challenge of attracting experienced managers and staff to multi-service, multi-functional organisations, had particularly long-lasting consequences and the implications for the delivery and oversight of social services, for example, were under-estimated.

During the early days of transition, a case of child abuse in Caerphilly had a considerable effect on social services functioning. In **1998**, the then Welsh Secretary called for further measures to review and improve child protection arrangements at Caerphilly CBC on the grounds that managerial supervision was poor and that communication between the various child protection agencies was ineffective. While staff concentrated on re-examining historical child abuse cases, it was suggested to this Review that *eyes were off the ball* in terms of **adult protection**. Even the publication of *In Safe Hands*[213] in **2000** which set out the Welsh Assembly

[211] Where The Beeches was located

[212] Where Bank House and Grosvenor House were located

[213] Guidance issued under S7 of the Local Authority Social Services Act 1970

Government's framework for adult protection procedures[214], did not effectively displace the authority's disproportionate focus on child protection issues.

The **National Minimum Standards** (NMS) under the Care Standards Act 2000 contain standards which relate to the prevention of abuse, for example, Standard 18 of the NMS for care homes for older people states:

The Registered Person ensures that service users are safeguarded from physical, financial or material, psychological or sexual abuse, neglect, discriminatory abuse or self-harm, inhuman or degrading treatment, through deliberate intent, negligence or ignorance, in accordance with written policies.

In **2001**, a South East Wales Executive Group for the Protection of Vulnerable Adults was established to coordinate the development and implementation of a south east Wales joint agency framework. Signatories to the framework included Blaenau Gwent CBC, Caerphilly CBC, Torfaen CBC, Gwent Healthcare NHS Trust, CSIW, Blaenau Gwent LHB, Caerphilly LHB, Torfaen LHB and Gwent Police.

In **2002**, *A Report of the Joint Review of Social Services in Caerphilly CBC*[215] stated

Caerphilly social services is not yet serving people well and, despite some encouraging signs, prospects for the future are uncertain…social services in Caerphilly are improving, albeit from a very low base…social services expenditure across different service user groups shows spend is significantly higher in terms of children's services when benchmarked against other authorities…below average spending in adults' services, in particular in services to older people…

Delayed hospital discharges are an area of concern. The pace of development of home and community based services needs to quicken with the Council working in conjunction with partner agencies…Demographic trends analysis shows a 2% annual increase in the number of people over 75, which can only exacerbate current problems…Caerphilly CBC…is like a merry go round with high staff turnover that leads to problems of continuity and hinders the pace of progress at all levels…Social services has a poor record of undertaking timely reviews in…adults' services…a key area for improvement.

In **March 2002**, the Leader of Caerphilly CBC was quoted[216] as *demanding an inquiry into how a disgraced GP* (that is, a former colleague of Dr P Das) *landed a job with one of Wales' biggest private nursing home firms* i.e. Puretruce Care Ltd with *22 care homes…with nearly 1,000*

[214] This guidance was described by Luke Clements and Pauline Thompson as *process orientated* and *without powers to enable local authorities to protect victims of abuse. Clements L and Thompson P.* (2007) *Community Care and the Law* 4th Edition London: Jessica Kingsley Publishers)

[215] Audit Commission

[216] http://www.thefreelibrary.com/SEX-FOR-CASH+DOCTOR+IN+HOMES+JOB+STORM%3B+Inquiry+call+over+shamed...-a085917693 (accessed on 8 November 2014)

places for older people...Dr [P] *Das confirmed that no checks had been made with police before Bhagat was taken on.*

In **September 2003**, the South East Wales Executive Group for the Protection of Vulnerable Adults published, *Protecting Vulnerable Adults: Interagency policy, procedures and practice guidance for responding to alleged abuse and inappropriate care of vulnerable adults in the South East Wales area.* This stated that:

*Large scale investigations, e.g. those involving a group of vulnerable adults…or a number of establishments are complex…Joint planning and management need scrupulous attention…**The responsibility for coordinating a large scale investigation is with the social services nearest to where the vulnerable adult lives at the time of the alleged abuse**…**Whenever complaints about abuse suggest a criminal offence may have been committed, the police must be contacted urgently. This takes priority over other enquiries. The safety of the vulnerable adult must be given the highest priority**.*

*While social services are responsible for coordinating an adult protection case and the police for leading an investigation into an alleged criminal offence, **the identification, assessment, protection and care of vulnerable adults is an interagency and multi-disciplinary responsibility**.*

***…if the vulnerable adult needs urgent medical attention this should be arranged without delay…**early police involvement makes sure forensic evidence is not lost or contaminated.*

***If during the investigation/assessment there is evidence that the vulnerable adult(s) is exposed to considerable risk, immediate action must be considered to protect them.** This may include moving the vulnerable adult to a place of safety…*

*If following a police investigation into an alleged crime, the CPS finds there is insufficient evidence to prosecute, an Adult Protection Case Conference may be held to review the case and plan appropriate action. The police **must** inform other agencies and the vulnerable adult if there is insufficient evidence to prosecute. **It is essential to assess any remaining issues not addressed by the police e.g. overall practice and management issues to do with the care of the vulnerable adult and others who might be at risk**…*

Alan Sayers' death at **Bryngwyn Mountleigh** in **2004** did not result in a Protection of Vulnerable Adult (POVA) referral. However, there were subsequent POVA referrals from this home.

In **April 2004**, the Western Mail[217] published an article entitled *Elderly will suffer as care home crisis deepens.* This stated that five care homes in Caerphilly *fear they could be forced to close within 12 months in the face of paltry funding increases.* Anna Bentley, of **Belmont Residential Home** anticipated being *forced to close within 12 months,* not least since *'pointless' new regulations…*disallow *double rooms…April 2005 is crunch time – if the fees are increased to*

[217] http://www.thefreelibrary.com/%27Elderly+will+suffer%27+as+care-home+crisis+deepens.-a0114912458 (accessed 8 November 2014)

offset the reduction in the number of rooms we may be able to keep on going. We will carry on but it will come to the point when we have to ignore the inspectors and the regulations.[218] Mrs Bentley questioned the want of parity across fees for private care home residents and residents in local authority homes.

In **September 2004**, **Caerphilly CBC** and **Puretruce Health Care Ltd** commissioned a report from Gordon Cole[219] to *identify whether the contractual standard of care…was being met*[220] at **Holly House**.[221] He visited the home on four occasions and noted in his report that *there is no doubt that the quality and standards of care more than comply with regulatory requirements.*

During **October 2004**, a period of intensive assessments by District Nurses began at **Brithdir** arising from failures noted by the **CSIW** and **POVA** procedures in relation to pressure ulcer prevention and treatment.

In **December 2004**, **Caerphilly CBC** confirmed that it was *prepared to lift the current embargo* (on placements at **Holly House**) *up to a maximum of 29 beds pending the Tribunal decision.*

Also in December 2004, **Caerphilly LHB** and **Caerphilly CBC** confirmed that the embargo in place on **Brithdir** would be lifted, subject to conditions.

During **February** and **April 2005**, Gordon Cole made two further visits to **Holly House**. His findings did not tally with those of the **CSIW** inspectors.

The decision of the **Care Standards Tribunal** in relation to **Holly House** was produced in **May 2005**. Mr Roger McCarthy QC for **Puretruce Health Care Ltd** proposed the continuing involvement of Gordon Cole.

In **June 2005**, **Caerphilly CBC's Director of Social Services** featured in the BBC Wales broadcast, *Week In Week Out: Taking Care?* This programme expressed a deeply felt discontent with the track record of care at **Holly House** and the **Merthyr Tydfil Nursing Home**.[222] It was noted that an independent consultant had been employed by **Caerphilly CBC** to write a report about the care provided at **Holly House**. The Director of Social Services himself confirmed that he would not place a loved one there since the home did not meet minimum standards *in all respects.* He went on to note that the *first and best option is to make* a failing home *better.* NHS nurses began working at **Holly House**, at public expense, to

[218] In 2009 Mrs Bentley pleaded guilty to 37 offences, many of which related to the inadequate care of residents at Belmont (see Section 8)

[219] *A policy adviser and representative for Care Forum Wales and an independent consultant providing advice to local authority and independent sector care providers,* (p2 of *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006)

[220] *Puretruce Health Care Ltd v National Assembly for Wales* [2004] 0371 (EA-W) 15 May 2005

[221] A home in Caerphilly owned Dr P Das and Dr N Das

[222] A home owned by Dr P Das and Dr N Das See Appendix 1

ensure the safety of residents. In other words, improvement of standards was proposed as the initial solution.

Also in June 2005, POVA referrals were made to **Caerphilly CBC** concerning **Brithdir**. During **November 2006**, Caerphilly CBC gave notice that the contract with **Brithdir** was to be cancelled on the grounds that there had been no improvements.

The decision of the **Care Standards Tribunal** (**September 2006**) noted that *one of the more bizarre financial decisions taken by Dr* [P] *Das was his attempt to extract "cheap money" from Caerphilly CBC in **June 2005**,* that is, *within a very short time of the Tribunal's decision giving him a last chance to save Holly House, Dr Das wrote to the Director of Finance of his company's main customer and revealed that it had pressing debts totalling £49,360 that it could not pay. Dr* [P] *Das in effect threatened Caerphilly that if they did not help him financially he would be forced to leave them without a home in which to place the vulnerable adults for whom they had responsibility.*

During **2006**, **Caerphilly CBC** had *'all qualified' social work teams.*

In a report prepared for this Review[223] **Caerphilly CBC** stated that from the outset, *agencies worked together through the multi-agency POVA process. It appears Police were made aware of all the POVA referrals in Mountleigh Bryngwyn and Brithdir nursing homes.* However, Caerphilly believed that *all referrals at these homes were being considered by the police as either key cases to take forward to a prosecution or as supporting evidence. The usual POVA process of individual strategy meetings appears to have been replaced by overarching meetings where both multiple referrals and systems failures in Mountleigh Bryngwyn and Brithdir nursing homes were discussed. This appears to have assisted staff and particularly the police to gain a broader picture of the concerns however,* it *led to a situation where the individual POVA referral investigation outcomes could not be provided as the case lay with the police as part of…Operation Jasmine. This situation continued for a considerable length of time.*

During **August 2007**, an Occupational Therapist employed by **Caerphilly CBC** *raised POVA and other care concerns*[224] about **Belmont**. Caerphilly CBC *developed a Provider Performance Monitoring Protocol* because *the systems failures…required urgent and specific attention.*

In **January 2008**, **Caerphilly Area Adult Protection Committee** ratified a document, headed ***2002-current day***, which was known as the *Jasmine 'lessons learned'* or *'106 lessons.'*[225] It was widely shared by Caerphilly CBC and Gwent Police at conferences in Wales and England concerning adult protection, for example.

From **2008** onwards, the authority's *Provider Performance Monitoring Protocol* was used.

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[223] 3 October 2014

[224] Caerphilly CBC Improvement Journey: Report for Jasmine Review

[225] See Appendix 5

Between **2008** and **2010**, **Gwent Police** referred 10 social workers to the **Care Council for Wales** (CCW), none of whom had been charged with an offence. Most of them had responsibility for reviewing older people placed in the Das' homes. *Each case was reviewed with account taken of the context within which these individuals were working and the fact that the employer had assessed each individual and, in some cases, put additional training in place. As a result it was concluded that it would be unlikely that findings would be made against these individuals in a professional conduct hearing. All cases were therefore closed in August 2010.* [226]

In **May 2009**, the service managers responsible for POVA and for Commissioning Adult Services at **Caerphilly CBC** had an article published [227] about the *interagency challenges to improving provider performance.* This highlighted concern about poor standards in some registered homes as evidenced by increasing numbers of referrals to the authority and by the suspension of placements; the significant variations in the performance of providers; the failure to develop a strategic approach to managing contracts and collating POVA issues from sources such as the local health board, NHS Trust and contract monitoring; and the use of *'overarching' meetings*,[228] for example. The article noted that engaging with service providers was enhanced *when it was realised that the regulator and contractor were working together and asking for one consistent set of improvements to be made...discussions with providers with regard to monitoring/inspection unsurprisingly revealed frustrations at the number of different monitoring agencies and episodes of monitoring.* Finally, the article questioned the merits of adopting a reactive stance and using embargoes since these did not have any track record of achieving sustained improvements.

Caerphilly CBC's contract monitoring reports were posted on the Council's website. These include the outcomes of *out of hour's contract monitoring visits.*

Also in May 2009, the Welsh Government published statutory guidance, *Escalating Concerns With, and Closures of, Care Homes Providing Services for Adults.* Issued under S7 of the Local Authority Social Services Act 1970 and sections 12 and 19 of the National Health Service (Wales) Act 2006, it sets out responsibilities and the ways in which these may be discharged. The guidance states that:

Escalating concerns will warrant proactive or reactive intervention from those commissioning services, possibly from one or more commissioning agencies, designed to improve the quality of services and, where possible, prevent what might be avoidable home closures.

[226] Operation Jasmine Review: Evidence from the Care Council for Wales

[227] Giordano A. and Street, D. (2009) Challenging provider performance: developing policy to improve the quality of care to protect vulnerable adults, in *The Journal of Adult Protection,* 11 (2), 5-12

[228] These were used to manage more than one referral or concern related to the same service or provider.

In **January 2010**, the **Care and Social Services Inspectorate Wales** (CSSIW) undertook an *Inspection of Adult Protection in Caerphilly County Borough Council.* Its report on the results stated that:

Caerphilly CBC has worked hard to make the protection of vulnerable adults a strong and high quality service…and has worked diligently to continue to improve the work of its specialist Adult Protection team. There has been a strong emphasis on getting the processes right so as to provide a clear indication of what action has been taken, what was decided and what the benefits were to vulnerable people. The local authority has been concerned about the inconsistent quality of registered social care services which it either provides or commissions…There have been particular issues associated with a continuing Police investigation into standards of care in residential care homes offering personal care and nursing, which has had a significant impact in Caerphilly. It has focused resources on solving these and other, difficult adult protection considerations…

During **August 2010**, *Fulfilled Lives, Supportive Communities: Commissioning Framework Guidance and Good Practice* was published by the Welsh Assembly Government and NHS Wales. This built on *Promoting Partnership in Care – Commissioning Across Health and Social* Services.[229] Both publications contained a change of terminology from *planning and procurement practice* to *commissioning* and the core features of commissioning were to be activities which ensured that services were planned and organised to meet the *outcomes required.* This involved a *whole system perspective,* familiarity with population needs, best practice and local resources in order to plan, implement and review changes to service provision.

Brithdir was sold in **2006.** It was taken over by Mr Bamrah of **Broadway Care Centre Ltd** and renamed **Hillside**. Subsequent concern about the quality of care at **Hillside**, using Caerphilly's *Provider Performance Monitoring Protocol,* led the Council to terminate its contract in **December 2011**. Mr Bamrah unsuccessfully challenged the process which led to this decision.[230]

In **May 2013, Caerphilly CBC** revised its *Provider Performance Monitoring Protocol* again[231]*,* which enabled information about a commissioned service to be shared in forums other than POVA meetings – and operationalised the requirements of the *Escalating Concerns* guidance. The rationale for the Protocol included a wish to engage proactively with partner agencies in order to *reinforce their expectations of quality services being provided.* This resulted in an expanded role for the contract monitoring team in order to gain *a more comprehensive view of the quality of care services provided.* The approach involved (i) monthly Quality Assurance meetings *to consider and discuss issues relating to any service/ provider* and (ii) *Provider Performance Monitoring Meetings* which were to be triggered by evidence of *poor*

[229] Welsh Assembly Government 2003

[230] [2012] EWHC 37 (Admin) Case No: CO/12238/2011

[231] This was revised regularly following its creation in 2007/08

performance. There was an expectation that all commissioners would have *an informed and independent view* concerning the quality of service provision *rather than be reliant upon inspection reports from the regulatory body or other agencies.*

The tasks **Caerphilly CBC** faced in being the authority in which three of the six Operation Jasmine homes were based are all too familiar to authorities who work with those who provide care services for frail older people with extensive support needs. Caerphilly CBC has currently a *Contract Default Process* with which to address potential and actual contract breaches. The process begins with a meeting with the provider to *agree a way forward…to improve the situation and performance…Where the contract is terminated with a care home, the Caerphilly CBC Care Home Closure Policy will be used to ensure a smooth transition for service users to a new service provider.*

Although the authority acknowledges that the task is incomplete, the reforms and initiatives adopted – described as *The improvement journey* – focus on accountability for the safety and wellbeing of older people, by for example: linking POVA coordinators with care home provider forums and the out of hours team; providing feedback forms for staff visiting care homes; hosting the *Wales Commissioning Network* for information sharing about provider status and performance; evening seminars for elected members; providing workshops for commissioners, CSSIW and health staff; and adopting 'My Home Life'[232] and Dementia Care Matters.[233] Consent has been obtained from providers for commissioners to access copies of reports concerning food hygiene, fire and environmental health. Reviews are offered to self-funding residents.

These reforms are taking place against such deep-rooted and ongoing issues (for all local authorities) as:

- An embargo on placements becoming the pretext for not making improvements
- Less than credible threats of home closure given the shortage of EMI provision and prospective residents subject to *delayed discharges* in general hospital provision
- The dilemma inherent in *waiting* for providers to improve as they commit to adhering to action plans or promise to appoint staff to key roles for example
- Legal challenges by owners disputing the accuracy of critical CSSIW reports
- The expectation of some providers and partner agencies that local authorities and health services will willingly provide staff to failing homes at no cost to the providers
- A widespread belief among private care home providers that local authority provision is given an unfair advantage

[232] *A UK wide initiative that promotes quality of life and delivers positive change in care homes for older people* http://myhomelife.org.uk/ (accessed 18 February 2015)

[233] An organisation which seeks to transform care for people with dementia http://www.dementiacarematters.com/person.html (accessed 18 February 2015)

- Uncertainty about actions which may be legitimately taken when the police have investigatory primacy, irrespective of the duration of the police investigation
- The development of new homes without reference to the population profile or knowledge of service assessment and requirements
- The resistance of people's relatives to the prospective closure of a home. Typically, but not always, these will be the relatives of people who have not been harmed in the home in question
- The role of home owners and staff in (i) encouraging relatives to challenge the decisions of health and social care managers and regulators, (ii) the citing of research about the implications of moving a person to another home for their mortality and (iii) supposed deference to older people's human rights.

Section ten: the Health and Safety Executive

In this section…

> *…the responsibilities of the Health and Safety Executive (HSE) under the Health and Safety at Work Act 1974 are outlined. The section cites agreements with the Welsh Local Government Association and the Care Standards Inspectorate for Wales and sets out in a table the tasks and issues it addressed in relation to the Puretruce Homes between 1995 and 2006. The investigation lead transferred to the HSE during 2011 and the charges laid against Dr P Das, Puretruce Health Care Ltd and its Chief Executive are detailed.*

Under the **Health and Safety at Work Act 1974** (HSWA), the main responsibility of the **Health and Safety Executive** (HSE) is to ensure the health and safety of employees at a wide range of workplaces from construction sites, garages, major hazardous installations, factories, schools, farms and local authorities to healthcare premises. However, under s.3 of the Act, it is also responsible for ensuring that employers (and the self-employed) protect people other than employees from risks arising as a result of, or in connection with, the activities of people at work. In addition, under s.7, employees themselves have a duty to take care of the health and safety of those who may be affected by their acts or failure to act. There is also a duty, under r.3 of **Management of Health and Safety at Work Regulations 1999,** to carry out a sufficient assessment of the risks to non-employees which arise from, or are connected with, the employer's undertaking. Under s.37 of the HSWA, if an offence under these provisions is committed by the organisation, any director or manager may be found guilty where it is proven, for example, that the offence was committed with their consent.

Recognition of the significance of these provisions for the well-being of residents can be found in guidance issued by the HSE in relation to health and safety in care homes.[234]

A ***Memorandum of Understanding between the Health and Safety Executive, the Welsh Local Government Association and the Care Standards Inspectorate for Wales*** was issued in December **2006**. Its aim was *to facilitate cooperation and coordination between the HSE, the Welsh Local Government Association (WLGA) on behalf of local authorities in Wales and the Care Standards Inspectorate for Wales (CSIW).*

The Memorandum stated that:

LAs are the principal enforcing authority in…residential care... (para. 9)

…HSE and LAs do not, in general, seek to apply HSWA to matters of clinical judgement or to the level of provision of care as other legislation and regulatory bodies deal with these matters

[234] *Health and Safety in Care Homes was first published in 2001.* See http://www.hse.gov.uk/pubns/priced/hsg220.pdf (accessed 22 February 2015)

(for example, making a decision or judgement on whether bedside rails should be provided) (para 12)

…allocation of the enforcement of health and safety in care homes is split between residential and nursing care. It should be noted that the legal distinction previously applied under the Registered Homes Act 1984 was removed following the implementation of the Care Standards Act 2000. All such homes are designated care homes. LAs take the lead for residential care and HSE take the lead in nursing care (para 28).

CSIW will take the lead in enforcement in relation to any issue relating to service user safety within the Care Standards Act and associated Regulations. HSE and LAs will be responsible for regulating employees' health, safety and welfare matters. In the event that individual inspectors are unable to reach agreement as to who should take the lead in a particular situation, the areas of dispute should be referred to the relevant line managers in the organisations concerned to agree the way forward (para 30a).

Where joint inspections or investigations identify significant breaches of the law on the part of the employer or an individual, enforcement will normally be taken by the regulatory body with the enforcement lead on that issue and after consultation with the other regulators (para 30d).

…Where the HSE or LA inspector identifies a need for formal enforcement action in relation to patient safety issues within CSIW's remit, this will be referred to the CSIW. HSE and LAs will only take such action where there is, in their reasonable opinion, serious and imminent danger or risk of serious or imminent danger to service users; they will also contact the CSIW inspector as soon as is practical to inform them of the action taken… (para. 30e.)

CSIW, HSE and LAs will to the best of their endeavours keep each other informed about work in which the other has an interest, and inform the other without undue delay of any relevant information that would require their action or assist their investigations (para 30k).

The Memorandum of Understanding includes an *Enforcement matrix* which states that

CSIW will take the lead in matters concerning *Service User Safety – risks arising directly from the management of individual service user needs… except when there may be circumstances where HSE/LA will, in the exercise of discretion, have to take enforcement action even if primary enforcement responsibility rests with the CSIW. This matrix is intended as a guide rather that a prescriptive list.* The examples of *Service User Safety risks* are, *scalding, drownings, burns from hot surfaces, falls from height (windows etc.), wandering and absconding from establishments, use of cot-sides and lap-belts, management of challenging behaviour e.g. restraint techniques, client to client violence, manual handling risks to service users, self-harm including suicide* and *consumption of chemicals.*

This Memorandum[235], which was signed by Geoffrey Podger (Chief Executive, **HSE**), Steve Thomas (Chief Executive, **WLGA**) and Robert Pickford (Chief Executive, **CSIW**), was to be *reviewed at agreed intervals.*

During **May 2009**, an HSE Board Paper 184372[236] described Operation Jasmine as

…a very significant, but confidential investigation, being led by Gwent Police into many deaths. HSE is contributing in line with the Work Related Death Protocol[237]. Our support is [5 part-time staff]*, all based during the investigation at the HQ of the Police Investigation. This investigation is likely to continue for at least one more year and possibly longer.*

Correspondence from the HSE Head of Operations Wales and the Marches during **November 2014** explained that if a breach of S. 3 HSWA 1974:

was or is a probable cause of, or significant contributory factor to, the injury or the risk complained of…the policy directs that HSE should generally consider investigating if there was or is a high level of risk, or we need to act/investigate in the interests of justice. It is such circumstances which led us to become involved in the investigation in pressure ulcer injuries at Brithdir Care Home. Just as with the relatives of those in the home, the injuries were not evident to HSE Inspectors at their visits. We did not receive any concern about pressure ulcer injuries from any member of staff, relative or healthcare professional in all the time considered by the Operation Jasmine investigation. They came to our attention when [we] *were invited by Gwent Police to join their investigation. We did so having been presented with evidence of the grossness and scale of the injuries and on the understanding that there was not any other regulator able to secure justice in respect of the organisational failings by Puretruce* Health Care Ltd*.*

As the Head of Operations, Wales and the Marches noted however:

HSE has long recognised that the breadth of Section 3 [of the Health and Safety at Work Act 1974] *had the potential to overwhelm our resources (no matter how large or small) and cause us to look into areas which overlap with other legislative regimes aimed at protecting people from harm. To deal with this we have developed policy to prioritise our work with respect to Section 3 and arrangements to liaise with relevant regulators abutting that remit. The history of our enforcement priorities under Section 3 from November 2003 to the present* [is] *published on our website with further detail contained in the Health and Social Care microsite. Generally, the direction of these policies with respect to healthcare was for the HSE not to apply HSWA to matters of clinical judgement, standards of clinical governance or the level of*

[235] Correspondence from the HSE Head of Operations Wales and the Marches in November 2014 stated that the *Memorandum of Understanding…was drafted to formalise the increasing liaison that was occurring between ourselves and CSIW over healthcare issues in the early 2000s…I understand that there was regular telephone conversations with CSIW regulators about the Puretruce homes. With or without the MoU, I am assured that there was substantial co-operation and coordination between HSE and CSIW*

[236] http://www.hse.gov.uk/aboutus/meetings/hseboard/2009/270509/p-may-b09-49.pdf (accessed 20 February 2015)

[237] http://www.hse.gov.uk/pubns/wrdp1.pdf (accessed 20 February 2015)

provision or quality of care as there existed better placed regulators to regulate in these areas…We regulated the homes in question for major non-clinical risks to patients such as trips and falls, scalding, electrical safety and with some aspects for risks that apply to both staff and patients alike such as manual handling. The Table below captures these concerns in relation to all **Puretruce Care** homes and captures the HSE's lead responsibility for generic health and safety arrangements, *manual handling to reduce injury to staff…control of legionella, construction and refurbishment work* and *maintenance of work equipment for example.*[238]

Once the **Crown Prosecution Service** determined that there was insufficient evidence to pursue gross negligence manslaughter and wilful neglect charges, the **HSE** took primacy for the investigation during **August 2011**.

Between **1994** and **2006**, the **HSE** issued 12 Improvement Notices to homes owned by the Das' companies, that is, until **Puretruce Care Ltd** went into administration. Further, the **HSE** initiated legal proceedings against individual homes on four occasions.

Health and Safety Executive interventions at the Das' homes

The Das' Homes	Dates of contact	Tasks and Issues	HSE response
Aberpennar	7/1997 4/1998 7/1998 3/2001 9/2002 12/2003	*…risk assessment* (RA) *for hot surfaces…no formal manual handling (MH) training for staff – 50% of residents immobile; joint visit with HSE Employment Nursing Advisor. Improvement notices not complied with; correspondence; visit; visit to gather evidence re…home failure to have arrangements to manage risks from patient handling work activities; information from CSIW re* resident's *death from choking…CPR not given…cause of death heart failure…not reportable under* Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR); *visit, poor management and use of bed rails, no RAs in place, manual hoists not reaching floor*	*Improvement Notices for MH and hot surfaces served; legal proceedings initiated; prosecution for failure to comply with improvement notices; statements taken; police investigation, non-reportable death; letter sent*

[238] Mandelstam M. (2011) *How we treat the sick: Neglect and abuse in our Health Services* London: Jessica Kingsley Publishers, notes, in relation to the Health and Safety Executive, that *its self-imposed no-go areas might be justifiable if successful prosecutions were taking place at the hands of other enforcement bodies, such as the CQC* [England's CSSIW] *or the Crown Prosecution Service. But they are not…* (p326)

		level , MH RA training needed…further action necessary	
Bargoed	4/2003 8/2003	*…investigation of complaint re unsafe gas tumble drier; telephone call to CSIW re* this *complaint*	
Baybridge	2/2002	*Visit…ambulift with no sprag clutch, MH training records poor, MH assessment of residents need more detail Portable Appliance Testing (PAT) date passed*	*Letter sent*
Bedwellty (formerly Nirvana)	1/1996 3/2001 3/2001	*…visit…RA risk of water temperatures. Windows needed restricting, no MH assessment carried out, only one hoist for the building, refresher training needed, no safety policy; visit to gather evidence re company and home failure…to manage risks from patient handling work activities;* x2	*Improvement Notice served; statements taken* x2
Beeches	1/1995 2/1995 5/1995 1/1996 6/1998 10/1998 12/1998 3/1999 7/1999 3/2001 10/2002 7/2004 10/2005 11/2005 3/2006 9/2006	*Visit…to investigate complaint re electrical work; visit; visit…arranged to inspect all homes currently owned by company; visit; visit…to determine compliance with inspection report. Inadequate policy/ competency re H&S and MH, no thermostatic valves on baths, no PAT regime, lift…out of date, legionella cleaning regime out of date, inadequate MH assessments re longer-term residents, management of clinical waste improved…deficits due to lack of Planned Preventative Maintenance* (PPM) *regime; visit…*re *compliance with MH, H&S policy and hot water controls; joint visit with CSSIW re concerns to structural safety of the building; visit…proposed prosecution; visit* re hot water pipework *and temperatures; Head office visit to meet Directors re proposed prosecution for non-compliance with 4 notices served at* ***Beeches, Blaenafon***[239]***,*** ***Parklands*** *and* ***Bryncoed*** *homes. Further*	*Letter sent* x3; *statements taken* x2; *prosecution proposed for non-compliance with Improvement Notice; letter sent; Improvement Notice served ; Improvement Notice served on MD as individual*

[239] There is no further information about this home other than that the CSIW informed the HSE during September 2006 that it was *now closed*

		notice to be personally served on MD requiring him to fulfil his responsibilities…and produce a corporate strategy for health and safety; prosecution for failure to comply with notices served at these homes; visit x3 – the last *to assess control of risks from bedrails; Contact with CSIW. Informed that…Beeches…now closed*	
Brithdir	11/2003 2/2004 5/2004x2 8/2004 11/2004 2/2005 4/2005x2 6/2005 7/2005 2/2006x2 10/2006	*Joint visit with CSIW re MH, expired Employers Liability Compulsory Insurance, MH* inadequate*, awaiting delivery of stand aid, insisted on interim measures…risks not well managed…MH RA not always completed on referral…not all care staff have received MH training…accident records and H&S policies not available; visit, H&S documentation not available…unable to produce accident history records. Poor management/ use of bedrails; visitx8; phone call with clinical nurse manager, training plan to complete MH training in all homes. Requested copies of training certificates for 2 trainers; complaint received re risks…from bedrails and unsafe MH…bedrails found to be below required standard; informed that Brithdir now closed*	*Letter sent; Improvement Notice served re lack of manual handling training for staff; 2 Improvement Notices re…effective management of H&S* and *implementation of risk management system for violence and aggression; instant visit report*
Bryncoed House[240]	6/1998 7/1998 10/1998 12/1998 1/1999 11/2000 6/2001	*Visit…no H&S policy documentation, inadequate equipment provision; visit, no current policy, more depth to care plans and MH needed, RA required, water temperature needs adjustment; taped interview with Director of Nursing re non-compliance with Improvement Notice…company not taken action in response to Notice; visit to look at MH provision; visit to Swansea…to take statements from Registration and Nursing officer…re company and home*	*Improvement Notice served; prosecution proposed; letter sent;* x2

[240] See also Beeches

		failure…to manage risks from patient handling	
Brynheulog	3/2001 4/2003x2 7/2004	*Visit to gather evidence re company and home failure to have arrangements to manage risks from patient handling; visit re fall from hoist incident, no trained staff for hoist available, poor MH patient assessment; visit re accident; visit*	*Statements taken;* x2
Cardonnel Court	3/2001	*Visit to gather evidence re company and home failure to…manage risks from patient handling*	*Statements taken*
Carlton Heights	1/1996x2	*Visit…matters requiring attention – MH, refresher training for key lifters, resident assessments…increase number of clinical waste ins, no safety policy or procedures, no maintenance contract on gas cookers, some windows require openings to be restricted; visit*	
Glanffrwd	6/1998 7/1998 4/1999 4/2001x2	*Visit in response to complaint re company's failure to address water temperatures, radiators and hoist inspections; letter…matters raised…being remedied; visit – water temperatures exceeded…MH lack of equipment, radiators unguarded, open unfenced swimming pool; visit to gather evidence re company and home failure to…manage risks from patient handling* x2*…bath water temperatures over 60%*	*Letter sent; statements taken; water temperature referred to Director; statements taken*
Glan yr Afron	3/2001	*visit to gather evidence re company and home failure to…manage risks from patient handling*	*Statements taken*
Holly House	1/1996 10/2003 7/2004 1/2005 4/2005 8/2005 6/2006	*Visit; visit with CSSIW…few staff had MH training. A number of injuries in the accident book for staff whilst moving and handling residents; visit* x4; *Contact with CSIW. Informed that Holly House…now closed*	

Llys y Coed	3/2001	*Visit…completed MH audit, reviewing staff training…little standardisation across Puretruce…assessor will be appointing deputy in next two weeks recognises need for training plan. Home has three hoists, suppliers have been in…to provide training for all staff…currently 20 patients…require some form of handling interventions*	
Manor Parc	1/1996 7/1997 2/1998	*Visit…assessment of risk from water temperatures. Windows need restricting, no MH assessment, no safety policy, no maintenance of electrical equipment; visit;* telephone notification *that Manor Parc had closed*	*Improvement Notice served re scald risks*
Merthyr	1/1996	*Visit; visit to gather evidence re company and home failure to…manage risks from patient handling*	*Statements taken*
Parklands[241]	1/1996	*Visit*	
Red Rose	2/1994 8/1994 12/2003	*Visit* x2*; visit accompanied by general manager…all structural repair work to the floor and cellar has been carried out. Water tanks chlorinated. Requiring attention – assessment of risk from water temperatures. Windows needing restricting. No MH assessment. No safety policy. No maintenance of electrical equipment*	*Letter sent* x2*; Improvement Notice served*
Silverdale	1/1996	*Visit…attempts made in MH assessments in care plans, training needed. Outside clinical waste store contained other rubbish, no Control of Substances Hazardous to Health (COSHH) assessments, build-up of rubbish in handyman's work room, oxygen cylinders not securely stored*	*Improvement Notice served*
Valley Manor	1/1996 3/2001 5/2006x3	*Visit; visit to gather evidence re company and home failure to…manage risks from patient handling; telephone call to CSIW to discuss proposed visit. CSIW indicated*	*Statements taken; Instant visit report*

[241] See also Beeches

	6/2006	*little issue with this home compared to others in the group; visit to assess control of risks from bed rails; telephone call to CSIW to inform of outcome of visit to home; visit to follow up actions re control of risks from bed rails*	
Valley View	1/1996 2/1996 4/1996 10/1998 2/1999 6/1999 9/1999 11/1999 3/2001	*Visit; inspection report sent; RAs received. Letter; Visit…Police and Criminal Evidence* (PACE) *statement taken re prospective prosecution for non-compliance with Improvement Notices re* ***Beeches*** *and* ***Blaenafon*** *homes; telephone call with home re current Notices and proposed prosecution. Advice given re MH training providers; conversation with solicitor for home to discuss prosecution case; visit, safety policy needs improvement. Progress needed on MH and survey of building; investigation into incident re inadequate training and equipment for manual handling. Limited manual handling required; visit to gather evidence re company and home failure to…manage risks from patient handling*	*Improvement Notice served; PACE statement; letter sent; letter sent to complainant; statements taken*
Village	3/1996	*Visit*	*Letter sent*

The HSE explained that its *information systems do not retain information on premises where we have had no intervention after seven years. Hence HSE does not hold any information on our interventions at Bank House, Grosvenor, Belmont or Bryngwyn Mountleigh,* that is, the non-Puretruce homes. However, the **HSE** did provide a timeline of their involvement with Operation Jasmine:

During **November 2005**, **Gwent Police** invited the HSE to attend the Strategic Partnership Board (SPB, see Gwent Police Chronology) which considered the death of **Gladys Elvira Thomas** at **Bryngwyn Mountleigh**. At a subsequent meeting of the SPB it was agreed that there was a *limited need for HSE involvement as principal issues under consideration were financial matters not issues under the Health and Safety at Work etc. Act 1974 (HSWA).*

Also during November, the HSE attended a Protection of Vulnerable Adults (*POVA) meeting followed by a meeting of* the *police-led investigation team.* The HSE decided that it had a *limited role* because the *emerging issues were outside the scope of HSE's role – alleged neglect, staffing issues and professional misconduct.*

In **February 2006**, the HSE met with **Gwent Police** and gathered that the police were *focusing on financial and immigration issues.* The HSE visited **Brithdir** twice in February, on one occasion with the **CSIW**.[242] During this visit, the HSE looked *at the laundry, means of access, manual handling equipment, including hoists and bedrails.* The latter *emerged as the main health and safety concern.* The next visit was *part of a wider initiative to look at bedrails across all the Puretruce homes.*

During **April 2006**, the HSE attended a SPB meeting at which *concerns about Brithdir* were *discussed principally with regard to bedrails.* On the same day, *Gwent Police took* the *lead on investigation,* that is, decisions concerning *investigations into care at the nursing homes would be taken on by Gwent Police and the HSE would be contacted if there was a need for further involvement.*

Almost two years later, in **February 2008**, **Gwent Police** invited the HSE to attend a SPB meeting at which that HSE learned *that the police enquiry may have established that breaches of health and safety legislation may have occurred. In addition, the disbanding of the SPB in its present format was required by HSE as a number of the organisations attending, Caerphilly LHB and Caerphilly CBC Social Services may themselves be liable to enforcement under health and safety legislation for potential breaches*[243]*.* Within four weeks, *the Strategic Partnership Board had dissolved.* By the end of February, HSE had seconded an Inspector to Operation Jasmine and a *Gwent Police and HSE investigation*[244] began.

During **July 2008**, HSE attended a Gwent Police briefing *on the scope and extent of the police enquiry to date.*

In **November** and **December 2008**, the HSE allocated additional resources to Operation Jasmine, that is, an *Inspector, two administrative support* personnel and a *Principal Inspector as* the *Senior Investigating Officer* (SIO).

During **April 2009**, the HSE established *priorities for potential breaches of legislation. In line with Gwent Police priorities,* HSE made *enquiries on named resident at Brithdir Care Home; scoping other Puretruce Healthcare Ltd care homes; Grosvenor Nursing Home and Bank House Nursing Home.*

During **June 2009**, a Senior Enforcement Lawyer was appointed to the HSE to provide *independent legal oversight of the HSE investigation and act as liaison with **CPS**.*

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[242] Feedback from the HSE on 30 April 2015 states, *To the knowledge and recollection of the HSE Inspector, pressure ulcers* were *not raised as a concern or identified as an issue by CSIW*

[243] Correspondence from the Head of Operations Wales and the Marches in November 2014 confirmed that *it was in respect of our consideration within Operation Jasmine as to whether CSIW, as an organisation, had fulfilled their duty in respect of HSWA Section 3. It was certainly not our intention to intimate that any individual inspector would ever be considered as potentially culpable*

[244] Correspondence from the Head of Operations, Field Operations Directorate, Wales and the Marches in June 2014 stated that the HSE *investigation team did not find sufficient evidence of breaches of health and safety law by Dr Mrs N Das to support further specific investigation into her role and activities*

In **September 2009**, the SIO decided to halt the investigation at **Baybridge** and **Silverdale** *and focus on priorities.*

In **October 2009**, the investigation team met to examine the role of Dr P Das*. Gwent Police continue to take the lead and retain primacy. The HSE continues to support the police and obtain evidence for potential health and safety charges in line with the Work Related Death Protocol.*

During **April 2010**, *in accord with HSE's enforcement policies and procedures and Criminal Procedure and Investigations Act* (1996), *the failings of the agencies already identified from evidence collected by Gwent Police was considered.* It was confirmed that the police was to continue its investigations at **Grosvenor Nursing Home** and **Bank House Nursing Home** *with input from* the HSE.

In **May 2010**, the HSE took *further statements from Caerphilly CBC and Caerphilly LHB to consider potential breaches.*

Legal advice received in **June 2010**, *confirmed* that *Caerphilly LHB cannot be prosecuted for any offences committed by their predecessor bodies.*

During **August 2010**, HSE engaged *experts for the HSE cases considered and retained with Terms of Reference. HSE continue dialogue with **CPS** and **Gwent Police** on allegations outside of HSWA.*

During **October** and **December 2010**, HSE engaged and met with a Queens Counsel (QC).

In **January 2011**, a further Inspector was allocated to the HSE team.

In **April 2011**, *on advice from Queens Counsel and HSE's legal advisors' office, investigations of Caerphilly CBC Social Services and Caerphilly LHB were halted. Further, Counsel confirmed advice that there was sufficient evidence to charge one (only) Director, the Managing Director and the company, Puretruce Healthcare Ltd.*

In **August 2011**, the *investigation lead transferred from Gwent Police to HSE.* Separately, the **CPS** *confirmed their proposed charges alongside HSWA offences.*

In **September 2011**, the ***CPS*** *confirmed their charges alongside HSWA offences.* The HSE confirmed the charges as follows:

*Two charges were laid against **Puretruce Health Care Ltd** under Section 3(1) of the Health and Safety at Work Etc. Act 1974 (HSWA), relating to the treatment of residents on dates between 2002 and 2006.*

Concerning **Puretruce Health Care Ltd** -

between 01/05/2002 and 31/12/2004 - HSWA s3(1) – offence – failed to conduct its undertaking, namely Brithdir Care Home, in such a way as to ensure, so far as is reasonably practicable, that residents of the home were not thereby exposed to risks to their health and safety associated with pressure area damage

and

between 01/07/2005 and 31/05/2006 - HSWA s3(1) – offence - failed to conduct its undertaking, namely Brithdir Care Home, in such a way as to ensure, so far as is reasonably practicable, that residents of the home were not thereby exposed to risks to their health and safety associated with pressure area damage

Two charges were laid against Dr [P] *Das under Section 37(1) of the HSWA.*

Concerning Dr **Prana Das** –

between 01/05/2002 and 31/12/2004; HSWA s3(1) being a Director of PHCL is thereby guilty of an offence under s33(1)(a) & 37(1) HSWA – failed to conduct its undertaking, namely Brithdir Care Home, in such a way as to ensure, so far as is reasonably practicable, residents of the home were not thereby exposed to risks to their health and safety associated with pressure area damage and that offence was committed with his consent or connivance or was attributable to his neglect

and

between 01/07/2005 and 31/05/2006 - HSWA s3(1) being a Director of PHCL is thereby guilty of an offence under s33(1)(a) & 37(1) HSWA – failed to conduct its undertaking, namely Brithdir Care Home, in such a way as to ensure, so far as is reasonably practicable, residents of the home were not thereby exposed to risks to their health and safety associated with pressure area damage and that offence was committed with his consent or connivance or was attributable to his neglect

Two charges were laid against Mr Black under Section 37(1) of the HSWA.

Concerning **Mr Paul Black** –

between 01/09/2003 and 31/12/2004 - HSWA s3(1) being a Manager is thereby guilty of an offence under s33(1)(a) & 37(1) HSWA - failed to conduct its undertaking, namely Brithdir Care Home, in such a way as to ensure, so far as is reasonably practicable, residents of the home were not thereby exposed to risks to their health and safety associated with pressure area damage and that offence was committed with his consent or connivance or was attributable to his neglect

and

between 01/07/2005 and 31/05/2006 - HSWA s3(1) being a Manager is thereby guilty of an offence under s33(1)(a) & 37(1) HSWA - failed to conduct its undertaking, namely Brithdir Care Home, in such a way as to ensure, so far as is reasonably practicable, residents of the home were not thereby exposed to risks to their health and safety associated with pressure area damage and that offence was committed with his consent or connivance or was attributable to his neglect

Two charges were laid against Mr Black under Section 7(a) of the HSWA.

Also concerning **Mr Paul Black** –

between 01/09/2003 and 31/12/2004 - HSWA s7(a) being an employee is thereby guilty of an offence under s33(1)(a) HSWA – failed while at work to take reasonable care for the health and safety of residents at Brithdir Care Home who may have been affected by his acts or omissions at work

and

between 01/07/2005 and 31/05/2006 - HSWA s7(a) being an employee is thereby guilty of an offence under s33(1)(a) HSWA – failed while at work to take reasonable care for the health and safety of residents at Brithdir Care Home who may have been affected by his acts or omissions at work

In **October 2011**, summonses were served *on the three defendants.*

In **November 2011**, a hearing was held at Caerphilly Magistrates Court.

In **January 2012**, a hearing was held at Cwmbran Magistrates Court.

During **February**, **April** and **July 2012**, there were four *Plea and Case Management* Hearings at Newport Crown Court.

In **September 2012**, Dr P Das *suffered injuries following burglary.*

In **October 2012**, there was a further *Plea and Case Management Hearing* at *Newport Crown Court.*

In **November 2012**, the HSE's *Head of Field Operations Wales* discontinued the *investigation of Grosvenor Nursing Home and Bank House Nursing Home on the basis that deaths were due to failings of professional practice by clinical staff.*

In **January 2013**, a hearing was held at Cardiff Crown Court.

In **March 2013**, *charges were Laid on File* at Cardiff Crown Court and *family representatives* were *invited to meet the* HSE *SIO, Queens Counsel and Gwent Police…to explain the outcome of the case and court hearing.*

In **October 2014** the HSE provided a document entitled: *A factual summary for the assistance of the Operation Jasmine Review.* The summary has another purpose - *to provide HM Coroner with a factual summary of a lengthy and complex investigation so as to assist him/her in performing their duties under coronial law.*

Correspondence from the Head of Operations Wales and the Marches in **November 2014** stated:

Pressure ulcers arise from poor quality care. As the quality of care is an issue which others are better placed to regulate, we do not see the development of policy, procedure and practice in this area as matters for HSE…With respect to prosecuting for pressure ulcers in Wales, HSE will

continue to apply its published Section 3 policy in respect of priorities for enforcement. However, the new offence of 'ill-treatment/wilful neglect' [245](in England and Wales) will allow the police to act against employers as well as individual carers. HSE's view is that the proposed offence (due to become law) would allow the police to take action against the likes of Puretruce who fell so far short of acceptable standards.

[245]https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319042/Ill-treament_or_wilful_neglect_consultation_response.pdf (accessed 1 July 2014)

Section eleven: the National Health Service

In this section…

> *…the context of NHS reorganisation in 2003 is considered. Up until 2002, the inspection and regulation of nursing homes had been the responsibility of Health Authorities. Aneurin Bevan University Health Board, which took over the functions of Caerphilly Local Health Board, identified material from its predecessor body in the period from 2003-2006. Concern associated with frequent Protection of Vulnerable Adult (POVA) referrals, the imposition of embargoes on admissions to homes and non-action to CSIW requirements, led to the LHB providing training to Puretruce employees in 2004. On three occasions, District Nurses and additional NHS nursing support supplemented the work of Brithdir staff. A notice to cease placements at Brithdir during 2005 resulted in the transfer of older people from this home in 2006.*

The need to meet growing demands on existing diagnostic, treatment and rehabilitation services, as well as end of life care, and the concomitant increases in cost and a need for more efficient and effective service delivery, led to a series of reorganisations of the NHS in Wales. A reorganisation in **September 2003** concerned the replacement of the five existing Health Authorities with 22 Local Health Boards (LHBs), coterminous with the 22 local authorities. It was the LHBs that were now responsible for registering and inspecting nursing homes. An organisational change of this nature, including new management structures and re-configured geographical service boundaries, was a challenge to continuity and existing partnership arrangements. However, a number of structures and processes were set up with the aim of nurturing collaboration and problem-solving across the various sectors, not least in terms of protecting frail, older patients.

Under the new regime, **Caerphilly Local Health Board** (Caerphilly LHB) was the body responsible for local health care services at the time of Operation Jasmine[246]. The material discussed below is mainly concerned with its activities in the period from **2003–2006**,[247] although the police investigation in fact continued until **2012**. Nevertheless, certain pivotal events prior to **2003** are also relevant. For example, as early as 1995, the television programme *Wales This Week* had expressed concern about the *serious neglect of patients* in three care homes owned by Dr P Das and his wife Dr N Das and the fact that *some of their*

[246] Caerphilly LHB is no longer in existence as a result of further reorganisation. However, documents relevant to the period have been made available to this Review by the Aneurin Bevan University Health Board (ABUHB) which took over the functions of the Caerphilly LHB in 2009

[247] Feedback from the Aneurin Bevan University Health Board, 28 April 2015, stated: *it is important to note that as there was not a complete record of events, this* [chronology] *had to be pieced together from historical documents of various types. Generally, when compiling a chronology involving other agencies, a merged, inter agency chronology allows cross checking of information. Whilst we believe we have provided a true and accurate chronology, verification of events concerning others cannot be verified.*

elderly patients end up in nursing homes owned by them. Although the **Community Health Council** received complaints from residents' relatives, former staff *and local doctors who* had *spoken privately about the acute state of some of their patients in* the homes, the **Mid Glamorgan Health Authority** (which was the responsible health locally at that time) *declined to release their inspectors' reports* and the **Mid Glamorgan Family Health Services Authority** asked: *Need* nursing home owners who are GPs *necessarily be involved in the nursing home other than actually owning it?*[248]

In terms of policy, *In Safe Hands: Implementing Adult Protection Procedures in Wales* had been issued by the **Welsh Assembly Government** in **2000**. This defined *neglect* as, *including failure to access medical care or services, negligence in the face of risk taking, failure to give prescribed medication, poor nutrition or lack of heating.* It was followed, in **March 2003**, by further guidance in the document *Fundamentals of Care: Guidance for Health and Social Care Staff – Improving the quality of fundamental aspects of health and social care for adults.* This documented 12 *practice indicators: communication and information; respecting people; ensuring safety; promoting independence; relationships; rest and sleep; ensuring comfort, alleviating pain; personal hygiene, appearance and foot care; eating and drinking; oral health and hygiene; toilet needs;* and *preventing pressure sores.*

In addition, the South East Wales Executive Group for the Protection of Vulnerable Adults[249] published its own local guidance in **September 2003** in the document *Protecting Vulnerable Adults: Interagency policy, procedures and practice guidance for responding to alleged abuse and inappropriate care of vulnerable adults in the South East Wales area*. The signatories to this included Gwent Healthcare Trust, Blaenau Gwent LHB, Caerphilly LHB, Newport LHB and Torfaen LHB. It stated that:

- *Staff have a duty to report any concerns they have about the potential abuse of a vulnerable adult*
- *Agencies are committed to interagency training, development and learning from experience of adult protection work* (p16).

It also stated that:

All health professionals, including GPs and their practice staff, primary health care team workers, community nursing services, staff in hospital wards and accident and emergency units, are well placed to pick up signs of adult abuse. They have a duty to report any concerns they have (p28).

[248] See Appendix 1

[249] Representing the five local authorities in south east Wales: Blaenau Gwent CBC, Caerphilly CBC, Monmouthshire CC, Newport City Council and Torfaen CBC. Each of these authorities had their own multi-agency procedures and each identified the need to have *codes of practice based on a consistent framework*

There is a single reference as such to *pressure sores* in a checklist entitled, *Categories of abuse: how serious is the abuse?* Examples of *neglect* on a continuum from *serious* to *extremely serious* include:

- *Occasional lack of care leading to discomfort or inconvenience e.g. being left wet*
- *Lack of care leading to e.g. pressure sores or medical problems*
- *Serious continuing neglect leading to e.g. malnutrition, dehydration*
- *Failure to access life-saving services or medical treatment/care*
- *Neglect of needs leading to threat to survival*

The policy's *possible indicators of abuse* (p107-115) cover several clinical disciplines, for example, *enforced sedation; inappropriate use of medication; injury fracture or marks incompatible with the explanation; injury not properly cared for; untreated pressure sores; ulcers; poor skin condition or hygiene; significant weight loss without explanation; withholding of specialist equipment or aids; restriction of free movement; malnourishment; dehydration; inadequate heating and lighting; lack of personal care, including help with hygiene, managing continence; dirty or unhygienic surroundings; failure to obtain and use necessary devices; restriction or denial of right to medical or social care; lack of response to complaints; service users in dirty or unkempt state.* The procedures list the *characteristics of abusive settings and employees,* that is:

- *low staff morale and feeling powerless to influence practice;*
- *inappropriate staff attitude and limited understanding of the people they care for;*
- *conflict within staff groups or between staff and managers;*
- *inadequate management, staff supervision and support, training and development;*
- *poor pay;*
- *high staff turnover; low staffing levels over a period of time;*
- *rigid, inflexible work routines;*
- *isolated settings with: little contact with the neighbourhood, community; few visitors; little interest shown by managers* (p118).

During **October** and **November 2003**, Caerphilly LHB became aware of the *frequent…POVA referrals* to Caerphilly CBC concerning **Holly House**[250] which included residents' injuries from falls and the *lack of management* of people with diabetes and pressure damage. An embargo was put in place. The **Care Standards Inspectorate Wales** (CSIW)[251] was also concerned about the inadequate management support and poor staff morale.

[250] Although Holly House was not one of the six Operation Jasmine homes, its closure impacted on Brithdir. Both homes were owned by Dr P Das and Dr N Das

[251] The regulator responsible for registering and inspecting care homes - see Section 8

During **January** and **February 2004**, an *overarching POVA strategy meeting*[252] was attended by Caerphilly LHB. This noted that *the police were not taking action in respect of the cases…Reassessments had been satisfactory. The meeting noted a lack of evidence of the care home in achieving the action plan.* However, a visit by **Caerphilly CBC** to **Holly House** the following month noted *improvements*[253] which resulted in the embargo being lifted. *The plan was to monitor progress for six months with the option to serve notice on the local authority contract should concerns be continued.*

In **April 2004** the Welsh Assembly Government published guidance entitled *NHS Funded Nursing Care in care homes.* This outlines a *Model Contract between LHBs and Care Homes.* With reference to accessing NHS services, the guidance states that:

Care home residents should have access to the full range of specialist NHS support that is available in other care settings and to people receiving care at home…All residents of care homes should be registered with a local GP so that they can access the full range of NHS services that are, and must be free for patients….Although a GP may not charge NHS patients – directly or indirectly – for the provision of general medical services, a GP may enter into arrangements to provide professional services to anybody or institution, including care homes.

During **May** to **June 2004**, concern about the failure to (i) sustain improvements and (ii) act on the **CSIW** requirements led **Caerphilly LHB** to offer *training in older adult mental health to Puretruce Ltd homes.*[254] A **CSIW** inspection strengthened concern across sectors and an embargo was reintroduced. At the same time, *POVA concerns began to increase* about **Brithdir**'s residents in respect of *poor care…pressure damage and…the professional misconduct of a GP visiting the home.*[255]

In **July 2004**, the **CSIW** was planning to cancel **Holly House**'s registration and **Caerphilly CBC** and **Caerphilly LHB** met with the owners to express their low expectation of the company being able to meet the required standards. However, **Caerphilly LHB** offered to supplement the company's efforts over four weeks by providing additional qualified nurses to assist in improving care planning and standards of care. No charge was to be made for this and the offer was accepted.[256] A meeting with the families of **Holly House** residents was *unanimously angry* and it was *alleged…that a personal vendetta was being waged by the regulator against the provider.* CSIW's position was unchanged: *the company could not sustain any improvement.* Also during July, a POVA referral resulted from the hospital admission of a **Brithdir** resident who had *significant pressure damage.* This resulted in District Nurses *being*

[252] These were used to manage more than one referral or concern related to the same service or provider

[253] This became a very significant intervention, that is, the CBC professionals disagreed with the findings and concerns of CSIW inspectors. Feedback from the Aneurin Bevan University Health Board dated 28 April 2015 states, *need to verify details with CCBC*

[254] Feedback from the Aneurin Bevan University Health Board dated 28 April 2015 states: *The training was offered as it was identified that residents were being 'inappropriately lifted'* and to address the *non-action to some CSIW requirements*

[255] Information provided by ABUHB

[256] A further, significant LHB intervention

dispatched to undertake assessments of all residents in respect of pressure damage and to review record keeping and *a formal investigation was requested into the conduct of a GP who had contact with* a **Brithdir** resident. The District Nurses noted the *limited input of registered nurses on upper floors* and *defensive staff*.

In **August 2004**, the **CSIW**'s report accompanying its notice of proposal to cancel **Holly House's** registration was described by **Caerphilly LHB** as *detailed and worrying…NHS nurses had indicated that 80% of residents would be put at risk* if they had to move. *However, there was…sufficient evidence to apply the term 'institutional abuse.'*[257] *Relatives with concerns about...care at Holly House were also coming forward…*they *had not felt able to voice their concerns at the public meeting…The Caerphilly LHB and Caerphilly CBC pursued an option of temporary registration of LA beds to allow staged decommissioning and also considered the capacity of hospital wards as a last resort…Brynheulog home was prepared for 15 residents and Caerphilly LHB was working with the Gwent Healthcare Trust in respect of staffing arrangements to support the change in status.*

In **September 2004**, **Caerphilly CBC** produced a chronology of POVA strategy meetings[258] concerning **Puretruce Health Care Ltd** from **2002** to **September 2004** and *contract monitoring was increased.* District nurses assessed 28 **Brithdir** residents and reported *issues in respect of pressure damage, weight loss* and *smell of urine* for example. *Additional NHS nursing support was identified.* An embargo was put in place. At a meeting to advise Dr P Das *of the intention to discontinue LA contractual arrangements with Holly House* at which *a new matron was in place…*Caerphilly LHB and the local authority agreed to *commission Care Forum Wales*[259] *to review…evidence…visit the home and talk to Gwent Healthcare Trust nurses to measure the improvements made.*

Concern about **Brithdir** persisted and District Nurses *assessed all residents for a third time* and a *pressure relief audit* was undertaken…**CSIW** *were in discussion with the police.*

In **November 2004**, *an official report* described as *from Care Forum Wales…provided by the owner of Holly House was received* by **Caerphilly LHB**. *This indicated that the owner was now meeting legal requirements and whilst there were issues of sustainability it was acknowledged that significant improvements had been made. It was agreed that the embargo on Holly House should be lifted to allow 29 residents.*

In **December 2004**, an *overarching POVA strategy meeting* concerning **Brithdir** *identified significant improvements* which *resulted in lifting the embargo,* albeit with conditions, that is, restricting new residents to two per month and monthly monitoring of the action plan and

[257] Defined in the South East Wales Executive Group for the Protection of Vulnerable Adults (2003) interagency policy, procedures and practice guidance as: *includes isolated or repeated unacceptable and unprofessional acts, behaviours and practices, including pervasive ill-treatment, violation of rights and duty of care* (p14)

[258] This is part of the initial investigation – all relevant professionals are invited to gather and share information about the alleged abuse and to decide what response is needed and by whom

[259] http://www.careforumwales.co.uk/ (accessed 24 February 2015) *Care Forum Wales represents…care homes, nursing homes and other independent health and social care providers*

reviews of residents by a *senior nurse* from **Caerphilly LHB** and Funded Nursing Care (FNC) assessors. However, once again, there was concern about sustainability. Their input was to be reviewed after three months. Also, *regular monitoring by the local authority continued.*

In **March 2005**, **Caerphilly LHB**'s senior nurse reported that **Brithdir** *had made considerable improvements to the standard of care, particularly in respect of tissue damage, nutrition and care plans.* In respect of **Holly House**, **Caerphilly LHB** *noted its position…the continued support…had resulted in improvements. Gwent Healthcare Trust nurses had provided clinical support and clinical supervision to the matron. The continuance of support rested on the outcome of the appeal. The ongoing concerns about stability and sustainability of the home required reconsideration of the position with regards to commissioning with the company…contingency plans were being considered in respect of the closure of Holly House.*

In **April 2005**, **Caerphilly LHB** received reports written by a Consultant Psycho-geriatrician which had been commissioned by **Puretruce Ltd** as part of its appeal to the **Care Standards Tribunal** against the **CSIW**'s decision to cancel **Holly House**'s registration. These cited *evidence that moves of vulnerable older people (particularly those with cognitive impairment) are potentially at risk of increased morbidity and mortality* and *expressed the view that the decision to deregister should be informed by the need to balance the associated risks and benefits for the relatives.* A summary of this report for **Caerphilly LHB** stated: *The risks associated with relocation can only be considered as potential and must be weighed against the risks associated with individuals remaining in an environment where there can be serious concerns regarding the ability of the organisation and care team to appropriately assess and meet the complex care needs of the resident group.*[260]

Also during April, *some improvements* were noted at **Brithdir**. However, *because some areas still required attention, there was agreement to extend the review process and meet again in July.*

A sample **Caerphilly LHB** *Contract for the Provision of NHS Funded Nursing Care* between the LHB and a *care provider* during **1 April 2005** to **31 March 2006** set out the *Administrative Arrangements; the Obligations of the LHB; Definitions;* reviewing arrangements for *Residents whose Care is Supported by a Local Authority; Method of Payment for NHS Funded Nursing Care; Continence* (assessment); *Equipment and Services; Short Term Nursing Care; Assessment and Discharge Procedures; Notification of Entitlement; Claiming for the NHS Funded Care Contribution; Reassessment; Supply of Information Leaflets and Forms; Monitoring; Obligations of the Care Provider; the Referral/Assessment Process; Complaints; Appeals; Closure of a Care Home; Confidentiality; Information sharing; Patient related records; Commencement of Payments; Cessation of Entitlement to Payment Indemnity and Insurance; Termination; Equal Opportunities; Default; Variation; Health and Safety.* The Contract's *Schedule A* outlines the *Discharge and Assessment Procedures* and *Schedule B* is entitled

[260] This quotation is also attributed to Caerphilly LHB in *Health Board summarised timeline of pivotal events: Jasmine Review* August 2014

Fundamentals of Care and lists the *12 aspects of care as described in the Welsh Assembly Government* document.[261]

In **May 2005**, the **Care Standards Tribunal** allowed the appeal with two conditions: *the appointment of a full time deputy manager and the requirement for the company to provide CSIW with a report every two months from an independent health and/or social care consultant…identifying progress made against set targets and maintain the National Minimum Standards for Care Homes (Wales) 2002 and the Care Homes (Wales) Regulations 2002.*

In **June 2005**, *the first report of the independent consultant Indicates: positive improvements (Holly House) but acting manager and staff struggling to maintain regulatory requirements and minimum standards; lack of confidence about the future of the home; difficulty in obtaining supplies and repairs as cash purchase required, urgent action needed to invest in basic facilities, the fabric of the building and staffing. Reasonable timescales need to be set and met consistently to allow staff to concentrate on improving standards of practice instead of struggling to keep things going.*

Puretruce Ltd requested a qualified Gwent Healthcare Trust nurse to act as the Registered Manager to cover staff absence for 4-6 weeks. Informed that Gwent Healthcare Trust staff were unable to act as a Registered Manager and advised re staffing issues.

In **July 2005**, *local authority contract monitoring continued in respect of Brithdir…Plan to continue contract monitoring visits and review again* in *three months.*

In **August 2005**, *Magistrate calls for the immediate closure of Holly House as a consequence of gas supply fittings not complying with standards as noted at CSIW inspection visit…18 residents assessed…supported and relocated to Bryngwyn[262] 10, and Brithdir 8….Following the move, concerns were raised in respect of 5 POVAs, 2 Brithdir and 3 Bryngwyn – all related to poor care and neglect. It was noted that the owner was moving patients from one home to another without any consultation. One resident was the subject of two POVAs raised in respect of both homes.*

During **September** and **October 2005**, a **POVA** referral concerning a **Brithdir** resident resulted in *nursing assessments* which involved FNC assessors. *Issues identified included poor skills and knowledge of staff relating to physical care, catheter care, use of pressure relieving equipment and insulin administration. Agencies met to consider necessary actions that included redrafting of action plans and monitoring. Embargo re-established and cancellation of the contract considered…Letters to inform families.*

Four families expressed concerns about the care at **Bryngwyn** and a POVA resulted from a complaint. *CSIW Inspectors visit reported as positive. Investigation undertaken by the Caerphilly LHB for the POVA identifies recommendations, including a review of management*

[261] See March 2003 above

[262] Bryngwyn Mountleigh

and organisational structures, active engagement with relatives and establishing a key worker/named nurse system.

Further POVAs in October in respect of residents at Bryngwyn resulted in a police investigation. All residents at Bryngwyn Mountleigh assessed and body mapping[263] *undertaken. Embargo recommended.*

In **November 2005**, *following an overarching POVA strategy meeting concerning Brithdir residents with significant pressure damage, lack of appropriate skills and actions not taken…the decision is taken to cease commissioning care.*

The level of concerns regarding the care provided within the independent sector led to the police led multi-agency investigation under POVA procedures and an initial meeting was held. This investigation was subsequently called Operation Jasmine. This was strategically directed by a Gold Group that received information from an Investigation Team. Caerphilly LHB seconded a senior nurse to work as part of the investigation team. The investigation concerned Mountleigh Bryngwyn and Brithdir and was concerned with events spanning a number of years…it was agreed that:

- *all POVA cases should be subject to strategy meetings and then…considered as to whether the case should be included in a running 'schedule of concerns'*
- *assessments and reassessments by FNC assessors to continue*
- *nursing posts established to support the delivery of care in care homes across Caerphilly (mental health liaison nurse and practice development nurse appointed by Caerphilly LHB)*
- *Local enhanced service developed to ensure GP services reached into the private sector*
- *Nursing and Midwifery Council (NMC) being advised of all nurses subject to investigation*

Embargoes were in place for both homes and *senior District Nurses provided additional support in respect of wound care. Decision made to serve notice on the contract for Brithdir…Caerphilly LHB receives legal advice which notes the positive obligation on Caerphilly LHB to provide nursing care for residents in care homes which are registered and recommends…12 weeks' notice of termination rather than immediate termination. Notice to cease funding placements* at **Brithdir** *from 23 May 2006 is given.*

In **December 2005**, **Caerphilly LHB** noted that there was a *strategy being developed to move Brithdir residents…not enough beds available in nursing homes or hospitals. Should there be an emergency closure then ways would be looked at to establish temporary care in the home until residents can be safely moved. First contingency plan would be to step in with staff and resources to keep home safe and then decant in a managed way. Training for staff on pressure*

[263] See http://www.pcs.org.uk/en/resources/health_and_safety/health_and_safety_reps_toolkit/body-mapping.cfm (accessed 24 February 2015) for an example of the process, albeit in relation to employees rather than residents

area care continued to be *provided for both homes. District Nursing assessments ongoing – Waterlow assessment*[264] *and bed/mattress audit undertaken and providing care to residents requiring nursing placements.*

Letters received from families unhappy about the decision to close the home.

In **February 2006**, Bryngwyn Mountleigh was taken over by **Southern Cross**. It became known as **Millview House/Lodge**.

In **March 2006**, a judicial review was *lodged in respect of cancellation of contract. CSIW preparing a cancellation of* registration *notice. Care in Brithdir being supported by District Nurses going in twice a day. Describe care home staff as 'hostile and resentful.' Letter to the Royal Courts of Justice to update the Court* regarding *ongoing agency concerns and general standards of care, in particular those raised under POVA. Patients* were *being assessed and reassessed. Risk assessments also being undertaken to enable authorities concerned to weigh their duty of care to residents against the appreciated risk of moving elderly and infirm individuals to alternative care homes.*

In **March** and **April 2006**, a *rapid but managed transfer of care is undertaken.* There was *continued supplementation of nursing care by NHS nurses (although this could not be 24 hour care).* There were *District Nurses/rapid response team attending residents every evening to deliver care, particularly wound care,* and the *very close monitoring of care* continued.

These events set the stage for the identification of key health and social care policy developments, that is:

- In **July 2007**, the National Public Health Service for Wales published *Infection Control Guidelines for Care Homes: The prevention and control of healthcare associated infection in care homes.*[265]
- In **May 2009**, the Welsh Assembly Government issued statutory guidance, *Escalating Concerns with, and Closures of, Homes Providing Services for Adults.* This aimed to address the management of escalating concerns about homes providing care and support to people, including nursing care.

Also during **2009**, there was a further NHS reorganisation which resulted in the creation of seven new Health Authorities (including the ABUHB), by merging eight NHS Trusts with the 22 Local Health Boards, to deliver all health care services within a geographical area. Community Health Councils, which provide an independent voice in the health service, were similarly reorganised.

[264] A tool to assess the risk of a patient developing a pressure ulcer

[265] The families which had relatives at Brithdir recalled very poor standards of hygiene. The Expert Panel commissioned by Gwent Police noted that nursing staff did not ensure the maintenance of adequate hygiene standards

In **February 2010**, the review of *In Safe Hands*[266] made recommendations for *Local Health Boards and NHS Trusts*, that is, they *should ensure they have robust safeguarding arrangements, including:*

*Investigating all incidences of serious pressure ulcers (Grade 3 and 4) to assess whether they have resulted from neglect…LHBs should…*ensure *that settings providing continuing healthcare have the necessary staff and equipment to support adults at risk (including those at risk from pressure ulcers)* (p17).

Since unattended pressure wounds characterised the experience of too many frail older people in the homes known to the Gwent Police investigation, the **May 2010**, publication by Public Health Wales of Dr Sharon Hillier's paper is critical: *Pressure ulcer prevention in Wales: Reducing the Harm*. The paper confirmed that *pressure ulcers are common in healthcare settings…the cost of pressure ulcers is high both for the patient…and to the health service because of the cost of treatment and prolonged hospital stays;* that since older people are more at risk of developing pressure ulcers, the latter *are going to be an increasing problem in the future* and *effective prevention strategies are urgently needed in Wales.* Older people *in nursing or residential care homes* were identified as a *population at risk* and yet the incidence of pressure ulcers among this population is not known in Wales. The paper stated that although the Care Standards Act 2000 regards pressure ulcer damage of grade 3 and 4 as potential indicators of neglect, in clinical settings such as orthopaedic units and community hospitals there is *wide variation* in reporting pressure ulcers as *critical incidents.* Dr Hillier's paper is silent on the effectiveness of adult protection procedures.

One of the lasting achievements of Operation Jasmine for the ABUHB is its acknowledgement that there were fissures in the rickety structure of policies, procedures, contracts and guidance because nothing substantive improved for the residents of **Holly House**, **Brithdir** and **Bryngwyn Mountleigh**. The fissures became enormous cracks since these homes were inadequately managed; they offered far less than that which residents required; and yet their funding streams mostly continued – and residents' families had no sense of the scale of harm, even as they became unwitting bystanders to the NHS' grim role of patching, fixing or making their relatives as comfortable as possible at the end of their lives.

The ABUHB had no enthusiasm for persisting with an approach which did not work and in which lead agency responsibility for stating, "Enough is enough!" was either silenced by short term improvement initiatives or absent altogether.

The ABUHB informed the Review that it did not want contracts with residential homes which focused solely on agreements about payment, that is, a replication of a system that had not worked. They wanted contracts which confirmed the centrality of providing a service in which

[266] Magill, J., Yeates, V. and Longley, M. (2010) *Review of In Safe Hands: A review of the Welsh Assembly Government's Guidance on the protection of vulnerable adults in Wales,* University of Glamorgan: Welsh Institute for Health and Social Care

the *basics of safety is a given;* communication with people's relatives; and a greater investment in pooling information about residents' experience of particular homes. This required the ABUHB to assert their responsibility for checking out homes in advance of placing people, for example by inviting the home to complete a *Provider Placement Checklist;* paying greater attention to the detail and monitoring of care planning; proactively seeking information from people's relatives; inviting NHS colleagues visiting the home to complete an *NHS Visiting Professional Provider Feedback Form* and identify the *Clinical Actions and Recommendations.*

Although the ABUHB is encouraged by the positive feedback concerning its proactive approach, it accepts that there is too little choice in terms of identifying options for care and support. It is anomalous that the origins of existing residential services for frail older people in Gwent owe more to business opportunism than to a consideration of what individuals with dementia and families identify as important as they begin to consider the transition to some form of residential provision.

Section twelve: Analysis part one - the legal context of residential care and corporate governance

Aled W. Griffiths, Chaynee Hodgetts, and Roisin Ni Thuama

In this section…

> *…you will learn about the lack of legal safeguards in relation to the provision of residential care by non-listed private companies. These are not subject to the UK Corporate Governance Code and legislative provisions that apply to listed public companies. This means, for example, that a sole director is sufficient to run a company without external or independent scrutiny, a not uncommon situation in the care market. Despite the weaknesses in the current legal position concerning private, non-listed companies (which needs urgent reform), Dr P Das and Dr N Das could have been made accountable on other grounds in both civil and criminal law. It is unclear why such steps were not pursued.*

1. Corporate Governance - Introduction

There appears to be an urgent need to consider how best to ensure better corporate safeguards in relation to the residential and nursing care of elderly and other vulnerable individuals. There have been numerous corporate scandals of late, so much so that websites compete with claims and counter claims as to listings on the top ten or twenty corporate failures in terms of gravity based on considerations of unethical, capricious, and reckless behaviour.[267] Yet, save perhaps for reference to the Southern Cross collapse,[268] a browser is unlikely to find references to corporate care providers within such lists. Paradoxically, this is both surprising and wholly explicable. It is surprising given the size and competitive nature of the care market.[269] It is also explicable, because few care providers, Southern Cross[270] being a rare exception, are, or have been, publically listed companies. The vast majority of corporate bodies providing care, as is also the case across the corporate sector as a whole, are private

[267] A web-search of the term "*corporate scandals,"* for instance, leads to sources such as "*The 25 Biggest Corporate Scandals Ever*", or "*The 10 Biggest Scandals in Modern History*". Academic discussion on the lessons to be learnt from the corporate failures is very varied ranging from legal, economic, sociological, psychological and management discourse. See, for instance, J. W. Salacuse, "Corporate Governance in the New Century," (2004) Comp. Law 25(3) 69- 83; A. Young, "Frameworks in regulating company directors: rethinking the philosophical foundations to enhance accountability," (2009) Comp. Law, 30(12), 335-361

[268] www.bbc.co.uk/news/business/14102750 (accessed 11th May 2015). At its peak, Southern Cross Healthcare was the largest independent care home business in the UK, with more than 700 homes nationally, and almost 40,000 beds. The Company failed financially and was also the focus of a Serious Case Review, (Orchid View). http://www.hampshiresab.org.uk/wp-content/uploads/June-2014-Orchid-View-Serious-Case-Review-Report.pdf (accessed 11th May 2015) The SCR had been set up after an Inquest into the deaths of 19 elderly people had found evidence of` institutional abuse. It is worth noting that one of the Operation Jasmine homes, Bryngwyn, Mountleigh, was taken over by Southern Cross in November 2005

[269] J. Forder and S. Allan "Care Markets in England: Lessons from Research" (2012) PSSRU Discussion Paper 2815, University of Kent

[270] ibid

non-listed companies,[271] which are not subject to the monitoring Codes[272] and the supplementary legislative provisions that apply to listed public companies. A detailed discussion of the distinctive legal features of the types of legal entities[273] possible is beyond the scope of this Review, save only to emphasise that the academic, practice, and sometimes-legal solution promoted as a shield against corporate failure is the appointment of non-executive independent directors.[274]

The impetus for this solution can be traced back to the influential Cadbury Report of 1992.[275] It was established against the backdrop of various financial scandals, which also, in the course of its deliberations, was obliged to extend its remit to consider the implications of the Maxwell fraud involving secret files and secret loans. The recommendations, fine-tuned and supplemented by subsequent Reports and Codes[276] cover the operation of Boards of Directors, the establishment, composition and operation of key board committees, the importance of and contribution of non-executive directors, and the reporting and control mechanisms of a business. The resulting monitoring and regulatory framework established can at best only be described as *soft* law, but the point worth repeating is that even this softly-softly approach does not apply to most of the corporate sector, since the vast majority of

[271] The Code applies to the FTSE 350. Companies House "Statistical release: Companies Register Activities 2013 - 2014" (July 2014, Companies House) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380779/CompaniesRegisterActivities2013-2014.pdf (accessed 11th May 2015). This states: *There are over 23 types of Corporate Body held on the Register. Each have their own requirements to provide information to Companies House, as outlined in various Legislation and Royal Acts.* It states that, on the Total Register, there are: 3,103,821 Private limited companies, 91,879 Private limited by guarantee with no share capital, 59,689 Limited liability partnerships, 41,610 Private limited by guarantee with no share capital (exempt from using 'Ltd'), 27,317 Limited partnerships, 7,821 Public limited companies (PLC)

[272] The Code applies to public listed companies on a "comply or explain" basis. It does not apply to non - listed companies The Reports simply suggest that the remainder of the corporate sector be encouraged to follow the Guidance

[273] The providers of adult social care can range from sole traders, partnerships, limited partnerships, limited liability partnerships, private companies limited by shares, private companies limited by guarantee, public companies, and public listed companies. It should be noted that the minimum share capital necessary to incorporate is small. Only a £1 of contributed capital is necessary for a private company whereas £50,000 (*authorised capital*) is necessary to register a public company (s.763 CA 2006). However, all the total sum need not be paid up front, with the result that a public company may register with as little as £12,500 paid up share capital, together with an obligation for shareholders to pay another £37,500 if required (see D. French, S. Mayson, & C. Ryan, C*ompany Law* (2014, Oxford University Press at page 57). The primary advantage of incorporation is the benefit of limited liability - the company is treated in law as a separate legal person with the result that the financial liability of shareholders is normally no more than their shareholding. In some circumstances such as fraud, it is possible to "lift the corporate veil" and pin financial liability on individuals but it is rare. Usually, shareholders are shielded from financial risks (see C. Nyombi "Lifting the veil of incorporation under common law and statute," (2014) Int. J.L.M. 80)

[274] The usual approach in Western economies in recent decades is to require that a high proportion (often the majority) of Board Members should be independent non-executive directors. They are regarded as an essential tool to improve the monitoring role of the Board. See R. Wolf-Georg, "Independent Directors: after the crisis," (2013) E.B.O.R., 14(3), 401-424. However, there is considerable scepticism as to how effective and how independent such appointments can be. See, for instance J. Liu and T. Andersson, "Mind the Gap: Expectations on the Role of the UK Non-Executive Directors," (2014) Regent's Working Papers in Business & Management 2014, Working Paper 1402: RWPBM1402

See also Department of Health and Institute of Public Care, *"Owning up to Care" - A guide to the ownership and funding models of care organisations*" (January 2013). The report aims to provide a factual guide to the different legal models of ownership of care providers, and some insight into the ways in which care companies and organisations may be funded

[275] The Report can be read here: www.ecgi.org/codes/documents/cadbury.pdf (accessed 11th May 2015)

[276]The latest version (September 2014) is entitled the UK Corporate Governance Code

companies are private and unlisted. There were about twenty British healthcare companies listed on the London Stock Exchange in the 1990s, but, not surprisingly, given the debacle and bad publicity surrounding Southern Cross, all but one has since disappeared.[277] The current UK Corporate Governance Code echoes earlier versions, and, for instance, includes provisions to ensure a degree of externality and role differentiation within the corporate structure.

Main principles A2 & B2 of the Code respectively specify:

There should be a clear division of responsibilities at the head of the company between the running of the board and the executive responsibility for the running of the company's business. No one individual should have unfettered powers of decision.

Except for smaller companies[278] *at least half the board, excluding the chairman, should comprise non-executive directors determined by the board to be independent. A smaller company should have at least two independent non-executive directors*.

2. Private Companies

As outlined above, the requirements of the Code do not apply to non-listed public limited companies nor do they apply to private companies. Dr P Das and Dr N Das' L- Giri corporate 'empire'[279] is a case in point. They were the sole directors and the sole shareholders in the above named holding company and a chain of subsidiary private companies, which, if regarded as a single corporate entity, at its pinnacle, owned no less than 24 homes providing nursing and residential care for some 1,000 individuals.[280] The public interest associated with the care of such a large number of adult residents, and the public sponsorship involved, has no impact on their obligations in terms of corporate governance. In fact, the operation could nowadays be lawfully carried by just one of the couple, since the *Companies* Act *2006* has reduced the minimum registration requirement for directors from two to a single director.[281] The *Act* has also relieved such companies from the requirement to hold Board meetings.[282] Indeed, Dr N Das is now the sole director of the remnant of the Das' group of companies[283] Moreover, a review of First-Tier Tribunal (Health Education and Social Care Chamber)

[277] Only Circle Health, the first private company to take over an NHS hospital, and Caretech, a small AIM-listed player, remain listed. Private equity groups, having been privatised in the 1990s, predominantly own private providers of mental health and elderly care in the UK. See G. Plimmer, "Specialist Care group Cambrian seeks IPO" *Financial Times*, February 9, 2014

[278] A smaller company in the Listing context is one that is below the FTSE 350 throughout the year immediately prior to the reporting Year

[279] See Appendix 1

[280] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) (5 September 2006).

[281] s.155, which came into force in October 2008

[282] The AGM requirement does not apply to private companies - see CA 2006, Part 13, Chapter 14, and s.288 CA 2006, which provides for matters to be resolved and decided upon by exchange of notes rather than formal face-to-face meetings

[283] See Company Record saved as pdf, entitled "Puretruce Health Care Limited 03035216" (accessed 17.11.2014)

decisions shows that **single director** corporate providers are not uncommon.[284] Indeed, the above Tribunal Case Reports, with one significant exception, make little or no reference to corporate governance in their deliberations. Moreover, the exception relates to a not-for-profit organisation limited by guarantee rather than a private company limited by shares. Be that as it may, the reference warrants inclusion:

Unlike some voluntary not-for-profit organizations, SCS was solely under the control of Mr and Mrs Hyland and for example, there was no Board of Trustees or other similar body used to formulate policy for the organisation or provide a forum for discussion of new developments and practice in this challenging area of care.[285]

3. Dr P Das

Dr P Das was a colossus within the company - his influence and hands-on approach are everywhere to be seen in the tribunal cases and the contiguous evidence. The company's culture and operation were therefore miles short of the expectations referred to above in respect to listed companies.

Professor Wells, citing from the *Australian Criminal Code Act 1995*,[286] defines "corporate culture" as: *an attitude, policy, rule, course of conduct, or practice existing within the body corporate generally or in the part of the body corporate in which the relevant activities take place*.[287]

Any application to be a listed company would have failed for reasons such as: the need for three years' audited accounts, evidence of working capital for current needs, and at very least twelve months' operation. His influence across the company is of significant importance in law in that it should have assisted in the attribution of criminal liability to the company for the catalogue of concerns and wrongs committed. However, it also needs to be emphasised that he was not the only person responsible. Dr N Das might also have been held accountable. Directors in law have separate and collective responsibility for the management of the company. They have specific statutory duties to exercise independent judgement[288] and

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[284] See, for instance, *Agape House Limited v Care Quality Commission* [2014] UKFTT 839 (HESC) (22 August 2014); *Willow House Domiciliary Care Agency Ltd (Formerly Willow House Ltd) and Mr L Wilson (Appellants) v Care Quality Commission - Respondents* [2010] 1709.EA and 1714.EA; [2011] UKFTT 359 (HESC) (29 June 2011)

[285] The actual case related to a provider of services for young people - see Synergy Child Services Ltd (SCS) & Oras v OFSTED [2009] UKFTT 260 (HESC) (16 October 2009)

[286] Specifically s.12.3(6)

[287] Celia Wells, "Corporate criminal liability: a ten year review" [2014] Crim. L.R. 849, 865.
This definition is also noted by Neil Cavanagh, "Corporate criminal liability: an assessment of the models of fault" [2011] J. Crim. L. 414, 433

[288] s.173, CA 2006

reasonable care, skill, and diligence.[289] Moreover, it is no defence to claim that she had effectively abdicated her responsibility to her husband, a co–director.

It is not uncommon for husbands and wives in small private companies to be fellow directors. The wife of the founder director may be on the Board even though she may not be very active within the company. Irrespective of how active she may be, she can be held liable.[290] In *Secretary of State for Business, Innovation and Skills v Reza*,[291] a disqualification of director's case (see below) which arose out of a Scottish nursing home failure, the passive wife of the active director was also disqualified by the Court from being a director. As reported and admitted in the case, she was only made a director because of perceived tax advantages, and in case it might have been helpful to have a director in the care home, and available to sign documents. As was made clear in Lord Malcolm's judgement, she had not met her legal responsibilities as a director and had allowed her husband to run the company's affairs without any input by her over her 18-year period of office. In his Lordship's words:

The public interest demands that directors of companies take an active interest in the affairs of the company, and are mindful of their personal responsibilities for the proper running of the business. Part of the court's task is to reflect that public interest and deter others from mistakes such as those made by the respondent. Her case is not one of delegation, but of abdication of responsibility. The current regime relies upon the vigilance and competence of directors, and the case law is clear that incompetence can include inactivity.[292]

Disqualification on the ground of "unfitness" is only available under the relevant Act when the Company is also insolvent (see discussion on disqualification below).

As reported in the second Tribunal hearing[293] in the present case (see paras 87-88) the company was issued with a winding up petition by HM Revenue and Customs in respect of unpaid taxes amounting in total to £303,634. This money was eventually paid by the company. However, the directors could still have been pursued under the legislative provisions since the term "insolvent" is defined very broadly. It includes voluntary as well as involuntary liquidation.[294] They could also have been disqualified on other grounds (see below). It is also worth noting that this example of "brinkmanship"[295] is reflective of L-Giri's conduct across its corporate responsibilities as illustrated by evidence from the First Tribunal. By the date of the hearing, fresh issues had arisen in relation to this matter, with respect to

[289] s.174, CA 2006

[290] D. Milman, "Directors, governance and managerial responsibility: new developments in UK Law," (2013) Co L., 346 1-5

[291] [2013] CSOH 86

[292] *Secretary of State for Business, Innovation and Skills v Reza* [2013] CSOH 86, at 19;

D. Milman, "Directors, governance and managerial responsibility: new developments in UK Law," [2015] Co. L. 346, 1-5

[293] *Puretruce Health Care Limited (Holly House) v National Assembly for Wales* [2005] 544 (EA-W) JP

[294] s.6 (2) Company Directors Disqualification Act 1986. See discussion by J. Lowry and A. Reisberg, *Pettet's Company Law: Company Law and Corporate Finance* (2012, Pearson) 565

[295] *Puretruce Health Care Limited v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006, 274

financial viability, and a statement was filed by an employee of Companies House, confirming that enforcement proceedings were being contemplated because no accounts had been filed by the company from 2002-2004.[296]

4. Limited Companies Owned by Dr P Das and Dr N Das

As a matter of fact and law, Dr Prana Das and Dr Nishebita Das have historically used the private limited company vehicle to incorporate their various business interests.[297]

Those dissolved businesses are:

		Incorporation date	Company Secretary	D*	D*
1. Puretruce Pharmacy Ltd	02908284	14/03/1994	ND	ND	PD
2. Puretruce Care (Developments) Ltd	03533297	24/03/1998	ND	ND	PD
3. Puretruce Care Ltd	02105273	03/03/1987	PD	ND	-
4. Puretruce	03277799	08/11/1996	ND	PD	-

* Director

Two limited companies continue to exist, they are:

		Incorporation date	Company Secretary[298]	D*	D*
1. Puretruce Health Care Ltd	03035216	20/03/1995		ND	
2. L-Giri	04158929	13/02/2001		ND	

Dr N Das is a director of the companies listed above, and was a director and/or company secretary of the dissolved companies. In each company Dr N Das has the same start dates as her husband.

Dr N Das served in the role as director and company secretary in companies 1 and 2. From their historic way of dealing with company matters, the tables evidence that Dr N Das and Dr

[296] *First Tribunal Decision, Puretruce Health Care Limited v National Assembly of Wales* [2004] 0371 (EA-W), para 77

[297] See Appendix 3 for further detail

[298] There is no need for a Company Secretary with a one-person company

P Das assumed similar responsibilities and adopted a shared approach to company matters within their group.

Irrespective of the additional evidence that can be adduced from re-visiting the now dissolved firms, all that is required in law to hold Dr N Das accountable is that she was registered as a director of the companies at the centre of this human tragedy.

It should be noted that the relevant legislation provides a very wide definition of director. It includes any person occupying the position of director, by whatever name called.[299] The emphasis is on what they do, rather than how they are described.

As Milman observes:

This elasticity has an upside from the viewpoint of fixing "guilty" individuals with liability… In cases where an individual is not a de jure director (that is not officially designated as one), the question of whether that same person might be treated either as a de facto (within s.250 CA 2006) or shadow director (within the meaning of s.251 CA 2006) will then arise.[300]

A *de facto* director is therefore one who, though not formally appointed, is acting as one. Such individuals are equally liable as those actually appointed.[301] Shadow directors are those to whose directions or instructions the directors of a company are accustomed to act.[302] They may be, but need not be, in the shadows.

Should Dr P Das recover from his injuries, the question needs to be asked as to whether he is in fact operating as a *de facto* or shadow director?[303]

5. Silent partner – fact or fiction?

At the meeting between Gwent Police and the Crown Prosecution Service (CPS) and the aggrieved families,[304] Dr N Das was described as *a silent partner*. Such a description misrepresents her legal status. A silent partner[305] is a passive financial investor with no responsibilities for the day-to-day running of a business. If Dr N Das did not assume a role in the running of the company, and was truly a 'silent partner' then the proper vehicle for the structure of that business would have been a partnership, under the *Limited Partnership Act 1907 (LPA 1907).* This conveys a right on a person who does not engage in the day-to-day running of the business, to be recognised as a "limited" partner - the term actually used in

[299] s.250, CA 2006. The same definition is used in related legislation such as that which relates to disqualification of directors or insolvency

[300] D. Milman, "Directors, governance and managerial responsibility: new developments in UK Law" [2015] Co. L. 346, 1-5

[301] For a definition of a de facto Director, see the one provided by Lord Collins in *Commissioners of HM Revenue and Customs v Holland* [2010] UKSC 51 at 93

[302] s.251 (1) CA 2006. Professional advisors will not usually be regarded as shadow directors. See C. Noonan and S. Watson "The nature of shadow directorship: ad hoc statutory intervention or core company law principle," (2006) JBL 76.

[303] ibid

[304] See Appendix 4, CPS notes, in particular the statement made by Detective Sergeant Ceri Llewellyn (CL) Gwent Police, see page 4, section 5, paragraph 2

[305] Section 4(3), Limited Partnership Act 1907

legislation.[306] However, there is a requirement in law, under *s.5* of the *LPA 1907* to register the business as such, or, if not so registered, the *general partnership rules apply.*

In law, they would be held to be jointly and severally liable for all partnership obligations.[307] However, Dr N Das was not a partner, limited, or otherwise. An inspection of the company's registration documents reveals that Dr N Das was registered as director, company secretary, or both in every company incorporated by the couple. The corporate history suggests that her involvement could not have been minimal. An indication of the degree of her involvement can be ascertained from the following corporate administrative necessities.

Firstly, there are two forms which are required by law to be filed each year by registered Companies. Those forms are (1) the Annual Accounts (AA) and (2) the Annual Returns (363/AR01). Both forms (AA/363 - now the AR01) need to be signed. Either Dr N Das signed the documents, in which case it evidences involvement in the management of the company, or Dr N Das did not, which may indicate either (1) possible fraud or (2) possible failure to comply with statute.

Secondly, all applications to dissolve a company must be signed by both directors. This applies to companies 1, 2 and 3 (DS01 FORMS).[308] Thirdly, company 4, Puretruce Care Ltd, was struck off by the register for failure to provide statutory documents (AA and AR01) during the period when the receivers took control. At the relevant time, Dr N Das was the company secretary and thus the person responsible for filing these documents.

Fourthly, Dr N Das was also company secretary and director of Puretruce Pharmacy Ltd, while her husband was the director. The noun "pharmacy" is a protected title. Puretruce Pharmacy Limited was registered with the Pharmaceutical Society on 27th July 1994, and deleted from the register on 6th May 1999. The registration process included authorisation to use the title 'pharmacy'. However, the company Puretruce Pharmacy was not dissolved until 23 December 2003. It follows that, although Puretruce Pharmacy Ltd was not registered to use the protected title from the end of the registration period up to the date of dissolution, it continued to do so. Finally, it should be noted that the date of Dr P Das' injuries[309] occurred on 2nd of September 2012, whereas his position as director and company secretary of L-Giri Ltd was not terminated until **564 days later**, on 20th March 2014. Presumably the Das' or their legal team had communicated the seriousness of the head injury to the Police/CPS before this

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[306] ibid

[307] Every partner in law is liable jointly with his co-partners, and also severally for everything for which the firm while he/she is a partner. s.12, Partnership Act 1890

[308] See s.1003 (2) (a) CA 2006. The statutory provision requires the application to be made by the directors, or by the majority of them - which could mean both

[309] News reporting of Dr P. Das' injuries:

- BBC News Wales, "Care home enquiry: Dr Prana Das will not stand trial," 6th March 2013;
- Ben Frampton, "£11.6m care homes case scuppered by doctor's "savage beating," South Wales Argus, 6th March 2013

date. On the one hand, it was maintained by Dr P Das' legal team that he lacked capacity to stand trial, yet he continued as a registered director and company secretary of L-Giri Ltd.

Scrutiny of the submitted documents reveals that it is not possible to determine which of the Das' signed the requisite company documents, as there is a signature only (with no accompanying name printed below). Furthermore, the tick box, which serves to evidence that the contents are true, has not been completed, presumably providing the Das' with a possible, though arguably dubious, loophole, should the contents prove inaccurate.[310]

The case for also imposing legal liability on Dr N Das can also be made on more general grounds. The corporate table above shows six companies which were incorporated by Dr N Das and Dr P Das. The structure evidences a course of dealing between these individuals, showing that they both undertook significant roles in each of the companies that they incorporated. By reviewing this evidence, it is possible to say that both Dr N Das and her husband were integral to the formation and management of all six companies. It does not demonstrate, for example, that either took a back seat. On the contrary, it demonstrates that they both played active roles from the time they registered their first business in 1987. From the corporate table, it appears that it may have been arbitrary who the registered director or company secretary was. Dr N Das is now the director of the two remaining firms (i) Puretruce Health Care Ltd and (ii) L-Giri. Although beyond the brief and expertise of the authors, questions could be asked about the financial viability of the companies, and also the use made of company's assets. Early opportunities to have prevented the companies from trading may well have been missed.[311] It is possible that a forensic accountant could determine to what extent, if any, monies were sent along the chain of companies to disguise the true financial position, and whether the conduct breached criminal[312] and/or civil provisions.[313] Given that there is evidence of moving money around and of not paying staff and other liabilities,[314] the conduct may have amounted to "wrongful trading".[315] They may have been trading when

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[310] Dr P. Das' propensity for making contrary claims is illustrated by his assertion that he was not the Responsible Individual of Brithdir, even though his name was entered as such on the registration documents. See *Puretruce Health Care Limited v National Assembly for Wales* [2004] 0371 EA-W at paras 69-72

[311] On 14.10.03, CSIW were notified that 15 of the 21 homes which Dr P. Das was a director of had gone into receivership. Note that s.216 AND s.217 of the Insolvency Act 1986 provide safeguards against the so-called "Phoenix Syndrome". The provisions prohibit a director of a company that has gone into insolvent liquidation from being involved for five years in the management of a company of the same name, or a name that is so similar as to suggest an association with it

[312] s.993, CA 2006 - fraudulent trading

[313] Insolvency Act 1983 ss. 213-215. These civil sanctions effectively lift the corporate veil, and individuals can be held liable for the debts, and arguably there were missed opportunities to make use of these provisions.

[314] Staff not paid, Registration not paid, money moved around, tax not paid.

[315] To succeed under Section 213, it is necessary to be able to show an intent to defraud creditors, whereas negligence combined with misuse of corporate personality and limited liability is sufficient under s.214
Such activity is referred to as "wrongful trading." Section 213 applies to anyone carrying on a business and therefore includes shareholders, whereas Section 214 only applies to Directors. Both sections could therefore apply. If wrongful trading could have been established, then Dr N. Das would not escape liability. In *Re Brian D Pierson (Contractors) Ltd* [2001] 1 BCLC 275, it was confirmed that is no defence for a director to claim that they did not play an active role. In the words of Wilkinson J.: "*One cannot be a "sleeping director"; the function of "directing" on its own requires some consideration of the company's affairs to be exercised*."

they were not actually solvent. The Second Tribunal case stated: *On 14 July 2005 the Applicant company belatedly filed its accounts for the year ended 31 October 2003 with Companies House in Cardiff. These accounts showed that the company made a loss of £513,475 in that year. In the previous two years the company had made losses of £633,677 and £1,599.570 and the deficit in shareholder's funds had increased from £754,857 in 2001 to £2,868,302 in 2003. But for the profit on the sale of Holly House to the Puretruce Pension Fund, the loss in 2002-03 would have been £878,673 (adjusted for the pension contribution). The accounts also showed that Dr* [P] *Das owed the company £235,157 as at 31 October 2003 on his director's loan account (increased from £177,370 on 31 October 2002) and that the company owed its bankers £2,829,131*.[316]

A forensic financial audit may also assist in assessing whether the assets were being used for proper purposes. As the company tables illustrate, Dr P Das and Dr N Das were the only directors and the only shareholders, so there were no internal checks on whether they were using their corporate powers and corporate assets for proper purposes.[317] Such an audit would also shed light on how much the directors were paid directly, that is in terms of salary, indirectly by dividend, and/or through perquisites and benefits in kind. As it stands, evidence in the public domain shows that monies from the company were directed to a pension fund in the names of both Dr P Das and Dr N Das.[318] Ascertaining the actual financial package would no doubt highlight the involvement by the Das' individually and collectively or jointly.

6. What might have been done?

Families and others, including, no doubt, those individuals who have been, or may still be, the subject of ongoing disciplinary or professional censure and de-registration, must wonder why, and whether there is justification for the fact that the two major players have, to date, yet been untouched by civil and criminal sanctions. Are they beyond the law?

Firstly, though beyond the scope of this Review, the company may well have been liable in contract to both public and individual commissioners of services given the reported poor standards and care provided. Secondly, companies can be held vicariously liable for the civil wrongs of their employees; civil liability is imposed when there is a sufficiently close connection between the wrongful acts of the employees, and the activities that those persons were employed to undertake. If this test is satisfied, the fact that the wrongful acts may not have been authorised is not crucial. The extensive nature of the liability is illustrated by the facts and decision of the House of Lords in *Lister v Hesley Hall Ltd*,[319] where it was held that a warden's tortious acts in sexually abusing children in his care were so closely connected with his employment as to warrant the imposition of vicarious liability on his employer. In deciding that the company was liable, their Lordships took the view that the court must not simply

[316] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) (5 September 2006), paragraph 38

[317] s.171, CA 2006

[318] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) (5 September 2006), paragraph 85

[319] *Lister v Hesley Hall Ltd* [2001] 2 All ER 769, HL

consider whether the acts of sexual abuse were modes of doing an authorised act, but must also consider whether there existed a close connection between the tort and the employee's duties. They concluded that the company had undertaken to care for the resident children, and had entrusted that obligation to the warden. His torts were so closely connected with his employment that it would be fair and just to hold the company vicariously liable. Individual employees within the Das' companies[320] have similarly committed tortious acts and there can be no doubt that there was a very close connection between the tort committed and the employee's duties. The care was poor and the directors had been put on alert since the very first television exposure in 1995. An allied, but more peripheral, consideration is whether public agencies, such as the local authorities and health boards, involved in brokering adult placements in these homes could also be held liable, subsequent to their becoming aware of, or suspecting, poor standards. Liability can arise from delegation when a clear statutory duty to provide a service can be established.[321] Though perhaps possible, this seems unlikely, given the loose nature of the role played by public authorities in facilitating adult placements.[322]

Corporate criminal responsibility is achieved in three different ways. Firstly, the courts treat some regulatory statutory offences as imposing liability directly on the company.[323] This company, for instance, may have committed a number of regulatory offences under the *Companies Act*, which in turn could, and arguably should, have led to proceedings under the *Company Directors Disqualification Act 1986* (see below). Secondly, under common law, both individuals and companies can be held criminally responsible where the degree of negligence is gross.[324] The Law Commission summarised the doctrine when it stated that the governing principle is that those who control or manage the affairs of a company are regarded as embodying the company itself.[325]

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[320] See details of the television programmes summarised in Appendix 1

[321] *Woodland v Essex County Council* [2013] UKSC 66. The Supreme Court decided that the local authority could be held liable, holding that the local education authority had owed a non-delegable duty of care to ensure that reasonable care was taken to secure the safety of a pupil who was attending a swimming lesson provided by an independent contractor

[322] See *NA v Nottinghamshire CC* [2014] WLR (D) 35. Here, it was held by the High Court that a local authority, which exercised reasonable care in placing a child with foster parents, and in supervising the placement, could not be held vicariously liable for abuse perpetrated by the foster parents. The judgement also concluded that it would not be fair, just or reasonable to find a local authority had a non-delegable duty of care, so as to make it legally responsible for the foster carers' actions. Clearly, it is arguable that the looseness of the role of public authorities in arranging adult placements does not give rise to a legal duty, so that the question of delegation does not arise. However, the vulnerability of some of the adults involved might persuade the Courts that such a "*Pontius Pilate*" approach would not make for good law. If the possibility of delegation was accepted, then questions could follow as to the reasonableness of such placements continuing, once concerns about standards had been raised

[323] A wide-ranging Law Commission Consultation Paper No. 195, *Criminal Liability in Regulatory Contexts,* suggests that there is a need to curb the escalation of criminal law by means of regulation - where such provisions are necessary it is suggested that there should be a defence of due diligence which should rest with the accused. It also suggests that there is a need to consider whether there should be an offence of negligently failing to prevent a crime when a company commits an offence and an individual director or equivalent does not prevent the offence (Consultation Paper, Part 5)

[324] The use of gross negligence manslaughter for corporations was abolished by s.20 of the CMCHA 2007

[325] Law Commission, *Legislating the Criminal Code Involuntary Manslaughter*, Law Commission No. 237 (1996) para. 6.27

The common law has developed a method of attributing such conduct by individuals, to being that of the company, by the doctrine of identification, which, in essence, requires evidence of culpability, by an individual, who can, in the context of the offence, be regarded as the "controlling mind" of the company.

As Cavanagh observes:

For instance, take the case of R v OLL Ltd and Kite …. Both the company and its managing director Mr Kite were convicted of manslaughter. In the words of the trial Judge, Ognall J 'Mr Kite and the company… stand or fall together. One for all and all for one.' [326]

A reading of the case suggests that the Judge was much influenced by the fact that, months prior to the tragic incident, letters had been sent by two experienced instructors, warning Mr Kite of the potential fatal consequences of failing to act. The evidence suggested that Mr Kite may perhaps have been more concerned about sales than safety. Again, parallels could be drawn with the Das' companies.[327]

Thirdly, the legislature can establish a stand-alone offence. This is precisely what has happened in relation to corporate manslaughter.[328] The *Corporate Manslaughter and Corporate Homicide Act 2007 (CMCHA 2007*), which came into effect in April 2008, provides for corporate liability where attribution of conduct to senior managers is possible.[329] It is therefore broader in its remit than the directing mind criteria necessary under the common law.[330]

The UK Ministry of Justice provided the following justification for the change introduced:

The offence addresses a key defect in the law that meant that, prior to the new offence, organisations could only be convicted of manslaughter (or culpable homicide in Scotland) if a '*directing mind*' *at the top of the company (such as a director) was also personally liable. The reality of decision making in large organisations does not reflect this and the law therefore failed to provide proper accountability and justice for victims. The new offence allows an organisation's liability to be assessed on a wider basis, providing a more effective means of accountability for very serious management failings across the organisation.* [331]

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[326] Neil Cavanagh, "Corporate criminal liability: an assessment of the models of fault," [2011] J. Crim. L. 75(5), 414-440; *R v Kite & OLL Ltd* [1996] 2 Cr App R 295

[327] According to the TV programmes staff resigned and wrote warning letters, though the warnings were perhaps less stark. See Appendix 1 which includes summaries of the broadcasts about the Puretruce homes

[328] Referred to as corporate homicide in Scotland

[329] Corporate Manslaughter and Corporate Homicide Act 2007 (CMCHA 2007)

[330] See S.M. Solamain, and A. Begum, "Impunity of frequent corporate homicides by recurrent fires at garment factories in Bangladesh: Bangladeshi culpable homicide compared with its equivalents in the United Kingdom and Australia," [2014] Comp. Law 35(10), 289-309

[331] Ministry of Justice*, A Guide to the Corporate Manslaughter and Homicide Act 2007* (October 2007), page 3

However, the Act makes no provision for prosecution of individuals; it is the company alone that must be the subject of the proceedings.[332] Furthermore, there is some evidence to suggest that Company Directors are nowadays opting to plead guilty to corporate manslaughter under the new Act in order to avoid any risk of personal prosecution.[333]

The deaths and wrongs that are the subject of this Review occurred before the *CMCHA 2007* came into force. However, the narrower attribution requirement of directing mind would be no obstacle in the instant case since, as highlighted above, Dr P Das was very active within the company. He had the cheque books, decided which bills would be paid, and what and how much nursing equipment pressure-relieving devices such as beds and mattresses could be provided, for example. He was the "Mr Kite" of the company. In fact, successful prosecutions to date, even under the new legislation, have been against small companies.[334]

Thus, as these issues occurred before the new Act came into force, any successful prosecution would be based on the common law. Individual officers of an organisation including directors, managers and employees can be prosecuted under the common law offence of gross negligence manslaughter, if their own grossly negligent behaviour results in a death. The offence is punishable by way of a maximum of life imprisonment.

The leading case of *R* v *Adomako*[335] has effectively established a four stage test in order to succeed with a prosecution:

i. Did the accused owe a duty of care towards the deceased?
ii. If so, has the accused breached said duty of care?
iii. Did that breach cause the deceased's death?
iv. Having regard to the risk of death involved, was the conduct of the defendant so bad in all the circumstances as to amount to a criminal act or omission?

Before discussing the various components of this test, it is important to note that it is not necessary to prove that an individual intended to cause harm. This was clearly established by Lord Mackay in *Adomako*,[336] where it was also emphasised that the offence could be

[332] Some are suggesting that it will no longer be possible to succeed against individuals. However, the new Act makes no provision and the prosecution of individuals will still be possible albeit by means of the traditional attribution standard of the directing mind. Section 20 of CMCHA 2007 has abolished the common law procedure in relation to companies, but the procedures are applicable to individuals - it simply means that the CMCHA 2007 cannot be used. See Solamain and Begum, op. cit. at 295

[333] See Celia Wells, "Corporate criminal liability: a ten year review" [2014] Crim. L.R. 849-878

[334] As it stands, there is no statutory definition of what a "small" company is. The legal position, by default, is that anything that is not a public company is a private company. Academics, however, often refer to small companies as having particular problems, and, in the context of attribution, small generally equates to "intimate" or "close" - in other words, those in control are involved and know what is going on. Interestingly, the legal position may change, due to the Small Business, Enterprise and Employment Bill. The definition in the Bill, at clause 7(1), refers to companies as "small", if they have a turnover of less than £25 million

[335] *R v Adomako* [1994] 3 WLR 288 (HL); Professor D. Ormerod, "Smith and Hogan's Criminal Law" (Oxford University Press, 13th edition, 2011), 553

[336] *R v Adomako* [1994] 3 WLR 288 (HL)

committed by omission, or a series of omissions. It was thought that the first three elements of the test were questions of law to be decided by a judge - and, if the evidential burden was sufficient for the case to go to the jury, they decided the final question.[337] However, in *Willoughby*,[338] it was considered that matters usually to be left to the jury included the existence of a duty, any breach, and the issue of gross negligence.

In *Willoughby*, it was observed:

As it seems to us, the clear implication from the words used by Lord Mackay of Clashfern, Lord Chancellor in R v Adomako [1995] 1 AC 171, in the well-known passage at 187B to 187C, particularly the words "the jury must go on" is that existence of duty, breach causing death and judgment of criminality are all three usually matters for the jury.[339]

This precedent made it easier to put a case for consideration before a jury, and, given the evidence available, it seems surprising that this was not done.

Again, in *Adomako,* Lord Mackay explained the jury's role of deciding on "gross" negligence:

..the essence of the matter, which is supremely a jury question, is whether, having regard to the risk of death involved, the conduct of the defendant was so bad in all the circumstances as to amount in their judgement to a criminal act or omission.[340]

Furthermore, in *Misra and Srivastava*,[341] it was noted that: "*Risk must be a serious and obvious risk of death, not serious injury*."[342]

Academics in the area of wound care have observed:

Pressure ulcers are associated with fatal septic infections and are reported as a cause of thousands of deaths each year in the United States. Incapacitating chronic and neurodegenerative conditions are common comorbidities…[343]

It can be argued that both directors owed a duty of care. To establish that a duty has been breached involves an objective test - it is simply necessary to establish that the accused has failed to do what a reasonable person would do in their position.[344] As the relevant section of the CPS website notes:

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[337] ibid

[338] [2004] EWCA Crim 3365

[339] *R v Willoughby (Keith Calverley)* [2004] EWCA Crim 3365

[340] ibid

[341] *R v Misra and Srivastava* [2005] 1 Cr App R 328

[342] ibid

[343] M. D. Redelings, N.E. Lee, F. Sorvillo, "Pressure ulcers: more lethal than we thought?" (2005) Advances in Skin & Wound Care 18(7), 367-372. See also K. T. Whittington and R. Briones, "National prevalence and incidence study: 6-year sequential acute care data" (2004) Advances in Skin & Wound Care 17(9), 490-494.

[344] *R v Adomako* [1994] 3 WLR 288 (HL)

It does not matter that the defendant did not appreciate the risk (the foreseeable risk of death) only that the risk would have been obvious to a reasonable person in the defendant's position. (R v DPP ex parte Jones [2000] CLR 858 and AG ref No: 2 of 1999 3 All ER 182.[345]

The accused must also be grossly negligent. Whether their conduct was grossly negligent is a question of fact. Again, it is to be determined by applying an objective test. The grossly negligent conduct of a defendant corporation (if prior to the CMCHA 2007), or an individual director, will be judged against the standard of care of a reasonable organisation or individual. The notion of the reasonable man can also be construed in terms of "the reasonable person" in a given profession.[346] Although the offence does not require any malice, the accused's conduct must fall so far short of reasonable standard of care as to warrant criminal consequence, and a reasonable person in the same circumstances would have appreciated that there was a risk that death would follow. These homes were subject to multi-agency allegations of neglect, unexplained injuries, pressure wounds, medication issues and inappropriate treatment of existing medical conditions.

In addition, Dr P Das (Director) and Mr Paul Black (Chief Executive) were charged with a number of counts. Dr P Das was charged with two counts of consenting or conniving to a failure to discharge a duty as a director at Puretruce, these failures being attributable to neglect. He was also accused of theft relating to three cheques totalling £23,080.65 due to Woodstock Limited for work carried out, and four counts of false accounting totalling £314,656.65. Mr Paul Black was charged with two counts of consenting or conniving to a failure to discharge a duty as a manager at Puretruce, these failures being attributable to neglect. He faced two alternative charges of failure to discharge a duty relating to competence, sufficient nursing cover, training, staff monitoring, adequate records and sufficient equipment. Furthermore, Puretruce Health Care was charged with two counts of failure to discharge a duty to ensure residents at Brithdir Care Home were not exposed to risks to their health and safety. The charges were ordered to lie on file - thus, none of the trials were held.[347] It is also evidenced in the indictment that Dr P Das and Mr Black were originally charged with *Health and Safety at Work Act 1974* (*HSAWA 1974*) offences individually.[348]

One of the main concerns was with regards to pressure sores. The then Deputy Chief Constable Jeff Farrar, of Gwent Police, was reported in the South Wales Argus as having told the BBC that police had seen: "*people with pressure sores corroded down to a state that they*

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[345] CPS website, "Homicide, Murder and Manslaughter" http://www.cps.gov.uk/legal/h_to_k/homicide_murder_and_manslaughter/#gross (accessed 11th May 2015 - "Involuntary Manslaughter": "Gross Negligence Manslaughter": "The Breach of the Duty of Care")

[346] *R v Litchfield* [1998] Crim. L.R. 507

[347] No trial occurred after Dr P. Das' injuries. This, and all details of charges, were sourced from:
- BBC News Wales, "Care home enquiry: Dr Prana Das will not stand trial," 6th March 2013;
- Ben Frampton, "£11.6m care homes case scuppered by doctor's "savage beating," South Wales Argus, 6th March 2013

[348] See original indictment, in Section 10 about the Health and Safety Executive

are corroded down to the bone and where we have got people that are so dehydrated that it's a significant cause of their death."[349]

As the relevant section of the CPS website notes:

Neglect tends to have a physical impact. The development of pressure sores should be considered a primary indicator of neglect or poor care practice, but by no means a conclusive indicator.[350]

It has been reported that: "*the CPS said there was not enough evidence to charge key figures… with gross negligence manslaughter or wilful neglect*."[351]

However, on causation, Solamain observes:

According to the doctrine of causation as applied in criminal law, negligent conduct must be one of the causes and need not be the sole cause, and more than one person may be liable for the offence. Again, an objective test applies to determine whether the accused's conduct was a cause, which needs to be an "operating and substantial" cause of the death, it need not be a major cause, but "it must be something more than de minimis".[352]

Thus, for example, a policy of restricting the use of incontinence pads to one a day might amount to an operating and substantial cause of death, in cases where pressure sores are causative of death. The bereaved and injured families, who are calling for a public inquiry, have apparently been advised by the Crown Prosecution Service (CPS) that proceedings had not been instigated because the CPS reasoned that the case would fail on the basis of lack of evidence of causation.[353]

Given the clear direction in *Adomako*[354] about how the offence can be committed by omission as well as commission, it is a matter of some concern. The bewilderment and anger of families is not surprising.

One notable observation on the case law of gross negligence manslaughter was made by the then Lord Chief Justice, Lord Judge, who noted: *In short, the offence required gross negligence*

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[349] David Deans, "Families tell TV probe of care home trauma," South Wales Argus, 4th June 2013

[350] CPS website, "Prosecuting Crimes against older people": http://www.cps.gov.uk/legal/p_to_r/prosecuting_crimes_against_older_people/#neglect ("Neglect")

[351] Fran Abrams, ""New law needed" after collapse of care home neglect case", BBC News, 4th June 2013

[352] S.M. Solamain, and A. Begum, "Impunity of frequent corporate homicides by recurrent fires at garment factories in Bangladesh: Bangladeshi culpable homicide compared with its equivalents in the United Kingdom and Australia," [2014] Comp. Law 35(10), 289-309

[353] Causation is not precisely defined in the new Act. It requires proof that death was caused by the way that an organisation managed or organised its activities. Organisations, however, act not only through directors, and managers but also through front line workers. The Law Commission, in its Draft Bill on corporate killing, suggested that management failure may be regarded as a cause of a person's death notwithstanding that the immediate cause is the act or omission of an individual. (See Celia Wells, "Corporate criminal liability: a ten year review" [2014] Crim. L.R. 849-878)

[354] *R v Adomako* [1994] 3 WLR 288 (HL)

in circumstances where what is at risk is the life of an individual to whom the defendant owes a duty of care. As such, it serves to protect his or her right to life.[355]

To establish grossness is a hurdle, but it is not simply a consideration of the degree of negligence, but also, of the amount of damage done. So, for instance, it would be no defence to explain to the court that all that had occurred was that you had left a hall door open, if your job was to look after ten children and you operated your business on a busy road. If having left a door open, the children made their way onto a busy road to be hit by a truck, then the door being left open amounts to negligence - whether it is gross or not is a matter for the jury. Arguably, the doctor directors' knowledge door should have been opened when the first television programme was broadcast in 1995.[356]

What caused the pressure ulcer damage? Was it an act or omission? The legal position is that it is not relevant whether the cause was an act or omission. Did this damage contribute to or cause the death(s) of unnamed persons? This has been determined by medical experts commissioned by Operation Jasmine. These are matters of causation accepting that it was not a single act, such as leaving a door open, but rather a continuous failure to act, which could be considered as arguably leading to the deaths of several patients, as the bleak outcomes demonstrate.

The jury, in the light of the testimony, would also determine the last consideration, that is, the seriousness of the conduct. Prosecution evidence would include photographs, forensic evidence, and testimony from clinicians who had examined the individuals. The families remain convinced that such evidence is available.

The fact that the two company directors were also doctors is of some relevance, although, in this situation, it would appear their role was as directors. As directors they are required to exercise reasonable care and skill and at the standard of their knowledge and experience.[357] In a number of disqualification cases there has been a movement towards a more rigorous standard. For instance, in *Barings PLC*,[358] Parker J, in *dictum* which was supported in the Court of Appeal, referred to the: *continuing duty to acquire and maintain sufficient knowledge and understanding of the company's business… to enable them to properly discharge their duties as directors*".[359] Moreover, the Judge went on to say that, whilst directors are entitled to delegate particular functions to those below in the management chain, the exercise of the

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[355] *R v Evans* [2009] EWCA Crim 650, at 52

[356] *Wales This Week* expressed concern about some of the homes then owned by Dr P. Das and Dr N. Das

[357] Other jurisdictions, for example, Germany, Austria, Spain, and Portugal, require directors to apply the due care of a diligent and conscientious Manager. See C. Gerner-Beuerle and E. P. Schuster, "The evolving structure of director's duties in Europe," (2014) E.B.O.R. 15(2), 191-223

[358] [2001] 1 B.C.L.C. 523

[359] ibid
This was echoed in the later case of *Secretary of State for Business, Innovation and Skills v Reza* [2013] CSOH 86, at paragraph 3, where Lord Malcolm observed: "As a director, she was responsible for all aspects of the company's business. She was obliged to acquire and maintain sufficient knowledge of the business to enable her to discharge her duties"

power of delegation does not absolve the director from the duty to supervise the discharge of the delegated function. It is, of course, a moot point as to whether a Court would expect more of them as doctors and not just as managers, given the health care and nursing business in which they operated. In a hospital where there was a failure to meet the standard of care that could not be pinned on a certain doctor, it would then be the hospital that would be responsible. They were not 'just' doctors, they were "supervising doctors".

As directors, their corporate duty is to the company, and as sole shareholders they would be free to carry on without internal challenge. The need for externality for those involved in *public functions*, with independent monitoring on Boards, is obvious.

The composition of Boards varies from company to company,[360] but in the instant case it is clear that the interests of only the shareholders were represented on the Board. The interests of other stakeholders, now provided for and called for under the *Companies Act 2006*, were not reflected on the Board. *Section 172* specifies what is required of directors in promoting the success of the company. It provides:

(1) A director of a company must act in the way he considers, in good faith, would be most likely to promote the success of the company for the benefit of its members as a whole, and in doing so have regard (amongst other matters) to–

(a) the likely consequences of any decision in the long term,

(b) the interests of the company's employees,

(c) the need to foster the company's business relationships with suppliers, customers and others,

(d) the impact of the company's operations on the community and the environment,

(e) the desirability of the company maintaining a reputation for high standards of business conduct, and

(f) the need to act fairly as between members of the company.[361]

[360] There are some four possible structures within the UK unitary board model - a Board with only executive directors; a Board with a majority of executive directors; a Board with a majority of non-executive directors; a Board with only non-executive directors. (See B. Tricker, *Corporate Governance* (2012, Oxford University Press), Chapter 2). Given the hands on activities of both directors, it appears that the Das' model was akin to the first listed - a Board comprising of executive directors only. The fourth model suggests a structure that is similar to the European two tier Supervisory Board. In the German approach to corporate governance, for instance, large and public companies are required to have a two tier board structures - Supervisory Board comprising of outsiders, and a Management Board comprising of Executive Directors. It could be argued that given the one-time size of the Das' care regime that such a structure would have been appropriate. Such a Supervisory Board might consist of family carers, and others representing the public interest and professional specialisms. Be that as it may, it is clear that present corporate arrangements offer little protection. Indeed, as others have outlined in some detail, serious questions need to be asked as to whether the existing legal framework, despite recent reforms, is fit for purpose. See S. Wilson, "How the company became an entity: a new understanding of corporate law," (2015) J.B.L. (2) 120-141

[361] It is evident from the Parliamentary discussion relating to this section that Ministers believed that this provision would have a radical beneficial effect and that it would entrench the concept of "enlightened shareholder" into the legislation. Others are more sceptical, noting that the words "have regard" have traditionally been given very little weight by the Courts.

7. Professional Regulation

"*A director may belong to a professional body*,"[362] as is the case in the instant case. In such circumstances some scholars suggest that the most effective way of ensuring an effective outcome is to utilise the professional bodies.[363]

In *Roylance v General Medical Council (No. 2)*[364] a doctor was the Chief Executive officer of a NHS Trust, and his responsibilities extended to over nine hospitals and some 6,500 staff. He had qualified as a doctor, and, prior to his appointment to the executive position in the Trust had acted as a consultant radiologist. He retained his medical registration. He was found guilty of serious professional misconduct as a registered medical practitioner on the grounds of failure to take action over the years, when concerns were being raised about the excessive mortality of infants.[365]

Travers notes that:

Upholding the decision taken by the GMC Professional Conduct Committee, as it then was, the Privy Council observed that misconduct involved some act or omission, falling short of what would be proper in the circumstances, which was linked to the profession of medicine, though not necessarily occurring in the carrying out of medical practice, and serious; that in the doctor's work as chief executive officer of a hospital there was a sufficiently close link with the profession of medicine for the committee to be entitled to find him guilty of professional misconduct.[366]

Similar arguments could, perhaps, be made in relation to the directors at the centre of Operation Jasmine, since both of them were doctors. They were arguably sufficiently close with the homes' activities to undertake a professional interest to ensure that good standards were maintained.

In the Court of Appeal decision of *Bolton v the Law Society*,[367] Lord Bingham declared:

It is important that there should be full understanding of the reasons why the tribunal makes orders which might otherwise seem harsh. There is, in some of these orders, a punitive element: a penalty may be visited on a solicitor who has fallen below the standards required of his profession in order to punish him for what he has done and to deter any other solicitor tempted to behave in the same way. Those are traditional objects of punishment. But often the order is not punitive in intention. Particularly this is so where a criminal penalty has been

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Although the clear intention of the section is to promote corporate social responsibility, it may amount to no more than a paper tiger

[362] D. Travers, "Towards professional-model regulation of directors' conduct," [2013] Int. J.L.M. 140

[363] ibid

[364] [2000] 1 AC 311

[365] ibid

[366] ibid

[367][1994] 1 WLR 512

imposed and satisfied. The solicitor has paid his debt to society. There is no need, and it would be unjust, to punish him again. In most cases the order of the tribunal will be primarily directed to one or other or both of two other purposes. One is to be sure that the offender does not have the opportunity to repeat the offence. This purpose is achieved for a limited period by an order of suspension; plainly it is hoped that experience of suspension will make the offender meticulous in his future compliance with the required standards. The purpose is achieved for a longer period, and quite possibly indefinitely, by an order of striking off. The second purpose is the most fundamental of all: to maintain the reputation of the solicitors' profession as one in which every member, of whatever standing, may be trusted to the ends of the earth. To maintain this reputation and sustain public confidence in the integrity of the profession it is often necessary that those guilty of serious lapses are not only expelled but denied re-admission. […] ***A profession's most valuable asset is its collective reputation and the confidence which that inspires.***[368]

It should also be noted that the proceedings before a tribunal are less formal - there are fewer restrictions in terms of the evidence that can be adduced. The civil standard of proof applies. Some restrictions were imposed on the activities of Dr P Das,[369] and, given the precedent established in *Roylance*[370] above, it is perhaps surprising that no action to date has been taken in respect to his partner doctor director.

In a not dissimilar case in Birmingham:

Two doctors who failed to seek specialist medical care for elderly patients in their nursing home, even when they were gravely ill and dying, were struck off by the General Medical Council.[371]

This case has been subject to academic discussion.[372]

In another case, the NMC struck off the home manager and owner, the deputy manager, and several nurses, where five residents had died within a fortnight.[373] The NMC noted that the Chair of the Conduct and Competence Committee said:

[Residents] were unable to care for themselves, extremely vulnerable and completely reliant on the registered nurses at the home… A number of residents were found to be suffering from severe grade four pressure sores which had not been correctly treated and which in some cases were so deep that tendons and/or bones were exposed… They were malnourished, some were

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[368] ibid

[369] www.southwalesargus.co.uk/news/2259711.blackwood_gps_practice_restrictions_extended/ (accessed 11th May 2015)

[370] [1994] 1 WLR 512

[371] www.theguardian.com/society/2006/jan/21/health.uknews (accessed 11th May 2015)

[372] M. Mandelstam, *Safeguarding Adults and the Law* (2013, Jessica Kingsley Publishers) 208

[373] http://www.northamptonchron.co.uk/news/local/parkside-house-nurses-guilty-of-misconduct-1-5740378 (accessed on 15th May 2015)

dehydrated and lived in a care home that was described as run-down, filthy, and stocked with faulty or inappropriate equipment.[374]

8. Evidence and Standard of Proof in Tribunals

As indicated above, the standard of proof that is required in relation to professional disciplinary procedures is the civil standard - the balance of probability, and not the higher criminal standard of beyond reasonable doubt. The same is true of Care Standards Tribunals and also in relation to the disqualification of directors (see below).

The decision of the First Tribunal *not* to cancel the registration of the home was reached on the "finest of margins".[375] The Chair was critical of some of the evidence presented by the regulatory bodies[376] and the Panel was persuaded to give the company a last chance, in the light of some perceived improvements in the weeks prior to the hearing. The Panel was asked to consider a wide range of issues, including the likely impact on the residents of having to move. Surprisingly, one key expert witness, was allowed to provide evidence in what would appear to be a number of conflicting roles - on the basis of joint instructions by the parties, and also as a privately instructed expert on behalf of the Appellant Company, Puretruce Health Care Ltd.[377] There is arguably a need for detailed guidance as to the weight, and admissibility, of such evidence. Such guidance might also reinforce the approach that needs to be taken in respect to the civil standard. There is no "heightened civil standard," as is sometimes claimed, in relation to serious allegations.[378]

As Lady Hale observed:

In our legal system, if a judge finds it more likely than not that something did take place, then it is treated as having taken place. If he finds it more likely than not that it did not take place, then it is treated as not having taken place. He is not allowed to sit on the fence. He has to find for one side or the other. Sometimes the burden of proof will come to his rescue: the party with the burden of showing that something took place will not have satisfied him that it did. But generally speaking a judge is able to make up his mind where the truth lies without needing to rely upon the burden of proof.[379]

The potency of the decision is clear. It becomes obvious in the context of the case, which involved serious allegations of abuse against a child.

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[374] ibid

[375] *Puretruce Health Care Ltd v National Assembly for Wales* [2004] 0371 EA-W at page 16

[376] *Puretruce Health Care Ltd v National Assembly for Wales* [2004] 0371 EA-W, page 13, at paragraph 113.

[377] *Puretruce Health Care Ltd v National Assembly for Wales* [2004] 0371 EA-W, page 13, at paragraph 109.

[378] Sometimes referred to as the "cogent evidence rule." In other words, the Court or Tribunal should not be required to operate on the basis that the more serious the allegation, the less likely it is the event occurred - and, hence, the stronger the evidence required to establish an allegation on the balance of probabilities.

See A. Bainham, "Striking the balance in child protection," (2009) C.L.J. 68(1), 42-45

[379] Lady Hale, in *Re B (Care Proceedings: Standard of Proof)* [2008] UKHL 35, at 32

9. Disqualification of Directors

As was illustrated above in the case of *Secretary of State for Business, Innovation and Skills v Reza*,[380] it is possible for a non-active director to be disqualified. Dr N Das (the wife), as evidenced above, was involved in the company. The *Company Directors Disqualification Act 1986 (CDDA 1986)* provides, as the title suggests, a process by which directors can be barred from being a director or in any way directly or indirectly involved in the promotion, formation, or management of a company. Neither Dr P Das nor his wife (Dr N Das) has been subject to disqualification proceedings to date. Disqualification can arise on the basis of general misconduct and also on the ground of unfitness. It should also be stressed that a disqualification may be made on grounds which are, or include, matters other than criminal convictions, notwithstanding that the person in question may be criminally liable in respect of those matters.[381] *Section 2 CDDA 1986* covers disqualification after conviction of an indictable offence "*in connection with the promotion, formation, management, liquidation or striking off of a company, with the receivership of a company's property or with his being an administrative receiver of a company*".

Relevant offences include health and safety offences. Charges laid on file in this case, following injuries sustained by Dr P Das, have been previously discussed.[382]

Section 3 of the *CDDA 1986* also provides for disqualification for persistent breaches of companies legislation, and again there would appear to be good evidence of this. A person is to be taken to be in persistent default if it can be proved that within a five year period he has been guilty of three or more defaults in relation to *Company Act* provisions. Other provisions within the Act include *s.4* (fraud in a winding up), s.5 (conviction for failing to make a return to Companies House), *s.6* (conduct making the director "unfit"), *s.8* (after an investigation of a company), and *s.9A* (breach of competition law). These proceedings are civil so the standard of proof is on the balance of probability. There is a two year limitation period (*s.7 (2*) but the Court has discretion to waive the deadline. Given the lengthy time lapse, it is unlikely that the waiver could be used in this case. Why, for instance was there no investigation under s.8 in the public interest, since the provision applies to any misfeasance, breach of any fiduciary duty, and breach of general duties as a director? (See Part 1 of Schedule 1 of the *Disqualification Act 1986).* Both could have been considered, as the *Reza* case above[383] confirms. It is also worth noting that the company had been the subject of a documentary for "Wales This Week" which was broadcast as early as 1995. A number of explanations can be suggested. Firstly, there are staff capacity issues in relation to intervention. The Insolvency Service, the agency which drives the process, though the subject of some commendation, is

[380] [2013] CSOH 86

[381] Section 1(4) Company Directors Disqualification Act 1986

[382] BBC News Wales, "Care home enquiry: Dr Prana Das will not stand trial," 6th March 2013;
Ben Frampton, "£11.6m care homes case scuppered by doctor's "savage beating," South Wales Argus, 6th March 2013

[383] [2013] CSOH 86

under strain.[384] Secondly, there is a marked tendency to curtail the ambit of the intervention to financial and solvency issues. Lord Hoffman, for instance, has stated that disqualification is:

..concerned mostly with fairness under the insolvency law and the obligations of a businessman to his creditors rather than general questions of corporate governance.[385]

General questions of corporate governance are therefore not excluded, but the emphasis is on financial management. Thirdly, there may be a lack of co-ordination between the various agencies such as Companies House and the Insolvency Service. The company appeared to persistently fail to comply with its corporate obligations and may also have been in some financial difficulties. Fourthly (and linked to the above point), is perhaps the perception that care providers are well served by separate regimes. As noted above, however, it appears that issues of corporate governance are rarely discussed in the Care Standards Tribunal. It may be a case of falling between multiple stools. Be that as it may, the disqualification option in relation to directors of care and nursing homes needs firmer legislative entrenchment. Perhaps the easiest and most effective solution would be to specify that persistent breaches of care regulations and standards would amount to misconduct, in the context of disqualification.

Disqualification of directors is an important issue as the examples below highlight. For example, if an individual is disqualified, other restrictions may apply. That is, they may not sit on the board of a charity, school or police authority; be a pension trustee; be a registered landlord; or sit on a health board or social care body.[386] In contrast, under s.17 of the CDDA 1986, it is possible for a disqualified director in limited circumstances to be granted leave to continue acting as a director. It is also the case that knowledge of disqualification is not always made known to the care regulators. Detailed research[387] into the operation of s.17 made the following observations:

Another area of concern for vulnerable customers/clients is care homes. At least eight of the companies that remain active in September 2010 are in this business. For ***these companies leave was sought and obtained*** *with certain conditions. The involvement of disqualified directors in care homes, however, illustrates a wider point about the need for persons disqualified as directors to consider whether industry regulators need to be informed. The following story appeared in the press in 2010.*

A banned company director who the Insolvency Service found had "dishonestly obtained (or produced) false invoices" while he was a director of a care home management company, is

[384] D. Milman, "Directors, governance and managerial responsibility: new developments in UK Law," [2015] Co. L. 346, 1-5

[385] A. Hicks, "Disqualification of Directors: No Hiding Place for the Unfit" (1998, Chartered Association of Certified Accountants)

[386] www.gov.uk/company-director-disqualification (accessed 11th May 2015)

[387] A. Belcher, "What makes a director fit? An analysis of the workings of section 17 of the Company Directors Disqualification Act 1986," (2012) Edin. L.R. 16(3), 386-409

under scrutiny from the Care Quality Commission for continuing to be involved in care services without informing them.[388]

Better co-ordination of the relevant agencies is clearly needed.

10. Health and Safety

Health and safety issues have been cited in disqualification cases, and obviously, can be stand-alone grounds for prosecution. Individuals can be held liable under the common law and statute law. The legislation also provides for the prosecution of both companies and individuals within companies. Moreover, employers' responsibilities are not confined to employees,[389] but extend to "others" which clearly include cared for patients and residents.

Section 3(1) of *HSAWA 1974* provides:

It shall be the duty of every employer to conduct his undertaking in such a way as to ensure, so far as is reasonably practicable, that persons not in his employment who may be affected thereby are not thereby exposed to risks to their health or safety.

Furthermore, *s 40* elaborates:

In any proceedings for an offence under any of the relevant statutory provisions consisting of a failure to comply with a duty or requirement to do something so far as is practicable or so far as is reasonably practicable, or to use the best practicable means to do something, it shall be for the accused to prove (as the case may be) that it was not practicable or not reasonably practicable to do more than was in fact done to satisfy the duty or requirement, or that there was no better practicable means than was in fact used to satisfy the duty or requirement.

Section 40 places a considerable onus on those responsible for the health and safety of those affected by their undertakings, and, in effect, appears to be requiring that they demonstrate that they did all they could to prevent the breach from occurring. It is thus possible that prosecution of a company, whose undertakings may affect many, may be easier than prosecution of an individual employee. However, as Professor Wells observes: *Here in the United Kingdom, health and safety and other regulatory schemes have been tacked on to criminal law, creating a hybrid beast*.[390]

Travers[391] highlights that the limitation of the resources available to the Health and Safety Executive may mean in practice that prosecutions are rarely undertaken, until such time as there have been serious adverse causes - opportunities for earlier prevention are therefore missed. Moreover, successful prosecutions at this earlier stage could facilitate more effective use of the disqualification procedures outlined above. Put simply, the company could possibly

[388] ibid

[389] Employees' health, safety and welfare are covered by s.2 of HSAWA 1974

[390] Celia Wells, "Corporate criminal liability: a ten year review" [2014] Crim. L.R. 849, 850

[391] D. Travers, "Towards professional-model regulation of directors' conduct," [2013] Int. J.L.M. 140

have been prosecuted at an earlier stage and disqualifications of directors subsequently considered. Some deaths and considerable suffering might thus have been avoided.

Opportunities for effective co-ordination may, therefore, have been missed. Since 1998[392] there has there been an agreed protocol between relevant agencies as to how to co-operate in the circumstances of work related deaths.[393] In relation to the HSE and the CPS, it stipulates that each agency will investigate within its own area of operation (HSE into health and safety breaches and the police into any possible manslaughter) and that any prosecution arising should be managed jointly. Under the new *Act*, and also under the *HSAWA 1974*, a jury can find guilt on both charges.

It is also surprising that so few of the early cases, which could, and possibly should, have led to prosecution, were brought to the attention of the Coroner, so that inquests[394] could have been held into the deaths, in instances where a decision not to prosecute had been made.

11. Existing provisions – some reflections

In terms of any future similar instances, there would be a range of charges that could be of relevance. There is the option of gross negligence manslaughter, or health and safety charges, as previously discussed. As these have already been elaborated upon, there is no need to discuss them again here. There also remains the option of charges under *s.44* of the *Mental Capacity Act 2005*,[395] or, if this is not possible, perhaps *s.127* of the *Mental Health Act 1983*.[396]

There is now the option of statutory corporate manslaughter, due to the *CMCHA 2007*. However, as outlined above, this Act has led to some debate in terms of whether it may have the potential to be used as a shield to protect individuals from criminal liability, and potentially avoid a custodial sentence. A full discussion of the potential application of the new Act is beyond the scope of this Review.

Professor Wells, the leading academic in this area of law, notes: …*the wording has opened a Pandora's Box inviting defendants to play off the CMCHA and the HSWA against each other*

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[392] A Prosecutors' Convention was published in September 2009

[393] *Work-related deaths: A protocol for liaison* (England and Wales) (2011)

[394] The Coroners Act 1988, Section 8(1) ("Duty to hold inquest") states:
"*Where a coroner is informed that the body of a person ("the deceased") is lying within his district and there is reasonable cause to suspect that the deceased—*
(a)has died a violent or an unnatural death;
(b)has died a sudden death of which the cause is unknown; or
(c)has died in prison or in such a place or in such circumstances as to require an inquest under any other Act,
then, whether the cause of death arose within his district or not, the coroner shall as soon as practicable hold an inquest into the death of the deceased either with or, subject to subsection (3) below, without a jury." …
Of additional relevance are the Coroners Rules 1984, and, subsequently, the later provisions of the Coroners and Justice Act 2009. Note that the latter provision was not in force at the time

[395] Ill-treatment or neglect

[396] Ill-treatment of patients

(with their different burdens of proof) and to use plea bargaining to shift blame onto the company and away from individual directors.[397]

Nevertheless, the statutory basis of corporate manslaughter, under the *CMCHA*, is considered a development in the law of corporate manslaughter.

One other approach, which would appear to be hypothetical and academic at present, could be to consider whether unlawful act manslaughter (also known as constructive manslaughter, as the test for this form of manslaughter is "constructed" on the foundation of a lesser criminal offence), might be another way to deal with other instances in future?

As the offence of unlawful act manslaughter is one of common law, there are different methods of interpretation. However, the main way of interpreting the requirements of unlawful act manslaughter appears to be as follows:[398]

i. Was there an act (and was it done intentionally)?
ii. Was the said act unlawful (a criminal offence, not a tort[399])?
iii. Was the said act dangerous, because it was likely to harm somebody (not necessarily to somebody in particular, but just a risk of some harm[400])?
iv. Did the said unlawful and dangerous act cause death?

Noting the notion of intention, in brackets above, it was thought the act would need to be intentional. It was generally construed that unlawful act manslaughter required *mens rea*, and thus was not compatible with strict liability offences,[401] though views on this varied.[402] However, after the case of *Meeking*,[403] it would appear that even strict liability offences may be used as the founding, or base, offence, in a prosecution for unlawful act manslaughter. Whether this will remain the case may depend on subsequent precedent, as, in such situations, it was thought that gross negligence manslaughter may be a more suitable option.[404]

With unlawful act manslaughter, there is no need for subjective foresight of harm,[405] and a person may still be liable if the harm that occurred was different to the type of harm that was foreseen, or that was objectively foreseeable.[406]

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[397] Celia Wells, "Corporate criminal liability: a ten year review" [2014] Crim. L.R. 849, 858

[398] *Attorney General's Reference (No. 3 of 1994)* [1998] 1 Cr App R 91

[399] *Franklin* (1883) 15 Cox CC 163

[400] *R v Church* [1965] 2 All ER 72; *R v JM and SM* [2012] EWCA Crim 2293

[401] *R v Lamb* [1967] 2 QB 981

[402] *Andrews v DPP* [1937] AC 576

[403] [2012] EWCA Crim 641

[404] ibid

[405] *R v Newbury and Jones* [1977] AC 500

[406] *R v JM and SM* [2012] EWCA Crim 2293

Causation would still be debatable in such cases, but could be approached in a similar manner to those instances of gross negligence manslaughter, as previously discussed, and noting the general criminal law doctrines of causation as appropriate.

However, this may be challenging in the care context, as unlawful *act* manslaughter requires an act, rather than an omission. It would perhaps be a moot point as to whether the consideration of omission-based conduct as a "criminal act" by charging with a carefully thought out indictment, would allow for such conduct to be considered an "act." One way of looking at this may be to use the "continuing act" principle, as in the case of *Fagan*,[407] or the doctrine of supervening fault (creation of a danger) as in the case of *Miller*.[408] However, whether either would succeed is debatable, and it is possible that gross negligence manslaughter may still be a preferable charge in care cases.

Lastly, it is necessary to consider the latest additions to the law on this area, introduced in the *Criminal Justice and Courts Act 2015*. This *Act* introduces two new offences - that of ill-treatment or wilful neglect by a care worker - and that of ill-treatment or wilful neglect by a care provider.

12. The new "care worker" and "care provider" offences

The *Criminal Justice and Courts Act 2015*[409] has introduced two new offences of relevance. Whilst these provisions clearly have no bearing on the tragic events which are the subject of this report, they are of significant relevance to any future cases.

Section 20 provides for the "care worker offence" of "ill-treatment or wilful neglect":

(1) It is an offence for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that individual.
(2) An individual guilty of an offence under this section is liable—
(a) on conviction on indictment, to imprisonment for a term not exceeding 5 years or a fine (or both);
(b) on summary conviction, to imprisonment for a term not exceeding 12 months or a fine (or both).
(3) "Care worker" means an individual who, as paid work, provides—
(a) health care for an adult or child, other than excluded health care, or
(b) social care for an adult, including an individual who, as paid work, supervises or manages individuals providing such care or is a director or similar officer of an organisation which provides such care.
(4) An individual does something as "paid work" if he or she receives or is entitled to payment for doing it other than—
(a) payment in respect of the individual's reasonable expenses,

[407] [1969] 1 QB 702

[408] [1982] Crim. L.R. 527

[409] The Act was given Royal Assent on 12th February 2015

(b) payment to which the individual is entitled as a foster parent,

(c) a benefit under social security legislation, or

(d) a payment made under arrangements under section 2 of the Employment and Training Act 1973 (arrangements to assist people to select, train for, obtain and retain employment).

(5) "Health care" includes—

(a) all forms of health care provided for individuals, including health care relating to physical health or mental health and health care provided for or in connection with the protection or improvement of public health, and

(b) procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition, and "excluded health care" has the meaning given in Schedule 4.

(6) "Social care" includes all forms of personal care and other practical assistance provided for individuals who are in need of such care or assistance by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs or any other similar circumstances.

(7) References in this section to a person providing health care or social care do not include a person whose provision of such care is merely incidental to the carrying out of other activities by the person.

(8) In this section—

"adult" means an individual aged 18 or over;

"child" means an individual aged under 18;

"foster parent" means—

(a) a local authority foster parent within the meaning of the Children Act 1989,

(b) a person with whom a child has been placed by a voluntary organisation under section 59(1)(a) of that Act, or

(c) a private foster parent within the meaning of section 53 of the Safeguarding Vulnerable Groups Act 2006.

(9) In relation to an offence committed before section 154(1) of the Criminal Justice Act 2003 comes into force, the reference in subsection (2)(b) to 12 months is to be read as a reference to 6 months.

(10) In relation to an offence committed before section 85 of the Legal Aid,
Sentencing and Punishment of Offenders Act 2012 comes into force, the reference in subsection (2)(b) to a fine is to be read as a reference to a fine not exceeding the statutory maximum.

Furthermore, *s.21* provides for the new "care provider" offence of "ill-treatment or wilful neglect":

(1) A care provider commits an offence if—

(a) an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or wilfully neglects that individual,

(b) the care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, and

(c) in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.

(2) "Care provider" means—

(a) a body corporate or unincorporated association which provides or arranges for the provision of—

(i) health care for an adult or child, other than excluded health care, or

(ii) social care for an adult, or

(b) an individual who provides such care and employs, or has otherwise made arrangements with, other persons to assist him or her in providing such care, subject to section 22.

(3) An individual is "part of a care provider's arrangements" where the individual—

(a) is not the care provider, but

(b) provides health care or social care as part of health care or social care provided or arranged for by the care provider, including where the individual is not the care provider but supervises or manages individuals providing health care or social care as described in paragraph (b) or is a director or similar officer of an organisation which provides health care or social care as described there.

(4) A "relevant duty of care" means—

(a) a duty owed under the law of negligence, or

(b) a duty that would be owed under the law of negligence but for a provision contained in an Act, or an instrument made under an Act, under which liability is imposed in place of liability under that law, but only to the extent that the duty is owed in connection with providing, or arranging for the provision of, health care or social care.

(5) For the purposes of this section, there is to be disregarded any rule of the common law that has the effect of—

(a) preventing a duty of care from being owed by one person to another by reason of the fact that they are jointly engaged in unlawful conduct, or

(b) preventing a duty of care being owed to a person by reason of that person's acceptance of a risk of harm.

(6) A breach of a duty of care by a care provider is a "gross" breach if the conduct alleged to amount to the breach falls far below what can reasonably be expected of the care provider in the circumstances.

(7) In this section—

(a) references to a person providing health care or social care do not include a person whose provision of such care is merely incidental to the carrying out of other activities by the person, and

(b) references to a person arranging for the provision of such care do not include a person who makes arrangements under which the provision of such care is merely incidental to the carrying out of other activities.

(8) References in this section to providing or arranging for the provision of health care or social care do not include making payments under—

(a) regulations under section 57 of the Health and Social Care Act 2001 (direct payments for community services and carers);

(b) section 12A of the National Health Act 2006 (direct payments for health care);

(c) section 31 or 32 of the Care Act 2014 (direct payments for care and support);

(d) regulations under section 50 of the Social Services and Well-being (Wales) Act 2014 (anaw 4) (direct payments to meet an adult's needs).

(9) In this section— "Act" includes an Act or Measure of the National Assembly for Wales; "adult", "child", "excluded health care", "health care" and "social care" have the same meaning as in section 20.

Sections 22-25 have not been included here, but cover excluded care providers, penalties for the care provider offence, and the application of the care provider offence to unincorporated associations. It should be noted that *s.25* emphasises the *Act* does not preclude action under other legislation, if the interests of justice so require.

Firstly, it must be acknowledged that the protections afforded to both adults and the young in these provisions are considerable, and to be welcomed. These new provisions appear to be relevant to a wide range of people, to whom they can provide a degree of reassurance. It is particularly notable that, under *s.20*, the definition of a care worker includes not only those who have care of individuals, but also those who are paid to supervise or manage the aforementioned - specifically including directors. This new definition, which treats those "supervising," or "managing," and even "directors" as being "care workers," is noteworthy and broad. The potential penalties, of fines, and/or a term of imprisonment (maximum 12 months if summary conviction, or five years if conviction on indictment) are relevant to all potential "care workers".

However, in order to take a balanced view, it must be noted that the *s20* provisions, in terms of wording of the offence, are not dissimilar to that of *s.44* of the *Mental Capacity Act 2005 (MCA 2005)* - and thus, that any difficulties that were encountered in interpretation of the *2005 Act* may be relevant here. It must also be borne in mind that the existing precedent on ill-treatment and (wilful) neglect, as a result of *s.44 MCA 2005*, may be helpful in interpreting the new provisions.

Turning to the *s.21* "care provider" offence, there is further material to consider. The definition of "care provider" is capable of covering both individuals and bodies corporate. For this offence, there appears to be a three-part test.

A person, as a care provider may be liable due to the provision, arrangement, or employment of persons to care, or assist with care, should those persons then ill-treat or wilfully neglect the individual. However, the test requires more in order to show liability, in that "*the care provider's activities have to be managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected*". This "gross breach" test appears similar to that in the *CMCHA 2007*, and the common law of gross negligence. Thus, it could, in theory, fall on any points associated with other tests of grossness of breaches. In addition, it must be shown that, "*in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur*." This appears to be similar to the "but for" approach to causation, and perhaps adds an additional and arguably unnecessary hurdle.

It would appear that there is a test of grossness of any breaches, for offences (*s.21)* ("care providers"), but no similar test for offences under *s.20* ("care workers").

As corporations cannot receive custodial sentences, it is thus clear why the penalties for the *s.21* offence,[410] whether on indictment or summary conviction, are that of a fine, and/or remedial (and/or) publicity orders.

Comparing both *s.20* and *s.21* in terms of their application to individuals, it could be debated whether there is any significant difference in the potential application of the later part of the definition of a "care worker"[411] (who might be described as senior "care workers," e.g. including those "supervising," or "managing," and "directors") and the definition of a "care provider"[412] ("who provides such care, and employs, or has otherwise made arrangements with, other persons, to assist him or her in providing such care"). It could be that some may fall under both the definition of a care worker (the individual offence) and that of a care provider (the individual and corporate offence). However, if convicted of the former, they are likely to receive a custodial sentence – but if convicted of the latter, can only receive a fine[413] (with possible remedial and/or publicity orders). Furthermore, the *s.21* (individual and corporate) offence has a "gross breach" test, which brings into consideration all relevant preceding precedent, and may make it more difficult for a jury to convict.

Bearing in mind the difficulties sometimes associated with proving individuals have committed ill-treatment or wilful neglect generally, if charging a senior "care worker," under *s.20*, it may be possible to offer an alternative count of *s.21* (the "care provider" offence). When faced with the latter alternative count, it may be interesting to see whether a conviction would be secured on the former.

[410] Noted in a separate section, s.23, Criminal Justice and Courts Act 2015

[411] s.20(3), Criminal Justice and Courts Act 2015

[412] s.21(2)(b), Criminal Justice and Courts Act 2015

[413] The level of the fines that are imposed against anyone found guilty are yet to be seen

Furthermore, the use of plea bargaining would not appear to be beyond possibility. The situation could thus become similar to that of the new offence of corporate manslaughter, whereby the penalty is a fine, instead of the likely custodial sentence, if the individual is found guilty of gross negligence manslaughter individually. As indicated above: *companies (via their directors) have chosen to plead guilty to corporate manslaughter to save directors from gross negligence or HSW charges*.[414]

Despite this risk, the new offences are welcome, and will hopefully provide some reassurance to those who may be receiving care. However, there remains a potential for discontinuity between corporate expectations, and the ability to effectively monitor the activities of private companies.

13. Changing the focus to corporations

A detailed discussion about the need to change the law in relation to criminal responsibility is beyond the scope of this Review. However, there are a number of current suggestions, which merit serious consideration. For instance, as Professor Wells observed (citing J. G. Stewart):

Treating individual and corporate criminal liability as mutually exclusive (rather than operating hand in hand) is conceptually dangerous. Only prosecuting business representatives as individuals provides corporations with incentives to scapegoat their employees, whereas a unique focus on the corporation allows individuals to avoid their own moral responsibilities by pointing to the surrounding corporate structure.[415]

Neil Cavanagh comes to a similar conclusion, but with different reasoning. Cavanagh takes a more sociological approach and suggests that it would be better in reality to determine culpability on the basis of corporate culture. Such an approach would examine a corporation's *organisational processes, structures, goals, cultures, and hierarchies*[416] to determine if it can be shown that a corporate culture of non-compliance with the law exists. It then *becomes possible to infer corporate mens rea by the corporation itself*.[417] In essence, the necessary *culpability* is found in the corporate culture rather than in the mind of an individual.

He discusses the case of the loss of *Herald of Free Enterprise* as a compelling example of possible advantages of such an approach, commenting:

It can be confidently asserted that under the corporate culture doctrine P&O would have been convicted of manslaughter. The mens rea would have been established from the corporate

[414] ibid

[415] Celia Wells, "Corporate criminal liability: a ten year review" [2014] Crim. L.R., 849-878, here citing J. G. Stewart, "The turn to Corporate Criminal Liability for International Crimes: Transcending the Alien Tort Statute" [2014] 47 New York Journal of International Law and Politics 121

[416] Neil Cavanagh, "Corporate criminal liability: an assessment of the models of fault" [2011] J. Crim. L. 414, 432, here citing W. Laufer, "Corporate Bodies and Guilty Minds" (1994) 43 Emory Law Journal 647, 666

[417] Neil Cavanagh, "Corporate criminal liability: an assessment of the models of fault" [2011] J. Crim. L. 414, 432, here citing C. M. V. Clarkson, H. M. Keating, and S. R. Cunningham, *Criminal Law* (2010, Sweet and Maxwell) 249

practices and the lack of 'obvious and necessary safety procedures.' Furthermore, the inquiry found that P&O was 'from top to bottom infected with the disease of sloppiness'. From this it can be concluded that a culture that sanctioned the commission of the crime existed.[418]

The earlier discussion of the L-Giri 'empire', however, also suggests that both the company and individual directors could perhaps have been prosecuted and disqualified under existing law. The advantage of adopting a corporate contextual approach would be obvious in the context of the Operation Jasmine investigation.

No doubt there are a number of very important questions left unanswered. Perhaps most importantly is: why did Gwent Police and the CPS delay taking action until 2012, when in fact Evelyn Jones, whose cause of death is linked directly to neglect at Brithdir, died in November 2005?

Clearly, there have been recent moves towards better co-ordination between the agencies but there are particular issues that need to be addressed in relation to the care sector.

Several important issues stand out:

i. The need for mandatory independence on the Boards of companies who provide such care;
ii. Consideration of the need for supervisory Boards;
iii. The need to specify breach of care standards regulations in the context of disqualification;
iv. Consideration of guidance for Tribunals in terms of standards of proof, weight, and admissibility of evidence, especially by expert witnesses;
v. Consideration as to how to best ensure that companies providing care to vulnerable adults are not engaging in "wrongful trading;"
vi. Consideration as to whether the corporate social responsibility provisions currently provided for, under *s.172* of the *Companies Act 2006*, need to be given additional teeth, particularly in the context of health and social care, where there is an obvious public interest in ensuring safety and well-being;
vii. Consideration that the statutory provision allowing for single director companies ought not to apply to the health and care sector;
viii. Where there is a history of insolvency, even voluntary, in companies involved with nursing or social care, consideration of whether there should be a presumption of disqualification;
ix. Consideration of whether the regulatory bodies need additional training on the responsibilities of directors, and should not be diverted by claims of non-liability based on passive involvement;

[418] Neil Cavanagh, "Corporate criminal liability: an assessment of the models of fault" [2011] J. Crim. L. 414, 432, 433

x. Consideration that there may be a need for additional training to ensure that both regulators and providers are made aware of the vicarious liabilities of providers for the torts of their employees;
xi. Consideration of the need for a legal presumption in favour of reporting deaths in a care context to the Coroner;
xii. Consideration of whether the definition of an "unnatural death" should include where individuals have died with pressure wounds and/or similar evidence of possible neglect or lack of care;
xiii. Consideration that corporate criminal responsibility should possibly be based on corporate conduct across the organisation, rather than the present practice of pinpointing responsibility on individuals; and,
xiv. Consideration of a Law Commission review of how to better corporate safeguards in relation to the residential and nursing care of elderly and other vulnerable individuals.

14. Conclusion and call for a review of the law

This Review has been driven and inspired by the genuine and justified concern of grieving and aggrieved relatives, who believe that their loved ones have suffered unnecessarily, and that those they believe to be primarily responsible have not been held to account. The relatives themselves, together with those who suffered, are victims. As it stands, relatives of victims of crime have no legal right to demand a review of a decision not to prosecute - but, as a result of European intervention, this position will change in relation to serious crimes.[419]

This analysis of the legal context highlights the shortcomings of the existing corporate governance frameworks, and confirms that there is an urgent need for the imposition of externality to existing corporate structures. Nevertheless, this Review suggests that there were missed opportunities for earlier intervention, including potential for action under the *Company Directors Disqualification Act 1986*, the *Health and Safety at Work Act 1974*, and the criminal law. More detailed consideration needed to be given to the issue of Dr N Das' possible breaches of duty since explanations provided by some of the investigative bodies in terms of her potential passivity as a director are unconvincing.

A number of speculative explanations could be suggested as to why these failures occurred, but a major area of concern is whether causation could be established. It can be suggested that the decision in *Willoughby*[420] allowed some considerations in gross negligence manslaughter cases, to be left to the jury - such as the existence of a duty, any breach causing death, and the issue of gross negligence. The relatives of those who suffered have seen some of the potential evidence that could have been put to the jury, and therefore are confident that the standard of proof could have been reached. In hindsight, perhaps the investigation

[419] Directive establishing minimum standards on the rights, support and protection of victims of crime (2012/29/EU), Article 11 provides that: "Member States shall ensure that at least the victims of serious crimes have the right to a review of a decision not to prosecute"

[420] [2004] EWCA Crim 3365

took on some of the characteristics of an inquiry, rather than an attempt to impose culpability at an earlier stage.

Earlier success might also have been achieved by the regulatory agencies, and it is ironic that the primary explanation for the failure to close down one of the homes at the First Tribunal may have been the very recent improvement in a provision, partly the result of assistance provided and paid for by the local authority and the health board.[421] The distinction between commissioners, regulators and providers was arguably compromised, and the question needs to be asked as to whether the public sector should be engaged in buttressing the private sector. Indeed, there may well be some issues of *ultra vires*. However, the public authorities should be commended for their persistence in pursuing the issues to a Second Tribunal. In particular, the tenacity of one CSIW Inspector, Mrs Alison Price, deserves special credit.[422]

The relatives' call for a Public Inquiry is totally understandable. We would support a call for a detailed review of corporate safeguards and a review of the application of criminal and civil law in this context. Indeed, as suggested at the outset of this review, we would recommend that an appropriate development would be a Law Commission review, with wide terms of reference, of corporate governance in the sector, together with wider considerations of adult protection.

[421] *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) (5 September 2006), paragraph 243

[422] Mrs Alison Price and another Inspector were interviewed by Gwent Police under caution. Both were advised that they were potentially guilty of malpractice in public office

Section thirteen: Analysis part two - the events concerning the care homes investigated as Operation Jasmine

In this section…

> *…the clearest finding of the Review emerges in that mistakes were made, that is, that there were a number of errors of judgement. These most particularly concern a series of legal issues (as Aled Griffiths, Chaynee Hodgetts and Rois Ni Thuama describe in Analysis – Part One). Since the Review was inevitably based on only partial information, there is no clear and overarching structure with which to make sense of the events relating to Gwent Police's investigation. This section considers mistakes in relation to issues of governance and professional judgement.*

1. The Positive Impact of the Media

Little has remained the same, in terms of professional response to harm in residential care, since the **1995** television broadcast[423] about the *serious neglect of patients* at Dr P Das and Dr N Das' nursing homes. However, practice at their homes appears to have remained static over the years. The 1995 broadcast was a strident warning signal that **the care of frail older people was being severely compromised ten years before Gwent Police's Operation Jasmine investigation**. It would appear that the troubling facts exposed by this and subsequent broadcasts were met with the feeling by the relevant bodies that it would be incredibly disruptive if the full extent of the harm was accepted: that is, where would these frail elderly people be transferred to? **The NHS**'s clear and definite responsibility for regulating nursing homes at this time resulted in inspections – as well as a number of responses to specific concern about the practices of Dr P Das – and yet the outcome of these was not officially recognised or shared more widely than with the individuals responsible for them. Such abrogation of responsibility made it possible for damaging practices within the homes to become established and – arguably – tolerated. As a result, the media stepped into the breach.

A further television programme during **2005** also reflected the disbelief expressed by a number of health and social care professionals that the Care Standards Tribunal had upheld Dr P Das' appeal against the proposal to cancel the registration of **Holly House**. The broadcast showed the range of harm, neglect, incompetence and breaches of standards which occurred at Holly House and **Merthyr Tydfil Nursing Home**, two of Dr P Das and Dr N Das' homes, of which there had once been *an empire of 25 homes* across south Wales. They illustrate the signature flaws which characterised their homes:

- not enough money being invested in terms of equipment such as, for example, hoists

[423] See Appendix 1

- delays in securing medical advice and treatment, including pain control
- inadequate wound care
- food being rationed with residents malnourished and dehydrated
- inadequate recruitment practices and insufficient staff
- residents' safety compromised with a number sustaining unexplained injuries
- residents being poorly supervised
- errors in the administration of medication
- residents' hygiene was wanting
- infection control was inadequate
- rationed incontinence pads
- suppliers of homes requesting cash payments since some had *been owed thousands by Dr* [P] *Das in the past*

The **Care Standards Inspectorate for Wales** (CSIW) made many unannounced visits, the findings of which were dismissed by Dr P Das as *nit-picking.* Dr P Das was also reported to the Health Authority by **Dr Jonathan Richards**, a Professor of Primary Care who had had patients at the Merthyr Tydfil Nursing Home.

There was a yet further television broadcast during **June 2013** which reinforced and expanded on footage from the 2005 broadcast. This again reflected concern that *Britain's biggest investigation into the neglect of the elderly in nursing homes* [that is, Operation Jasmine] had *collapsed in dramatic fashion leaving…a host of unanswered questions.* The shocking circumstances of **Evelyn Jones**' suffering and death from extensive, deep and infected pressure wounds were described by her family, and were freeze framed in photographs. She had been resident at **Brithdir**, another of the Das' homes. Similarly **Stanley Bradford**'s family described their shock on seeing him in hospital in such a frail, emaciated and diminished condition after being admitted from Brithdir. Neither family had been informed by staff at the home that their relatives had developed pressure ulcers. **Marian Barnes**' family could not believe Brithdir staffs' account of how she sustained a broken femur. As a result, they ensured that, on discharge from hospital, she should not return to the home.

A former sister in charge at another of the Das' homes, **Hengoed Hall**, confirmed during the programme a deliberate practice of understaffing and cutting back on the provision of sufficient food and incontinence pads, for example.

The programme described two principal setbacks to the police investigation:

i. The **Crown Prosecution Service**'s determination that the evidence arising from the police investigation did not reach the required threshold to bring charges of gross negligence manslaughter and wilful neglect. This resulted in the **Health and Safety Executive** bringing lesser charges against Dr P Das who was also being accused of theft and false accounting
ii. An attack on Dr P Das at his home during **September 2012**. In **March 2013** Cardiff Crown Court was told that Dr P Das was unlikely to ever recover sufficiently to stand

trial. As a result, the Crown Prosecution Service decided not to proceed against the Chief Executive Paul Black or the Das' company Puretruce Health Care Ltd.

Radio 4's *File on Four* also gave coverage to the problems which arise in attempting to prosecute cases of neglect. This programme focused on the circumstances and deaths of **Gladys Elvira Thomas**, **Evelyn Jones**, **Stanley Bradford** and Linda Carter's father.

In parallel with the television and radio broadcasts and the BBC News, the South Wales Argus and the Western Mail have, over many years, tracked events and informed readers of concerns about the Das' homes and the practices within them. The extent of such coverage, across television, radio and press in describing the very grave conditions which existed at Hengoed Hall, **Silverdale Nursing Home**, Holly House, Merthyr Tydfil Nursing Home, **Aberpennar Court**, **Bay Bridge** and Brithdir[424] suggested that the problems to be dealt with – some of which were still emerging - were considerable. These revealed a growing patchwork of problems with an increasing number of agencies becoming involved. For example:

- (during and after 1995) Gwent Community Health Council, Mid Glamorgan Health Authority[425] and Mid Glamorgan Family Services Authority, the Welsh Office, Caerphilly Miner's Hospital, Ystrad Mynach Hospital, Llandough Hospital, Mid-Glamorgan council and the Health and Safety Inspectorate
- (during and after2005) The Care Standards Inspectorate for Wales,[426] Mid Glamorgan Health Authority, Caerphilly CBC social services, Caerphilly Local Health Board, Torfaen CBC social services, Torfaen Local Health Board, Torfaen Advocacy Service, South Wales Fire and Rescue Service, the General Medical Council, the Nursing and Midwifery Council, the Health and Safety Executive and Gwent Police.

In addition to these agencies, residents' relatives and professionals such as GPs and District Nurses were visiting the homes – and yet the indisputable build-up of problems from 1995 was still awaiting resolution in 2005. Because the Das' businesses grew and thrived, irrespective of the workplace cultures within their homes, the outrage of residents' families also grew. The disturbing evidence broadcast in 1995 was met with organisational nonchalance. Over time, the agencies involved appeared to operate to the limits of their capacity as they attempted to deal with a complicated tapestry of events with a long history. Furthermore, there was no single agency which assumed a lead role in addressing breaches of trust, neglected contractual duties, and the harm endured by these frail older people. Extensive media coverage proved insufficient in securing a fair and legally sanctioned resolution.

[424] Coverage was also given to Bryngwyn Mountleigh and Fairfield Nursing Home which were not owned by the Das'

[425] Responsible for registering and inspecting nursing homes

[426] Which took over from Health Authorities in 2002

2. Questions about the Governance of the Gwent Police Investigation: Operation Jasmine

In terms of the governance of Operation Jasmine, questions arise in relation to the legal issues, the position of the Crown Prosecution Service (CPS) and the police investigation. The question of prosecution was not properly considered, nor does it appear that Gerard Elias QC was asked by the CPS to explain the advice he had given to Gwent Police. Seemingly without reference to Mr Elias, the decision-making in relation to Operation Jasmine was transferred by the CPS, initially to Cardiff, and then on to York. The superficial evidence was that pressure ulcers were the substantive cause of the death of these frail older people, as well as inadequate care. This should have been sufficient. That is, there was sufficient evidence and a strong case. Prosecutions should have occurred during 2006-2008. The CPS' correspondence and notes[427] contain a number of errors. It has been speculated to the Review that it was feared that:

i. Operation Jasmine was the tip of the iceberg
ii. It would result in calls for a Public Inquiry
iii. There was potentially no end-point
iv. A trial may have been critical of the inspectorates
v. A trial may have been critical of the CPS' decision-making
vi. A trial could have been a profoundly challenging *first*. How might the Welsh Government address criminal manslaughter prosecutions in relation to the deaths of frail older people if it was proved that businesses responsible for their care were reckless in the way in which they ran care homes?

A refrain by a number of those concerned with the situation was: *It's a conspiracy!* Speculation flourishes where agencies pass up the opportunity to participate wholeheartedly in a process designed to *learn for the future.*[428]

During the seven years from the start of the police investigation up until Dr P Das' trial, mistakes were made. They may have occurred because Gwent Police's understanding of nursing homes, and the contexts within which they operate, was incomplete, and because the parameters of the investigation were too broadly drawn, that is, *to investigate the circumstances of all the deaths where there are or have been concerns* and *to investigate all allegations or suspicions of abuse.* Feedback from Gwent Police on 5 May 2015 confirmed that Operation Jasmine involved six care homes but in the same communication stated that, *for Brithdir, read also any other home owned by Das/Puretruce.* Such an open-ended investigation would explain why there seemed to be no boundaries to an investigation which strayed into the emerging territory of the Protection of Vulnerable Adults (for which local authorities had the lead responsibility) as well as into the inspection activities of the CSIW (the CSSIW after April 2007). However, as the priorities of the police investigation were

[427] Appendix 4

[428] The expectation of the First Minister

revised, so were the different phases of its inquiry.[429] For example, in **April 2006**, **Evelyn Jones** and **Edith Evans** had been placed in Phase 1, but by **August 2006**, they had been re-located into Phase 3. However, the Review was informed that **Evelyn Jones** and **Edith Evans** were re-located on a further occasion. It is not clear what gave rise to this approach.

The unclear boundaries of Operation Jasmine created difficulties for Gwent Police and those agencies which had undertaken to work with it. All key agencies had endorsed the value of joint working and collaboration in the form of processes and protocols, that is:

i. South East Wales Executive Group for the Protection of Vulnerable Adults – *Protecting Vulnerable Adults: Interagency policy, procedures and practice guidance for responding to alleged abuse and inappropriate care of vulnerable adults in the South East Wales area.* The Group was established to coordinate the development and implementation of a south east Wales joint agency framework. Relevant signatories to the 2003 framework included Blaenau Gwent CBC, Caerphilly CBC, Torfaen CBC, Gwent Healthcare NHS Trust, the CSIW, Blaenau Gwent LHB, Caerphilly LHB, Torfaen LHB and Gwent Police

ii. *Work-related deaths: A protocol for liaison (England and Wales)* – which was first introduced in 1998. Signatories to the protocol included the Crown Prosecution Service, the police through the Association of Chief Police Officers, the Health and Safety Executive and local authorities through the Welsh Local Government Association

iii. *Memorandum of Understanding between the Health and Safety Executive, the Welsh Local Government Association and the Care Standards Inspectorate for Wales* in 2006. This sought *to facilitate cooperation and coordination between the HSE, the Welsh Local Government Association (WLGA) on behalf of local authorities in Wales and the CSIW.*

Whether Gwent Police fulfilled Operation Jasmine's Terms of Reference or remained loyal to its investigation parameters, is not known to the families of the older people who were the focus of the investigation, the local authorities concerned, the Local Health Boards, or the CSSIW. Nor do they know why Gwent Police set up a parallel 'Operation Vermont' which hinged on the death of **Dorothea Hale** and practices at Grosvenor Nursing Home.[430]

Although emergencies require action, concern regarding the triggering event of **Gladys Elvira Thomas'** death appeared to drift from its critical phase into a long investigation which threw Gwent Police and potential partners into confusion. The question: *What on earth were the police doing?* is a moot one as Gladys Elvira Thomas' death became a memory and inter-organisational cooperation and partnerships were overshadowed by ambiguity, suspicion, loss of agencies' credibility, and then silence so as not to compromise a trial with an ever-

[429] The North Wales Police Review refers to the investigation's *phases*

[430] See Section 6 The Gwent Police chronology

receding start-date. North Wales Police reviewers identified areas of concern in the Gwent Police investigation in relation to **Evelyn Jones** over a two year time frame. In all there were 22 recommendations put forward for consideration.

Even though national and regional structures and forums had developed appropriate procedures before Gwent Police's investigation began, these were set aside in favour of an untested alternative which had no explicit reference framework. This lack of a relevant framework made it challenging for all agencies as historical (i.e. pre-Gladys Elvira Thomas) abuses became subject to critical examination. Furthermore, agencies lost some autonomy of action as activities which were normally within their powers became restricted because the Gwent Police had primacy over how the investigation should be conducted. This is exemplified, for example, in (i) the minutes of the Strategic Management Board Operation Jasmine of 15 November 2005 which stated: *all new referrals to the hospital were to be reported straight to the* police; and (ii) correspondence between Welsh Government lawyers and the Gwent Police (see Section 6, police chronology) and the position of Caerphilly CBC in relation to Belmont, that is, *due to these extraordinary circumstances, the POVA* [Protection of Vulnerable Adults] *processes would be closed and left open only to the Operation Jasmine investigation. Due to the police investigation these cases had not been managed in line with the usual POVA processes*.

The merit of protective provisions and procedures is that they have been made subject to public scrutiny as well as being subsequently rehearsed and used. This enables professionals and partner agencies to become competent in their application, modification and development. For example, Caerphilly CBC abandoned the Protection of Vulnerable Adults framework in favour of hosting *overarching POVA meetings* which do not feature in the relevant 2003 guidance on policy, procedures and practice. This was unmerited in that the detail about individuals and the scope for identifying themes was lost. As a result, as more and more problems became revealed, the well-thought out responses set out in procedures and protocols were set aside by an executive decision not to make use of them.[431] Clear thinking, on the one hand, and action, on the other hand, are not necessarily in opposition. As the North Wales Police reviewers discovered, it became *difficult for the investigation to maintain an overall strategy.*

The Terms of Reference of the Gwent Police investigation initially focused on the Bryngwyn Mountleigh homes. These terms were soon extended, however, because of concern over Brithdir. As a result, the ultimate focus of Operation Jasmine settled on the prosecution of Dr P Das, Paul Black and Puretruce Health Care Ltd.

Gwent Police engaged the services of a retired CSIW Regional Director. This person seemed unfamiliar with negotiating a 'draft' inspection report, that is, the opportunity for a provider/

[431] See Scarry, E. (2011) *Thinking in an Emergency* New York: W. W. Norton and Company

Responsible Person to ensure that a report was factually accurate prior to publication.[432] The Review was advised that this person was apparently instrumental in two CSIW Inspectors being interviewed under caution by Gwent Police. It appears that the impetus for the malpractice allegation against two CSIW Inspectors was the claim that they were responsible for the deaths of older people. Nevertheless, the commissioning of a person who had previously worked for the CSIW was described to this Review as *a poorly arranged secondment on CSIW's part,* and as an inappropriate arrangement in relation to such a high profile investigation as Operation Jasmine.

The multi-agency Strategic Management Board which was set up by Gwent Police also ran into difficulties. Although partnership as a concept features in the relevant guidance, in fact partnership with the CSIW could be unfamiliar to the other agencies involved. It was however essential, given their experience of inspecting the Das' homes from the time of the CSIW's establishment in April 2002. (Prior to this date, Mid Glamorgan and other health authorities had been responsible for inspecting the Das' nursing homes and local authorities were responsible for inspecting their care homes). Gwent Police adopted a high risk strategy when the CSIW was excluded from the investigation. This action exposed the investigation to both incredulity and scepticism among health and social care professionals. A coordinated investigation with a network of agencies was what was needed and yet, confronted by so many challenges, Operation Jasmine appeared to limit itself to increasing the number of police investigators at the expense of cooperation with the other relevant bodies.

Finally, the assumed task of investigating *all allegations or suspicions of abuse* was vast, particularly with a hard-to-grasp command structure. This presented Gwent Police with considerable operational difficulties in coming to terms with such an all-encompassing challenge that went far beyond normal policing skills.

3. The Use of Expertise

Another body set up by the Gwent Police was an expert panel principally made up of clinicians. This worked in parallel with the multi-agency Strategic Management Board (as well as an Investigation Management Board). This was because **Gwent Police** were seeking the technical and specialist advice of a panel whose expertise spanned general practice, nursing care, gerontology, mental health care, pressure ulcer wound care and pharmacology as well as social care and adult protection. The selection of potential experts was governed by concerns such as whether or not a person was familiar with the home owners (for example the Review was told that one clinician was not recruited having been a guest at the wedding of the Das' daughter). Gwent Police had to include a range of disciplines, given the breadth of

[432] An example of the process and opposing views is reflected in *Puretruce Health Care Ltd v National Assembly for Wales* [2004] (EA-W) 15 May 2005, *Dr* [P] *Das maintained that the report was factually incorrect, despite the fact that both Rachel Pritchard and Paul Black* (Puretruce employees) *accepted that the report was factually correct at the time that it was written* (paragraph 27)

problems that were being revealed. The panel produced their findings concerning the deaths of **Alan Sayers** and **Gladys Elvira Thomas** within six months, but the North Wales Police reviewers expressed concern about the length of time taken to produce subsequent reports. Although the panel was initially invited to produce *combined reports*, by **July 2008**, it was required to produce *individual reports.* This protracted the process. The gap between the panel members with their disparate areas of specialist knowledge and the operational requirements of a police investigation (which, in any case, lacked precise parameters) became considerable. Moreover, the prosecution of a number of nursing staff became a distracting diversion, but was seen by certain panel members as an assertion of *their duty to report individuals to their professional bodies.* Thus it would seem that the expert panel became a decision-maker in its own right.

The duration of Operation Jasmine presented the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC) with a problem. These professional regulators could not take action before Gwent Police had concluded its investigation – one that increasingly took on a searching and sifting remit for elder abuse in residential care without apparent end. The tension between the values and goals of a police investigation and those of the clinical regulators is seen in the fact that the fitness of nurses to practice should be determined immediately concern arises. The Review was informed that on countless occasions, the NMC asked Gwent Police for information in that it is the only organisation that can prevent a nurse from practising. However, such timely information was not forthcoming. That the NMC's Conduct and Competence hearings were not held until **September 2014**, (that is almost 10 years after the setting up of Operation Jasmine), and then lasted until **2015**, is a matter of considerable concern.[433]

4. The Limits of Local Authorities' Adult Protection Procedures

The raised profile of adult protection (or adult 'safeguarding') since the publication, **in 2000,** of the guidance *In Safe Hands* was significant for social services. Although the number of POVA referrals to local authorities in south-east Wales during this period has not been made available to this Review, local authority social services were certainly receiving referrals, often under the vague and all-encompassing term 'abuse'. The term's meaning can range from crimes against property to the neglect, discrimination, humiliation, mistreatment, violence against, and sexual assaults, of adults, including frail older people, as well as lack of attention to such 'basics' as hydration and nutrition.

Although 2000 was not a time when advances were made in the practical application of the guidance (not least because the new responsibilities placed on the agencies were unfunded), it was, nevertheless, a time when local authorities did attempt a more coordinated and multi-agency approach to the complex tasks of protecting and promoting the welfare of vulnerable

[433] For example, it is not known how many nurses continued to work during the Gwent Police investigation

adults. In identifying a useful means of classifying abuse, *In Safe Hands* sought to strike a balance between:

i. protecting adults and recognising that they had autonomy
ii. the circumstances of individuals and those of institutions, such as nursing homes.

There was a broad consensus that abuse could be described in terms of physical and sexual assaults and harm, financial and material abuse,[434] psychological harm and neglect and that a distinction could and should be made between a victim and a perpetrator. Furthermore, the vulnerability and mental capacity of individuals were relevant reference points for adult protection. There was also an acknowledgement that the fear of reprisals and confrontation, shame and distress can all impact on the decision of individuals and their relatives on whether to make a referral to POVA – or even make a complaint.

Although the multi-agency sign-up to procedures was welcome, how these were to be operationalised was a more complicated matter. The critical and long-term task facing local authorities was to dovetail the procedural arrangements of adult protection with inspections, professional regulation, law enforcement, complaints, clinical governance and serious untoward incidents, and internal disciplinary processes (see, for example, the chronology of Bryngwyn Mountleigh). Coupled with this were certain structural problems, that is, NHS personnel are typically dispersed over many work locations. Moreover, partnership working rarely acknowledges the importance of ensuring that partnerships are implemented at all levels - most particularly, involving front line workers.

In terms of care homes, a manager's perceptions about the seriousness and significance of abusive acts (as well as failures to take action) are the result of prior experience, knowledge and understanding of adult protection policies - as well as the combinations of factors which can result in skin damage - all of which impact on their responses to offending care staff. The boundary between *good* and *not so good* services challenges POVA practitioners because it draws them into the interlocking concern of poor practice and neglectful practice. Where individuals and their services share the values of POVA and are motivated to achieve these, then staff training, for example, is instrumental in remedying poor practice in the short term. However, this Review has shown that when shared values do not exist, reforms may be promised and only superficial remedial action undertaken.

Local authorities and health boards face subtle pressures in that they are also typically involved in processes which determine the fee levels of care providers. This creates a double bind situation, that is, a dilemma is created by the fact that local authorities and health boards determine priorities in providing and commissioning care as well as addressing the consequences of poor and neglectful care. Are they therefore inhibited in taking action against those providing poor care?

[434] Since 'financial abuse' includes theft and fraud and 'sexual abuse' includes rape and indecent assault, there is a concern that the UK's POVA processes may obscure and decriminalise the crimes experienced by adults with care and support needs

Insofar as the adult protection outcomes for residents of the six homes are known, it seems they were minimal. The relatives of residents describe a bureaucratic process which had no discernible impact on the endemic inattention to people's untreated pressure wounds and comfort generally. Even reporting pressure ulcers to local authority POVA personnel appeared to dilute the urgency with which:

- residents at *high risk* of developing pressure ulcers were identified, for example, those with diabetes
- pressure ulcers require urgent *and* comprehensive treatment, including the monitoring and recording of a wound's progress and a clear means of accessing additional expertise and advice, since no improvement occurred in terms, for example, of reducing hospital admissions, residents' care plans, staff supervision, staff training, or in seeking advice on such issues as tissue viability.[435]

During November 2005, the Strategic Management Board of Operation Jasmine noted that *The CSIW inspection* (of Bryngwyn Mountleigh) *will be postponed…as agreed by the POVA strategy meeting.* Later in 2007, since one hospital pathologist declined to undertake a post-mortem on **Dorothea Hale** because her circumstances were the subject of a POVA investigation[436] it would appear that clinicians were unwilling participants in the POVA process. Arguably it became difficult to strike a balance between the cooperative expectations of POVA and the responsibilities of individual professionals or agencies to investigate or inspect within the context of an expanding police investigation.

Although homes are expected to report pressure ulcers to the regulator (typically those of grade 3 and above[437]), this Review shows that there were too many occasions when this did not happen. Furthermore, although Brithdir residents developed multiple and deep pressure wounds (which were only sporadically recorded), the home had no coherent or consistent means of either preventing, or treating, wounds within a timeframe discussed with GPs and other clinicians. Pressure-relieving mattresses were introduced only belatedly, without any credible appraisal of residents' continuing deterioration (and since needs change over time, a number of factors would influence the selection of the type of mattress, for example).

The reporting of deep pressure ulcers, dehydration and malnourishment by Accident and Emergency services to local authority POVA personnel is an anomaly since most of the problems of residents who are admitted via A&E[438] are clinical in nature. It was in fact the

[435] Brithdir inappropriately sought intermittent advice concerning pressure ulcers from a pharmacist

[436] See Police chronology – Section 6

[437] This is an unduly crude 'marker' because it is not possible to discern anything of the size, condition, location or progress of individual or multiple areas of pressure ulcers – which may deteriorate within hours

[438] In the USA, all patients who are admitted to hospital have their skin assessed by a doctor to determine whether or not they have skin injury – which are determined as *never events* (serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented). If subsequent skin breakdown occurs the hospital has to cover the cost of such injury

introduction of the *In Safe Hands* guidance which led to these being sent to local authorities for *investigation*. Operation Jasmine has confirmed that this is wholly insufficient in terms of:

- triggering urgent, clinical remedies
- establishing the scale of pressure ulcers within care homes in Wales; or
- locating this long-standing, clinical problem conclusively within the purview of the NHS.

Although the publication of *Pressure Ulcer Reporting and Investigation: All Wales Guidance* in 2014 provides a clinical response, the threshold at which referral is to be made requires careful scrutiny if consistency of treatment and reporting is to result.

5. What outcomes were expected?

In terms of outcomes for frail older residents, the following table makes distinction between what is known to have happened at Brithdir, for example, and what relatives reasonably expected would have happened.[439]

	What is known	What was expected
Frail older person(s) and their relatives	Belated medical advice; hospital admissions; relatives' concerns and complaints on the neglect-abuse continuum; the use of sedative medication which was not prescribed; residents isolated in their rooms; insufficient funding for essentials such as residents' food, incontinence pads and equipment;	A positive culture in which medical attention is prioritised for all; staff with time to provide attentive care; social work, reviews and Care Programme Approach[440] input; assistance to get about safely and engage in activities based on residents' interests
Brithdir staff	There was no Registered Manager; there was an inadequate number of care staff. There was high use of agency staff and no evidence of either supervision or training; insufficient funding for properly staffing the home; stressful working conditions	Sufficient, compassionate and motivated staff who were managed, supervised, trained, properly recompensed, interested and willing to work with residents, their relatives and visiting professionals
The provider	A business model based on profit-driven priorities; promises of reform; Brithdir provided with external	A change to contracts which leads to a change in the service

[439] See Brown, H. (2009) The process and function of serious case review *Journal of Adult Protection,* 11 (1), 38-50

[440] The CPA is a way that services are assessed, planned, coordinated and reviewed for someone with mental health problems or a range of complex needs http://www.nhs.uk/Conditions/social-care-and-support-guide/Pages/care-programme-approach.aspx (accessed on 12th April 2015)

	assistance from the NHS; commissioner imposed embargoes on new placements; the assessment and judgment of Inspectors subject to legal challenge	being provided; brakes on home ownership
The NHS	Belated medical treatment of residents; acceptance and tolerance of inattentive health care and deep pressure ulcers among residents	Recognition of the interrelationship between inadequate nursing home care and the consequence for primary care, secondary care and palliative care
The commissioners	An assumption that funded nursing home placements would deliver effective nursing care and that contracts would be honoured	Knowledge of the conditions necessary for promoting better care at Brithdir; and knowledge of where the home fitted into the wider system of provision
The CSIW/ CSSIW	High cost legal and regulatory intervention; caution in taking action which might compromise the police investigation	Timely enforcement intervention; more frequent inspection of homes; due diligence in registering providers with a poor track record
The Welsh Government	Accumulating concern about the shortcomings of the care 'market' in south east Wales	Action to lower and remove the obstacles to closing failing homes

6. The Challenges for Inspection and Regulation

The reorganisation of local government in Wales in **1996** and the reorganisation of the NHS in **2003** had, inadvertently, a negative effect on the delivery of services. In addition, the introduction of the Care Standards Inspectorate for Wales in **2002,** and its successor in **2007,** resulted in major programmes of re-registering and inspecting providers. The Inspectorate devoted much of its early existence to internal administrative arrangements. This had a high cost for staff in terms of uncertainty, of certain activities being discontinued, of changes to working relationships, the loss of key personnel and organisational memory. The CSIW was expected to collaborate with the Health and Safety Executive, local authorities' contracts/ compliance and health commissioners, each with its own protocols, approaches and disparate methods of logging concerns and events – yet with no single agency 'holding the ring' in terms

of an overview, and thus enabling credible information about a home's performance to be collated.

Earlier sections of this Review suggest that focusing on separate aspects of regulation – registration, standards and enforcement - may result in creating impediments to some courses of action. The assertion that inspection was intended to be a *constructive and enabling process* (as stated in the Preface of some CSIW/CSSIW inspection reports) may have impeded the way of Inspectors/the regulator from applying appropriate sanctions where these were clearly necessary. For example, the fact that certain residents had developed deep, infected pressure ulcers necessitating hospitalisation was not included in inspection reports on Brithdir. The number of requirements proposed by Inspectors was overwhelming – as was the length of their early reports.[441] (The inspection reports regarding Brithdir were from 48 to 76 pages in length and The Beeches' reports covered 51 to 92 pages). However, when the Inspectors proposed timeframes within which the requirements were to be addressed, it was in the knowledge that they had no capacity to check whether these had been or were being addressed. This makes it all the more remarkable that a particular Inspector was tenacious in visiting and following up on proposed requirements and was instrumental in ensuring the admission of certain residents to acute hospital care.

A reading of the inspection reports[442] prompts a question about the status of *good practice recommendations.* Some appear to be essential to people's health and wellbeing e.g. *Controlled drugs must be stored correctly and administration recorded properly* [e.g. Brithdir, December 2005]; and *Standard met – however a system of measuring and describing wounds needs to be put in place with the subsequent action to be taken recorded in the individual's care plan* [see for example, Grosvenor House July 2002]. It is not clear whether or not providers were obliged to comply with *good practice recommendations* and it is not clear how an *urgent requirement* differs from a requirement which has to be addressed *immediately*. Furthermore, some *requirements* refer to the role of several people in taking action e.g. *As a matter of urgency the registered provider, the responsible individual and the acting manager must collectively ensure that effective quality assurance and quality monitoring systems, based on seeking the views of service users, are in place to measure the home's success in meeting its aims, objectives and statement of purpose* [Brithdir, February 2006]. It is unlikely that that three people could take the lead in establishing that (i) quality assurance and (ii) the views of residents and were aligned with the home's statement of purpose. Since some requirements contained so many elements they should arguably have been specific and separate/stand-alone requirements e.g. *The registered provider and acting manager supported by the staff team need to demonstrate a commitment to lifelong learning and development for each service user, based on their individual choices and linked to implementation of their individual care plan* [**Brithdir**, February 2006]. However, there was so

[441] Rendering unhelpful Joe Howsam's (Director of Social Services, Caerphilly CBC) expectation that older people's families should *read past* the inspection reports (See Appendix 1, *Week In, Week Out* June 2005)

[442] See Appendix 2

much that was wrong with this home it is unlikely that an even longer list would have rendered residents safe from harm. Crucially, there did not appear to be any consequences for failing to act on the Inspector's *requirements* e.g. *The home had not provided a business and development plan, this had been a requirement since the home was first inspected in 2002* [**Brithdir**, February 2006]. Brithdir did not have a Registered Manager and disguising this fact with the names of individuals who were *Acting* Managers arguably downplayed the significance of this role.

The CSIW and, subsequently, the CSSIW experienced accumulating and disquieting pressure on its resources which were new to the world of inspection and were not likely to have been anticipated by politicians or lawyers drafting the Care Standards Act and regulations. These included:

- Harmful behaviour which was not addressed by the Care Standards Act 2000, e.g. limiting the home's food bill to the extent that catering staff elected to leave (see **1995** broadcast, Appendix 1), and providing meals to residents which were neither appetising nor nutritious (and on occasion *inedible* according to an Inspector who insisted that one Manager should purchase an alternative at a local supermarket for all residents immediately);
- A nurse manager who had signed a notice in Brithdir's kitchen stating *Please water down the milk*;
- Seeing and smelling residents' necrotic, deep pressure ulcers for which they had received neither treatment nor pain relief - in homes owned by local GPs;
- During an unannounced, evening visit while witnessing a *handover*, an Inspector recalled that *there were not enough staff on duty and* [the Inspector] *asked a member of staff to phone Dr* [P] *Das. He shouted abuse and the member of staff began to cry.* [The Inspector] *spoke to him and he went ballistic* [and gave] *the impression he was going to come and sort* [the Inspector] *out.* [The Inspector] *decided to leave and told the member of staff that if he turned up still angry the police should be called;*
- The Das' owned properties close to their care homes and these were rented to employees – other employees were accommodated in their residential care homes, i.e. on one occasion when an Inspector visited The Beeches there were two South African nurses living there, one of whom had family staying as well;
- There was uncertainty surrounding the qualification of nurses from Nigeria employed by the Das' for their homes. Gwent Police were advised by the Nigerian Embassy that the source address on their apparently implausible certificates of nursing qualification was located in one of the most dangerous parts of the country;
- On several occasions, Brithdir and other homes were threatened with the disconnection of gas and/or electricity supplies due to unpaid bills. Suppliers such as nursing agencies were aware of the pattern of late payment and there were occasions when food suppliers required cash on delivery;

- Bailiffs visited the Das' homes identifying equipment which was to be removed. Dr P Das asserted that since they belonged to another of his companies they could not be removed;
- The angry resistance of some people's families to the prospect of a home being closed. This included families whose own relatives had required hospital treatment arising from inattentive care. One Inspector was spat at by a relative who was insistent that The Beeches should remain open. Other relatives raised questions through their Assembly Member and at the subsequent appeal hearing against the decision to cancel its registration.

Reference to the summary of inspection reports (Appendix 2) shows that **The Beeches** resembled **Brithdir** in terms of gradual deterioration reflected in such regulatory transgressions as not being registered to provide the care required by people with dementia; the failure to complete admission documentation; the residents' inactivity; the absence of staff supervision; inattention to the fabric of the building; and unresolved concerns regarding medicines' management and storage. A continuing thread in inspection history of both homes is the lack of sufficiently qualified or experienced nurses. The recruitment of staff from abroad led to additional problems in terms of communication with residents and their families, their peers and visiting professionals, their supervision, training and management.

Belmont is illuminating as an example of a care home which had relatively few non-compliance issues after a single **2002** inspection resulting in over 50 requirements. However, Belmont shows that, what appeared to be evidence of improved compliance, did not lessen the risks to which residents were exposed. At the trial of the owners, Mr and Mrs Bentley, former Belmont staff alleged that they were instructed what to say to professionals including Inspectors. Such deceit, of necessity, compromises inspection. This home is also illuminating insofar as it had a long-established and stable staff team. Although it is high levels of staff turnover that are associated with inattentive practice, Belmont shows that a stable, if poorly led, untrained and unsupervised staff team may be as inattentive to and unaware of the support needs of frail older people.

Belmont was registered for 17 residents, 10 of whom had to share rooms. Reducing the number of shared rooms at the home was a theme within the inspection reports.

Belmont's inspection report of **October 2002** has a sense of pleading because so many of the recommendations are prefaced with the word *Please.* This suggests that polite persuasion could co-exist with the more starkly drafted requirements of other inspectors and unintentionally makes requirements appear optional e.g. *Please ensure that an accurate record is kept of all medication.* There is a possibility that such ostensible politeness mutes the force of a requirement.

Two GPs, Dr Uzair Subzwari and Dr SK Narang, and their wives were part of **Lightend Ltd**, the company which owned **Grosvenor Nursing Home.** Of the two GPs, Dr Narang is known to have had patients at the home who were registered with him.

The **July 2002** inspection report of Grosvenor Nursing Home includes good practice recommendations. The mixture of regulatory *requirements* and *good practice recommendations* is confusing. For example, in terms of *Planning for individual needs and preferences* it was noted, *Standard met – However a system of measuring and describing* [pressure ulcer] *wounds needs to be put in place with the subsequent action to be taken recorded in the individuals care plan.* Twelve years after this was written it would seem that pressure ulcers were an accepted fact among nursing home's residents.

The same inspection report suggests that this was a home which was on the borderline of providing minimum standards. Between **March 2001** and **June 2007**, the home had four places registered to care for people requiring terminal care. The CSSIW removed this category of provision during June 2007 since the nature of the palliative care provided was a concern.

Once the nature of **Dorothea Hale**'s pressure ulcers were known, a police investigation began and Blaenau Gwent CBC suspended further placements. (Ultimately Susan Reynolds, the manager who was not registered with either the CSIW or the CSSIW, was struck off the nursing register in **October 2014**.)

The CSIW were thwarted in their efforts to prosecute the provider since the documents which had been seized by Gwent Police were not made available to the inspectorate. In any event, they only had six months within which to take this course of action. Although the inspection reports highlighted concern about the absence of clinical and general supervision, supernumerary hours were not prioritised for the manager by the provider. The CSIW's efforts to arrange a *fit person interview* with Susan Reynolds (who formerly had been approved by Gwent Health Authority as the *Matron),* appear to have been ignored, even though she was in post during a major investigation of care practices at the home.

Grosvenor House Nursing Home was subject to delays in inspection, even though there was concern about the inaction of the provider. Poor coordination with the police investigation closed off the possibility of the CSIW prosecuting the provider. It is astonishing that the manager at the home was seeking registration at the time of a major concern about the service and a police investigation.

Although the history of inspection indicated that **Bank House** was responsive to the CSIW/CSSIW recommendations and requirements, there were persistent failings and ultimately the CSSIW requested monthly reports from the home. The circumstances of two women residents in particular rang alarm bells: one because of *neglect* and the other because of acute renal failure secondary to dehydration, extensive and infected pressure ulcers with evidence of delay in seeking medical attention. Four other cases were also considered. The CSSIW's efforts to secure a prosecution were frustrated by:

i. a want of clarity about the Operation Jasmine/police investigation and intentions
ii. the failure of the LHB to share records (citing the Data Protection Act 1998)
iii. the support of the family of a woman resident for the Registered Manager and the home and

iv. the CSSIW's Regulatory Manager deciding not to pursue a prosecution, not least since a woman resident had spent time as a hospital in-patient and Bank House took the required remedial actions including disciplining staff members. The home was allowed to retain its palliative care beds.

Almost 80 expressions of concern about neglect and unexplained injury were received by the CSIW/CSSIW about **Mountleigh Bryngwyn Care Home** between **2002** and **2009**. Given that 18 of these were directly associated with the transfer of 10 residents as a result of the emergency closure of **Holly House**, it is likely that these were attributable to the heightened anxieties of families whose relatives had transferred and the consequences, that is, the home could not cope with an additional ten residents. Mountleigh Bryngwyn Care Home was allowed to absorb displaced residents at a time when it had no manager and there were 28 outstanding requirements.

The CSSIW and, initially, the CSIW faced a series of challenges in spite of having broad powers on paper. CSIW determined that the purpose of an inspection was *to comment on the quality of care provided in the registered facility and the quality of life experienced by service users.* However, a comment does not have the same status as an assessment, for example. Arguably the *quality of life* and *quality of care and treatment* should have been re-calibrated to reflect the primacy of the health, welfare and wellbeing of older people.

It is striking that none of the six homes had requirements concerning the standards re *death and dying* because they had policies concerning *death and dying*. Yet the residents of these homes had to access A&E services at, or towards, the end of their lives – some with deep pressure ulcers which had developed during the period of their residence. All of the post-2002 inspection reports were available online – initially on the National Assembly website and subsequently, the regulator's website. However, it is difficult to identify a home which had a track record in *not harming* residents on the basis of these reports. Furthermore, the number of residents in each of the six homes is not consistently noted and the number of staff is never cited. Yet these are important considerations not just for the families of prospective residents, but also for service commissioners, some of whom make explicit requests for *one to one support* for example.

The Care Homes (Wales) Regulations (2002) required homes to notify the CSIW of *death, illness and other events* (Regulation 38).[443] This was not a consistently effective means of

[443] Notification of death, illness and other events

38.—(1) The registered person shall give notice to the appropriate office of the National Assembly without delay of the occurrence of—

(a) the death of any service user and of the circumstances of his or her death;

(b) the outbreak in the care home of any infectious disease which in the opinion of any registered medical practitioner attending persons in the care home is sufficiently serious to be so notified;

(c) any serious injury to a service user;

(d) a serious illness of a service user at a care home at which nursing is not provided;

(e) any event in the care home which affects the well-being or safety of any service user;

(f) any theft, burglary or serious accident in the care home;

(g) any allegation of misconduct by the registered person or any person who works at the care home.

(2) Any notification made in accordance with this regulation which is given orally shall be confirmed in writing.

notifying the regulator that necessary medical assistance had been secured. For example, the admission of **Hilda Scase** to hospital was delayed for two weeks because Brithdir's Matron did not consider it was necessary. The CSIW Inspectors responsible for the inspection of Brithdir learned that even the nurses employed at the home were unaware of the fact, extent and gravity of people's pressure ulcers (since some residents had undocumented wounds). However, the urgency with which they undertook to enforce standards was compromised when Gwent Healthcare Trust increased Brithdir's inadequate and untrained staff by fielding its own nurses.

The prospect of closing a home in which older people have been harmed produces a chain reaction. This is often characterised by challenges to the decision by the home's owner, making it difficult for all parties to distinguish the facts from the rhetoric of those seeking to advance their own interests. For example, Dr P Das informed the relatives of residents at The Beeches that he was not making enough money since Torfaen CBC was not sending enough older people to the home. The relative of one resident at The Beeches said that the family would hold the CSIW's Regional Director personally responsible for *pre-meditated manslaughter* should their parent be transferred to another home. The reality is that transferring frail older people from one home to another is stressful and not all will survive the process. The human rights implications for older people are typically cited (an argument put forward by Roger McCarthy QC on Dr P Das' behalf during the Care Standards Tribunal hearing of 2005), that is, the right to life (Article 2 of the European Convention on Human Rights); the right not to be subjected to torture, inhuman or degrading treatment (Article 3); and the right to respect for private and family life, home and correspondence (Article 8). The Care Standards Tribunal stated that *the points raised by Mr McCarthy would have had equal validity if made on behalf of the Respondent,* that is, the Care Standards Inspectorate for Wales. However, it is notable that, on the closure of Holly House, some of its former residents were transferred to another of the Das' homes. This was a source of considerable concern to Caerphilly CBC, the NHS and the CSIW. It is regrettable that it was a backdrop of *pressure for nursing home beds* which made a threat of home closure for substandard conditions so difficult to achieve.

Evidence of belated improvement and promises of further change were presented at the Care Standards Tribunal hearing, and swayed the decision of the Care Standards Tribunal – even though assistance to a home does not remove the obligations of the home to comply with standards. This decision affected the reputation of the CSIW as an enforcement agency with the task both of inspecting and, also regulating, homes. It was a serious setback for the role of the CSIW. The dilemma was how to deal with the known risks of re-locating very frail people, on the one hand, and, on the other, addressing the distress of the families, some of whom approached their local councillors and Assembly Member. There were major impacts for the NHS, in terms of the belated hospital admissions of very frail people dying from the complications associated with deteriorating and infected pressure wounds. In addition, as

mentioned above, Gwent Healthcare Trust's decision to field nursing staff to ameliorate poor practice and prevent admissions to hospital compromised the effectiveness of the CSIW.

The fundamental principle governing the CSSIW's current work is the well-being of people receiving services. It no longer creates volumes of *paper tigers* – it demands compliance. Its stepped *enforcement pathway*[444] begins with non-compliance notices developed to ensure that they provide a clear evidence trail from the outset. Full responsibility for compliance is located with the Responsible Individual and the Registered Manager. Timescales are not negotiable, requirements are no longer issued and action plans are no longer required. The volume of complex legal tests associated with different types of regulatory performance which exercised lawyers for months and months, enabled the Das' homes to become ever more dangerous settings. Although the legal tests still exist, the CSSIW has been schooled by such gross organisational deviance to acknowledge that a different approach was necessary.

There were incidents and events at the Das' homes, including the deaths of residents which were associated with deep and infected pressure ulcers, which were not reflected in inspection reports: even though many of the Written Notices of Action Required concerned the prevention and treatment of pressure ulcers this was not clear from the reports themselves. Arguably making such information explicit in inspection reports would significantly reduce the likelihood of anybody being placed there. Some forms of non-compliance are more observable than others, such as those relating to décor and maintenance. Less observable is the will to comply, the disposition of the owner and manager to address people's concerns and complaints, the truthfulness of care plans, and the willingness with which homes seek specialist medical assistance for residents, for example. The self-reported improvements at the Das' homes were implausible and unreliable. Their homes were out of control and consumed the CSIW/CSSIW resources with paperwork - which was readily challenged by the Das' solicitor. Since neither action planning nor tenacious visiting by Inspectors achieved the required compliance, the observable problems with the gas supply ultimately delivered the public purpose of ensuring that frail older people in their homes were removed.

Although the publication of inspection reports is timely in terms of proximity to the inspection visits, a great deal hinges on the degree of challenge by the provider. Some providers secure the services of solicitors to challenge drafts of inspection reports and the process of negotiating an agreed inspection report can take many months. Necessarily the CSSIW – as well as local authorities - must act fairly in their investigations and in relation to evidence. However, during the resulting challenge and counter-challenge concerning **Holly House**, **Brithdir** and **The Beeches**, frail older people were exposed to continuing harm.

The family of a woman resident at **Bank House** did not want any action to be taken against the home and wrote in support of the manager. Now there would be a clear audit trail via

[444] http://cssiw.org.uk/docs/cssiw/general/140429noncomplianceen.pdf (accessed 22 December 2014)

Service of Concern[445] records enabling more timely multi-professional judgement. Further, the view of a family about the care of their relative is not instrumental in determining whether or not the CSSIW takes action against a home. Urgent conditions may be imposed without the agreement of relatives or a provider. Furthermore, inspection frequency would be determined by a home's *risk rating*.

Mountleigh Bryngwyn Care Home would not be allowed to increase its number of residents with outstanding non-compliance notices and without a Registered Manager. The **CSSIW** would continue to insist on higher environmental standards – it resisted strong pressure from the Local Health Board and commissioners to relax building standards (en-suites and double rooms for example), in order that other providers could operate from the premises. Also, the CSSIW works closely with the Care Council for Wales[446] most particularly in relation to the absence and fitness of managers. It no longer tolerates absent managers and sanctions providers without registered managers. Although the CSSIW seeks to take account of POVA investigations by contributing to POVA meetings, this is *a huge drain* on resources.

The CSSIW has addressed the impasse associated with providers which do not adequately address non-compliance notices by distinguishing (i) issuing notices and (ii) notifications. The latter are reserved for the significant and egregious non-compliance issues which impact on the health, safety and well-being of people using services.

Currently, inspection reports of around 20 pages are easy to read and are not as overwhelming as their predecessors in terms of volume.

The Care Standards Tribunal hearing proposed the appointment of an *independent health and/or social care consultant* to provide the CSIW with reports every two months on the home under review. The Care Standards Tribunal made an unusual decision in this case in appointing a social care consultant.[447] He was described in the 2005 Tribunal[448] decision as *an independent health care consultant* (paragraph 29). He was, however, being instructed jointly by Puretruce Health Care Ltd and Caerphilly CBC, and it was in both capacities that he provided evidence to the Tribunal. The Tribunal heard that during **November 2004** he had been *favourably impressed with the improvements that he had seen at Holly House during the six weeks in which he was involved there* (paragraph 45). A further visit took place during **February 2005**, *this time under the instruction of the Appellant's solicitor,* (that is, as a *privately instructed expert,* paragraph 109) *to evaluate the continuity and progress on the matters detailed in the original report* (paragraph 48). Gordon Cole's favourable findings were

[445] http://cssiw.org.uk/providingacareservice/how-we-enforce/?lang=en (accessed 22 December 2014)

[446] http://www.ccwales.org.uk/ (accessed 22 December 2014)

[447] *A policy adviser and representative for Care Forum Wales and an independent consultant providing advice to local authority and independent sector care providers,* (p2 of *Puretruce Health Care Ltd v National Assembly for Wales* [2005] EWCST 544 (EA-W) 5 September 2006)

[448] *Puretruce Health Care Ltd v National Assembly for Wales* [2004] (EA-W) 15 May 2005

not shared by the CSIW Inspectors, including a Pharmacy Inspector who noted *six alleged breaches of the Regulations.*

The decision of the Care Standards Tribunal in **May 2005** noted that since *the burden lies on the Respondent* (that is the CSIW) *to show that the breaches have occurred*, the Tribunal *cannot find that all the alleged breaches have been proved…*the *perception* of the CSIW Inspector (Alison Price, a nurse by training) *of the situation at Holly House and that of Gordon Cole differ significantly* (paragraph 113). Roger McCarthy QC, *proposed the continuing involvement of Mr Cole…to identify areas where further action is required and to report on progress*. The Tribunal stated that *it would be helpful to the provider to have imposed on the registration a requirement for input and supervision…**at a level that the provider considers appropriate**…* [Emphasis added]. In the light of breaches of regulations concerning medication, for example, it is astonishing that (i) a clinician was not nominated – rather than a social care consultant (ii) the Tribunal hearing indirectly challenged the raison d'être of the regulator by implying that the judgement and competence of the CSIW Inspectors (including those with nursing backgrounds) could be disallowed if they were at odds with those of an *independent* social care consultant.

Although Caerphilly CBC was acutely aware of extensive and persistent breaches of standards at Brithdir, it mistakenly collaborated with the Das' in their joint appointment of Gordon Cole. Arguably this compromised the findings of their own POVA investigations and contract compliance monitoring.

The CSIW was ill-prepared for and fared poorly in the initial Care Standards Tribunal hearing which provided an early glimpse of how litigious is the task of proving that a home is failing. The courtesy of Inspectors can go only so far in correcting long standing deficiencies. Dr P Das sought to re-direct scrutiny away from himself and his companies, arguing, for example, that he could not feasibly monitor the work of subordinate employees, residents' GPs and clinicians responsible for hospital discharge. This current of blame affected the CSIW, plus its registration, inspection and enforcement activities, and was sustained in spite of Dr P Das' conduct and the Das' companies being publicly reproached in the media.

Dr P Das unfavourably caricatured the CSIW and local authorities by asserting that older people would suffer unless the private sector was treated as favourably as local authority homes. Portraying his business as a victim of inept inspections, in a locality in which there was no 'market' of providers competing on quality, rendered the CSIW and local authorities impotent. According to Kennedy (2014)[449]:

As a market, the care sector has some quite unique characteristics:

- *the purchase* [of a place for an older person] *is distressed and emotional, usually made in a time of crisis*

[449] Kennedy, J. (2014) *John Kennedy's Care Home Inquiry* York: Joseph Rowntree Foundation and Joseph Rowntree Housing Trust

- *switching provider is a tough decision*
- *supply is geographically restricted as people want to be near their neighbourhoods, friends and relations*
- *barriers to entry to the market are high*
- *some markets are monopsonistic (similar to a monopoly, but a large buyer, the local authority, controls much of the market and drives prices down).*

…Private care homes can be excellent but they need to operate in a functional market – one that is not just set up to compete on price; this is dangerous. If a care home is under financial pressure, there is a significant danger that corners will be cut and quality reduced.

The basics of the market need to be functional to promote competition based on quality. We need to be more open and honest about profit, about what is reasonable and set up the market to include minimum tariffs and functional commissioning practices to ensure that good care homes can be viable. We need to regulate the market in the truest sense…

…the opportunity cost of an impoverished care sector is huge for the NHS and the economy…The market is one that we have created but it doesn't work. The market should be managed to create what we want – good, viable care homes in the right places; crucially too, care homes with the skills and capacity to support our ageing communities and our NHS.

7. The Workforce Culture

By **2004**, the mobility of labour had extended throughout the European Union; Britain became a favoured destination for the citizens of several countries within the EU. This inward migration, which differed from the immediate post-war pattern, presented particular challenges in the south east valleys of Wales, not least in terms of communication with those who came to work in care homes. The fact that neither English nor Welsh was the first language of numbers of care home employees was a major concern for residents' relatives. They questioned how staff with a limited command of English could understand or be understood by older people, some of who suffered from sensory loss, and whose communication skills might be compromised by dementia. Although this observation was principally that of visiting relatives, the concerns of paramedics who had been summoned to one home is also relevant in that it proved not possible for them to be briefed about the patient's condition as the staff at the home could not speak English.

Dr P Das and Dr N Das also recruited staff from countries such as South Africa and Nigeria.[450] Dr P Das accused a CSIW Inspector of racism when she challenged the fact that Brithdir relied so much on agency nurses who similarly presented language problems. There is a perception

[450] Crisp, N. (2010) *Turning the World Upside Down* London: The Royal Society of Medicine Press, noted, *The UK had come under serious criticism from African countries, led by South Africa, in the late 1990s and had developed both an ethical recruitment policy and later, a code of practice…The flow of nurses from South Africa fell from its height* of *2114 in 2002 to 39 in 2007.*

that some residential homes for older people are increasingly disconnected from local communities and their history.

Some employees were apparently willing to accept poor working conditions since, on occasion they were told that they might not be paid, and that essential equipment, such as hoists, for example, could not to be afforded. It is known that the Das' rented accommodation to some of those employed by them. It also seems possible that some of the nurses they employed lacked the qualifications necessary for carrying out the roles and duties expected of them.

The Das' record during this period in Gwent's health and social care history is a world away from the essential and valued role played by so many doctors of Asian heritage in health care in contemporary Britain[451] - see for example, Weekes-Bernard 2013.[452]

8. Questions about General Practitioners and/or Company Directors of Homes for Older People

The ethical basis of medical practice is in the amelioration of suffering, a factor which is emphasised throughout the training of doctors and in the acquisition of a particular knowledge base. This, plus the constant risk of exposure to disease, justifies their particular status in society and the respect they enjoy from other professionals and from the general public. Unfortunately, that professional standing is not always a reliable indicator of the care and support which an older person receives where a doctor is also the owner, director and/or financial beneficiary of a residential and nursing home.

This Review established early on that the ownership of residential and nursing homes by GPs operating as business men and women is no guarantee of timely and attentive healthcare for residents and patients. Similarly, a GP as the partner of the owner(s) does not guarantee that residents and patients will receive the health care they require. There is no doubt that having GPs associated with the ownership of residential and nursing homes can lead to a conflict of interest, particularly where they are directly sourcing residents from their patient lists and/or are responsible for the primary healthcare of the residents and patients at such homes.

It was stated in the television broadcast of 1995 that Dr P Das and Dr N Das sourced residents for their homes from their practice lists. The theme was further developed in the second broadcast that year. The challenge in tackling such compromising practice lies in distinguishing those patients whose choice is influenced by their GP or hospital consultant from those who make a positive choice to move to a home which happens to be owned by their doctor or hospital consultant. Given the challenge of defining what would constitute

[451] http://news.bbc.co.uk/1/hi/health/3239540.stm (accessed on 12 December 2014)

[452] Weekes-Bernard, D. (2013) *Nurturing the Nation: The Asian Contribution to the NHS since 1948* London: Runnymede (accessed 12 December 2014)

sourcing patients, the General Medical Council[453] suggests that a more realistic approach may be to introduce arrangements to manage such conflicts of interest, rather than introducing safeguards which seek to prevent them. Such an approach would require the need for honesty and transparency when such conflicts arise.

9. How do we improve the care provided to older people?

The compassionate care of frail older people with dementia, including those with advanced dementia and palliative care needs, is a long-standing aspiration. However, it is salutary that aspects of palliative care such as the management of pain and the provision of emotional comfort were remote from the experience of residents who were the subject of Operation Jasmine. The use of opiates and access to palliative care teams, for example, did not feature at the end of their lives, perhaps because the needs of those who are able to express them are more easily addressed.

Bearing in mind the partial information on which this Review is based, it seems that the disquieting evidence that people with dementia are less likely to receive pain control than their cognitively intact peers[454] is confirmed. Yet the compatibility between 'person-centred care,' 'relationship-centred care' and palliative care suggests a new direction needs to be sought when care planning for frail older people in Wales.[455] Although dementia has an uncertain trajectory - the terminal stages of which may be difficult to determine - the final days of too many older people identified by this Review were plagued by painful pressure ulcers, swallowing difficulties and the absence of oral care.

Around 400,000 older people in the UK live in care homes and are looked after by over a million care workers. John Kennedy's challenge is pertinent. *Care homes don't and cannot work in isolation: they are in a system. Doing more to them from above won't improve care – it hasn't up to now. Likewise the inspection system can't, on its own, improve care; it can only tell us what it is measuring. In order to improve the status, consistency and quality of care, we need to make sure that the system supports care homes as well as holding them to account.*

[453] Correspondence from Niall Dickson, Chief Executive and Registrar of the GMC, 1 May 2015

[454] Sampson, E.L., Gould, V., Lee, D. and Blanchard, M.R. (2006) Differences in care received by patients with and without dementia who died during acute hospital admission: a retrospective case note study, *Age and Ageing,* 35, 187-189

[455] Welsh Government (2013) *Together for Health – Delivering End of Life Care: A delivery plan up to 2016 for NHS Wales and its partners*

Conclusions and Lessons

All reviews are written with the benefit of hindsight. Their value lies in providing a means of bringing together what may previously have been disparate pieces of partial information. This allows the origins of error and failure to be more starkly observed. However, since in themselves scandals fix nothing permanently, what is required is a more sustained form of reckoning.

The Justice for Jasmine relatives reflect that growing number of citizens who want to hold to account certain care home owners, businesses, boards of companies and the professionals associated with placing older people in homes which are known to be harmful. They have learned the hard way that the conscience of a care home owner is insufficient to ensure the delivery of competent care and support. Families were offered a narrow and unimaginative menu of options for their relatives, sometimes by entrepreneurial medical doctors who owned care homes: that is, doctors who apparently recommended their own homes to patients on their practice list, and occasionally retained them on their lists. Such practices are discouraged by General Medical Council Guidance, but seem to have thrived among a small number of GPs in south east Wales. While this may reflect practice elsewhere in the UK, Operation Jasmine has brought the situation to the foreground in Wales. Indeed a range of homes known to Operation Jasmine displayed considerable insensitivity to the fears and grief of people's relatives.

The case set out by Sir Roy Griffiths (and eventually enshrined in the NHS and Community Care Act 1990) for outsourcing services from the public sector was not an argument for either yielding all control to businesses or paying providers and businesses, irrespective of how they cared for frail older people. The fact that the circumstances of older people in some homes in south east Wales were the subject of adverse television reporting 20 years ago says a great deal about the robustness of the practices they revealed - as well as the reluctance of the NHS to intervene decisively at that time. Such *normalisation of deviance*[456] over this critical period means that opportunities for confronting the situation and doing something about it were lost – as reflected, for example, in the continuously deferred building maintenance at The Beeches.

The outcome of Operation Jasmine has implications for us all, not simply for lawyers, policy makers, clinicians and adult protection/safeguarding practitioners. It was characterised by mistakes and as a result embodied many kinds of failure, but most particularly it reflected a failure of *the market* as a mechanism for the provision of residential care. Some older people were transferred from one failing care home to another. What was in place to prevent providers, who were impervious to rebuke, from providing care for frail older people at as low a cost as possible? Hilda Scase was a 'self-funder' and yet within 10 weeks of being a

[456] Vaughan, D. (1996) *The Challenger Launch Decision, Risky Technology, Culture and Deviance at NASA,* Chicago: University of Chicago Press

resident at Brithdir she had no back – such was the extent of her pressure ulcers.[457] There was no redress for her in terms of consumer legislation and nor, apparently, was this even considered. This was true (i) for those families who were paying an additional amount to that paid by a local authority ('top up fees') and (ii) the NHS and local authorities that contracted with these providers. The result was a service that was far from committed to building a culture of capable care with compassion. The regulator was impeded since, in endeavouring to enforce standards, it expected providers to spend more, most particularly in terms of the workforce, with a resulting reduction to profit.

The severest suffering was placed on older people. It is astonishing that not even people's deep pressure ulcers had an effect on the conduct of some business owners. There is scope for the Welsh Government and Public Health Wales to assume a lead role alongside the Welsh Wound Innovation Centre in challenging the tolerance of preventable pressure ulcers.

If whistle-blowers continue to direct their concerns solely at relatives, rather than internally to their organisations or professional channels, as happened at the time of the Operation Jasmine investigation, it becomes burdensome for them and poor practice may remain hidden.

Gwent police identified 63 people whose deaths were deemed suspicious. The police's primacy in the investigation meant that it would not disclose necessary information to the regulators of homes or to professional regulators such as the General Medical Council and the Nursing and Midwifery Council. So in addition to Justice for Jasmine families there remain a significant number of others for whom there has been no resolution and no recognition of the circumstances of the deaths of their relatives. Furthermore, the requirement of Gwent Police that the POVA referrals of frail older people should be routed directly to them for potential criminal investigation shut off the possibility of timely, local intervention.

During the course of the Review, two families came forward with an account of harm to their relatives in care homes in south east Wales. This suggests that the concerns considered here cannot be ascribed solely to historical circumstance and six homes. It also suggests that other homes outside the remit of Operation Jasmine were wanting in their care but escaped the scrutiny of the police investigation. It has been suggested to this Review that the duration of Operation Jasmine successfully diverted attention from other homes that were similarly failing older people.

To date, nursing and social work have been the only professions subjected to regulatory scrutiny via the Nursing and Midwifery Council and the Care Council for Wales. While nurses with lead roles in their homes (in supervising and administering nursing care and accessing primary care for their residents) have been taken to task, their managers and employers have not. The Care Council for Wales investigated the practice of 10 social workers, most of whom had been responsible for reviewing the circumstances of people placed in homes owned by

[457] Currently there is no requirement to undertake an assessment of an older person's skin integrity on admission to a residential facility. There is evidence, however, that Hilda Scase's skin was *without blemish* when she was admitted to Brithdir

the Das.' None of the social workers had been charged with an offence and the Care Council for Wales concluded that: *it would be unlikely that findings would be made against these individuals in a professional conduct hearing. All cases were therefore closed in August 2010…a consistent theme appeared to be a lack of clarity regarding the role and expectations of social workers undertaking reviews of individuals placed in care homes.*[458]

The Review has shown that supplementing staff in failing homes, by providing health and social care staff, compromises the effectiveness of the regulator. It is clear from this Review that the competence, professionalism and knowledge of managers and staff are critical variables in delivering valued care to frail older people. There is no evidence that the staff involved received training in mobility, hydration, nutrition, skin care and the prevention of pressure ulcers, or were even advised that 90% of pressure ulcers are preventable. Baroness Finlay informed the Review that she has been asking community specialist palliative care nurses who are going into nursing homes: *How can we improve care?* The response, consistently, has been *mandatory training*. Also, the specialist nurses who had wanted to offer time-efficient training of 10 minute sessions found that, although nursing home staff were keen, they were not made available by management. It is remarkable that nursing homes supporting frail older people are not required to demonstrate sufficient numbers of trained and competent staff who are able to meet the overarching aims of the service. Neither are they encouraged to work with community specialist palliative care nurses - sharing their shifts between the community and the nursing homes for example.[459]

No single agency can tackle the harm which results from poor care in residential homes for older people. The police investigation Operation Jasmine had divisive consequences and failed to protect older people from home owners who had scant regard for the health and welfare of their residents. Partner agencies were unable to exercise their responsibilities to respond to concern because of the primacy of an investigation which spanned too many years. Furthermore, it is lamentably clear that reporting pressure ulcers to POVA – for which local authorities have the lead responsibility – is inadequate as a response to the urgent clinical care needs of frail older people.

There is an uncomfortable comparison with historical child abuse investigations where, for example, the retirement of key individuals has not been regarded as a barrier to pursuing inquiries. However, it has been put forward as a rationale for limiting information shared with this Review.

Finally, private care homes are businesses and, unfortunately, weaknesses exist in the current legal position concerning private, non-listed companies. Businesses need be made accountable for their trading practices. Directors should be subject to the same rules and accountability framework as other sectors.

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[458] Care Council for Wales (2014) *Operation Jasmine Review: Evidence from the Care Council for Wales*

[459] Baroness Finlay proposes that such opportunities should be available for at least 10 days per year, per team. The specialist palliative care team would remain responsible for the development and support of team members and provide peer-to-peer learning opportunities

Concluding lessons

- scandals fix nothing permanently

  The answer cannot reside in an exhortation to read *106 lessons,* in rare and piecemeal interventions or a plan to avoid mistakes. It lies in understanding the complexities of the care home infrastructure and the associated business models - as well as in employing talented and competent managers to recruit, supervise and train staff to support frail older people in homes that are their workplaces[460]

- citizens cannot rely on the consciences of care home owners to deliver acceptable care and support to frail older people

  Good governance is critical to quality and safety in homes for frail older people as well as residents being and feeling embedded in relationships - with their relatives, friends and advocates and with health and social care practitioners and the wider agencies - of which they are a part. All should insist on participating to ensure that there is *a window* so that residents can look out, the community can look in,[461] and there is scope for residents to be and to feel part of their neighbourhood

- it is assumed, without evidence, as acceptable practice to group older people with dementia together in particular homes, without sufficient staff, who are inadequately managed, trained and supervised, on the grounds that they all have similar needs

  Since the growth of the sector has preceded reflective research to guide its structure, function and direction, the investigatory attention of the media has been instrumental in highlighting the consequences of the deficient practices (including planning processes which advantage developers), it is up to (i) commissioners to engage with the reality of the impoverished lives of too many residents with diminishing capacity and (ii) the sector to demonstrate the effectiveness of their interventions and support arrangements, including how a culture of valued relationships may be nurtured, for example.

- older people's injuries, pain and life-threatening deep pressure wounds were unobserved, unreported, reported inaccurately and/or reported belatedly – and yet, in this case, no crimes were identified by the CPS

  The rhetoric of concern has to be matched with credible action. It is essential that all necessary clinical care is provided alongside timely processes to identify ways of preventing further harm – which must include prosecution

[460] Roger Clough writing for the Wagner Committee in 1988 and talking then of reports of abuse and neglect that go back more than 30 years said: *is not only in exhortation, not only in planning to avoid mistakes, it lies in understanding the complexities of residential work and of the systems in which people work and live – and then working out the best system to promote the well-being of the residents.*

[461] See: 'A Window in Homes; links between residential care homes and the community', Ruth Elkan and Des Kelly, SCA 1991

- the public sector should not under-write companies which have produced considerable rewards for the few at the expense of the many
  This means that local authorities and the NHS have to demonstrate long-term prudence, pool their learning from older people, families and research, build on their knowledge of the strengths and weaknesses of the whole sector and combine their purchasing power. Being explicit about what they will commission and why - should herald a new relationship with older people, their families and providers
- private interest pursued at the expense of others has a long history, however the public interest cannot be subordinate to the short term personal gains or even the criminality of a minority of directors of care homes
  The external scrutiny of the care and support of older people by commissioners, care managers and regulators should be matched by ensuring that companies in this sector open their boards to independent scrutiny. A lasting achievement of Operation Jasmine has to be a readiness to adopt a long term view. Companies which have demonstrably failed older people should be allowed to fail and their directors should be disqualified. They have depleted public trust. The needs of frail older people cannot be subordinate to those financially sophisticated businesses and/or powerful directors; if that situation should prevail we will remain ***in search of accountability*** indefinitely.

Recommendations

It is recommended that

1. the residential and nursing care home sector:

(i) becomes *a sector of primary national strategic importance* for Wales, recognising that low investment in the social care system means higher costs for the **National Health Service** and affects economic potential by failing to support a modern and trained labour force

(ii) is shaped by explicit policies to regulate and allow intervention in the social care 'market' to improve the quality of care by directly addressing issues such as pay and working conditions, staffing levels and the knowledge and expertise of commissioners of publicly funded services

(iii) care home managers are registered and are members of a professional body which sets professional standards, has disciplinary powers and provides them with a voice on national policy and

(iv) develops credible quality indicators[462] to inform strategic planning for health and social care - see J. Kennedy (2014) *John Kennedy's Care Home Inquiry* York: Joseph Rowntree Foundation and Joseph Rowntree Housing Trust

2. the Welsh Government, in association with **Public Health Wales**, ensures that:

(i) the significance of deep pressure ulcers[463] is elevated to that of *a notifiable condition*

(ii) senior clinicians, including Registrars, General Practitioners and Tissue Viability Nurses, assume a lead role in preventing avoidable pressure ulcers[464] and in developing a National Wound Registry, assisted by the **Welsh Wound Innovation Centre**

(iii) senior clinicians are made responsible for notifying **Public Health Wales** of deep pressure ulcers and

(iv) where **Public Health Wales** has been informed of the existence of deep pressure ulcers, a process is identified whereby that information is communicated to the **Care and Social Services Inspectorate Wales** or the **Healthcare Inspectorate Wales** and appropriate commissioning authorities as well as to people's families

3. the **Protection of Vulnerable Adults** (POVA) process:

(i) defines more narrowly and specifically its functions

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[462] For example, from the demeaning experiences of frail older people illuminated in this and other reviews, it is possible to build on frameworks of valued care and support such as, for example, the 'Senses Framework' [M. Nolan, U. Lundh, G. Grant and J. Keady (2003) *Partnerships in Family Care: understanding the caregiving career* Maidenhead: Open University Press McGraw-Hill Education]

[463] That is, a focus on severe, deep tissue injury and unstageable pressure ulcers

[464] Although clinicians estimate that 90% of pressure ulcers are preventable there is a well-documented disparity between clinical practice and research evidence

(ii) strengthens protective outcomes for individuals where there is an allegation or evidence that harm has occurred, by ensuring that either a care assessment or a review of that individual's care plan is undertaken. The outcome of the process should be specific action rather than simply a determination of, for example, *institutional abuse*

(iii) ensures that the NHS is accountable for fulfilling its lead responsibility for investigating such major and potentially lethal conditions as deep pressure ulcers in the residential and nursing care sector

4. Inquests should be held, notwithstanding the fact that the deaths of **Stanley Bradford**, **Megan Downs**, **Edith Evans**, **Ronald Jones**, and others known to the Coroner, have already been registered

5. **Gwent Police** provides the families of older people in the six homes included in Operation Jasmine with the information prepared by members of the expert panel and ensures that they are supported during and after this process

6. **NHS Wales** considers how the responsibility for reporting hospital deaths to the Coroner is undertaken by senior clinicians and considers the need for a legal presumption in favour of reporting the deaths of residential and nursing home residents to the Coroner

7. the **General Medical Council (GMC)**:

(i) collaborates with **NHS Wales** to identify ways in which conflicts of interest can be managed that arise from the admission of patients of **General Practitioners** and other **GMC registrants** (hospital consultants, for example)[465] into residential and nursing homes in which such doctors are company directors, or are related to the directors of these homes

(ii) ensures that all **General Practitioners** and **other GMC registrants** are informed about what constitutes a conflict of interest[466] and how to manage this in practice. Given that declaring a conflict by itself would have been an inadequate safeguard given the findings of this Review, the GMC may wish to consider the specific example of clinicians owning nursing and care homes

(iii) considers in its review of the Medical Register, the potential for recording information on declared conflicts of interest

[465] And by extension, registrants of the Care Council for Wales – the social care workforce regulator. The CCW has a Memorandum of Understanding with the Health and Care Professions Council which registers social workers in England

[466] GMC (2011) *Conflicts of interest: what our guidance says* London: GMC; and GMC (2013) Financial and Commercial arrangements and conflicts of interest (http://www.gmc-uk.org/guidance/ethical_guidance/21161.asp (accessed 7 April 2015)

8. the **General Medical Council** and the **Nursing and Midwifery Council (NMC)** consider the need for continuing reform[467] to ensure that fitness to practise proceedings are conducted as quickly as practicable, while maintaining their primary purpose of protecting the public

9. the **Director of Public Prosecutions** refers the Operation Jasmine Investigation to the Special Crime and Counter Terrorism Division (formerly known as the Special Crime Division) of the **Crown Prosecution Service**

10. the **National Police Chiefs' Council** ensures that the primacy of a police investigation delivers the ability of (a) the **Care and Social Services Inspectorate Wales** and (b) professional regulators, such as the **GMC**, the **NMC** and the **Care Council for Wales** (CCW) to take forward civil and criminal action; and address concern about alleged fitness to practise within a defined time frame

11. the **National Police Chiefs' Council**, the **Health and Safety Executive**, the **Care and Social Services Inspectorate Wales** and the professional regulators share what has been learned as a result of this Review and collaborate to specify and confirm the components of a framework for undertaking timely team and parallel action in future

12. the **Law Commission** reviews the current legal position in relation to private companies with particular relevance to the corporate governance of the residential and nursing care sector[468]

Should these recommendations be adopted the citizens of Wales could expect to see:

- improved quality of care provided to frail older people in residential and nursing care homes
- greater attention to corporate conduct and improved corporate safeguards in the residential and nursing care sector
- tangible, NHS–driven investment in eliminating deep pressure ulcers among frail older people; and the cruel failures in general practice and nursing care identified by the Operation Jasmine investigation replaced with more credible primary, secondary and palliative care responses
- a system of safeguarding which explicitly directs clinicians to intervene competently, professionally and appropriately in addressing the injuries and final illnesses of frail older people

[467] In the light of the Law Commission's (2014) *Regulation of Health and Social Care Professions Etc Bill*

[468] Given the clear public interest in ensuring the well-being and safety of residents, the Law Commission may wish to consider whether or not corporate criminal responsibility should be based on corporate conduct across an organisation, rather than the current practice of pinpointing responsibility on individuals

End Note

The battle of being mortal is the battle to maintain the integrity of one's life – to avoid becoming so diminished or dissipated or subjugated that who you are becomes disconnected from who you were or who you want to be. Sickness and old age make the struggle hard enough. The professionals and institutions we turn to should not make it worse. But we have at last entered an era in which an increasing number of them believe that their job is not to confine people's choices, in the name of safety, but to expand them in the name of living a worthwhile life (p 141).

The terror of sickness and old age is not merely the terror of the losses one is forced to endure, but also the terror of the isolation. As people become aware of the finitude of their life, they do not ask for much. They do not seek more riches. They do not seek more power. They ask only to be permitted, insofar as possible, to keep shaping the story of their life in the world – to make choices and sustain connections to others according to their priorities. In modern society, we have come to assume that debility and dependence rule out such autonomy (p 146-147).

If to be human is to be limited, then the role of caring professions and institutions - from surgeons to nursing homes – ought to be aiding people in their struggle with those limits. Sometimes we can offer a cure, sometimes only a salve, sometimes not even that. But whatever we can offer, our interventions and the risks and sacrifices they entail, are justified only if they serve the larger aims of a person's life. When we forget that, the suffering we inflict can be barbaric. When we remember it the good we do can be breathtaking (p260).[469]

Atul Gawande

[469] Gawande, A. (2014) *Being Mortal – Illness, Medicine and What Matters in the End,* London: Profile Books, Wellcome Collection

Appendices Contents

Appendix 1

Transcription of a video recording of (i) *Wales This Week* and (ii) transcription extracts of a follow-up *Wales This Week* programme, both broadcast by HTV Wales during 1995

(i) This first programme was prefaced by the following: *Nursing homes come under scrutiny now in Wales This Week.* **Clare Hudson**, the reporter and editor of the programme began by introducing **Dr Das** who then interviewed him as he walked to his surgery, extracts of which were shown intermittently through the programme.

*This is **Dr Prana Ballava Das**, a doctor by profession but he also owns a string of private nursing homes. There's nothing to stop GPs owning nursing homes but **Dr Das**' have been criticised for serious neglect of patients, acute understaffing and penny pinching. The allegations of neglect centre around this care home in Caerphilly, **Silverdale** - home to **Agnes Irene Wilkes** for the last few months of her life. She was there because she needed constant nursing care but when she was admitted to hospital six months later, medical staff were shocked to discover bed sores on her back. Although it is too late for his mother who died recently, **Melvin Wilkes** wants to prevent this kind of neglect ever happening again*.

Melvin Wilkes: *I can do something now for the people who are left. I can't do nothing for my mother, I accept that, but I wish to God I hadn't put her there. If my mother had said to me, I wish I could put the clock back.*

Clare Hudson: ***Tish** and **Dave Reed** are also very angry about the care her mother received at another of **Dr Das**' homes. She's confused and forgetful and needs round the clock supervision and help with even the simplest tasks, but during her time at **Holly House** in Rhymney Valley, she was sometimes left sitting in her urine soaked clothes and was allowed on one occasion to wander away from the home.*

Dave Reed: *A person suffering with the problems that she's suffering with deserves dignity, deserves attention and they don't really ask for much more than that and I don't think they got either*.

Clare Hudson: *In Caerphilly, another family was worried. **Lily May Warman** was very frail from breaking her femur and she went to **Silverdale** to recuperate but the alarm bells soon started ringing. During an afternoon visit her son was shocked to find her almost naked in a public lounge.*

Gwyn George: *Mam was sat there, dressing gown up to her thighs and that's all she had on - nothing else at all.*

Clare Hudson: *Relatives are not alone in voicing their concern. Former members of staff are also questioning the methods employed by **Dr Das**. **Dawn Goll** was the night sister at one of **Dr Das**' homes. She has resigned as she feels that under-staffing put the nurses under strain, making life difficult for them and for their patients.*

Dawn Goll: *If you are going to have a nursing home, run a nursing home and own a nursing home, you have got to put people in and these are nursing cases or elderly people. They are*

not units of money. It's not a question of how much each patient is worth. You must give them the best care you can and you must give your staff the best facilities for nursing you possibly can.

Clare Hudson: ***Dr Das*** *is prolific in his ownership of nursing homes, with eight homes to his name he is the largest owner in Wales. Six of the homes are in mid-Glamorgan and the other two in Gwent, providing almost 400 beds for the elderly and infirm of south Wales.* ***Dr Das*** *rejects any criticism of the way they are run.*

Dr Das: *We are doing a good job so leave us alone. That is why we are the largest in the country and we must deserve a pat on the back and not any criticism.*

Clare Hudson: *Maybe* ***Irene Wilkes*** *would have disagreed. She died, still suffering from the appalling bedsores that developed when she was in* ***Silverdale Nursing Home****. She had been at this home in Bedwas where she was very happy but following a spell in hospital it was decided that she would continue to need 24 hour nursing care. She went into Silverdale and* ***Melvin Wilkes*** *soon started to believe that his mother wasn't receiving the best possible care. His concern began to mount when clothes belonging to her, with her name marked on them, began to go missing.*

Melvin Wilkes: *One time I went in there and I seen my mother in a dress that didn't belong to us and I said: My mother is dressed in somebody else's clothes and they said*, "*Well there's been a mishap."*

Clare Hudson*: But things only got worse. Cosmetics he brought for her disappeared. Then her watch went missing and her wedding ring. The last straw came when Mr Wilkes found that his mother's TV had gone.*

Melvin Wilkes: *When I went into her room I found the TV was gone. I asked my mother, "What's happened here?" "The staff took the TV – the night staff." I said, "What permission have they got to take anything? It's yours."*

Clare Hudson: *Sitting, eating and sleeping. That is all* ***Irene Wilkes*** *did all day and every day in* ***Silverdale****. There were rarely any activities provided. She was able to walk but not encouraged or helped to do so. She was hardly ever out of her chair.*

Melvin Wilkes: *People are there and they are human beings and they need help and they just need something – if it's a singsong – anything to get them going. But to wake, get out of bed and just sit in a chair for a long period and you see people coming and going, I mean that's no life.*

Clare Hudson: ***NHS Wales*** *have recently issued guidelines on nursing homes. According to these, Homes are where people live…patients should be offered social and mental stimulation in a humane and secure environment. It wasn't just boredom that made life difficult in* ***Silverdale Nursing Home.*** *At times the physical environment in which residents sat all day could be extremely unpleasant because there'd be a strong smell of urine.*

Melvin Wilkes: *Some days I'd go downstairs – the smell of urine was enough. I used to put it that old people and geriatrics, you will get this, but sometimes it was bad.*

Colin Hobbs, **Gwent Community Health Council**: *It should certainly be clean and airy and should certainly not smell. Problems with incontinence nowadays is really unforgiveable because the services are available and if there are difficulties, well then, agencies are able to come in and provide the appropriate advice. So there really is no excuse, no excuse for the problem of that kind.*

Clare Hudson: ***Melvin Wilkes*** *feels this environment was having a bad effect on his mother's physical and mental condition. He would take her out for the day but persuading her to go back in the evening became a trial. She hated being in the home and she was slowly sinking into a deep depression.*

Melvin Wilkes: *She used to dread then going back and she used to beg me often not to take her back. When I mentioned it to the staff they said, "Well it's just part of senility – people getting older." I said "I find it strange because my mother loves company and she's never moaned before."*

Clare Hudson: *Finally, on* ***November 18th*** **[1994]** *last year she was admitted to Caerphilly Miner's Hospital. She was suffering from bronchial pneumonia and diabetes. But after her clothes were taken off nurses were shocked to see that she had painful bedsores on her back and buttocks. The doctor treating her was appalled.*

Melvin Wilkes: *He said this has been due to neglect for a long period of time.*

Clare Hudson: *Is that the word he used – "neglect?"*

Melvin Wilkes: *Yes, then he started showing me things and then I could see then the neglect of my mother.*

Clare Hudson: *You actually saw it?*

Melvin Wilkes: *When I saw her stripped off and could see then, you know, down to her pants and she was lying on the bed and he was going through with me and I could see the condition of what she was in.*

Clare Hudson: *Must have been a terrible moment for you.*

Melvin Wilkes: *It was because you honestly believe, and you think, in these nursing homes they've got the nurses to look after these people.*

Clare Hudson: *Now, no amount of care could make her last few weeks comfortable. She was transferred to Ystrad Mynach Hospital where she died of bronchial pneumonia on January 6th* **[1995]**. ***Melvin Wilkes*** *has written an official complaint to* ***Mid Glamorgan Health Authority*** *about the care his mother received at* ***Silverdale Nursing Home****. They say they are investigating the complaint. We asked* ***Dr Das*** *whether he would do an interview to discuss complaints made against his nursing homes. He declined but we caught up with him outside his surgery in Cefn Forrest, "There are criticisms that people are being neglected."*

Dr Das: *Untrue, absolutely untrue. All that I can say, if they have any allegations they should come to me. I haven't had – I am hearing from you.*

Clare Hudson: *The **Health Authority** have received complaints*.

Dr Das: *I haven't had. If you are saying that, you have known all of these I will investigate.*

Clare Hudson: *Elderly people make up a growing proportion of the population. Providing and paying for care for those who need it is becoming a major political hot potato. In line with care in the community policy, long term hospital wards for the elderly are being closed and private nursing homes are filling the gap. Fees are paid by the patients themselves or by social services. Nursing homes like this one in Cardiff have to be registered and inspected twice a year by health authorities. This home aims to provide much more than the standards required but there is criticism that monitoring of standards isn't stringent enough and that some homes are much better than others.*

***Dr Das** and his wife **Nishebita** are the sole owners of eight nursing homes in the valleys, most of them in the Rhymney Valley. Another one is planned. Their company **Puretruce** is the biggest owner of nursing homes in mid Glamorgan and there is concern that this reduces the choice available for elderly patients receiving care in the area. **Mrs Das** is also a GP and the couple share a practice in the Valley. Some of their elderly patients end up in nursing homes owned by them. Critics, including former members of his staff, feel **Dr Das**' position as a GP and nursing home owner is unethical.*

Ann John, *former **nursing home cook**: In my opinion a doctor is a doctor and a businessman is a businessman. I don't think it should be both.*

Clare Hudson: *But there are no rules preventing a doctor from owning a nursing home and there are a number in Wales who do. The authority which oversees GPs says it is satisfied that there are no ethical problems.*

Mike Jenkins, **Mid Glamorgan Family Health Services Authority**: *I would rather believe that the GPs – all of whom are extremely busy – were too busy looking after their patients than to consider owning a nursing home – but then the question would arise – need they necessarily be involved in the nursing home other than actually owning it?*

Clare Hudson: *The **Silverdale Home** in Caerphilly, it's the most recent addition to the Das 'empire' and as there is no other nursing home in the town, it was an ideal place to open one. When **Lily May Warman** needed nursing care after breaking her leg, **Silverdale** seemed the right place for her but her family soon had reasons to worry. Her clothes started disappearing and then one day her daughter in law found her sitting alone with her arm and chair covered in her own vomit.*

Gwyn George: *It was shocking because we didn't really know the length of time my mam was covered in vomit.*

Clare Hudson: *Should she have been alone?*

Gwyn George: *No – my way of thinking – the nurses should be there all the time checking everybody out.*

Clare Hudson: *On **January 2nd*** [**1995**] *after spending just three weeks in **Silverdale**, **Lily** was rushed into Llandough Hospital Cardiff. She was suffering from bronchial pneumonia but doctors were angry to find that she was also severely dehydrated. For some reason she didn't have sufficient liquid in her body.*

Gwyn George: *They did emphasise it was a separate issue from bronchopneumonia. He seemed to emphasise on that dehydration – that she was seriously dehydrated and she shouldn't have been. Basically, that's what he was telling us.*

Clare Hudson: ***Lily May Warman** died some hours later. The following day **Gwyn George** complained to the **Silverdale** matron that his mother had been dehydrated on admission to hospital and he is sending a complaint to **Mid-Glamorgan Health Authority**. We asked for permission to film inside **Dr Das**' home. We were refused and when we were filming on the pavement outside the matron tried to prevent us continuing*. [A man emerged from the building and put his hand over the lens of the camera.]

*This is **Hengoed Hall**, another of **Dr Das**' homes. People who work here claimed staff numbers were cut down to dangerous levels when he took it over one and a half years ago. They say understaffing and drastic cost cutting made it difficult for them to give patients the right care. They say they couldn't live up to the high standards advertised.* [A leaflet about the home stated, "At **Hengoed Hall** we care."]

Lyn Pennells, a former matron at **Hengoed Hall** said: *We just couldn't care for them to the standard that they needed the care. There were ill residents there, not just little old ladies that needed meals they were very poorly residents and without trained staff you can't care for them to the standard that's required.*

Clare Hudson: ***Lyn Pennells** was asked to cut her qualified staff down from six during the day to four and from three during the night to one. She refused to do so but when she left, things changed. When **Dawn Goll** was a night sister at **Hengoed Hall** she was often told to work three nights a week on her own – the only registered nurse in the building. What do you think of that – for 60 people?*

Dawn Goll*: It's a practice that's not acceptable. You can't expect one trained nurse to be responsible for 60 patients.*

Clare Hudson: [to **Dr Das**]: *Were you aware that there was only one nurse on night duty and that was on the rota?*

Dr Das: *I'm not aware of that, no. No, even if by mistake it has happened, by accident. It's not our fault if people have not come for example and for sickness over which you have no control.*

Clare Hudson: *But **Dawn Goll** maintains she was regularly working alone, not just on occasions. She resigned saying in writing that she was no longer prepared to accept such a*

great responsibility. ***Mid-Glamorgan Health Authority****'s guidelines state that …there should be two qualified members of staff on duty at night for up to fifty patients.*

Melvin Wilkes *feels his mother suffered as a result of understaffing at* ***Silverdale****. He claims that she would often complain that staff didn't answer her buzzer when she called for them. He didn't believe it until one day his mother wanted to go to the toilet and he repeatedly pressed the buzzer. No one came.*

Melvin Wilkes: *When I went to the member of staff I said I've been buzzing downstairs – "Oh" they said, "We've been inundated up here and it's so busy and we've only one pair of hands." But I said, "Well surely, if she's downstairs and wanted to go to the toilet, then she's got to wet herself." "Oh – the thing is, we can't be everywhere."*

Clare Hudson: *Staffing wasn't the only thing to suffer when* ***Das*** *bought Hengoed Hall. Staff were told to cut down on the basic necessities like incontinence pads and food. The regular supplier of incontinence pads refused to supply the home. They'd been owed thousands by* ***Dr Das*** *in the past. Former members of staff felt under pressure from the administrator to cut down on everything.*

Carol Cheshire: former **staff member**: *She would tell us that we were using too many incontinence pads and* ***Dr Das*** *had told her that she wasn't to allow it. Anything we wanted to do for the residents we were told "****Dr Das*** *would not like it."*

Clare Hudson: *As many of the residents were incontinent, a steady supply of pads was essential to their basic comfort and dignity. But under the new regime even the pads were rationed. This put great strain on patients and staff.*

Carol Cheshire: *So many would be dished out and then we were told we had to manage with that. We were also given a book which had to be filled in with who had what pad and how long for and why we changed it. And there was a day when we had to take residents to breakfast, some of them without pads and they had to sit in that condition throughout breakfast because there were no pads in the home.*

Clare Hudson: [to **Dr Das**]: *There are also claims that you are scrimping and saving in your homes on the most basic necessities.*

Dr Das: *No*

Clare Hudson: *That* ***Puretruce*** *are not getting incontinence pads for example when they need them.*

Dr Das: *Incorrect*

Clare Hudson: *We have heard claims that this has happened.*

Dr Das: *Whatever you have heard it is incorrect.*

Clare Hudson: *Former staff at Hengoed Hall have also told that when **Dr Das** took over the homes there was also immediate pressure to reduce spending on food. They were told to get cheaper meats, less cake mix and basics like bread and milk.*

Robert Lance, **former nursing home cook**: *It's penny pinching. These are basic food products we're talking about and if you are going to cut down on the basics, you have no chance of the luxuries. You can't order extra things and give them treats and things when they started to cut down on the milk and the bread.*

Clare Hudson: *Another **former cook** at the home had the same experience and she also left because she felt her conscience would not allow her to continue working there. She felt the patients were suffering.*

Ann John: *I wasn't happy about the amount of food we could cook. I wasn't happy working there any more – not like I was.*

Clare Hudson: *Why not? What was making you unhappy about being there?*

Ann John: *Well the old people, they can't speak for themselves a lot of them in there and I felt that they wasn't having the right care in the way of food. They weren't having the right amount of care in the way of food.*

Clare Hudson: ***Dave** and **Tish Reed** removed her mother from a nursing home owned by **Dr Das** because their repeated complaints about her care had brought no response. **Mrs Reed** would be shocked at her mother's condition when she took her home for the day.*

Tish Reed: *She'd have stockings rolled around her ankles and more often than not I used to have to change her because she'd be wet. The supply of incontinence pads was non-existent virtually for her. At one point I was told that she wasn't incontinent but she was – even when she was living with us.*

Clare Hudson: *They decided to take her out of the home, **Holly House** in Maes Y Cwmmer after she was found by a family friend wandering by a main road a few miles away. The home had told the police that she was missing but not the family. Within hours of announcing their decision to move her to another home, **Dr Das** was on the telephone to the family.*

Dave Reed: *Why does it take that – pulling my mother in law out of the nursing home, to make his very first attempt to contact us at all? Why did it have to be? All he seemed to be really worried about was the money he was going to lose – the money that he was getting from her. At no stage did any sympathy or feelings come from the phone call or from any of the staff.*

Clare Hudson: *The local health watchdog has had complaints from relatives about nursing homes run by **Dr Das**. They have also heard from former members of staff that cost cutting has reduced the standards of care. Now they're hearing from local doctors who have spoken privately about the state of some of their patients in **Dr Das**' homes.*

Colin Hobbs: *I am deeply concerned about some of the cases which have been spoken to me about. For instance, patients have been suffering from bed sores. Not simple, straightforward*

bedsores but those which are advanced and in fact become infected and therefore can, in fact, be life threatening.

Clare Hudson: ***The Community Health Council*** *asked* ***Mid Glamorgan Health Authority*** *to release their inspectors' reports on* ***Dr Das****' homes. They have turned down this request and the* ***Health Council*** *has now asked the* ***Welsh Office*** *to intervene. But one former member of staff saw one of the reports on* ***Hengoed Hall****.*

Carol Cheshire: *Everything was criticised – the way the kitchen was being run, the standard of care that we couldn't give because we didn't have the people; the state of the linen, shortage of linen; the fact that there was no proper soap in the bathrooms.*

Clare Hudson asked **Dr Das** about the **Mid Glamorgan**'s inspection reports.

Dr Das: *No. The reports…if there is any constructive proposal in the reports, whatever they want, we cooperate with them.*

Clare Hudson: *We asked the* ***Health Authority*** *to comment on the treatment of the patients shown in this programme. We made repeated attempts to speak to a senior official but no one was available. They sent a statement which said that "Complaints have been received about nursing homes, including those you referred to. The* ***Health Authority*** *has dealt with the complaints and where required has monitored the ongoing situation." But critics think that stronger action is needed.*

Carol Cheshire: *They keep giving him planning permission. He keeps getting registration for the other homes he takes over – so I can't understand why something hasn't been done before now.*

Clare Hudson: ***Dr Das*** *and his family seem to be prosperous but critics say his affluence is at the expense of his nursing home patients. They say his ownership of so many homes in one area damages patient choice.*

Colin Hobbs: *Given also that the* ***Welsh Office****, central government if you like, often talk about people's choice and people's decisions and then exercising their choice, here we have a situation where choice goes absolutely out of the window.*

Dr Das: *If there are any complaints they should come to me first – who will be in a position to put it right.*

Clare Hudson persisted.

Dr Das: *I haven't had any. Thank you very much.* [He walked away.]

Melvin Wilkes: *We work hard all our lives, the likes of me and my wife. We're going to go into these nursing homes and you know, unless somebody makes a stand to do something, to put things right, what future have we got?*

Investigation by ***Catrin Griffith****…Editor* ***Clare Hudson****…MCMXV*

(ii) The second *Wales this Week* programme began with the warning that: *This programme contains some scenes which may upset some viewers.*

It opened with the shot of a woman having the dressings for *pressure sores* changed on her legs.

Clare Hudson: *This delicate procedure is an everyday event in Welsh private nursing homes…for the patient it is painful but necessary and everything is being done to the highest nursing standards. The staff have all the right equipment to reduce the chance of infection*. However, she contrasts practice at this home with practice at **Fairfield Nursing Home**[470] in Haverford West about which former staff have made *serious allegations*. A photograph was shown of a person's pressure ulcer – exposing the hip bone – perhaps 6 inches in diameter.

A nurse who worked during the night for only two months described the pressure ulcers of two patients, *I'd never seen pressure sores like this before…two ladies had deep, open, weeping sores the size of my hand on both hips. In addition one had a sore on her back and her elbow*. Later in the programme she explained that *flesh was eaten away…I didn't have the proper equipment with which to change the dressing, I didn't have any pressure reliving mattresses to nurse them on*.

The relatives of one patient, **Margaret Beer**, described their experience of finding their mother in urine soaked clothes. Ultimately, her deterioration was so stark that her daughters decided to move her out. They attributed this understaffing, inexperienced staff and poor, unhygenic practice.

Clare Hudson: *The owner of **Fairfield** leaves a great deal of the decision-making to her husband, **Dr RC Choudhrey**.*[471] *He frequently works as a locum consultant physician at a nearby hospital. He spoke to **Wales This Week** on his wife's behalf and defended the standards of care at the home…In a previous programme we highlighted concerns about the **Silverdale Home** in Mid Glamorgan owned by a local GP. There are now warnings of the danger of a conflict of interest when doctors own nursing homes. Some people claim that doctors involved in the process of referring people into nursing homes could be open to accusations of undue influence.*

David Hinchcliffe, **MP**: *I think you have to tread very carefully where there are GPs, doctors involved in providing such forms of care because there are very close connections between their referral arrangements, discharge arrangements as a hospital doctor and the provision of private nursing care. I think that it's a very worrying development*.

Dr Choudhrey defended his position in terms of *morality…professionalism* and *ethics,* asserting that he had …*never influenced anybody to be placed in Fairfield or anywhere else*.

[470] Which opened in 1992 and had 40 beds

[471] Fairfield is *"actually owned and registered in the name Mrs Choudhrey but she delegates most of the responsibility to her husband…"*

Clare Hudson: *Long term care for the elderly has moved almost entirely into the private sector either in residential homes or nursing homes. Very few old people now spend their last days on hospital wards. They are more likely to end up living in the more homely atmosphere of a nursing home. The growth in the private sector has been dramatic. In **1989** there were 6000 beds in private nursing homes in Wales. Six years later, in **1995**, that figure has more than doubled to 13,000 beds. If financial help is needed care is paid for by social services. Those with several thousands in assets have to pay for themselves. The government feels that the nursing home is a better setting for attaining the highest standards of care*.

Rod Richards, **Welsh Office Minister** stated that provision for older people was an improvement on public sector care in the **NHS**.

David Hinchcliffe: *My worry about the present government's attitude is that they're so tied to an ideology of the free market and to privatisation that they lose sight of the fact that there are certain inconsistencies between a profit approach to care and the basic needs and well being of individuals*.

Another nurse and former employee at **Fairfield** described how difficult it was to work in the absence of *basic equipment* to attend to people's pressure ulcers. *…we had no galley pots, containers for the solutions, we had no tweezers for packing gauze and we had no latex rubber gloves. At one point we were bringing in tweezers from home and soaking them in boiling water*.

Clare Hudson: [re pressure ulcers] *…current thinking is that they are preventable*. **Pat Ramdany** of the **Royal College of Nursing** spoke of the urgency of attending to signs of ulcers developing and treating them before they progress.

Dr Choudhrey: *Elderly people when they become immobile, get into that age, suffer from various illnesses, body defences are down, they become incontinent. With the best will in the world, skins gets soaked occasionally, if not all the time. They are on drugs, in general I'm talking, which can affect your constitution, can make you prone to breakup of skin in particular and very much more liable to get a pressure sore*.

Clare Hudson described *good practice* and the importance of movement and exercise, noting that some homes employ physiotherapists. She noted that …*even if a patient is bedbound, good care can keep their skin healthy.*

Dr Choudhrey challenged the claims of nurse whose resignation letter of 22 **September 1994** stated that her decision was *due to the very poor standards operating at **Fairfield** and the severe shortage of equipment and materials*. He asserted that anything that was required was provided. The letter of resignation triggered no reply from either the Matron or **Dr Choudhrey**. The ex-employee then made a complaint to **Dyfed Health Authority**.

Clare Hudson: *Every nursing home has to be registered with the Health Board and regularly inspected by them,* [since they are] *responsible for ensuring adequate standards of care for all*

nursing home residents. Although the ex-employee spent two hours with the Health Authority inspectors she heard nothing of the outcome.

Clare Hudson: *There have also been complaints about understaffing in **Fairfield**. At night one qualified nurse and two care assistants were left to cope with 40 patients. This is lower than what is required by the **local health board***. A former care assistant described the working conditions as "*impossible."*

Clare Hudson reported that first impressions can be deceptive since former staff claimed that when *visitors had closed the doors,* **NHS guidelines** were set aside e.g. staff were required to get residents out of bed at 5.30 a.m. – even though breakfast wasn't served until 9.00 a.m. The Matron was alleged to rationalise this with the claim that *they sleep all day in their chairs*. She denied that this practice prevailed, however, as **Clare Hudson** noted, *the home concedes that this did happen in the past.*

Clare Hudson: *People are often referred from hospitals like Withy Bush where **Dr Choudhrey** often works as a locum consultant. Social workers liaise with doctors to decide whether an elderly person needs 24 hour care in a nursing home and relatives are given suggestions of suitable homes. Since his wife opened **Fairfield** other home owners say referrals to their homes have declined dramatically*. One nursing home owner, **Chris Farr**, noted that *where we used to enjoy a large number of inquiries and all of a sudden they dry up and disappear you have to start asking questions.*

Dr Choudhrey refuted the allegation: *I am very well aware of the medical ethics of my profession and I can assure you not in any single instance at any time during my career here, nobody can accuse and prove that I was even associated with any suggestion of where one person should be placed…*

Margaret Beer's **daughters** recalled that there was *not much choice* since **Fairfield** was one of three nursing homes listed and the other two were full. Finding out that their mother had been lying on a bathroom floor for 40 minutes was distressing. Although the Matron denied that this had occurred, there was an acknowledgment of *teething problems soon after the home opened*.

Two residents spoke very favourably of their experience of **Fairfield**.

Sue Parfitt had been the first matron and *was sacked after she made a complaint*. She was concerned *that vital equipment was often locked away and qualified nurses were having to do the cleaning.* She wrote to the Health Authority with four other members of **Fairfield** staff. She reflected that *I think they felt it was my fault that things were so bad in the home…it was a very unfair interview*.

Dr Choudhrey said that the Health Authority found no substance in the allegation and defended his decision to sack **Sue Parfitt** claiming that *the home was disrupted when that girl was here*.

Clare Hudson: *The **Local Health Authority** refused to be interviewed but issued a statement saying "This is a well-planned nursing home, well-furnished and maintained and the facilities and care offered to patients are of an acceptable standard." They refused to release copies of their inspectors' reports on the home. The **Welsh Office** is soon to publish new guidelines about the inspection of nursing homes and from next year Health Authorities will have to publish their reports.*

Rod Richards, **Minister** reflected that it was not up to him *to comment on what Health Authorities do…we issue guidelines which Health Authorities are expected to comply with*.

Clare Hudson: *Critics say that inspections in Wales are overstretched and that they sometimes have to be cursory. Wales has well below the recommended number of inspectors for its 13000 nursing home beds. Some are arguing that inspections need to be totally independent of the Health Authorities and should be given a freer hand to raise standards*.

David Hinchcliffe: *I think they need more power and in particular, much more independence. At the moment they are constrained in the work that they can do. We have to ensure that they are independent and that they don't feel that if they make a recommendation, somebody who is in charge of their work will lean on them and say, "Look – this frankly is going too far." They need to be applying national standards and national criteria to be independent and unfettered in the process of doing that.*

Rod Richards: *Clearly if certain aspects of the way that a nursing home is conducting its business is considerably below standard then clearly they have to improve on that. One wouldn't wish to see an inspection insisting on certain things, which are deemed to be unnecessary, being imposed.*

An ex-employee recalled the tiredness and frustration she felt working at **Fairfield**. **Dr Choudhrey** had the final say, claiming "*We provide excellent care."*

*Investigation by **Catrin Griffith**…Journalist **Peter Hughes**…Editor **Clare Hudson**…MCMXV*

A summary of the BBC Wales broadcast *Week In Week Out: Taking Care?*

This programme, which was broadcast on **28 June 2005,** opened with reporter **Penny Roberts** asking:

*If frail, elderly people were abused in a nursing home it would be stopped wouldn't it? You'd expect vulnerable residents to be safe in the hands of those paid to care for them, wouldn't you? Would a doctor fail elderly residents time and time again? This GP, [**Dr Prana Das**] owns a string of nursing homes. Tonight, we expose how he has been doing it for years"*

Shan Kendrick, the daughter of **Ken Picket**, a former resident of Holly House, observed "*I couldn't even say he was treated like an animal because I wouldn't want an animal to be treated that way."*

Alun Owen was employed at Holly House for 15 months. An "insider" and former acting manager at **Holly House Care Home**, he blew the whistle on **Dr Das** to the **Care Standards Inspectorate for Wales**. He observed *At the time when I was there I would not have put my relative there. Knowing the risks associated there, I couldn't say it was 100% safe at all times… I was getting nowhere. I'd had enough. I wanted [the regulator] to put pressure on **Dr Das** from their angle. The safety was compromised because there were areas during the day when residents were not being observed. They'd wander, go into people's rooms, anything could happen. We had a couple of falls unobserved – fell out of chairs. It can happen if there's staff in the room, but with adequate staffing, it does minimise the risk.* **Alun Owen** acknowledged that staff were forced to compromise their professional standards. ***Dr Das*** *didn't invest enough in the home. We were lacking in equipment, especially hoists. Although we were breaking the law with moving and handling, the job still had to be done… If you could put pressure on Dr Das you wouldn't be issuing all these notices.* **Alun Owen** regretted that he could not *wave a magic wand* to get what **Holly House** required.

Families had no idea that **Holly House** had known failings and that residents' care was so poor. **Penny Roberts** described **Holly House** as *a nursing home for elderly mentally ill people who were totally dependent on the staff. It was trusted by families to care for their loved ones.* The external signage indicated that it was a care home.

Paul Black, a Director of Puretruce, showed **Penny Roberts** around **Holly House** noting, *As far as nursing is concerned, this is the highest level of care you can have. A lot of these residents are not only mentally ill, they can have physical problems with their health. You don't want people in too large numbers.* [At Holly House] *we try to keep things much like home…a nice dining room for small numbers of people. We like to give the right ratio of care. What we've got to do is make sure that residents are happy and things are calm.*

Penny Roberts noted that placements at **Holly House** cost up to £500 per week. She *looked beyond* **Paul Black**'s *sales pitch* to reveal *a catalogue of failings, of institutionalised abuse* even though the home remains open for business and the owner, **Dr Das** *remains defiant*.

Dr Das responded to questions and allegations about his homes posed by Penny Roberts with the claim:

I am very proud of what we have done. We have done a great deal of work in the community. The community is benefitting in terms of jobs and in terms of care provided…You are talking about the failures, you are talking about complaints. No matter how much you do, some people you can't make them 100% happy.

Clive Davies, the son of ex-miner **Albert Davies**, recalled that his father went into **Holly House** when at 91, he became increasingly forgetful and the family were not in a position to support him. His daughter **Myrtle Davies** described a *very proud man* who on admission *had a wardrobe full of new clothes*. However, when they visited **Mr Davies**, he was wearing other residents' clothes which did not fit him. It was *terrible bruises to his face* which prompted his family to question the care their father was receiving. *They told us he was falling down. We called in the social worker to come in to see him and by the time we spoke to the social worker in front of the management, he never fell again.* However, on a visit during November 2003, **Mr Davies** met detectives in his father's room at Holly House. They learned that **Mr Davies** had been assaulted by a member of staff who had been suspended. Ultimately there was insufficient evidence to prosecute this member of staff. **Mr Davies** died a week later of pneumonia. It subsequently emerged that no one had ensured that he had received adequate medical treatment, i.e. he was not receiving the medication he should have had and he was not having his blood monitored. **Mr Davies** was not shown dignity at the end of his life or even when he died. His family would have removed **Mr Davies** had they known that **Holly House** was so wanting. When the family viewed his body, his eyes and mouth were open and "stickers" were still in place on his chest. *It was heart-breaking to see him.* **Clive Davies** reflected that, *He was a very good father. He shouldn't have gone through this at the end of his life.* Following a complaint by **Clive Davies**' family, the **Care Standards Inspectorate for Wales** found that **Holly House** staff were not trained in dealing with bereaved families.

Dr Das challenged the family's upheld complaint and the suggestion that since staff were *looking after the living ones. There is not time to look after the dead ones. It is absolutely nonsense I would say. From my perspective it would not have happened… I don't know. I wasn't there.*

Penny Roberts noted that during the period that **Albert Davies**' family were concerned about **Mr Davies, Holly House** was under the close scrutiny of the **Care Standards Inspectorate for Wales**. It undertook 20 announced and unannounced visits to **Holly House** at a time when 2-3 were the norm. These identified *serious breaches* of standards which meant that residents were at risk. The breaches included, *inter alia,* poor recruitment practices, inadequate staffing levels, inattention to hygiene and infection control, the compromised dignity of residents, risk assessments and *inadequate systems to ensure the safety and welfare of the residents*.

Dr Das was warned that standards had to improve. He ignored the warnings and was dismissive of the evidence chronicled by the inspectorate asking, *How can they say it is*

failing? Failing at what? It's a lot of nit-picking obviously. When you look for problems in any home you will find them. The main thing is - are these problems affecting residents? In ***Holly House*** *that is not the case*.

Dr Jonathan Richards, a GP and **Professor of Primary Care** asked: *Does [**Dr Das**] have the insight and understanding into his own responsibility? Is this what society has a right to expect? If he doesn't have insight and understanding, is he the right person to be running [**Holly House**]?*

Ana Palazon of **Help the Aged Wales Executive** confirmed that it is not possible to provide a safe service without adequate numbers of staff. She spoke of the practice of *cutting corners* and asked *How far are we going to go before it is too far?* She stated that the **Care Standards Inspectorate for Wales**' report concerning **Holly House** provided irrevocable evidence of *a breach of trust and a breach of standards*.

During **2002**, standards were so poor at the **Merthyr Tydfil Nursing Home** that its registration was cancelled. This home was owned by **Dr Das**.

Lynda Jones was distressed by her father's suffering at the **Merthyr Tydfil Nursing Home** that she wanted **Dr Das**' company to be put out of business. Her father, **Idris Sutton**, developed terminal bowel cancer and he was admitted to this home during July 2000. Lynda Jones said *He was special. So much loved and then he goes into that place*. She recalled the reassurance she gave her father. Since he *wasn't going to be left or forgotten* on the days when he was well she used to bring him home in his wheelchair. Although her father called it a *hell hole*, she encouraged him to *give it a bit longer dad, try and settle down. If you don't like it we'll bring you home.* She was distressed that 12 days after his admission he had carpet burns, he was not being given sufficient pain relief for his cancer and he was left in a filthy condition. On one occasion when he was at her home, she offered to wash him and he asked if she didn't mind. She reassured him that she did not because she had helped to wash him during his illness before his admission to the nursing home. She was shocked that it took *six waters to wash the faeces from underneath him.* Seven of **Lynda Jones'** eight complaints about her father's care were upheld.

Penny Roberts listed the upheld complaints concerning practice in **Dr Das**' home: lack of consultation with a GP; poor personal hygiene; inadequate wound care; unsatisfactory wound care; failure to call in a GP; privacy and dignity not respected; poor communication and record keeping. She challenged him with the question: *You're a GP – don't you care about this?* **Dr Das**' responded: *We have no control over people complaining. These complaints, you can make complaints, you have to prove it, they have to prove it…how valid that proof is?* He was dismissive of **Penny Roberts'** assertion that the complaints had been investigated by social workers and nurse professionals and she reminded him that the complaints she had listed were all upheld.

He said, *It was five years ago. I had no idea about this particular case. People do come to nursing homes with a plethora of diseases and at an advanced age. Nursing homes are not*

hospitals...I have been providing minimum standards – much more than that throughout my care homes.

This claim was challenged by **Dr Jonathan Richards** who had visited patients at the **Merthyr Tydfil Nursing Home**, (which has since closed), and witnessed **Dr Das**' standards. He noted that patients were *not clean, in soiled bedding, they had infected ulcers… malnourished, dehydrated…When with adequate numbers of trained staff it wouldn't have happened. People should have the right to be cared for to the highest standard in terms of the quality of life, especially when they are frail and vulnerable. The owner should be held accountable.*

Dr Richards also questioned how **Dr Das** could confirm to the **General Medical Council** every year that he was acting with probity, providing the highest quality of care in all aspects of his working life when customers, rather than patients, were receiving such a poor service. He asked, *How could a GP sign [such confirmation] if in fact people are not receiving a safe, efficient and effective service?* **Dr Richards** reported **Dr Das** to the **Health Authority** and an investigation was launched.

Lynda Jones expressed concern about the other residents *who didn't have family who were crying, Get us out of here!* She expressed disgust that **Dr Das**' was trusted since her father's experience *shouldn't be happening* to anyone. **Shan Kendrick** endorsed this view stating that residents require care and help to maintain their dignity and that homes *should be answerable for what they have done or not done in my father's and other people's care*.

Shan Kendrick observed that her father, **Ken Picket**, *knew what was wrong with him* since his mother had had Alzheimer's. This had prompted him to reflect *I don't care what happens to me – but not that*. **Mr Picket**'s wife had been ill and was *unable to cope* with her husband's Alzheimer's. The family undertook to find him a secure place in a nursing home. They visited several homes on the Council's "Preferred Provider" list and **Mr Picket** went into **Holly House**. **Shan Kendrick** recalled that it was in a *nice location with gardens and sunny conservatories* and that she had been put at her ease by the head nurse. She was reassured that **Holly House** provided a secure, specialist Elderly Mentally Infirm service. However, the staff lost **Mr Picket** on two occasions. On the first occasion he was found asleep in an airing/laundry cupboard and on the second he was found wandering the gardens, close to a road. **Dr Das** had no misgivings about **Mr Picket**'s care and denied that **Holly House** was *lucky* that **Mr Picket** had been found. He stated that the latter was the result of *good supervision*. **Dr Das** observed of such patients that they are:

*Very demanding, very difficult individuals those who are mentally infirm…therefore in a matter of minutes they are normal then they are not normal. [**Mr Picket**] was found on the campus. It is good supervision. He was found and staff brought him back to his bed. It's not unusual in EMI nursing*.

Shan Kendrick is angry that she was not warned about the Council's concerns regarding **Holly House**. She explained that she and other families do not know the right questions to ask. **Joe Howsam**, **Director of Social Services** at **Caerphilly CB Council** commissioned an independent

report into **Holly House** because legal advice determined that the Council had to show that **Dr Das**' home *was not meeting contracted standards*. The Council had *serious concerns* about **Holly House**. He explained that the Council expects families to *read past the care standards inspection reports* and that in correspondence with families they are directed to such reports. **Joe Howsam** explained that the first and best option is *to make that place better*. This was accomplished by bringing in NHS nurses, at public expense, to train **Holly House** staff to ensure the safety of residents who wanted to stay. He outlined the Council's dilemma: the poor and neglectful care of some residents does not mean that other residents and their relatives wish to move. He explained that the term **Preferred Provider** is a misnomer since it merely means that the service is registered with the **Care Standards Inspectorate Wales**. **Jenny Roberts** asked **Joe Howsam** if he would put his loved one in **Holly House** and he replied: *Personally? No*. He reflected that **Holly House** was *good enough...whether it could improve and continue to be good enough is my concern*. He acknowledged that **Holly House** did not meet minimum standards *in all respects*.

Jenny Roberts told the viewers that although the **Care Standards Inspectorate Wales** had cancelled **Holly House's** registration, it was allowed to remain open since **Dr Das** appealed against the decision. The **Care Standards Inspectorate Wales** asked for the registration to remain cancelled. The **Care Standards Tribunal** upheld **Dr Das**' appeal since some improvements were noted in the independent report commissioned by **Caerphilly Council**. The **Care Standards Tribunal** gave **Dr Das** another chance with the expectation that improvements would continue. This decision left the Council with no option but to continue to monitor **Holly House**. In turn, this led to **MPs** calling for a change in the law.

Of **Dr Das**' track record as a home owner, the programme stated that since **2001**, only six homes in Wales had been de-registered and three of them belonged to **Dr Das**. He had been prosecuted and fined £3k during **2001**, since **Aberpennar Court** in Mountain Ash (a home which he no longer owned), had no one in charge; and during **2003**, the registration of **Bay Bridge** home in Cardiff was cancelled due to *serious failings* in the care provided. The broadcast ended with the breaking news that the **Care Standards Inspectorate Wales** was investigating a complaint about **Brithdir** - another home owned by **Dr Das**.

Dr Das' final observations to Penny Roberts were *I am not guilty. I have provided the best of care inside our means. I have no regrets.*

30 minutes

A summary of the BBC Wales broadcast *Week In Week Out: Wales' Nursing Home Scandal*

This programme was broadcast on **4 June 2013**. It included interview footage from an interview with **Dr Das** from the ***Week In Week Out: Taking Care?*** broadcast of **28 June 2005**.

The programme began with reporter **Tim Rogers** stating that the subject was *Britain's biggest investigation into the neglect of the elderly in nursing homes*. He set the scene by explaining that it was about older people with failing health who were in need of nursing home care, but that *what the families didn't know was that their loved ones were suffering behind closed doors* and that all were *victims of neglect*. He explained that for 7.5 years a **Gwent Police** team had been investigating neglect in six nursing homes. The investigation cost £11m and generated a huge amount of paperwork. However, a trial at the beginning of **2013** *collapsed in dramatic fashion, leaving families like those of* ***Evelyn Jones*** *with a host of unanswered questions*.

Ruth Phillips spoke about her grandmother, **Evelyn Jones**, *The pain and suffering she must have gone through to be in that state. Nobody deserves an ending like this. We just wanted an opportunity at least to be able to tell her story about what happened to her so it's not swept under the carpet*. What happened to **Evelyn Jones** became one of the key cases in the police investigation known as Operation Jasmine.

Evelyn Jones' daughter, **Marina Walters** and granddaughter **Ruth Phillips** recalled that **Evelyn Jones** *was very kind, very caring, she was quiet. She had a good social life and she was popular and well thought about in her community*. **Marina Walters** said that when her mother was admitted to **Brithdir** she was fit enough to say: *That's mine!* when food was being taken from her tray by another resident. She was also *quite talkative* and even able to accompany them to the door when they left. The family were away for two weeks and were shocked when they next visited her. She seemed different. She had slipped down in her chair and so they tried to lift her in the same way as a nurse would. Although they did so, gently, she had made whimpering noises. When she was asked what was the matter *tears rolled down her face*. **Evelyn Jones** then developed a chest infection and was admitted to the Prince Charles Hospital in Merthyr Tydfil. **Ruth Phillips** explained that her grandmother had been placed in an isolation room. She recalled such a *bad, pungent smell* of an ulcer that the great grandchildren could not stand it and were taken out. She described the wound on **Evelyn Jones**' back as being like *a really bad burn*. Images confirmed that the wound was 12.5" by 6" and that it was *black, blue and sort of festering around the edges*. Also *horrific* were *two holes in the coccyx area…one about the size of a two pence piece* both *smelling badly infected…could see the bones of her back penetrating through these holes…oozing black. The smell was horrendous*. The hospital staff were so appalled at the extent of **Evelyn Jones**' wounds that they contacted the **Social Services Department** and the police.

Jeff Farrar, the Chief Constable of **Gwent Police** explained that during **2006**, *there was a pattern across a number of homes. We were seeing deaths in circumstances which on the face of it were just not natural causes.* The investigation team were shocked by what they were

finding. *Where you are seeing pressures sores corroded to the bone; where people are vomiting faeces because they are so constipated; where people were so dehydrated this was a significant cause of their death – then in **2006** and now in **2013**, surely no one would expect anyone to live in those conditions?* **Jeff Farrar** also said *I do have to ask the question, how do we actually prove these cases? Now that's incredibly difficult.*

Pam Cooke, the daughter of **Stanley Bradford** said: *Someone has got to answer for all these failings that have happened*. She and her sister, **Gaynor Evans** described their father: *Dad was well dressed and he always had his cap and his walking stick.* On *a number of occasions* that they visited **Stanley Bradford** they did not see any carers – not even during visits lasting four hours. On two occasions they waited in his room him but lunch time and evening meals were not served. Although they went to tell staff – who explained that they had forgotten – they wonder how many other times this occurred. When **Stanley Bradford** was admitted to hospital and they saw him without a gown, they observed that *he was like someone from a prisoner of war camp. His chest had sunken in and his knees were like round balls. It was a real shock*. He died later that year at the age of 76. When his daughters were contacted by the police they thought it was because they had had gathered evidence that **Stanley Bradford** had been starved to death. However, they then learned that he had had unattended pressure ulcers. No one at the home had told them about these.

Jeff Farrar noted that *People do get pressure ulcers. It is a fact – but not to this extent. Would I want to put my family into a care home in these circumstances? Absolutely not.*

Tim Rogers explained that **Dr Das** had owned and run care homes across south Wales for more than 20 years. At its height, he had *an empire of 25 registered homes*. It was the largest business of its kind in Wales. The programme broadcast in **2005** had highlighted the concerns and complaints of families that had *stretched back years* and had been upheld by the **Care Standards Inspectorate for Wales**. Eventually, one of **Dr Das**' homes - Cardiff Nursing Home, **Bay Bridge** – had been closed.

Jeanette Kingston is a former staff nurse. After the 2005 broadcast she and her brother **Gareth Barnes** made contact. Their mother, **Marian Barnes** had been at **Brithdir**. They recalled that when they were looking at homes, *it seemed clean, the food was alright and the matron seemed quite nice there*. However, one morning they received a call to say that **Marian Barnes** had fallen. When they arrived their mother was already in the ambulance with a young carer who explained that she had found their mother on the floor. She had been shaking and said that she couldn't move. The carer had called a nurse for help and was told to get **Marian Barnes** dressed and to bring her downstairs. She had responded *I'm not moving her. She's in a bad way and needs to be seen*. **Gareth Barnes** explained that it was clear from the swelling in her leg that his mother had a broken femur although the skin was not broken. He said it *beggars belief* that it was subsequently explained that *She got up and walked*. Although **Marian Barnes** had had a bed with a cot side, this had not been attached the night previous to her fall. The home *tried to make out that she had crawled to the end of her bed*. Once she was well enough to be discharged from hospital, her daughter and son were

determined that she should not return to **Brithdir** noting: *All we wanted was for them to close the place down*.

Concerns about standards in homes *went back at least 10 years*. **Dawn Goll** had worked nights as the sister in charge of one of **Dr Das**' homes, Hengoed Hall, and recalled that she often worked alone and that endemic under-staffing was *dangerous for the staff and for the patients*. She explained that *the moment [**Dr Das**] took over, everything changed. He wouldn't have agency nurses. He cut down on the quality and quantity of food and also incontinence aids… If you are going to run a nursing home, these people are not units of money. You have to look after them and you have to give your staff the facilities to do it. If you are cutting back down on staffing levels and food and incontinence aids – where is that money going? They are paying for it and these people are entitled to good care*. **Dawn Goll** expressed particular concerns about inadequate staffing levels. *I would work five nights a week and very often I'd work three on my own. I wasn't the only one. There were other nurses being made to work on their own.* She asked *which do you go to?* if two patients at opposite ends of the building were having a heart attack and there was only one nurse present. *It's all very well **Dr Das** saying staff didn't turn up…or a case of sickness. No - that's not the case! There was a deliberate undercutting of staff to save money*. Although **Dawn Goll** resigned she retained the paperwork which confirmed how often she and others were the only nurses on duty. A subsequent Employment Tribunal accepted her claim that she had been constructively dismissed.

Tim Rogers referred to the fact that **Dr Das** was now coming to the attention of the **Care Services Inspectorate for Wales** which now had responsibility for registering nursing homes. However, ***Dr Das** wasn't going to give up his empire without a fight.* Interview footage from the **2005** programme confirmed that he challenged all complaints. However, nine of his homes were closed, prompting the question - How he was still permitted to continue running other nursing homes, including **Brithdir**?

Sarah Rochira, the **Older People's Commissioner for Wales**, observed that the investigation represented a *catalogue of failures* resulting in unchecked and *widespread neglect* which she attributed to *systemic failure…We failed to protect people when they needed our protection most*. She stated that there should be a *fitness to own test* since the existing fitness test *doesn't go far enough. If you have a history of running a home where older people have been victims of abuse or neglect then I don't think you should be allowed to run or own a care home in the future*. **Sarah Rochira** said that it is wrong to allow admissions to homes which are subject to investigations.

Tim Rogers explained that **Holly House**, which had been the focus of the **2005** broadcast, was eventually closed down and the closure occasioned the transfer of residents to **Brithdir**. However, the families with relatives at Holly House did not realise that **Brithdir** was also owned by **Dr Das**. As **Stanley Bradford**'s daughters confirmed: *If we'd known we wouldn't have put him in there. The authorities didn't tell us*. **Caerphilly Council** declined to be interviewed about the fact that families did not know that **Brithdir** was under investigation.

Similarly, the regulator, the **Care and Social Services Inspectorate Wales** (the regulator), **Dr Das**'s wife, **Dr Nishebita Das**, **Paul Black** (the Chief Executive of **Puretruce**), **Keir Starmer** , (the Director of Public Prosecutions) and the **Welsh Government** all declined to the contribute to the programme.

According to the programme, there were two key setbacks to the investigation. Operation Jasmine had gathered 12 tons of evidence into six care homes, two of which were owned by **Dr Das**. However, the **Crown Prosecution Service** (CPS) determined that the evidence did not reach the required threshold to bring charges of gross negligence manslaughter and wilful neglect. Although the Chief Police Constable at the time sought a meeting with the Director of Public Prosecutions to try to press the case, *the answer was still no.*

Jeff Farrar asked *If we haven't met the threshold after 75 detectives have spent six years and millions of pounds of tax payers' money, what have I got to do next time to meet that threshold?*

Ultimately a different route was sought by the **Health and Safety Executive** through identifying health and safety offences in relation to **Brithdir** and another home, **The Beeches**. It then brought charges against **Dr Das**, **Paul Black** and **Puretruce**. **Dr Das** was also accused of theft and false accounting.

The second setback was an attack on **Dr Das** at his home on **12 September 2012**. Burglars repeatedly beat him *about the head with a hammer*. During **March 2013**, Cardiff Crown Court was told that **Dr Das** was unlikely to ever recover sufficiently to stand trial. The **Crown Prosecution Service** decided not to proceed against the Chief Executive, **Paul Black** or **Puretruce.**

Stanley Bradford's daughters noted how they *felt cheated* that they were not going to see justice done *after all the waiting all this time.* **Ruth Phillips** said, *It's not just one person caring for somebody. We're talking about teams of people and yet not one person said - I've got a concern about **Mrs Jones**. Or maybe if they did, what happened? There's no answer for us. We'll never know. There is no closure for the family.*

Nick Smith MP has taken up the families' case and was featured challenging the Prime Minister at Westminster. *The wilful neglect of residents in their care homes is a crime but too often victims and their families do not get justice…Why don't we have a law that's fit for purpose?* In an interview with Tim Rogers, he explained that if you are a company director you should make sure *that you run the best possible care home and if you don't you'll be held accountable under the law. In the end, **Dr Das** was going to be prosecuted through health and safety and financial maladministration. That can't be right. We should be pursuing these people for poor care and if they do provide poor care they should feel the full force of the law. They should be prosecuted and made to go to prison for any criminal activity*. **Nick Smith** was seeking to lower the threshold to bring charges of wilful neglect and to place greater corporate responsibility on nursing home owners via a private members bill.

Jeff Farrar illustrated the frustration that this caused by contrasting the responses of the **CPS** to the neglect of a three year old left in a room without food or care with that of an elderly person left in a room. He asked: *What is the difference?* The **Crown Prosecution Service** confirmed that they should have offered fuller explanations to the police and to the families.

Sarah Rochira said that it is not known what happened to individual patients or who was responsible so that reassurance can be given to the public and in order to ensure that it does not happen again in Wales. She believed that a public inquiry was merited and a Welsh Government spokesman stated that a public inquiry was under consideration and also that legislation was being prepared concerning the protection of older people.

Tim Rogers concluded that **Dr Das**' empire of nursing homes *lies in ruins*, in that some were ordered to be closed and some were sold to other companies. All that remained was a single home in the Rhymney Valley.

Since a court case is unlikely, the families have been left wondering if they will ever get justice. **Pam Cook** and **Gaynor Evans** say of **Brithdir** (now under new ownership) that *it just holds so many bad memories…the way we saw our dad lying there, you think this and that, but we didn't have proof. We thought he was in good hands…I look at my dad's photo every night and say – sorry dad if we let you down. It's the way it made us feel that we'd let him down.* **Marina Walters** said, *I don't want answers learnt I want something done. We hear that all the time don't we? My mother went down to hell and thank goodness she's at peace now. I wouldn't want anyone going through what she went through*. **Ruth Phillips** said of her grandmother, *she was vulnerable, she was trusting and she was totally dependent. She was too weak to tell us what was going on. We trusted these people and they didn't give her the care that she needed.*

Notes from File on Four's *Elderly Care: Neglected Questions*

On **4 June 2013**, Radio 4's **File on Four** broadcast *Elderly Care: Neglected Questions*. This discussed the challenges in prosecuting cases of neglect and focused primarily on the frustrations associated with the collapse of Operation Jasmine. **Fran Abrams** interviewed **Esme Williams** whose aunt, **Gladys Elvira Thomas** was known to Operation Jasmine as a resident of **Bryngwyn Mountleigh Home** who was ultimately admitted to the Royal Gwent Hospital. Her niece noted that **Gladys Thomas** had *all this bruising on her…she looked as if she was dying.* She had a cracked collar bone and a broken rib and ligature marks on her wrists – and yet the home's documentation contained nothing about the origins of her injuries. **Jeff Farrar**, the **Deputy Chief Constable** of **Gwent Police** confirmed that they *soon had a major investigation* and that they were seeing deaths *in circumstances which appeared on the face of it were not natural causes…63 deaths which were a cause for concern.* **Jeff Farrar** explained that wilful acts are easier to prove that omissions, irrespective of the *terrible, terrible injuries* and circumstances in which people died.

Marina Walters, the daughter of **Evelyn Jones** was also interviewed. **Evelyn Jones** was a resident at **Brithdir** home. Family disquiet concerning **Evelyn Jones**' distress resulted in nurses

asking, *I don't understand. Why are you crying Evelyn?* A belated admission to hospital triggered contact with the police because *she didn't have a back. The spine was showing through and infection was deep into the bowel.* After the collapse of the case, **Marina Walters** wondered whether or not she didn't *fight hard enough…when someone can't explain it and there was obviously neglect, you know that's not right…there wasn't justice.*

During **2004**, **CSIW inspectors** reported a lack of investment in Holly House, that the premises were not always clean and that the home did not always have adequate equipment. During **2005**, they also found that **The Beeches** *appeared to be in chaos. Only three care staff appeared to be on duty.*

During **2006**, the **CSIW** had *increasing concerns about the care provided…*and the *negative impact on the health and wellbeing of residents.* Staff did not intervene when residents were distressed. Moving and handling practice was poor and staff had *little regard for the risks posed to service users.*

Nick Smith, the **Blaenau Gwent MP** recalled the complaints of constituents: ***Dr Das*** *would refuse to meet families to discuss the care of loved ones…he would…demand a home cut back on incontinence pads or the personal pocket money of residents. He'd engage in brinkmanship when it came to paying bills.*

Fran Abrams noted that it took *two formal tribunal hearings before* ***Holly House*** *was eventually closed…because of a technicality about gas safety…families continued put relatives into* ***Puretruce homes*** *largely oblivious to the ongoing investigations into the company.*

Stanley Bradford was **Gaynor Evans**' father. When admitted to **Brithdir** *he was bedbound after a major stroke.* **Gaynor Evans** recalled how *his spark went and there was a sadness looking about dad.* On two occasions she had to request food for him at meal times because the staff had forgotten him. He lost a great deal of weight and when **Gaynor Evans** saw her father in hospital she reflected that *it was like someone out of a prisoner of war camp.*

Gwent Police made the case to the **CPS** that they had *met the threshold test to put cases before the court for wilful neglect and gross negligence manslaughter.* However, the **CPS** did not support this. The **Chief Constable** went to see the **Director of Public Prosecutions** to persuade him to proceed but to no avail. Although some staff had breached their duty of care towards residents who had died, *there was insufficient evidence to prove that these breaches were either a substantial cause of, or a significant contributory factor to the deaths.*

Tim Spencer Lane of the **Law Commission** confirmed that *wilful neglect has a very high threshold to prove.*

Gwent Police turned to the **Health and Safety Executive**. As a result, **Dr Das** and his former Operations Director **Paul Black** were charged with breaches of the Health and Safety at Work Act 1974. **Dr Das** was also charged with theft and false accounting. However, the case collapsed because, following an assault, **Dr Das** was deemed *unlikely ever to be fit to stand trial.*

Linda Carter's father had resided in two of the homes involved in **Operation Jasmine**. When the trial collapsed she said that she felt she *had let my father down because I didn't see justice done for what had happened, not just to him but to other vulnerable people…we felt as if we'd all been let down.*

Paul Burstow MP noted that *we need to have a new standard of corporate accountability in the care sector…a new criminal offence of corporate neglect* aligned to *corporate manslaughter, which removed for the first time the need to evidence that there was somebody who…knew that the abuse was taking place but it would really be sufficient to evidence that, through acts of omission, poor management or whatever else it might be, that they actually contributed to the abuse.*

Linda Carter had the last word: *I'd like to think that there'd be some kind of public inquiry. I know it's going to be really soul searching for me and I'm going to feel angry again but I feel that justice has to be done.*

Appendix 2

Inspection reports from the six homes

The Tables set out below convey some of the challenges facing the Care and Social Services Inspectorate (CSSIW), set up in 2007 (previously the Care Standards Inspectorate for Wales, set up in 2002), as the single registration and inspection body for care homes in Wales. Previous to 2002, the registration and inspection of independent residential care homes was the responsibility of local authorities, with the registration and inspection of nursing homes being the responsibility of health authorities.

According to the *Guidelines on the Inspection Process* which preface the CSIW reports referenced in this Review, the *purpose* of an inspection is to *comment on the quality of care provided in the registered facility and the quality of life experienced by service users.* In addition, CSIW inspections were to pay attention to *whether there is evidence of the home applying the six core values of privacy, dignity, independence, choice, rights* and *fulfilment.*

Each of the 12 Tables in this Appendix identifies the domains[472] which the CSIW and subsequently the CSSIW reviewed when they made either an announced or an unannounced inspection. They provide examples of recommendations which metamorphosed into *requirements* and *good practice recommendations.* Because of their number, the recommendations and requirements are not reproduced in their entirety. This is not to suggest that the numerical summaries in the Tables adequately reflect the performance of individual homes in terms of their overall compliance with regulations and standards. Some recommendations and requirements have many elements,[473] they are problem-focused or risk-specific and some are repeated across domains. On the whole, the earlier reports are long and they read as an anthology of problems/risks, some of which are more acute than others, e.g. medicine management. The more pressing the problem/risk, the greater the likelihood that the home is required to address it *immediately.* More commonly, the homes are expected to remedy their identified failings within a specified number of weeks. Most reports make reference to *outstanding requirements* i.e. those which the home did not address within the timeframe previously proposed by the regulator.

For each home there are two Tables. The first outlines the initial CSIW report and the second, the final inspection i.e. that undertaken prior to the home being de-registered or no longer a focus of Operation Jasmine. The reports convey the tension between:

(i) determining priorities in the light of a home's quality of care at the time of the assessment and a home's history, that is, have the risks abated sufficiently for inspectors to turn their attention to new risks and priorities?

[472] The Care Homes (Wales) Regulations 2002

[473] For example, *The Registered Manager must ensure that the service users' psychological health is monitored, this is recorded, and any changes required in relation to this outcome…facilitated* p19, 2003 inspection of The Beeches

(ii) providing assistance to providers i.e. *It is intended that inspection should be a constructive and enabling process which gives providers opportunities to discuss concerns and ideas, which offers them assistance and advice and which helps to maintain and improve the quality of life for service users* (Introduction to CSIW inspection reports).

The reports can be seen as long answers to the question: is the Inspectorate satisfied that the continued registration of this home is justified? The reports specify the standards under consideration and provide the reasons for the resulting requirements, typically citing specific standards and regulations. They also make *good practice recommendations*.

This Appendix makes some summary points about each report concerning the six homes.

BRITHDIR

Brithdir: Inspection report of 21 October 2002

At the time of this inspection Mrs D V Patel was the *Person in Control* and Peter Smith was the Manager. Brithdir was a 40 bed, purpose-built nursing home in New Tredegar, Caerphilly. It was registered during February 1991. It had three floors with *limited grounds which…do not provide an external environment which is conducive to be used by the service user* (p8, July 2004). At the time of this announced inspection. The residents were categorised as having *dementia/ mental infirmity (nursing)* and *dementia/ mental infirmity.*

The 76 page report lists the 35 *outstanding requirements* from the preceding inspection e.g. *fire risk assessment undertaken on 14/12/00 must be addressed; patients must have access to the nurse call system;* and *each patient should have an individual activity programme.* The report's final 19 pages are the *Summary Inspection Report.*

Inspection domains	No. of pages*	No. of recs.**	Examples of recommendations
Choice of home	**5**	**14**	*-…must ensure that assessments are undertaken and care plans produced to meet the care needs of each service user's social interests, hobbies, religious and cultural needs; carer and family involvement and other social/ relationships are assessed, encouraged and documented* *-Accurate documentation of* [staff] *training must be maintained. Additional permanent registered nurses must be recruited* *-the service user or their named representative and the registered person should sign the contract*
Planning for Individual needs and preferences	**3**	**8**	*-…must ensure that care plans are appropriate to meet the needs of the service user. Specific and holistic in content* *-A comprehensive process of assessing all risks must be urgently implemented which must include risk of falls*

			-…must ensure that all service user files are stored in an appropriately secure filing cabinet and not in open file in the office
Quality of life	**4**	**16**	*-…must ensure that advocate services are provided when necessary and specifically for one individual identified by the inspector* *-Records need to be kept to reflect that community contact is in fact happening and made available for inspection…Additional community contact is required* *-The home's position on where they stand pertaining to the sharing of information and other agencies needs to be agreed and included in their confidentiality policy*
Quality of care and treatment	**8**	**30**	*-The home must provide a telephone for the use, in private of the service users and* [facilitate] *their understanding and use of this* *-…must ensure that the service users' psychological health, nutritional requirements, oral requirements and risk of developing pressure sores are regularly assessed, re-evaluated and monitored, this is then recorded and any changes required in relation to this outcome is facilitated* *-the home urgently needs a safe and appropriate outdoor area for recreational use and physical exercise*
Staffing	**4**	**16**	*-It is recommended that an additional care staff be employed…must urgently formulate a strategy to recruit additional staff* *-The company needs to show commitment to the training of their staff team and invest in their development* *-The induction programme needs to be a more in-depth service user focused procedure, the completion of which needs to be undertaken within 12 weeks of commencing employment, accurately documented and signed by the manager* *-All staff must receive an annual appraisal*
Conduct and Management of the home	**5**	**6**	*-…must formalise a development/improvement plan to meet the needs of the service user group with specific outcomes/ gains* *-Internal and external auditing systems must be put in place using tried and tested auditing tools and processes. The opinions of the service users and their families and other*

			appropriately involved individuals/ organisations must form part of this audit *-…must ensure that the service user's money is not in any way pooled*
Concerns, Complaints and protection	**2**	**6**	*-…all staff must familiarise themselves with the new complaints policy* *- all complaints must be investigated in an appropriate manner, documentation and evidence compiled and stored in a secure manner* *-an audit system needs to be put in place to ensure that the complaints procedure has been adhered to*
The physical environment	**6**	**57**	*-A routine maintenance and improvement schedule is needed and implemented to ensure the standard of accommodation is improved to provide a safe, acceptable environment* *-Tables are badly marked and require replacing* *-At least four additional assisted baths or showers must be strategically situated throughout the home to meet the minimum standard*

*****These are full pages and parts of pages

**Counting requirements/recommendations is an inexact process since there is repetition across domains and some recommendations set out a task and propose that the task should be reviewed

Brithdir: Inspection report of 5 July 2004

According to this 63 page report, the *Registered Provider* of Brithdir was Dr Das. There was no Registered Manager but Mrs Daphne Richards was the acting manager. The report noted that neither the home's Statement of Purpose nor the Service User Guide was available. Risk assessments for residents remained outstanding – requiring *urgent attention* - and *necessary equipment* was not available. The care of residents was *compromised* by a *reluctance to engage agency staff and a poor recruitment programme.*

The inspectors noted that *staff training* on *the promotion of tissue viability and prevention and treatment of pressure damage must be, as previously directed, prioritised;* that *recording systems…were difficult to identify, incomplete and not up to date; the company that owns Brithdir…has not as yet enlisted to enable them to apply for CRB checks for new employees. This must be urgently addressed.* Further, there were no advocates, *especially for those service users who do not have a social worker or relative…the meal observed was not acceptable…*and there was *no evidence…that the system in place to record and investigate complaints had been followed.*

It was noted that since the last inspection *there have been several Protection of Vulnerable Adults concerns, one still ongoing.* There are 16 pages of *Regulatory Requirements.*

Brithdir: Inspection report of 1 December 2005

The Registered Provider was L-Giri Ltd and Peter Smith was the acting manager. This 48 page report contains 14 pages of *requirements* which *were outstanding from the previous inspection report.* Brithdir was registered for people with *dementia/mental infirmity.* The majority of the unannounced inspection visits took place during 2004. The report notes that the *Care Standards Inspectorate for Wales and the lead inspector, wishes to apologise for the unacceptable delay in producing this announced inspection report, which was due to unexpected and unusual circumstances.*

Since the requirements are similar to those for earlier visits, the inspection noted: *The home required additional equipment to meet service users' needs e.g. air flow mattresses/ cushions. During an unannounced monitoring visit the inspector advised the home to undertake an audit of the equipment required and provide the inspectorate with a copy. This has not been provided.*

There was no evidence that care planning and risk management were reflected in the work of staff e.g. *one service user who had fallen six times in the previous six months did not have a care plan* and a resident *who had been admitted six weeks previously still did not have care plans to manage areas of need such as pressure relief, challenging behaviours and falls.* Furthermore, there were *inadequate diabetes management care plans.*

The report noted people's inactivity: *The home does not appear to provide activities for their service users and no individualised activity programmes had been formulated. This has been an ongoing requirement that needs to be urgently addressed.* With reference to pressure area prevention and care, there was a single sheet of paper. The inspector noted that a policy was *urgently needed to underpin and direct the service provided. A supply of equipment such as airflow mattresses and leg cushions was available at this inspection. However, this has not always been the situation…and the CSIW has on several occasions issued Written Notices of Action Required directing the home to provide urgently needed pressure relieving equipment…There had been during the inspection year serious concerns at the poor nutritional diet provided for service users and unsatisfactory kitchen facilities…The inspector has observed that the home does not at all times provide an adequate diet of quality protein, meat, fish, eggs and fresh fruit and vegetables.*

The inspection made clear that L-Giri Ltd's *continued breach of Regulation 24 (2) (c)* concerning equipment *must be urgently resolved* and that since anomalies concerning medication management and storage persisted…*the home must urgently rectify this situation.* Furthermore, the home's staffing numbers *have not always met the minimum requirements* and the home had not had a Registered Manager since January 2004. Financial details – *a requirement of the last two inspection reports…had not been provided...The general fabric of the home has been allowed to deteriorate.*

Brithdir: Inspection report 24 February 2006

L-Giri Ltd was the Registered Provider and Mrs Susan Greening was the Manager whose registration was *to be determined.* Registered as a *care home with nursing,* Brithdir had 40 places and the residents were noted to *have complex and highly dependent needs.* This 57 page report is based on 14 unannounced visits, a pharmacy inspection and an announced visit. The report's summary states that the CSIW *had increasing concerns regarding the care provided in the home…numerous breaches in regulations…still remain unresolved…having a negative impact on the health and well-being of the residents.* The concerns were *mirrored by Caerphilly CBC and Caerphilly LHB which purchased services from the home.* These bodies had written to L'Giri Ltd during November 2004, giving *six months' notice of their intention to cancel the contract* and *they undertook an embargo on the home. From November the LHB provided advice, support and direct care as risk management measures as a result of the perceived deficit in the ability of staff to meet service users' needs and working collaboratively with all other agencies, CSIW has been intensively involved in requiring the provider to meet regulatory requirements for the protection of the service users.* The inspector noted that at lunchtime, *many of the service users appeared drowsy…seven out of an approximate 12 appeared to be sleeping at a time when it would be expected that they would be interested, alert and anticipating the day* [and this] *requires investigation…fresh fruit, vegetables and salad stuff were not abundant…the impact that a poor diet has…is a very concerning situation.*

Inspection domains	No. of pages	No. of reqts.	Examples of requirements and recommendations
Choice of home	**3**	**8**	*-…must ensure that service users have a plan of care for daily living and longer term outcomes* *-training should be provided…in an ongoing constructive manner to ensure that staff individually and collectively have the skills and experience to deliver the services and care which the home offers to provide* *-…must ensure that when service users are admitted this is only on the basis of a full assessment undertaken by people trained to do so*
Planning for Individual needs and preferences	**2**	**5**	*-…should ensure that service users' plans set out in detail the action which needs to be taken by care staff to ensure that all aspects of the health, personal and social care needs…are met* *-…must, post assessment provide adequate and appropriate beds and associated equipment…that are adequately functioning and in good working order*

			-…must ensure that incidents which affect the well-being or safety of the service user are recorded and reported appropriately
Quality of life	**4**	**13**	*-…must facilitate appropriate assessment regarding service users' capacity to manage their finances…* *-…should make sure that opportunities are made available and the routines of daily living are flexible and varied to suit service users' expectations, preferences and capacities* *-must ensure that service users…exercise choice in relation to leisure and social activities and cultural interests; food meals and mealtimes; routines of daily living; personal and social relationships; religious observance. Evidenced documentation is required*
Quality of care and treatment	**8**	**34**	*-…to ensure pressure settings are checked or monitored on all pressure relieving equipment* *-…must ensure that service users have access to other health care professionals, treatment and advice when their health condition changes and when there are situations that the registered nurses feel not able to manage* *-Entries in the controlled drug register must be made at the time the recorded event occurs*
Staffing	**6**	**22**	*-…must ensure that staffing numbers and skill mix of qualified/ unqualified staff are appropriate to the assessed needs of the service users, the size, layout and purpose of the home* *-…must make provision for and facilitate…newly appointed staff (including all staff under 18) are registered within three months of starting work on a training programme leading to the appropriate qualification* *-New staff are confirmed in post only if the information required under regulation 19 is available (including Criminal Bureau certificates, UKCC or Care Council for Wales)*
Conduct and Management of the home	**4**	**16**	*-the CSIW have not been provided with an annual development plan for the home* *-…must ensure that safeguards are in place to protect the financial interests of the service user*

			-The registered provider must urgently address the lack of appropriate, efficient and effective management systems and processes
Concerns, Complaints and protection	**3**	**11**	*-Robust procedures for responding to suspicion or evidence of abuse or neglect (including whistle blowing)* to *ensure the safety and protection of service users should be facilitated as a working document backed up by appropriately trained staff* *-A record must be kept of all complaints made* including *details of* the *investigation and any action taken* *-…must ensure that all allegations of abuse are followed up promptly and the action taken is recorded*
The physical environment	**4**	**16**	*-The home must provide a sluice/disinfector on all three floors where nursing care is delivered* *-All areas of the home must be free from offensive odours and hygienically clean* *-Toilet seats that are damaged must be replaced*

THE BEECHES

The Beeches: Inspection reports of 9, 10 and 11 October 2002

The *person in control* was Dr Das and Mrs Grohmann was the Manager. The Beeches Nursing Home was a former general hospital in Blaenavon, Torfaen. It was registered during March 2002, to provide support to 29 *nursing older persons* and *10 older persons.* It had three floors. It was a listed building which the initial CSIW inspection described as *very large and not designed to meet the needs of the elderly, frail and confused* (p25) - and its inadequate maintenance was a continuing concern. There were 25 *outstanding requirements* from a preceding inspection, 20 of which concerned building and grounds maintenance. The initial report noted that the home's *environment does not facilitate appropriate exercise either inside or outside of the building.*

The CSIW's inspection report is 60 pages long. Although the fact that *two patients* were self-funding, is noted, it is not clear how many residents were at the home at the time of the inspection. The report indicates several areas of concern:

- the home was accommodating people with dementia and yet it was not registered to provide the care required by people with dementia
- requirements concerning Health and Safety which were *not always adhered to,* including medicine management and their storage
- the health, safety and welfare of residents – for which staff training was *urgently required*
- the unacceptability of staff working 12-14 days *without a break*, with some working *both days, onto night shift without time off work*
- *the number of beds which were unoccupied, the high dependency on registered nurse hours purchased and the financial implications of this*

It was noted that there was *good interagency co-operation,* that residents were referred to the geriatrician and GP as required and that there was involvement from people's relatives.

The report noted that staff recruitment should be *more proactive* and that *a system for clinical supervision is required.*

It was noted that the home had a policy on pressure ulcer care and records of these were *accurate.*

The Inspector congratulated the home's cook and all staff on their *appetising and attractive* meals and commended the fact that (i) there were some staff who had been at the home *for 20 years plus and* (ii) the manager was attending to matters requiring *urgent consideration* irrespective of the home's culture which *did not easily facilitate the Registered Manager's position.* However, *complaints did not appear to be followed through to a conclusion and actions undertaken.*

Inspection domains	No. of Pages	No. of Recs	Examples of *Minimum Standard Requirements/* recommendations
Choice of home	4	14	*-The brochure needs to be reviewed and amended to provide an up to date pictorial view of the home* *-Training undertaken must reflect the specific needs of the service user group i.e. the confused elderly person, and be updated on a regular basis* *-The Registered Manager must ensure that all admission documentation is completed within 5 days of admission*
Planning for Individual needs and preferences	2	10	*-The Registered Manager must ensure that the requirements/ recommendation obtained from testing/ examination of the equipment listed…is implemented…should [these] not be adhered to the inspector will…inform the Health and Safety Executive*
Quality of life	4	10	*-Group and individualised activities need to be formulated and implemented on a daily basis* *-Care plans need to reflect the users' personal interests* *-The Registered Manager should, where service users lack capacity, and do not have a representative/ family, facilitate an advocate for them*
Quality of care and treatment	8	46	*-Each individual must be provided with a lockable unit where they can keep private possessions* *-The employment of an activities coordinator or designated individual is required* *-The indoor environment needs urgent review to improve the safe movement around the building*
Staffing	5	10	*-…it is recommended that an additional care staff be employed on night shift and continuous review of this situation is maintained and additional staff allocated to meet the needs of the changing situation* *-…must urgently formulate a strategy to recruit additional staff* *-A formalised and agreed supervision system needs to be put in place for all staff*
Conduct and Management of the home	4	9	*-the Registered Manager needs to undertake a management course*

			-The Registered Manager must ensure that the service users' money is not in any way pooled *-an appropriate form of record keeping needs to be implemented for service users' possessions handed over for safe keeping*
Concerns, Complaints and protection	3	7	*-The Registered Manager must ensure that all complaints are processed within 28 days* *-Training in dealing with aggression needs to be part of the overall training plan*
The physical environment	11	87	*-Guttering and downpipes need repair and/ or replacing to prevent further water damage to the building* *-General repair and improvement of the conservatory is required before it can be used again* *-The staff toilets need urgent attention to bring them up to acceptable standards*

The Beeches: Inspection Report of June 2003 (from an announced visit during May 2003)

The *registered provider* was Dr Das and the Manager was Mrs Grohmann. The report is 51 pages long and lists *requirements* and *good practice recommendations*. It reiterates some of the concerns set out during the previous inspection e.g. the home needs to amend the brochure, to provide contracts to residents and/or their representatives, to address pre-admission assessments and the *unacceptable number of registered agency nurses,* that the home was accommodating people who *may be more appropriately placed.* Inattention to medicine management and storage was noted.

In terms of *planning for individual needs*, the risk of falls was not being considered and risk assessments were not being reviewed. However, people's routines were flexible, there was evidence of *community involvement* and an *advocate service* had been introduced. In terms of staffing, although an additional care worker had been made available to work at night, the screening of new employees was a concern. It was noted that the *responsible individual does not monitor the home or the services delivered as required by the regulations…essential equipment appeared not to be working correctly, needed repair or replacing…this work/ replacement programme had not been undertaken in spite of repeated requests from the registered manager to the Responsible Individual.* There were over 100 requirements listed with just over a half relating to the physical environment of The Beeches.

The Beeches: Inspection Report of November 2005

Dr Das and Dr N Das were the *Registered Provider* (s) but the home had not had a Registered Manager since December 2004 (Mr D Hill and Mrs R Pritchard were the *acting* managers during the inspection and report writing periods respectively). The home had 39 places, 29

nursing older persons and 10 *older persons.* At the time of the inspection there were 28 residents.

The introduction to this 92 page report noted that concerns about upgrading and repairing the building were unresolved. The CSIW acknowledged that between visits a home could improve or deteriorate and that The Beeches had deteriorated. Readers were advised that not all standards were considered *in depth* at each visit and further that, *this report is departing from the standard reporting practice and focuses only on the requirements noted…during the past inspection year.* Also, readers were advised to *read this report in conjunction with the previous annual inspection reports.* An *environmental inspection report* had identified *over 200 requirements.* During the unannounced visits (June 2004 - September 2005), *inspectors encountered serious breaches of health and safety in the home* i.e. some residents' rooms were deemed unsafe.

The report stated that the care provided at The Beeches had *greatly declined.* During August 2005, the CSIW proposed to cancel the home's registration. During September 2005, Torfaen CBC and Torfaen LHB jointly undertook a series of interventions, providing staff and repairing some equipment. The home had neither a business nor development plan and yet it continued to make *inappropriate admissions* and its documentation was *inadequate.* There were no activity programmes and the home had insufficient equipment to address the known support needs of residents, including essential pressure-relieving equipment. Medicines management and storage were unresolved concerns.

Each of the eight domains described the *inspector's findings* and listed the *actions required.* The final 33 pages of the report set out the actions required in their entirety.

Inspection domains	No. of pages	No. of reqts.	Examples of requirements
Choice of home	**4**	**9**	*-All new service users are admitted only on the basis of a full assessment undertaken by people trained to do so* *-…must ensure that service users have a plan of care for daily living and longer term outcomes* *- must urgently produce a service users' guide*
Planning for Individual needs and preferences	**4**	**7**	*-…must ensure that service users' plans are reviewed at least once a month and updated to reflect changing needs and current objectives for health and personal care and actioned* *-…must ensure that service users have access to their records and information about them held by the home*
Quality of life	**3**	**12**	*-…must ensure that the home is conducted so as to maximise service users' capacity to exercise personal autonomy and choice* *-…should make sure that opportunities are made available and the routines of daily living are flexible and varied* *-…need to demonstrate commitment to lifelong learning and development for each service user*

Quality of care and treatment	**9**	**36**	*-Training and developing an appropriate culture is required…* *-The acting manager must ensure that staff are instructed during induction on how to treat service users with respect at all times* *-…need to ensure that the incidences of pressure damage, their treatment and outcome are appropriately and comprehensively recorded in the service user's individual plan of care and reviewed on a continuous basis*
Staffing	**5**	**20**	*-…must ensure that staffing numbers and skill mix of qualified/ unqualified staff are appropriate to the assessed needs of the service users, the size, layout and purpose of the home. At all times this must be compliant with the home's staffing notice* *-the home's staff training and development programme ensures that staff fulfil the aims of the home and meet the changing needs of service users* *-All staff should receive a minimum of five paid days training per year including in-house training*
Conduct and Management of the home	**2**	**3**	*-…ensure that effective quality assurance and quality monitoring systems, based on seeking the views of service users, are in place to measure the home's success in meeting its aims, objectives and statements of purpose* *-the vast majority of the homes policies, procedures and practices have not been regularly reviewed in the light of changing legislation…This needs to be facilitated*
Concerns, Complaints and protection	**2**	**3**	*-…must ensure there is a simple, robust and accessible complaints procedure which includes the stages and timescales for the process and that complaints are dealt with promptly and effectively* *-A record must be kept of all complaints made and includes details of investigation and any action taken* *-…ensures that written information is provided to all service usersto enable them to raise a complaint with the CSIW at any time*
The physical environment	**23**	**288**	*-there was no sluicing disinfector in the* [sluice] *room which should be provided on each floor where nursing care is provided* *-Service user nurse alarm cord to be made accessible from the bed* *-Heating pipes need protecting*

MOUNTLEIGH

Mountleigh Nursing Home: Inspection of July 2002

The *Person in Control* was Mrs Mary Davies and the Manager was Mrs E Evans. Mountleigh Nursing Home was registered in May 1994. The home had 39 places: *3 residential dementia/ mental infirmity nursing* and *3 dementia/mental infirmity.* There were 29 *requirements outstanding from* the *last report* of November 2001. These included: *all agency staff must have a full induction; all patients must have a care plan from the day of admission; procedures must be put in place to measure and monitor wounds;* and *requirement for all staff to undertake moving and handling techniques.*

The final seven pages of the 62 page report lists the recommendations arising from each of the eight inspection domains.

Inspection domains	No. of pages	No. of recs.	Examples of minimum standard requirements
Choice of home	**3**	**7**	*-The home must provide a comprehensive service user guide in a format which is easily understood and ensure that all key players receive a copy* *-…must ensure that all service users have pre admission assessments and that this document is kept with their care notes* *-…needs to assert the number of registered nursing hours needed by the service users by the use of a recognised assessment tool*
Planning for Individual needs and preferences	**2**	**1**	*-A policy on service users' access to records must be formulated*
Quality of life	**3**	**6**	*-…should obtain information relating to the Data Protection Act 1998 and ensure that the staff team are made aware of the fundamental elements of it* *-Involvement in the home from community groups needs to be facilitated* *-…must ensure that all policies and* related *information is made easily available to the staff team, the service users and all key players*
Quality of care and treatment	**5**	**4**	*-Fixed screening needs to be constructed in bedrooms which have double occupancy* *-First aiders to be trained and in place on all shifts* *-…must ensure that risk assessments on all safe working practices are undertaken*
Staffing	**3**	**4**	*-…must ensure that a formalised training programme is put in place and a training matrix documented. A policy is required in relation to training with a strategy to enable the home to meet the requirements* *-All staff must have at least 5 days training per year*

			-…must ensure that all aspects of the supervision of the staff team, including herself and the care manager, are *implemented and documented*
Conduct and Management of the home	**3**	**6**	*-The manager needs to undertake a management course* *-The manager must have an appropriate job description* *-…must ensure as a matter of urgency that service users' money is not pooled*
Concerns, Complaints and protection	**2**	**2**	*-Standard fully met however, information relating to complaints should be included in the service users' guide* *-Training in dealing with aggression needs to be part of the overall training plan* *-The home needs to formalise a policy relating to staff involvement in the making of service users' wills*
The physical environment	**5**	**24**	*-The room containing the medi-bath requires repair of its floor covering* *-The grounds need regular maintenance and the improvement of safe access to this facility needs to be addressed* *-Grab rails…are now required in all parts of the home* *-When double rooms become vacant the service user must be given a choice to share or not* *-The home must provide 'nursing' type beds*

Mountleigh Care Home: Inspection of September 2003

By 2003, Mountleigh Care Home's Registered Provider was Apta Healthcare (UK) Ltd and the Registered Manager was Mrs Enda Evans. The home had 39 nursing places and three residential places. It was noted that residents are *frail* and *have a high level of physical dependency.*

This 32 page report acknowledged the changes in the home and confirmed that information about Mountleigh was up to date. Double rooms had been fitted with screens; it was noted that *mail is opened for those users who do not have the capacity to do so for themselves;* and *training and updating in pressure area prevention is ongoing.* The skill-mix of staff was described as *excellent.* The home employed two NVQ assessors. The home had an *ongoing improvement and maintenance plan.*

Mountleigh Care Home: Inspection of December 2004

The Registered Provider was Apta Healthcare (UK) Ltd and the Registered Manager was Mrs Dawn Harris whose *registration is to be determined.* Mrs Enda Evans, the Registered Manager during September 2003, was described as the *Care Manager.* The report noted that the residents were *very dependent, none having the capacity to manage their own finances, the staff team however supports them to undertake activities and practice choice…There is a social activities log and group activities programme.*

The 31 page report noted that *some staff* had not received five days training in the preceding 12 months and since that was *the same position that was reported in the last inspection report…the situation must receive urgent attention.* Most of the requirements listed in the report concerned *the physical environment.*

Mountleigh Nursing Home: Inspection of July 2005

The Registered Provider was *Apta Healthcare* and the Registered Manager was Mrs Enda Evans.

Concern was expressed that *a change in procedure/system* had resulted in less comprehensible assessment documentation. It was proposed that the service should revert to the *previous system.* Similarly, the inspection noted that residents' diets required attention. Other *action required* included: *medication is properly stored and returned to the pharmacist when it is no longer required…a record is maintained of current medication for each service user; the Manager must ensure she receives formalised supervision from an appropriate line manager;…must ensure that at all times there are appropriate numbers of staff on duty* (as cited in the previous inspection); *…ensures that all staff in the home are regularly and effectively supervised.* Most of the requirements listed in the report concerned *the physical environment.*

There was only one good practice recommendation in this 43 page document: *Information relating to service users' satisfaction should be included in the service user guide and updated at least yearly.* The final three pages list the home's *action plan* (and state that Mrs Enda Evans had resigned) and the penultimate section, consisting of 19 pages, listed a *summary of requirements,* including those *made since the last inspection report which have been met.*

Millview House and Millview Lodge: Inspection of February 2007

The Registered Provider was Apta Healthcare (UK) Ltd. Although no Registered Manager was named on the initial page, when the inspection began there was an acting manager, who had left, after which a manager was seconded from another home. *Action required: the Company to appoint a manager to make application for registration as a matter of urgency.*

The 20 page report states that the Self-Assessment Documentation *was returned to the CSIW late… inaccurately completed by the Acting Manager and was not signed by the Responsible Person from the company.* It also noted that Apta was providing documents to CSIW which were generic rather than home specific. A scrutiny of the files of three residents highlighted shortcomings in terms of assessments and care plan evaluations e.g. a resident described as being unable to communicate was in fact able to converse with staff.

The home had an activities coordinator. Information was recorded describing each person's engagement and choice. Residents had Memo Books for messages to be recorded by staff and relatives which were considered helpful.

The *controlled drug stock levels appeared to tally with the appropriate documentation; the soiled laundry to be kept to a minimum to minimise the risk of odour and cross infection;* 50

per cent of the staff did not hold NVQ Level 2 or above; and there were *communication and language difficulties with some staff members which sometimes created problems with information sharing between staff, families and professionals.*

Millview House and Lodge: Inspection of October 2008

The Registered Provider was Apta Healthcare (UK) Ltd/Trevor Brown and the Registered Manager was Elizabeth Lane.

The 20 page report stated that Millview House was registered to accommodate people *who suffered from dementia, mental infirmity and required both nursing and personal care.* Millview Lodge was a model of *'small group' living.* Only three *requirements* resulted from this inspection, i.e.

- *all care documentation must be completed…to reflect the care received on a day to day basis and countersigned by the Registered Nurses*
- *the home to evidence that the views of staff are recorded*
- *the house should be organised into two separate units.*

Millview House and Millview Lodge: Inspection of July 2009

The Registered Provider was Apta Healthcare (UK) Ltd/Geraint Morgan and the Registered Manager was Elizabeth Jane Lane. These two homes had 61 places for people requiring *care home nursing – elderly mentally infirm.* Millview House had places for 41 people and Millview Lodge had places for 20 people. They were managed separately.

The 16 page report noted that *nursing documentation* had greatly improved and no requirements were made.

Inspection domains	No. of pages	No. of reqts.	Examples of requirements and good practice recommendations
Choice of home	**2**	-	
Planning for Individual needs and preferences	**1**	-	
Quality of life	**2**	-	
Quality of care and treatment	**2**	-	
Staffing	**1**	-	
Conduct and Management of the home	**1**	-	
Concerns, Complaints and protection	**1**	-	
The physical environment	**1**	-	

GROSVENOR HOUSE

Grosvenor House: Inspection report of 23 July 2002

The person in control was Dr S K Narang and the Registered Manager was Mrs Sue Goode. The home, established in 1993, had 38 *nursing beds* and four *palliative care* beds.

This is a 32 page, announced inspection report and has a summary of five six pages *for public access but with access to the full report on request.* The report notes that the Hospice of the Valleys team *provide support, advice and undertake awareness sessions in palliative care for staff employed in the home.*

Inspection domains	No. of pages	No. of recs.	Examples of recommendations
Choice of home	**3**	**2**	**Standard met – however the home's complaints procedure needs to be updated with the name and address of the CSIW* *-service users' contract needs amending to reflect the relevant registration details* *-the contract needs to contain: rooms to be occupied; rights and obligations of the service user and who is liable if there is a breach of contract; terms and conditions of occupancy*
Planning for Individual needs and preferences	**1**	**-**	**Standard met – However a system of measuring and describing wounds needs to be put in place with the subsequent action to be taken recorded in the individual's care plan*
Quality of life	**3**	**1**	*-The home needs to ensure that a written agreement is drawn up on confidentiality with all other health/ social care agencies which includes the principles governing the sharing of information*
Quality of care and treatment	**4**	**3**	*-Failure to make arrangements for safe system for moving of residents* *-Information needs to be forwarded to CSIW of when staff attended the most recent fire lecture* *-Information needs to be obtained in relation to H&S "the provision and use of work equipment regulations 1992" and "Electricity at Work regulations 1989"*
Staffing	**3**	**5**	**Standard met – However the home will need to achieve the requirement of 50% of the workforce at NVQ Level 2 by 2005* *-Two written references must be obtained in every case before making an appointment. A reference must be*

			obtained from the applicant's present or most recent employer *-…needs to ensure that all staff are regularly and effectively supervised*
Conduct and Management of the home	**3**	**1**	*-Accounting systems and business plan were not available for inspection*
Concerns, Complaints and protection	**2**	**-**	**Standard met – however the Registered Manager was advised to obtain a copy of Blaenau Gwent CBC local policy*
The physical environment	**4**	**-**	**Standard met – however:* *-advice needs to be sought regarding window restrictors* *-[two toilets required]* attention and the inspector *observed a number of nurse calls were tied up out of reach* *-good practice maintains that nurse call pulls must be maintained at 12 inches off the floor in order for service users to be able to use at all times* *-as the home caters for service users requiring nursing and palliative care (including the need for infection control measures) it is advisable for liquid soap and hand towels to be made available in each service user's room for staff to wash their hands before leaving the room*

*Good practice recommendations, i.e. although the standards have *been met*, these are not requirements

Grosvenor House: Inspection report of 14 December 2005

The Registered Provider of Grosvenor House was Lightend Ltd and the Registered Manager was Mrs Susan Reynolds. The 29 page report is based on an announced visit during March 2005. The final five pages are a summary of the requirements. There were 32 residents at the time of the inspection.

The requirements set out in the report concerned the home's statement of purpose, its user guide and its statement of terms and conditions. With reference to *planning for individual needs,* there were three actions required which *do not* address the inspector's observations i.e. *risk assessments…not consistently linked into plans of care;* and *wound documentation did not evidence classification, grade or description of wound.*

The actions required in the domain *quality of life* refer to the inactivity of the residents and the insecure storage of the accidents book. With regard to staffing, the home did not have 50% of staff with NVQ Level 2 or above (see: *Staffing* in preceding Table); *inappropriate recruitment procedures had been followed;* and supervision remained to be *formalised.* The

home's complaints documentation required amending and the staff team had not received any training on the Protection of Vulnerable Adults. Grosvenor House had no policy concerning the management of aggression or the use of physical restraint as a last resort. Also, it was noted that the home required sluicing facilities on each of its three floors.

Finally, it should be noted that the *good practice recommendations* concerning medication include:

MAR sheets should be regularly reviewed; MAR sheets should be properly completed for administration and non-administration of medication; procedures for all aspects of medication handling should be up-dated and all designated processes should be adhered to; there should be effective date-checking and stock-control practices in place in conjunction with repeat prescription re-ordering; a list of signatures of nurses administering medication could be attached to the MAR sheets file for simple identification; and *pharmaceutical hazard warnings be kept filed together.*

Grosvenor House: Inspection report of 16 April 2007

The Registered Provider was Lightend Ltd and the Registered Manager was Mrs Sue Reynolds. The 30 page report begins with the statement that *this is the first inspection that the home has had since the reform of regulations and the registered persons are thanked for their cooperation in contributing to the new process.* There were no new requirements concerning the *choice of home* but the report noted *grave concerns* regarding the *standard of record keeping and care planning.* Concern was also expressed about residents who had lost weight i.e. the home *did not appear to be proactive in seeking further professional and specialist advice for individuals who had experienced significant weight loss.* In addition, although the Registered Manager stated that five residents' wounds were not pressure wounds, this was incorrect. A sling was required to be *decommissioned immediately* and *standaid foot rests were heavily soiled;* fire alarms were not being checked on a weekly basis and faulty smoke detectors had not been replaced. Also, staff were *sometimes working 12 hour shifts in a row.* There was neither regular clinical supervision nor general supervision of staff, including the manager.

Finally, poor infection control practices were in evidence, insufficient toilets, showers and baths. An oven which had been found to be *at risk* was still in use. The inspectors required that this was *immediately* put out of use.

Grosvenor House: Inspection report of 8 September 2008

This 21 page inspection report indicates that there was a new Registered Manager, David Liles and that Grosvenor House had made a considerable investment in improving its service in terms of maintenance and refurbishment. There was a *systematic cleaning routine* with positive implications for staff morale. There was also an annual development plan with actions and review *reflecting the aims and outcomes for service users. Seventy per cent* of the staff team had achieved NVQ Level 2 and above. Against a backdrop of such developments, *it*

was disappointing to note that recent evaluations of skin damage were not consistent with the policy in that there was no measurement or description of wounds at the dressing changes.

Grosvenor House: Inspection report of 10 August 2009

The Registered Provider was Lightend Ltd but the 19 page report stated that the Registered Manager was yet *to be determined.* The home was registered to provide *accommodation for up to 42 older people in need of nursing care, up to 12 of whom may have personal care needs.*

It noted also that *under the reform of regulation a proportionate approach to the inspection was undertaken and as such, the primary focus was on establishing compliance in those areas of greater concern based on an analysis of risk.*

The report stated that the *majority of the beds in service users bedrooms were noted to be of a divan type and not suitable for service users with nursing needs.* Irrespective of the *high volume of documentation* there was a lack of information and clarity from all staff concerning the pressure area status of a resident and there *appeared to be a lack of understanding regarding the grading of pressure sores.* Concern was also expressed about the number of staff on duty.

The home had 36 single rooms and three double rooms. The home was advised that an assisted shower was required.

Inspection domains	No. of pages	No. of recs.	Examples of requirements and recommendations
Choice of home	**2**	**-**	
Planning for Individual needs and preferences	**2**	**2**	*-…ensures that reviews of all service users plans are undertaken…to ensure that all aspects of the health, personal and social care needs of the service user are met* *-…ensure that the service user plan is drawn up with the participation of the service user and relatives/ advocates and agreed and signed* *- For the registered nurses to follow NMC guidelines regarding documentation* [good practice recommendation]
Quality of life	**2**	**2**	*-…to ensure service users are provided with activities specific to their needs and interests* *-…ensures that staff are ready to offer assistance in eating where necessary and provide suitable equipment for the storage of food*
Quality of care and treatment	**2**	**2**	*-…an action plan evidencing when appropriate equipment for individual needs will be provided i.e. hospital beds and bedrails*

			-…ensures that staff are trained and competent …specific reference to wounds/ pressure area management
Staffing	**2**	**1**	*-…ensure that staff are suitably competent, skilled and experienced to meet the needs of service users by evidence of mandatory training and development training for all staff*
Conduct and Management of the home	**1**	**1**	*-…ensures that the care home is conducted so as to promote and make proper provision for the health and welfare of service users*
Concerns, Complaints and protection	**1**	**-**	
The physical environment	**1**	**1**	*-…ensures that there are adequate shower and bath facilities, specifically a shower on the ground floor*

BELMONT

Belmont: Inspection Report of 8 October 2002

The *Person*(s) *in Control* were Mr D E and Mrs A C Bentley with the latter also being the Manager. This home was located in a large, detached house in Abertridwr and was registered for 17 older people with *dementia/mental infirmity* and *physical disability*. It had been registered since 1983. The home was *on a steep hill with pleasant views and where some of the outside areas are not fully accessible…service users are able to access the garden.* Belmont provided *a comfortable and homely environment* with *attractive gardens…well maintained and pleasant views from most rooms* (p4, report of September 2005). There were seven single occupancy rooms and five shared rooms.

The 41 page inspection report was based on an announced inspection. The final 10 pages are in *summary format for public access but with access to the full report on request.* The *Minimum Standard Requirements* and *Good Practice Recommendations* are set out in the body of the report and also in a summary Table consisting of five pages. It is not stated how many residents there were at the time of the inspection.

Inspection domains	No. of pages	No. of recs.	Examples of recommendations
Choice of home	**3**	**2**	*-Please provide a Statement of purpose and Service Users' Guide…Please ensure that the final version refers to the CSIW, not the National Care Standards Commission* *-Please provide service users with contact addresses of the CSIW and local social services and health care authorities*
Planning for Individual needs and preferences	**2**	**5**	*-Care plans need to set out in detail the action which needs to be taken by care staff to ensure that service users' needs are met. Particular attention should be given to the prevention of falls* *-Please keep copies of birth certificates and passports (if any) of staff* *-Please provide service users with the opportunity to maintain their personal records should they wish to do so*
Quality of life	**3**	**3**	*-Please develop a policy…about maintaining relatives' and friends' involvement when their service user enters Belmont* *-Please designate a private space within the home, separate from service users' own rooms, to enable them to meet with visitors* *-Please provide the inspector with a copy of the homes policies and procedures on confidentiality*
Quality of care and treatment	**5**	**12**	*-Please provide a portable telephone to enable service users to make and receive calls in private*

			-Please commence nutritional screening of service users on admission and re-assess periodically thereafter *-Please ensure that an accurate record is kept of all medication*
Staffing	**2**	**7**	*-please ensure there are a minimum of 59.5 domestic hours provided* *-Occupancy levels in relation to mentally inform and residential service users need to be kept under continuous review to ensure that staffing levels are sufficient to meet the assessed needs of both groups of residents* *-Please use an induction programme that takes into account guidance on induction that is published by the Care Council for Wales*
Conduct and Management of the home	**3**	**2**	*-A programme of continuous self-monitoring and self-improvement based on the views of service users is required to be introduced* *-The views of family, friends and other stakeholders should be obtained about how service users' needs are met*
Concerns, Complaints and protection	**2**	**5**	*-Please add a 28 day timescale for response to complaints and advise complainants that they may refer to the CSIW at any stage to the complaints policy* *-Please develop a procedure for responding to suspicion or evidence of abuse and disseminate to staff*
The physical environment	**6**	**16**	*-Please produce a programme of routine maintenance and renewal* *-Please advise the inspector what processes are adopted in the home to ensure the control of infection when: handling soiled articles, clothing and infected linen and cleaning commodes*

Belmont: Inspection Report of 18 July 2005

This 32 page report is largely complimentary of the regime in the home. No requirements were specified concerning the *choice of home* and only one concerning *planning for individual needs* i.e. *to develop a service user plan, generated from a comprehensive assessment, including what action the home takes to meet the health, personal and social care needs of the individual.* No requirements were specified in relation to *quality of life* and only one concerned *quality of care and treatment* i.e. *…keep an accurate record of all medication administered at the home.* Similarly there is only a single requirement *staffing* and only one in relation to *conduct and management of the home*, i.e. *to ensure all the necessary*

information and documentation is in place, including two written references, application form and employment history for all staff employed at the home; and *…required to submit a copy of the home's financial plan to CSIW.* There were two requirements concerning the physical environment – one concerning the reduction of shared rooms and one concerning *suitable sluicing facilities to prevent the spread of infection.*

The inspector described meetings with residents and relatives who were complimentary about Belmont. There was weekly contact with District Nursing and there was a *well-balanced and nutritious menu* which the inspector sampled. The home did not use agency staff.

Belmont: Inspection Report of 28 September 2005

In this 18 page report Belmont is described as accommodating *16 service users, all older people who may have a mental infirmity.* The final two pages list the 11 actions required and a single good practice recommendation. The report clearly separates the requirements met since the last inspection and the new requirements arising from the inspection on which the report is based. It was noted that the (same) owners were *committed to providing a well valued service to* residents *and have over the years complied with all requirements following inspection from CSIW…the home clearly demonstrates its ability to meet the needs of service users and staff have received appropriate training with regard to dementia…there is a high demand for places at this home.* The residents *generally have strong links with the local community and members of local churches visit…on a regular basis…*Residents are *registered with the local GP practices and all have annual health reviews.*

There were no requirements concerning *choice of home.* In this section of the report it is noted that Belmont had *regular contact with the CPN and district nurse.* In respect of *planning for individual needs and preferences,* the report identifies a requirement: *to include risk assessments in the service user plans.* Residents commented favourably on the quality of the fo*od which the inspector endorsed.* There were no requirements concerning *quality of life* or *quality of care and treatment.* In terms of *staffing,* Belmont employed *no agency staff* since the staff group was *well established* and each person received supervision every two months and an annual appraisal. The inspection stated that an induction programme was required *taking into account guidance published by Care Council for Wales.* Also, a *good practice recommendation* was made: *To develop a system where records are kept taken in relation to the dates of CRB checks for all staff.*

The report noted that there was *an open and inclusive culture within the home…relatives have always taken the opportunity to speak with the Inspector…and the feedback has always been positive.* With reference to the *conduct and management of the home,* the inspection identified as *action required*: *to develop effective quality assurance systems.* There were no requirements regarding *concerns, complaints and protection* and two concerning *the physical environment* i.e. *to provide each service user with a key to their individual room* and *to ensure all toilets and bathrooms have appropriate hand washing and drying facilities.* The report noted that Mrs Bentley was *an active member of Care Forum Wales*.

Belmont: Inspection Report of 20 September 2006

Mr D Bentley and Mrs AC Bentley remained the Registered Provider and Mrs AC Bentley continued to be the Registered Manager. Their care home had 17 places but accommodated 16 at the time of the inspection – *all older people who may have a mental infirmity.* The staff team were noted to *have worked at the home for a substantial time.*

This 19 page report is as positive as the preceding three reports.

Inspection domains	No. of pages	No. of reqts.	Examples of requirements and good practice recommendations
Choice of home	**1**	**1**	*-to ensure all service users have had their needs assessed prior to admission and the home has a copy of this assessment*
Planning for Individual needs and preferences	**2**	**-**	
Quality of life	**1**	**-**	
Quality of care and treatment	**2**	**3**	*-To ensure there are two signatures for all controlled drugs administered at the home* *-To ensure all records relating to medication are accurate and up to date* *-To ensure all staff responsible for the administration of medicines receive the appropriate training*
Staffing	**2**	**1**	*-To develop a system to record CRB checks and when updates are required* (a good practice recommendation)
Conduct and Management of the home	**1**	**-**	
Concerns, Complaints and protection	**1**	**-**	
The physical environment	**2**	**-**	

BANK HOUSE

Bank House: Inspection of September 2003

The Person in Control was Mr Lal (during 2002), Mrs J Lal, was the Registered Provider and the following year, Prem Lal was the Responsible Individual) and the Manager was Mrs Beverley Evans. This 64 bed home was located in Ebbw Vale. There were 50 residents at the time of the inspection. It had been registered since December 1993.

The report is 35 pages long and was published nine months after the inspection. The recommendations/requirements are listed in a table towards the end of the report and the report's final 8 pages summarise the preceding sections *for public access but with access to the full report on request.*

Inspection domains	No. of pages	No. of Recs.	Examples of recommendations
Choice of home	**3**	**1**	*-the home needs to undertake a policy/ procedure for the needs and preferences of specific minority ethnic communities and ensure social/ cultural or religious groups are catered for*
Planning for Individual needs and preferences	**2**	**-**	
Quality of life	**2**	**1**	*-…to ensure that a written agreement is drawn up on confidentiality with all other health/ social care agencies which includes the principles governing the sharing of information*
Quality of care and treatment	**3**		*-Standard met – however, the home must cease using the bench top steriliser and seek advice from the senior nurse for Infection Control and Communicable Diseases at the Public Health Department*
Staffing	**3**	**2**	*-New staff are only appointed if information…is available in respect of each individual. The home must ensure application to the CRB for new staff appointed* *-Care staff receive formal supervision at least once every two months*
Conduct and Management of the home	**3**	**5**	*-Where the home …handles the money of individual service users…ensures that any personal monies are not pooled with the finances of the home or other service users finances* *-A plan based on reviewing aims and outcomes for service users*

			-Views of families, friends, stakeholders needs to be sought to ensure that the home is meeting the needs of the service users
Concerns, Complaints and protection	**2**	**-**	
The physical environment	**5**	**14**	*-the following areas required addressing…carpets were stained, required shampooing / replacing in* [five rooms]; *cot side bumpers must be in place; hot water temperatures were excessive in the bathroom near* [two bedrooms] *-wheelchair footplates were not being used on service users' wheelchairs. Education and training needs to be undertaken for care staff on safe transportation of service users in wheelchairs* *-…demonstrate that they provide equipment and make adaptations that address the assessed needs of service users*

Bank House: Inspection of November 2003

This 42 page report states that Mr Panteg Lal and Mrs Beverley Evans remained the Registered Provider and the Registered Manager respectively. The home had four palliative care beds as well as residential and nursing beds and there were 53 residents. A double room was occupied by a married couple. The final four pages list what requirements needed to be met.

The inspection drew attention to the under-activity of residents and their need for stimulation, most particularly for residents with sensory impairments. The home was required to address screening in double rooms; water safety; *risk assessments for all safe working practice topics; staff supervision;* and a programme of routine maintenance and renewal implemented. The home was also advised that it would *continue to be monitored until the deficit in Registered Nurse staffing levels is addressed.*

Bank House: Inspection of April 2005

The Registered Provider was Mr P Lal and the Registered Manager was Mrs Beverley Evans. This 39 page report made an *immediate requirement* concerning residents' medication, i.e. that medicines should be handled *according to the requirements of the Medicines Act 1968,* Royal Pharmaceutical Society guidelines and the Misuse of Drugs Act 1971. The kitchen was a particular focus of concern in terms of, for example, cleanliness, chilling temperatures and food storage for example. The report also drew attention to the importance of activities for residents.

The bulk of the requirements concerned the physical environment i.e. attention to equipment maintenance, general re-decoration, the wear and tear on furnishings, furniture and hand

basins; water temperature; infection control and cleanliness, including routines for toilet cleaning. Further, the report identified requirements concerning staffing numbers and staff supervision. The home was required to have a copy of the National Assembly for Wales Protection of Vulnerable Adults Policy/procedure; to ensure that carpets were replaced in 12 rooms; and that residents using wheelchairs had footplates *(immediately).*

Bank House: Inspection of December 2005

This 33 page report named Mrs Lal and Mrs Syal as the registered provider(s). The report's final five pages summarises the requirements and good practice recommendations.

Requirements were made concerning the home's statement of purpose and its guide for residents. In terms of *planning for individual needs* it was noted that not all records were maintained and stored as required and that the *classification/grade of* residents' *wounds* was documented inconsistently. The latter was reflected in a good practice recommendation. Requirements concerning *quality of life* focused on confidentiality and residents' activities – or lack of them. A *good practice recommendation* concerning the *quality of care and treatment* focused on medication:…*to ensure that the home's medication policies/procedures are up to date/reviewed following the recent change in pharmacy system, as a matter of urgency.* With reference to *staffing,* the requirements highlighted the necessity of protected time for supervision and a training programme which reflects the home's registration.

The inspection required that the home's *conduct and management* should be enhanced by investing in an *Annual Development Plan,* by visits by the Registered Person and by the views of *stakeholders in the community.* Although refurbishment and redecoration were in evidence, most of the report's *requirements* concerned *the physical environment.*

Bank House: Inspection of May 2007

The Registered Provider(s) and Manager remained the same. The 29 page report was broadly positive. Notable *new actions required* included: *…to ensure that service users receive appropriate treatment, advice and support from any healthcare professionals; …to ensure that a service user's plan of care is generated from a comprehensive assessment of need; …to ensure that all entries in the nursing documentation* are *signed by the author* [this is a *good practice recommendation*]*; to ensure…appropriate foot rests* are *attached to wheelchairs…all staff attend statutory training; …to ensure that formal supervision is undertaken…to ensure an appropriate number and skill mix of staff is on duty in line with the home's staffing notification; to ensure that CSIW is informed of all deaths, incidents or events; …to make suitable arrangements to prevent infection, toxic conditions and the spread of infection; to ensure that an appropriate extraction system is fitted in the smoking lounge…*[and] *a safe system of moving and handling.*

Bank House: Inspection of April 2008

The Registered Provider(s) and Manager remained the same. This 22 page report opened with an expression of concern: *on at least four occasions service users had been admitted to the*

home despite them being outside of the home's categories of registration. Furthermore, the *provision of recreational activities required urgent attention, especially in the older person's unit.*

With reference to *planning for individual needs,* the actions required concerned assessment and care planning as well as ensuring that *appropriate action is taken in response to adverse incidents/events* and *that daily documentation clearly evidences how health care needs have been met.* The inspectors expressed concern that residents were up and dressed by 7.00am and that they did not *appear well groomed* as they waited for their breakfast. Some were sleeping in the dining room. Residents' under-activity was noted as requiring attention as a matter of *urgency.*

Once again the Registered Person was required to *ensure that suitably skilled and competent staff are on duty at all times and that staff are given the appropriate assistance, including time off to attend study sessions/training.* Finally, with reference to the *physical environment,* the inspection noted that *a number of areas were…dirty and odorous* and some lounge chairs were *covered in food debris…the same for a large number of wheelchairs.* Further, the inspectors noted *the continued use of wheelchairs without appropriate footrests.* The actions required included ensuring that *all equipment used in the home is appropriately maintained…the smoking lounge is appropriately managed in a way that does not impact on non-smoking service users, staff and visitors.*

Bank House: Inspection of April 2009

The Registered Provider was unchanged as Kamla Syal and Joyce Irene Lal. However, there was no Registered Manager. The home's *category* was as a *Care home nursing* – older people for whom there were 61 *places.* In the *Introduction* it is noted that *The Registered Person(s) is responsible for ensuring that the service operates in a way which complies with the regulations.* Under the heading: *Overall view of the care home* it was noted that …*Under the Reform of Regulation, a proportionate approach to the inspection was undertaken, and as such, the primary focus was on establishing compliance in those areas of greater concern based on an analysis of risk.*

The home was registered to accommodate up to 51 service users (aged 65 years and over) who required nursing care, up to 3 service users (aged 65 years and over) who required personal care and up to 4 service users who required palliative care. The home also had a separate unit (Meyrick wing) where 10 service users with dementia care needs could be accommodated. The home also accommodated three younger adults (aged under 65 years).

Concern about residents' under-activity was expressed and the *quality of care and treatment* highlighted *repeated concerns* regarding referrals to specialists e.g. for wound care, which had not been initiated and GPs had not been informed. Furthermore, the treatment room was dirty and emergency equipment had not been maintained. It was also noted that the *local authority and Local Health Board had put an embargo on placements* because of *a number of* POVA referrals. Finally, *a number of areas* were noted as *dirty and odorous.*

Inspection domains	No. of pages	No. of reqts.	Examples of requirements and good practice recommendations
Choice of home	**2**	**-**	*-to ensure that systems and processes implemented, specific to the delegation of duties by registered nurses, are audited, reviewed and amended if required in order to evidence appropriate care delivery* [good practice recommendation]
Planning for Individual needs and preferences	**2**	**2**	*-…to ensure that daily documentation clearly evidences how health care needs have been met* *-…to ensure that service user plans of care clearly set out how their individualised needs are to be met by members of the staff team* *-…to ensure that the implementation of a recognised pain assessment tool for all service users who require pain management…to evidence effective pain management* [good practice recommendation]
Quality of life	**2**	**1**	*-…must consult with service users and implement a plan of activities based on the outcome of the consultation exercise*
Quality of care and treatment	**3**	**4**	*-…must develop policies and procedures for referring service users to specialist and medical services.* *-…must provide evidence that they have assured themselves of registered nurses and care staffs competency to meet the needs of service users* *-Registered nurses are reminded of their roles, responsibilities and accountability* with *particular reference to the Nursing and Midwifery Council's 'code of professional practice'*
Staffing	**2**	**2**	*-…to ensure that suitably skilled and competent staff is on duty at all times and that staff are given the appropriate assistance, including time off to attend study sessions/ training* *- …to ensure that all registered nurses have formal 1 to 1 supervision. Records of which are to be maintained*
Conduct and Management of the home	**2**	**2**	*-…to ensure that the Regulation 27 visit incorporates all areas of service delivery including the opinion of staff, service users and their representatives* *-…to formulate a development plan for the home including what systems will be put in place to monitor and develop the service delivery*
Concerns, Complaints and protection	**1**	**-**	
The physical environment	**3**	**2**	*-…to undertake a full infection control audit…and provide an action plan* *-…to undertake a full audit of the premises, including furniture and fixtures, and provide an action plan*

Appendix 3

Summary overview of the companies owned by Dr P Das and Dr N Das

Key:

Dates in green are the relevant dates of incorporation

Companies in red are now dissolved

363 refers to the Annual Report (later AR01)

AA refers to the Annual Accounts

M - INFORMATION MICRO FILMED, AVAILABLE ON REQUEST. Not electronically available.

Years which have more than one AA refer to catch up years.

The data has been compiled for each company from the year of incorporation up to the year it was dissolved. In the case of firms (5&6) which still operate the information is to date.

1987 - 1996

		Co. Sec	Director	Director	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996
1. Puretruce Pharmacy Ltd	2908284	ND	ND	PD								14/03/1994	?	? AA
2. Puretruce Care (Developments) Ltd,	3533297	ND	ND	PD										
3. Puretruce	2105273	PD	ND		03/03/1987	M	M	M	M	M	M	M	363 AA	363 **AA**
4. Puretruce Care Ltd	3277799	ND	PD											08/11/1996
5. Puretruce Health Care Ltd	3035216												20/03/1995	363 **AA**
6. L'Giri	4158929													

1997 - 2006

		Co. Sec	Director	Director	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
1. Puretruce Pharmacy Ltd	2908284	ND	ND	PD	363 AA	363 AA	363 AA	363 **AA**	363 **AA**	App. Dis	Vol. strike off suspended	Dis. S652		
2. Puretruce Care (Developments) Ltd,	3533297	ND	ND	PD		24/03/1998	363 AA	363 **AA**	363 **AA**	363 AA	363 AA	363 AA	Dis. S652	
3. Puretruce	2105273	PD	ND		363 AA,AA	363 AA	363 **AA**	363 AA	363 **AA**	363 AA	363 AA	363 **AA**	**363** AA,AA	Dis. 652(5)
4. Puretruce Care Ltd	3277799	ND	PD		363 **AA**	363 AA	**363** AA	363 **AA**	363 **AA**	363 AA,AA	Rec'r apt'd	Rec'r apt'd	REC'R	Registrar strikes off for non compliance/Dis
5. Puretruce Health Care Ltd	3035216				363 AA	363 AA	363 AA	363 **AA**	363 **AA**	363 AA,AA	363 AA	363 AA	363 AA,AA	363 **AA**
6. L'Giri	4158929								13/02/2001	363 AA	363 AA	363 **AA**	63 AA,AA,A	363 **AA**

2007 - 2014

		Co. Sec	Director	Director	2007	2008	2009	2010	2011	2012	2013	2014		
1. Puretruce Pharmacy Ltd	2908284	ND	ND	PD										
2. Puretruce Care (Developments) Ltd,	3533297	ND	ND	PD										
3. Puretruce	2105273	PD	ND		Struck off/Dis									
4. Puretruce Care Ltd	3277799	ND	PD											
5. Puretruce Health Care Ltd	3035216				363 **AA**	363 **AA**	363 AA,AA	AR01 AA	AR01 AA	AR01 AA	AR01 AA	AR01 AA		
6. L'Giri	4158929				363 **AA**	363 AA,AA	363 **AA**	AR01 AA,A	AR01 AA	AR01 AA	AR01 AA	AR01 AA		

Operation Jasmine Review
Led by: Dr Margaret Flynn

From: Dr Margaret Flynn

Rhian Thompson
Secretary to the Review
(All Correspondence to the
Secretary to the Review)

Welsh Assembly Government
P08, 4th Floor, North Core
Crown Buildings
Cathays Park
Cardiff CF10 3NQ

Ms Catrin Evans - Head of the Complex Casework Unit.
wales.communications@cps.gsi.gov.uk
Sent by e-mail only

Date: 18 June

Dear Ms Evans,

Operation Jasmine Review

On 4 December 2013, the Rt. Hon Carwyn Jones AM, First Minister of Wales, established a review of Operation Jasmine and the events associated with it, "in order that we may learn for the future." The First Minister explained to the Assembly that it had always been intended that a review would follow the conclusion of the criminal investigation. However the "unusual circumstances" surrounding the efforts to prosecute the owner and the Chief Executive prompted the concern that there has been no story-telling of, for example

- the ways in which older people experienced their care
- their alleged abuses and
- the grief that has shadowed the efforts of the families' group, Justice for Jasmine.

Since the First Minister announced the Review, I have been meeting with people whose relatives were placed in the homes within the purview of Operation Jasmine and with professionals whose agencies are associated with the police investigation.

You may know that whilst the criminal proceedings concerning Dr Das are not concluded, concerns continue to be expressed about the disclosure to the Review.

I would be grateful if we could meet to consider a way forward and separately to discuss the charge of criminal manslaughter? The latter is a pressing concern of the relatives.

I look forward to hearing from you.

Yours sincerely,

Dr Margaret Flynn

CPS

Dr Margaret Flynn
Welsh Assembly Government
PO8, 4th Floor, North Core
Crown Buildings
Cathays Park
CARDIFF
CF10 3NQ

9 October 2014

Our ref: / Ein cyf: **EB/SE**
Your ref: / Eich cyf:

Dear Dr Flynn

RE: Operation Jasmine Review

Your letter of 18 June 2014, which was addressed to Catrin Evans, has been passed to me as Miss Evans is currently on leave. I must apologise for the delay in providing a substantive response. Unfortunately, all of our lawyers who have been involved in this case from Wales have now retired and it has taken some time to consider the issues and provide a response.
Mr Jim Brisbane, who was my predecessor as Chief Crown Prosecutor in Wales, has liaised with the Chief Constable of Gwent over the issue of disclosure of documents. He has assigned a lawyer in our Headquarters to consider the issue of disclosure and I understand that a meeting has been arranged between that lawyer and Mr Farrar and we should be able to make progress on that issue soon.

You have asked for a meeting with Miss Evans on the issue of manslaughter and for the reasons I am about to give, I do not think that such a meeting would be very helpful. In particular, Miss Evans was not the person who took any of the legal decisions in this case and the reasons for our decision on manslaughter have been given to the families in a meeting held in Cardiff on 5 July 2014, which was chaired by the former Director of Public Prosecutions, Keir Starmer. I enclose a copy of the notes of the meeting which may be of assistance.

It may be more helpful if I set out the reasoning in broad terms.

The offence of manslaughter by gross negligence involves a number of elements all of which have to be proved by the prosecution. Those elements were confirmed by Lord Mackay in the leading authority of R v Adomako [1995] 1AC 171 as follows:

1. the defendant owed a duty of care to the deceased
2. the defendant breached this duty

3. the breach caused the death of the deceased
4. the defendant's negligence was gross, that is it showed such a disregard for the life and safety of others as to amount to a crime and deserve punishment.

The case for manslaughter fails on point 3. This is the element known as causation or in other words was the negligent act a substantial cause of, or contribution to, the death. In order to prove this element we rely entirely on expert evidence from medical practitioners. We start with the cause of death and ask whether the negligent care was a substantial cause of death or in other words if that care had been of an acceptable standard would the person have died when they did.

In short, we did not receive such evidence in respect of any of the patients concerned. It may well be that some experts felt it was likely that the poor care was a substantial contribution to death or even that it probably was, but no one was able to provide evidence to say that they were sure and therefore the case could go no further.

Although it is of academic interest to see whether the other elements were proved, I am quite sure that we could not have proved manslaughter against any individual even if we had received expert evidence to prove causation. The prosecution would have to prove the case against each individual. It is not possible to say that the care in general was poor and therefore everyone involved in that care must have breached their duty. On the facts of this case, it was impossible to attribute blame to any given individual. It may have been possible to say, for example, that bed sores were attributable to a failure to turn the patient often enough. However, the task of turning patients was shared by many people and we could not say with any certainty which individuals had failed in their duty of care.

The final element which must be proved is that the negligence was gross. There is a big difference between proving negligence to a civil standard and proving gross negligence to the criminal standard. We have to prove that the conduct of the accused departed from the proper standard of care incumbent upon him involving as it must have done an obvious risk of death to such extent that it should be judged criminal. That is a very high standard to reach.

Therefore, the charges of gross negligence manslaughter could never be proved on the evidence available.

I hope that this is of some assistance, but please contact me again if you need any further information.

Yours sincerely

Ed Beltrami
Chief Crown Prosecutor

Encs

Operation Jasmine Meeting
on 5 July 2013 at Cardiff City Hall

Attendees:

Keir Starmer QC (KS)	Director of Public Prosecutions
Jim Brisbane (JB)	Chief Operating Officer and ex CCP Wales
CC Jeff Farrar (JF)	Chief Constable for Gwent Police
DS Ceri Llewellyn (CL)	Gwent Police
Lisa Beasant DC258 (LB)	Gwent Police
Gary Trotman (GT)	Gwent Police
Richard Millington (RM)	Gwent Police
Bethan Bromage (BB)	Gwent Police
Disclosure Officer	
Catrin Evans (CE)	
Malcolm McHaffie (MM)	CPS Special Crime
Mary-Clare Grant (MCG)	CPS Special Crime
Grenville Barker (GB)	CPS Wales CCU
Niki Sharpe (NS)	CPS Private Office
Relatives:	
Vivian Thomas (VT)	
Evelyn Jones (EJ)	
Catherin Cawte (CC)	
Valerie Meek (VM)	
Elizabeth Williams (EW)	
Gaynor Williams (GW)	
Loraine Bramen (LB)	
Gail Morris (GM)	
Russell Allen (RA)	
Tracy A Allen (TA)	
Joanna Hamen (JH)	
Marina Walters (MW)	
David B Wallis (DW)	
Maureen Cullen (MC)	
Lisa Davies (LD)	
Anna Buchanan (AB)	Director of Protection, Older People's Commissioner's Office

Pre-meet:

It was discussed that the CPS could potentially write to all the families (approximately 80) inviting them to discuss this with the Older People's Commissioner.

ACTION: GB/CE to write letters to attendees offering individual meetings with the CPS.

Note of meeting:

KS offered his sincere condolences to the families. RA on behalf of the families said they had prepared a list of questions.

JB explained that Gwent Police had started the Operation and that they had sought early advice from the CPS because of the emerging scale of cases. There had been

2 prosecutions in 2008 and since then the enquiry had widened. The options for prosecution were Gross Negligent Manslaughter (GNM) and wilful neglect. The police had to scope what they were looking at and the amount of material, experts' evidence, records and background. JB said the case had been transferred to the CCU based in Cardiff and the CCU would look at individual cases and would be then reviewed by lawyers in York. The case also involved fraud charges against Dr Das as there were financial irregularities.

MCG emphasised and clarified the role of the Special Crime lawyers in York. KS said the use of specialist prosecutors meant that there was no-one more qualified who could review the decisions.

KS explained the legislation and the general challenges in the case they had to overcome. KS said to prove GNM they needed to show causation and prove there was a link, that it was the cause of death. It was not enough to say it might have been or that they were exposed to a risk of death. KS said the challenge was proving a negative as the CPS had to prove that something was not done. The prosecution were not allowed to add up small malpractices to bring a group prosecution, it had to be individual cases.

KS said to prove wilful neglect they would not have to prove a link to death but the other problems remain and in reality they are the same hurdles. KS stated in his opinion the legislation was inadequate and needed to be changed as there was a gap in the law for people who were vulnerable. KS said they also needed to look at cases where there were issues around injuries and not necessarily where death had been caused.

VT said her relative Hilda Scace who had been suffering with mental health issues was fine before she went into the home, she had not been dehydrated as her skin was like a peach but then she had received inadequate care and her health deteriorated rapidly. VT said the nurses had lied afterwards but they had expressed their concerns weeks before in a letter to the Matron although they failed to send her to hospital themselves. VT said she expected the nurses to be more professional and that the families should be able to act as witnesses to prove the condition of the person admitted beforehand and then after. VT said she was angry because she had written to the CPS and received no reply.

DW spoke about his relative Evelyn Jones. DW said he had evidence that the injuries did cause death and read from a report to say she had suffered with malnutrition and her cause of death was "sepsis due to a pressure ulcer". DW said individuals were responsible for the death. KS said he understood frustration but the specialists had looked at all the available evidence and there was not enough to bring a prosecution because it was very difficult to prove. DW said he did not accept that and knew one of the nurses had been struck off since and despite an appeal had still remained struck off.

<u>Questions from the families:</u>

1. What were the charges available?

KS said it was GNM and wilful neglect and charges would be discussed further in the 1:1 meetings to be offered to the families. KS explained the Code test of sufficient evidence and being in the public interest to prosecute. KS emphasised that if there was insufficient evidence then they could not go on to consider if it was in the public interest as there had to be enough evidence first.

2. VT referred to a recent case which involved a young boy with learning difficulties in a care home where he had been treated very badly. Why had this case and the others not been prosecuted?

KS said there was not sufficient evidence so the second part of the test did not arise. RA said he was surprised there was no evidence on any of those cases and there were 60+ cases and no prosecutions had been sought. KS explained the role of the police and the CPS and that the police had presented the strongest 6 cases to them. RA asked if anyone had ever advised that one of those cases could proceed on a lesser charge. AB said they obtained expert's opinions and collected the strongest evidence, so there was nothing more that could have been done. The law was either inadequate, the threshold test was too high or the law was insufficient.

RA said all evidence had been put forward and no charge was possible on GNM and wilful neglect. KS said the next step was to look at exposure to risk and HSE to go down the order of seriousness. KS said charges were proposed to be tried in January this year and were allowed to lie on file after being considered by a QC. KS explained that the legislation for corporate manslaughter had recently changed, at the time they needed to show that the individual was the controlling mind and now that is not the case but the change in law is too late for these cases. KS reiterated that no-one was saying that it was not in the public interest to prosecute the cases but the sufficient evidence test was not met so they failed at the first hurdle.

RA said he had evidence but KS said there were different reasons for not being able to bring prosecutions in the individual cases. KS said the criminal test was the evidence had to prove a death was caused beyond all reasonable doubt and none of the evidence went that far. VT said the photos she had spoke for themselves and she described totally unacceptable injuries and said she was disappointed she had not had her day in court. KS said he understood but he could only ask his staff to apply the law as it existed.

AB asked if the police had attempted to obtain more evidence and Gwent Police confirmed they did try to get more evidence. MCG gave an example of a case that succeeded for GNM where the GP had missed a medical point and the expert said it was a gross breach which proved serious mistakes are enough. MCG said the expert was clear on causation and stated that the person would not have died without the mistake being made. MCG said under the cases in Operation Jasmine the expert could not say the breach caused the death. KS said some cases did obtain further evidence but it did not go far enough and it gave him no satisfaction to say there was not enough evidence.

3. When was the last neurology report for Dr Das?

GF said the matter had been referred to the General Medical Council (GMC) and they would alert the police if Dr Das tried to practice again. GF said he had no power to demand a medical check on him but the last medical report showed he was being cared for in a hospital and not being fit to stand trial, which is why the charges would lie on file.

VT said it was not just Dr Das alone, Dr Black was also responsible and she was concerned that Dr Das still had his passport so could leave the country and get better. KS said the likelihood was that he would never recover but if Dr Das recovered then the police and HSE would approach the CPS and the trial judge to resurrect the case and ask for it to be reopened.

4. Why could not Dr Das' wife and Dr Black be prosecuted?

CL explained that the police had wanted to prosecute the company, Mrs Das and Dr Black but the corporate case was not possible and the judicial view was that it would not be a fair trial without Dr Das present and Dr Black should not be prosecuted on his own because Dr Das was the most culpable.

VT said that she thought HSE should ensure that care home owners should be made responsible and provide care and adequate equipment before they are registered. She thought it should be a question for local authority and the care inspectorate for Wales and said she knew the standards had changed in Caerphilly Borough as a result of this operation.

CL said that Andrew Langdon had looked into the issue of whether a precedent had been set in detail. RA asked whether he was satisfied that he could not bring cases on all 66 victims. CL said the HSE looked at the 16 cases that they were asked to and they could only prosecute individually as explained earlier, counsel advised they could prosecute but HHJ Riddler had said no, they could not prosecute Black and Mrs Das. KS added that Dr Das did own all the care homes in cases considered by the CPS.

5. Why could prosecutions not be brought against other nurses?

KS said the CPS did look at other individuals but they could not prove charges against them as there was no causation link and Dr Das had responsibility for 'clinical care', not involved in individual care. KS explained the question regarding GNM and wilful neglect was difficult because the CPS had to prove what care was not provided that should have been. KS said he sensed the feeling in the room was that those who ran the home should be responsible but until recently that was not enough as you had to show that they were culpable but it was now easier.

VT said she hoped the law change and further changes would resolve these issues in the future but felt the outcome as it stood was a total injustice. DW asked who was running the company at present and CL said it was the silent partner who was Mrs Das. CL said they considered a prosecution for Mrs Das but the documents uncovered in the HSE prosecution showed she ran the company in a different way. CL said between 2005-2006 Mrs Das had taken a prominent role and she was instrumental in improving the fortunes of the company.

DW asked KS for his opinion on a public inquiry. KS said if there was a public inquiry, it should look at whether the law was adequate or not and he was happy to say the law in relation to GNM should be amended.

6. What did the 'stay' in the cases mean?

KS said it did not stop any civil action and it should not stop a public inquiry as a matter of law.

7. What about the bedsores and other causes?

KS said it was a strategic decision to only consider prosecutions on the strongest cases. KS explained HSE had no ability to prosecute those cases which is why they were not prosecuted under HSE, not because it was less important.

DW showed the room photographs and daily records which showed dehydration which he said showed neglect. KS said he had no pleasure at all that the threshold for prosecution was not met and understands how all the families feel and that they are entitled to say it is not good enough but he would need to think carefully about how to fill the gap in the law. KS said he would take away any other questions that people had and would come back to the families about what more could be done.

Conclusion of the meeting

JF said the social care for older people needed to be changed and he would put a board together to look at the care of old people. JF said there was generally an acceptance that old people die but that was not good enough and that thinking in society should change. JF said he had seen fewer injuries on people who had been murdered. JF thanked KS for making the effort to come to Cardiff to speak to everyone and address the points that had been raised.

RA thanked KS and everyone for their time. He said it was a poor outcome and not a situation he would ever wish to be in but he was grateful for everything done so far and thought it would be useful to have someone in KS's position on the Board so the law would change in the future. RA said he understood the causation argument but he was frustrated that people were effectively getting away with legal murder.

VT said she thought people needed to be responsible and answerable to questions of neglect whether it was wilful and/or passive.

DW said he understood changes were being made but he was concerned that although there were social services reports condemning these types of care homes they were still placing loved ones in them and this needed to be addressed.

KS thanked everyone for attending and said he would treat the meeting as the beginning of dialogue and not the end. KS said the next step would be individual meetings with families and then there would be general dialogue with everyone, as this was not something the CPS would walk away from.

Operation Jasmine Review
Led by: Dr Margaret Flynn

From: Dr Margaret Flynn

Rhian Thompson
Secretary to the Review
(All Correspondence to the
Secretary to the Review)

Welsh Assembly Government
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Crown Buildings
Cathays Park
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Date: 08 December 2014

Dear Mr Beltrami,

Thank you for your letter of 9 October 2014. I regret that you do not think that a meeting with Miss Evans, the Head of Complex Casework Unit, would be helpful.

I note that that the reasoning you *outline in broad terms* concerning the offence of manslaughter by gross negligence is contradicted by the accompanying notes and specifically, the penultimate paragraph on page 2:

DW spoke about his relative Evelyn Jones. DW said he had evidence that the injuries did cause death and read from a report to say she had suffered from malnutrition and her cause of death was "sepsis due to a pressure ulcer."

That is, the families are familiar with some of the content of expert medical reports which I understand had been commissioned by the Operation Jasmine investigation at a cost of £500,000.00. One such expert was prepared to assert that death from the pressure ulcers was *not the substantial cause of death, it was the only cause.* Since the CPS was privy to this expert witness testimony it is surprising that a prosecution was not pursued.

Gwent Police have been prepared to divulge only the minimum information in spite of an investigation which, I understand, cost £15m. It would appear that your predecessor favoured such nondisclosure of documents. Is this a decision with which you concur? It would have been helpful to have had a copy of the original correspondence from the CPS' specialist prosecutors in York in the light of the previous Director of Public Prosecutions' comments concerning corporate manslaughter legislation (para 3, p3 of the accompanying notes) and his view that the law in relation to gross negligence manslaughter *should be amended* (para 6, p4).

It is disappointing also to note that the families were incorrectly informed at the meeting with the previous Director of Public Prosecutions that Mrs Dr Das could not be prosecuted since she was a *silent partner* i.e. a passive financial investor with no responsibilities for the day to day running of the

business. Had she been a *silent partner* then Puretruce Healthcare Ltd would have been a partnership under the Limited Partnership Act 1907. Puretruce Healthcare Ltd was *not* registered as a Limited Partnership. Finally, Paul Black is given the title *Dr Black* on page 4 of the accompanying notes. Paul Black was neither a medical practitioner nor an academic. He had a career in sales and marketing, albeit for medical products.

You may know that the former Director of Public Prosecutions did not *come back to the families about what more could be done,* despite his promises. Moreover, he failed to conduct or delegate *individual meetings with families.* Thus from the point of view of the families it would appear that the CPS has indeed opted to *walk away from* the injustice.

I am enclosing a draft document a version of which will feature in the Review of Operation Jasmine. It has been drafted by lawyers.

Yours sincerely,

cc Alison Saunders, Director of Public Prosecutions

Dr Margaret Flynn

CPS

Part of rationale for delivering a "provisional draft" by end Feb 15

Rhian Thompson
Secretary to the Review
On behalf of Dr Margaret Flynn
Welsh Assembly Government
PO8, 4th Floor, North Core
Crown Buildings
Cathays Park
CARDIFF CF10 3NQ

11 December 2014

Our ref: / Ein cyf: **EB/SE**
Your ref: / Eich cyf:

Dear Dr Flynn

RE: Operation Jasmine Review

Thank you for your letter of 11 December 2014, which was hand delivered to me on the same date.

I have asked Mr Beltrami to look into the further matters that you raise and provide you with a substantive response in due course.

Yours sincerely

S Evans

Sarah Evans
Senior Personal Assistant
On behalf Ed Beltrami, Chief Crown Prosecutor

CPS

Rhian Thompson
Secretary to the Review
On behalf of Dr Margaret Flynn
Welsh Assembly Government
PO8, 4th Floor, North Core
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6 January 2015

Our ref: / Ein cyf: EB/SE
Your ref: / Eich cyf:

Dear Dr Flynn

RE: Operation Jasmine Review

Further to my acknowledgement dated 11 December 2014, I can inform you that enquiries are still ongoing and we hope to be in a position to provide a substantive response by no later than 27 January 2015. I apologise for the delay which has been caused as a result of our enquiries taking longer than anticipated and the Christmas period.

Yours sincerely

S Evans

Sarah Evans
Senior Personal Assistant
On behalf Ed Beltrami, Chief Crown Prosecutor

CPS

Dr Margaret Flynn
Welsh Assembly Government
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27 January 2015

Our ref: / Ein cyf: **EB/SE**
Your ref: / Eich cyf:

Dear Dr Flynn

RE: Operation Jasmine Review

Further to my letter dated 6 January 2015, I have now been provided with a further report from Catrin Evans, the Head of the Complex Casework Unit. Ms Evans has now concluded her enquiries in relation to the areas of concern you have raised in your letter hand delivered to the Crown Prosecution Service on 11 December 2014. I have also had the opportunity of reading the enclosed draft document enclosed therein.

I hope it will be of assistance to you if I deal with each area of concern in turn, and I have taken the liberty of breaking these down into a number of sub-headings outlined below:

Charging Decisions

In your letter you express concern that the prosecution has not advised the police to charge any suspect with offences relating to gross negligence manslaughter (GNM). In particular you highlight the concerns that were raised by Mr David Walters in relation to the death of his relative Evelyn Jones. You have also referred to expert evidence (not named) obtained by the investigation team and express surprise that a prosecution was not pursued. In the enclosed notes at page 22 you indicate that a number of questions remain unanswered and in particular ask why decisions were not made until 2012 in respect of Evelyn Jones when in fact Evelyn Jones whose cause of death is linked directly to neglect at Brithdir, died in November 2005.

As you are aware, in 2005 Gwent Police Force commenced an investigation into the standard of care being delivered to patients in Care Homes. The police received funding from the Home Office to maintain their investigation. Gross negligence manslaughter offences were considered and the Crown Prosecution Service was engaged. The case was allocated to a Senior Crown Prosecutor in Gwent who charged offences in March and September 2007 and up until 2008 had the assistance of a QC and Junior Counsel. In 2008, criminal proceedings concluded against carers and nurses at the Bryn Gwyn Mountleigh Nursing Home (not owned by Dr Prana Das) for offences of wilful neglect. Those who were convicted (the minority) received a Conditional Discharge.

The police investigation into deaths linked to poor care continued and focused on the prospect of prosecutions of 6 gross negligence manslaughter cases at the Brithdir Care Home. These 6 cases were selected as the provisional view of the police was that they provided the strongest evidence of GNM and wilful neglect - although this was not based upon any dedicated expert evidence. Expert medical witnesses were instructed. Their clear terms of reference were to identify if there was evidence against any individuals who may have committed acts/omitted to act which caused the death.

The CPS accepts that there were insufficient resources deployed from the start of the investigation. If CPS advice were sought in similar circumstances now, the matter would be referred immediately to our Special Crime and Counter Terrorism Division (formerly known as Special Crime Division) which deals with cases involving corporate manslaughter and gross negligence manslaughter involving members of the medical profession.

In April 2009, Operation Jasmine was transferred to the Cymru/Wales Complex Casework Unit (CCU). The CCU was responsible for reviewing the evidence and making the charging decisions. The Special Crime Division (SCD) conducted a quality assurance of the review notes and charging decisions made by the CCU. It is accepted that due to the size and complexity of the case, referral to the CCU should have taken place at an earlier stage and local senior management should have addressed that issue.

In June 2009 a very experienced lawyer Helen Allen from the SCD assisted the CCU by giving a presentation to the police concerning the legal necessities and difficulties in establishing GNM, and also identified the potential for the HSE to bring criminal proceedings. By this stage the HSE had a team dedicated to this case and were engaged with the police.

The police continued with the investigation and submission of files to the CCU for offences of GNM and 'Wilful Neglect' in relation to 6 patients at the Brithdir Nursing Home. The CCU concluded, with SCD providing quality assurance of the review notes and advice, that there was insufficient evidence to bring proceedings. It was not possible to establish individual responsibility, following a review particularly of the expert evidence. The prosecution would need to establish that there has been a grossly negligent act or omission by a single individual which caused or substantially contributed to a death. Significantly, it is not possible to **aggregate** together various negligent acts or omissions of a number of individuals, and to try and argue that in totality, these amount to gross negligence. By way of example, in the case of Brithdir, it would not be possible to argue that in combination, the acts or omissions of various nursing staff, management and carers etc over a period of time, constitute gross negligence manslaughter, as this would involve inviting the court to aggregate together the acts or omissions of a number of individuals, which is not permissible.

There was insufficient evidence to establish causation to the required legal standard. In order to prove causation the prosecution has to prove that a gross breach of a legal duty of care was a cause of death. It is the breach of duty that must be the cause.

There was insufficient evidence at that stage to establish 'wilfulness' defined in R v Sheppard (1981) as deliberately doing something that is wrong, knowing it to be wrong, or with reckless indifference as to whether it is wrong or not.

The advice was formally delivered to the police in January 2010 although the CCU preliminary views (which were repeated in the formal Advice) were expressed to the police in October 2009.

The advice was not accepted by the police. At a meeting with the police on 23 April 2010 the CPS, with the assistance of SCD, repeated the written advice indicating that on 4 of the cases a relevant cause of death could not be identified. Additionally, on the other two cases (Evelyn Jones and Edith Evans), that although there was a relevant cause of death there was no individual identified as being responsible and therefore there was no causation. It was agreed by the CPS that there may be some purpose in seeking reports from experts concerning particular behaviour by individuals in relation to the deaths of Evelyn Jones and

Edith Evans if it had been unclear to the experts that their terms of reference included consideration of individual responsibility. Nevertheless, the police sought the further opinion of the experts relating to all 6 patients – the deaths of Evelyn Jones and Edith Evans were the subject of a GNM review by the experts and all 6 were the subject of a 'wilful neglect' review.

A Director's Case Management Panel (DCMP) was conducted on 8 June 2010 by the former Director, Keir Starmer. It was agreed that Counsel would not be engaged and that the Advices were correct.

The police also sought the opinion of experts on the responsibility of senior management (particularly Dr Das) for offences of GNM and wilful neglect. If there was insufficient evidence to establish individual responsibility for those who had direct contact with patients then it is more difficult to establish responsibility by those with little or no direct contact.

An experienced Senior Crown Prosecutor, Mr Grenville Barker (now retired) considered the additional evidence on each of the cases. The police submitted the full files intermittently during the following months. The advices drafted by Mr Grenville Barker were quality assured by SCD. The final advice on the issues of GNM and wilful neglect were submitted to the police in August 2011. There was insufficient evidence to bring proceedings for these offences.

The 6 deaths investigated were Evelyn Jones, Edith Evans, Marjorie Green, William Hickman, Olive Megan Evans, and June Hamer.

Evelyn Jones

Evelyn Jones died in hospital on 30 November 2005 following admission from the Brithdir Nursing Home 30 days earlier for the treatment of pressure sores. It has always been accepted by the CPS that the cause of death was sepsis due to infected pressure ulceration of the back consequent upon immobility and dehydration. The expert was of the opinion that there had been a deficient night-turning regime at the Brithdir Nursing Home which led to the pressure sores developing and deteriorating. However, the expert stated that had all appropriate steps to rectify the deficient night-turning regime taken place when it was known that deterioration was in train then 'her chances of survival would have been so much better'. Causation for GNM could not be established as, even if all appropriate steps had been taken to rectify the deficient night-turning regime, then she may still have died when she did. As a matter of law whilst the cause of death was clear what is required in a case of this type is to prove that a gross breach of a legal duty of care by an individual was a cause of death; it is the breach of duty that must be the cause. As it was possible that she may still have died even if the steps had been taken the evidence was not sufficient.

The wilful neglect investigation centred upon the fact that there were gaps in recording that the repositioning of Evelyn Jones was taking place to prevent and treat pressure sores. However, the expert stated that 'I cannot be certain that care did take place…it is my opinion that the care, such as repositioning did not take place'. The expert could not be certain that care, such as repositioning, did not take place. When this was highlighted to the expert by the CPS she provided a written response indicating that 'I cannot be certain that care did not take place'. On this basis there was insufficient evidence to establish wilful neglect by any individual to the criminal standard.

Corporate Manslaughter

In order for the company to be guilty of the offence of common law gross negligence manslaughter, it is necessary for a senior individual who could be said to embody the company (also known as a 'controlling mind') to be guilty of the offence. This is often referred to as the principle of identification. A number of legal authorities illustrate this difficulty e.g. P&O European Ferries (Dover) Ltd (1991) 93 Cr APP R 72. This is the Townsend Thoresen Herald of Free Enterprise case. In this case the defendant company was acquitted because the prosecution was unable to show a controlling mind had been guilty of a grossly negligent act.

The controlling mind, or the identification principle, in essence states that it is only certain Directors or senior managers of a company whose acts and state of mind can properly be regarded as those of the company itself. A person can only be a controlling mind if they are a Director or other superior officer, carrying out the functions of management. Accordingly, the conviction of a company for manslaughter by gross negligence in the absence of evidence establishing the guilt of an identified human for the same crime, is not possible. There can be no prosecution of Puretruce Health Care Limited in respect of the death of Evelyn Jones or Edith Evans because there is insufficient evidence to establish the controlling mind of the company was personally guilty of gross negligence manslaughter.

Attorney General's Reference no 2 of 1999 (2000) Cr App R 207 (the Southern Rail Crash in which 7 people died) highlights the problem as per Rose LJ who stated the following:

"unless an identified individual's conduct, characterisable as gross criminal negligence, can be attributable to the company, the company is not, in the present state of the common law, liable for manslaughter"

"a corporation's liability for manslaughter is based solely on the principle of identification"

"the identification principle remains the only basis in common law for corporate liability for gross negligence manslaughter"

"we reject the suggestion that aggregation has any proper role to play"

The prosecution will have to prove therefore that an individual is a controlling mind and had a duty of care. Should a legal duty of care be established, the prosecution would then have to establish a causal link between such a person and the grossly negligent act or omission which has caused the death. Again, it is not possible to aggregate the negligence of a number of individuals, even if each is a controlling mind, in order to arrive at gross negligence.

The law is such that a Director does not owe a duty of care simply by virtue of their status as Director. The more remote a person is from direct involvement in care, the less likely they are to have a duty of care. Further, their duty of care if they do have one, is likely to be different to the duty owed by a person with direct involvement.

Dr Benshuita Das

In your letter you express some concern that the prosecution team has perceived Dr Benshuita Das to be a 'silent partner'. The term 'silent partner' was used during the meeting with the families in 2013 by the police. However, the CPS has always accepted that she is a Director of the company. Gwent Police Force confirm that the investigation team did not refer Dr Benshuita Das to the CPS for a charging decision as they were satisfied that there was insufficient evidence for her to be classed as a suspect. Having considered the evidence contained in the case papers the reviewing lawyer considered that no further lines of enquiry were required. I am satisfied that there was insufficient evidence to consider prosecuting her for offences of Corporate Manslaughter or GNM.

Dr Benshuita Das was charged with Health and Safety offences. When the decision was made that the trial could not proceed against Dr Prana Das due to ill-health it was decided that the prosecution would not pursue the allegations against her alone. This decision was made in conjunction with the Health and Safety Executive upon advice received from Andrew Langdon QC.

Disclosure of material

I am aware that Gwent Police has provided you with copies of a number Expert reports, documentation relating to the registration of Brithdir Nursing home along with the nomination of managers/responsible individuals and details of the investigative review of Operation Jasmine (completed by North Wales Police).

The disclosure of CPS advice has been raised with the Chief Operating Officer and he has taken the view that there is no reason to depart from the usual rule that advices between police and CPS remain confidential.

Meetings with the Families

In your letter you state that the families are of the opinion that the CPS appears to want to walk away from this injustice, and this suggestion is totally rejected. The CCU Head and the reviewing lawyer were both present at the main meeting with the families when the offer of further individual meetings were made at the time, and family members invited to seek further details and contact the CPS if they wished to do so. The CPS regrets that letters were not sent to family members following the meeting to confirm the offer of a meeting. Regrettably there was a breakdown in communication between the Area and Headquarters as to who was to take responsibility for writing to the families. The reviewing lawyer, Mr Grenville Barker has since left the organisation.

Change in the law - 'wilful neglect'

I note your concern that the former Director, Keir Starmer did not come back to the families as he had agreed at the meeting in 2013 that the law on 'wilful neglect' needed to be considered afresh and agreed with the families that he would support this. Since his departure from the Service the CPS has ensured that the CPS Policy Team has a lawyer working with other agencies including HSE to implement the new legislation on wilful neglect. It is anticipated that the new legislation will be in force by the end of April 2015.

The CPS welcomes the new changes in the law, and the details can be accessed at:

http://www.publications.parliament.uk/pa/bills/lbill/2014-2015/0049/15049.pdf

The Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations will also come into force at the same time. They set out fundamental standards to be met, breach of which in some cases will be a criminal offence.

I hope that this additional information is of some assistance, but please contact me again if you need any further information.

Yours sincerely

Ed Beltrami
Chief Crown Prosecutor

OSR00044

Caerphilly Area Adult Protection Committee

Protection of Vulnerable Adults Practice Improvement

2002 - current day

Communication - general principles

1. Good communication with other agencies at all times is vital
2. Good communication with families is vital
3. Family complaints must be responded to and when necessary, families updated further

Assessment & Practice

1. First assessments must recognise all needs, including mental health or behavioural problems
2. Appropriately trained staff must be used to undertake assessments with consideration given to staff continuity & continuity of service delivery
3. Assessments, care plans & Reviews (incl. S117 MHA) must be updated in a timely manner and must reflect change in needs/risks and how they will be managed
4. Risk management plans should be used to address risk to service users and to evidence decision making
5. When dealing with complex cases management advice/support should be provided through supervision

Contract & commissioning

1. Needs and welfare of self funders should also be considered
2. There should be full involvement of commissioning, contract and quality assurance staff and robust inter-agency contract monitoring to ensure service providers maintain standards of care. This enables early identification of deteriorating standards. Where standards have fallen below an acceptable level it will inform the inter-agency response particularly when action plans have been initiated or an embargo has been imposed by another commissioner
3. Action Plan monitoring must be evidenced and contingencies required for repeated Action Plan failure with evidence of robust challenge.
4. Application of embargoes should be consistent and any variation evidenced
5. There should be protocols in place for use of embargoes that evidences consistent decision making to protect and improve delivery of care
6. Responsibility for monitoring and information/evidence gathering during an embargo must be made clear. Use of and removal of embargoes requires risk assessments to evidence that risks have reduced, required improvements have been made and that Vulnerable adults are safe
7. Decision making in respect of embargo or cancellation of contracts must take into account evidence from other agencies including the regulator and a risk analysis which includes historic and current performance

Caerphilly Area Adult Protection Committee

Multi –agency POVA Process

Referral

1. Agencies must refer their adult protection concerns via the appropriate channel in a timely manner
2. Adult protection referrals must include all relevant information from referrers about the concerns
3. Those receiving adult protection concerns/referrals must make an immediate risk assessment in conjunction with the referrer and other key agencies to ensure the safety of the individual vulnerable adult and other vulnerable adults who may be receiving the same service. This should be evidenced.

Strategy Discussion

1. The person coordinating the response to the POVA referral has a responsibility to gather adequate information & evidence their information gathering
2. The need for a POVA referral should not be unnecessarily questioned or matters prevented from progressing through the POVA process
3. The person coordinating the response to the POVA must provide guidance to care managers and other parties gathering information to prevent risk of evidence contamination
4. The rationale for all decisions must be evidenced
5. POVA referrals should not be viewed in isolation but alongside previous individual POVA referrals and existing concerns about the care service or provider
6. Relevant information held within agencies must be reviewed and shared as set out within the regional interagency POVA policy and information sharing agreements prior to Strategy Meeting if it assists and informs the attendees in advance

Strategy Meeting

1. Strategy Meetings are better informed by good information gathering
2. Where there have been previous POVA concerns/referrals_actions need to be examined to inform the management of risk and prevention of further abuse
3. Strategy Meetings must be held within the time frame set in the regional interagency POVA policy and delays evidenced
4. There should be full involvement / attendance from all stakeholders and any variance challenged
5. The person chairing the meeting must follow the agenda to ensure consistency
6. Strategy Meetings to be consistently chaired and to high standard
7. The Strategy Meeting may need to consider whether legal advice or attendance is required.
8. Investigation reports must be made available to assist and progress Strategy Meetings
9. If it is not a Police matter, appropriately trained staff should investigate the POVA issues further

10. If it is not a Police matter, consideration must be given to the competence and independence of the investigator. Providers should not be over-relied upon to conduct own investigation
11. The Police must provide evidence for no further action in respect of a criminal investigation
12. Minute taking must be detailed and accurate.
13. Completion dates and persons responsible should be recorded alongside actions defined by Strategy Meeting
14. Immediate focus must be given to protective issues for the individual and others within care setting who may also be at risk
15. Adult Protection plans must be created
16. The POVA process must not be closed where there are incomplete actions
17. The involvement of other agencies should not lead to disengagement of others who have a duty of care
18. Multi agency risk management plans should be used to support the decision making
19. Stakeholders must attend or continuity of attendance provided to ensure previously requested actions completed, and results are made available to the Strategy Meeting
20. Promises by agencies to undertake action, must be kept or explanation for any variance
21. Meeting attendance requires requisite skills, experience, and authority
22. Full recognition to be given to potential criminal offences of ill treatment, neglect, or more serious offences associated with death
23. Potential criminal offences should not be dismissed as 'care issues'
24. To ensure accuracy, written updates or investigative reports from Police or Health investigations should be supplied to the meeting in addition to any verbal report
25. Investigations should be completed in a timely manner
26. Responsibility to be accepted for undertaking action or a contract signed for action to be completed
27. Action undertaken should embrace joint working and acknowledged benefits
28. The POVA process should not be used to fix problems when the remedy already lies within an individual agency e.g. emergency closure
29. The use of District Nurses to support and develop poor standards in failing care home requires critical risk assessment and to be subject of legal advice so as not to expose District Nurses & employing agency to risk

Case Conference

1. There should be full involvement / attendance from stakeholders and any variance challenged
2. The person coordinating the response to the POVA referral must follow meeting agenda to ensure consistency
3. Case Conference Meetings must be consistently chaired and to high standard
4. Minute taking must be detailed and accurate.
5. Completion dates and persons responsible should be recorded alongside Actions defined by the Case Conference
6. Immediate focus must be given to protective issues for the individual and

others within care setting who may also be at risk
7. Adult Protection plans must be used

Over-arching meetings

1. Overarching Strategy Meetings, if called, must deal with the specific protection issues of individual cases to a satisfactory outcome
2. Minute taking must be detailed and accurate.
3. Completion dates and persons responsible should be recorded alongside actions as agreed by the meeting participants
4. Immediate focus must be given to protective issues for individual and others within care setting and who may also be at risk
5. Case Conferences must be held to conclude individual POVA referrals
6. Adult Protection plans must be used
7. The POVA process must not be closed where there are incomplete actions
8. The involvement of other agencies should not lead to disengagement of others who have a duty of care
9. Multi-agency risk management plans should be used to support the decision making
10. Stakeholders must attend or continuity of attendance provided to ensure previously requested actions completed, and results are made available to the Meeting
11. Promises by agencies to undertake action, must be kept or an explanation provided for any variance
12. Meeting attendance requires requisite skills, experience, and authority
13. Full recognition must be given to potential criminal offences of ill treatment, neglect, or more serious offences associated with death
14. Potential criminal offences should not be dismissed as 'care issues'
15. To ensure accuracy, written updates or investigative reports from Police or Health investigations should be supplied to the meeting in addition to any verbal report
16. Investigations should be completed in a timely manner
17. Responsibility to be accepted for undertaking action or a contract signed for action to be completed
18. Action undertaken should embrace joint working and acknowledged benefits
19. POVA should not be used to fix problems when the remedy already lies within an individual agency e.g. emergency closure
20. The use of District Nurses to support and develop poor standards in failing care home requires critical risk assessment and to be subject of legal advice so as not to expose District Nurses & employing agency to risk
21. Consideration must be given to the vulnerable adult(s) being subject of "institutional abuse."
22. Protective measures for those already resident during the imposition of an embargo must be evidenced
23. Significant POVA activity or suspicious deaths must be taken into account during the imposition of an embargo and before it is lifted
24. Overarching Meetings must demonstrate a consistent strategy and defined issues of concern
25. Management intervention must be consistent and proactive with an early management intervention strategy consistent with the level or escalation of

concerns
26. Ownership of problems must be shared with mutual aid from stakeholders to successfully resource and solve problems
27. Meetings must be consistently chaired & to high standard

Provider & Relationship with Provider

1. Presence of provider for all or part of a meeting must be critically assessed when concerns exist about that same provider – their presence may inhibit the free sharing of information and the implementation of protective measures and may impact upon any future prosecution or regulatory action
2. Consideration must be given to the provider being considered "suspect" or in a conflict of interest and for a strategic management plan to deal with this within the POVA process
3. Consideration must be given to a process of structured information sharing with provider
4. Feedback to providers must be evidenced
5. Providers who are subject of considerable concern must not be allowed to investigate themselves
6. Staff training must be provided by persons who are qualified, competent or approved as trainers. Training received should be tested to establish whether care staff have understood the training they have received or how they will apply it in their practice.
7. Providers who fail or refuse to take up the offer of training for their care staff should cause concern for commissioners and trigger the contract-monitoring process.

Record keeping

1. Files to be kept in order & regularly updated
2. Case notes must be dated & signed off
3. Files to be stored with all relevant material included
4. POVA concerns to be stored separately and where necessary archived for the purposes of civil or criminal enquiries in accordance with each agencies data management policy
5. Structure of paper files to be safely secured
6. Confidential documents to be securely stored
7. Data to be stored against correct service user (paper / electronic)
8. Need for accurate dates & data entry
9. Outcomes / actions to be recorded accurately
10. Need for consistent administration standards for POVA
11. POVA actions to be made clear in minute record/Action Plan
12. Minutes must be checked, agreed, and signed by the chair as accurate

Appendix 6

An Introduction to Deep Pressure Ulcers

Professor Keith Harding, CBE, FRCGP, FRCP, FRCS, FLSW, Medical Director of the Welsh Wound Innovation Centre

It is impossible to dismiss the following photographs of pressure ulcers without wondering in sympathy - and shock - how such extensive clinical problems could develop. There is no doubt that the older people who developed these deep pressure ulcers, all of whom have died, would have wanted relief from their pain and discomfort - and have their dignity preserved. When pressure against the skin is greater than the pressure of blood delivering oxygen and nutrients, then skin cells and tissues are damaged. Deep pressure ulcers damage the skin, the muscle and bone. Left untreated, such pressure ulcers can be a cause of death.

Some of us are prone to developing pressure ulcers because of our health histories. For example, people who have limited voluntary movement and cannot easily change their position when seated or in bed may develop pressure ulcers resulting from their body weight compressing the skin and tissues. Where pressure ulcers develop depends on positioning – the heels, ankles, hips, shoulder blades, spine, sacrum and elbows are vulnerable since they are areas not well padded with muscle or fat. The back and side of the head, including the ears, and the skin behind the knees may also become damaged if people are not assisted to move their position in bed. Also, since the production of new skin cells among older people is slow and their skin is thinner and drier that of younger people, it is more susceptible to damage. Skin damage may also result from being dragged up a bed or a chair, that is, as a result of poor lifting and handling technique.

Typically, pressure ulcers are graded based on their severity. Initially, the skin is unbroken but it may be red or discoloured and does not blanch when touched. The site may be tender, warm or cold when compared with the surrounding skin. By the next stage, the outer layers of skin are damaged and may assume a blister-like appearance. If the cause of pressure is not relieved further tissue damage can occur. This will result in full thickness skin loss. If any further damage occurs, it is recommended that *alerts* are made to the Protection of Vulnerable Adults personnel of local authorities and that the Care and Social Services Inspectorate Wales is informed. The next stage of deterioration involves more extensive loss of tissue and may expose muscle, bones and tendons. Finally, an *unstageable* pressure ulcer means that it is difficult to determine the depth of the ulcer damage because the surface of the ulcer is covered with discoloured dead or dying tissue.

In addition to old age, there are other *risk factors* which are associated with the development of pressure ulcers. These include:

1. Limitation of a person's ability to move or reposition themselves
2. Loss of sensation – perhaps resulting from neurological disorders

3. Medical conditions which affect the blood flow such as diabetes and vascular disease
4. Previous history of pressure ulcers
5. Malnutrition, poor nutrition and dehydration
6. Level of alertness – resulting from disease, trauma or medication for example
7. Faecal incontinence
8. Terminal illness

The testimony of people's families [see Section 3] confirm that their relatives were often in the same position for long periods; that their oral care was poor; that they were excessively thirsty; that their diabetes was not well managed; that their meals were unappetising; that they lost weight; that their mobility declined; and that their hygiene was wanting. Crucially, people's families did not describe any means of preventing the development of pressure ulcers such as:

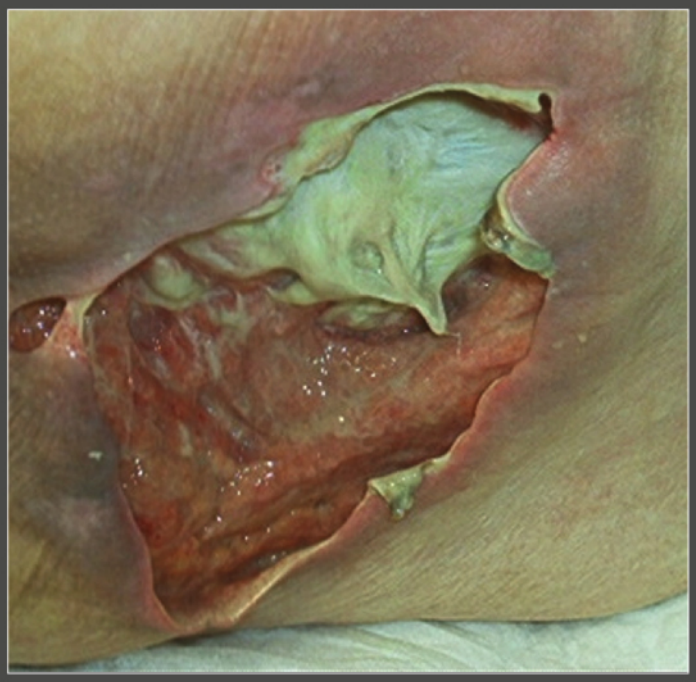
- A skin assessment on admission to the nursing home
- Regular skin assessments to check for signs of pressure ulcer development
- Encouragement to *keep moving*
- Assessment of health and nutritional status to establish who was *at risk*
- The provision of protein – energy dense food, supplements and fluids
- Accurate measurement of people's body weight
- Frequent adjustment to people's sitting and lying positions to redistribute pressure
- The provision of mattresses, cushions and other devices designed to reduce pressure on the bony parts of the body during the day and night
- Comprehensive and regular training programmes for the prevention of pressure ulcers available to staff at all levels as well as residents and their families
- Modern dressing materials – normally used when skin damage has occurred rather than preventing such damage developing, that is, dressings that gel over a wound and adhere to the surrounding skin; keep a wound moist and may assist in cleaning a wound; and foams used to absorb and retain fluid

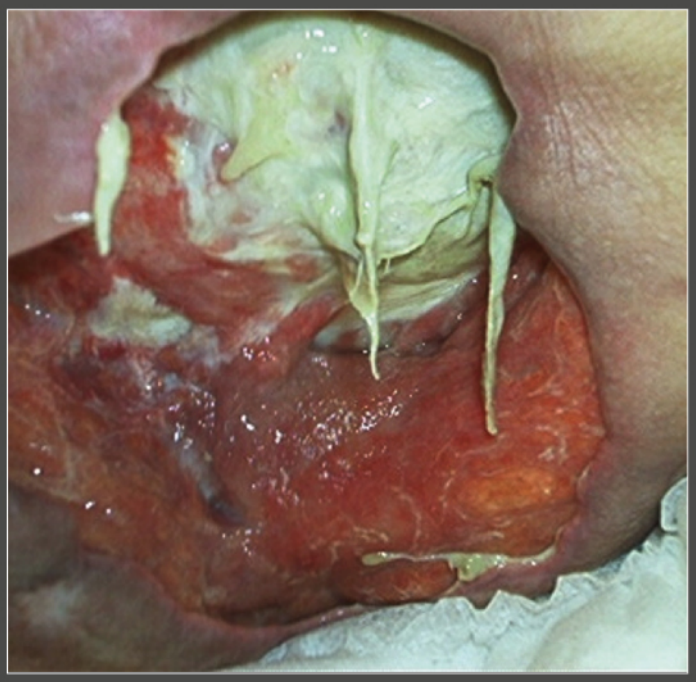
The economic cost of treating avoidable pressure ulcers (and it is estimated that 90% of them are preventable) is staggering.

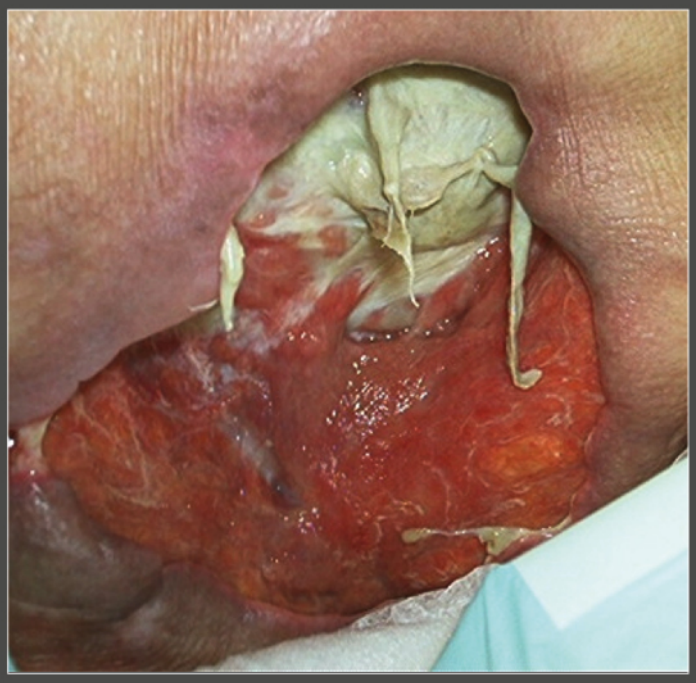
In my opinion it should be known and accepted that residents in nursing and care homes are at an increased risk of sustaining such injuries and appropriate prevention and treatment strategies should have both been in place and implemented consistently.

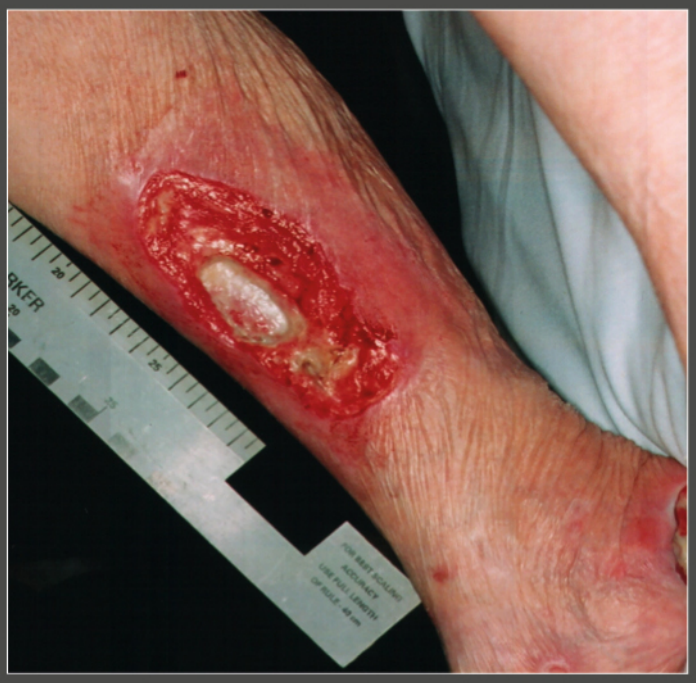
Warning:

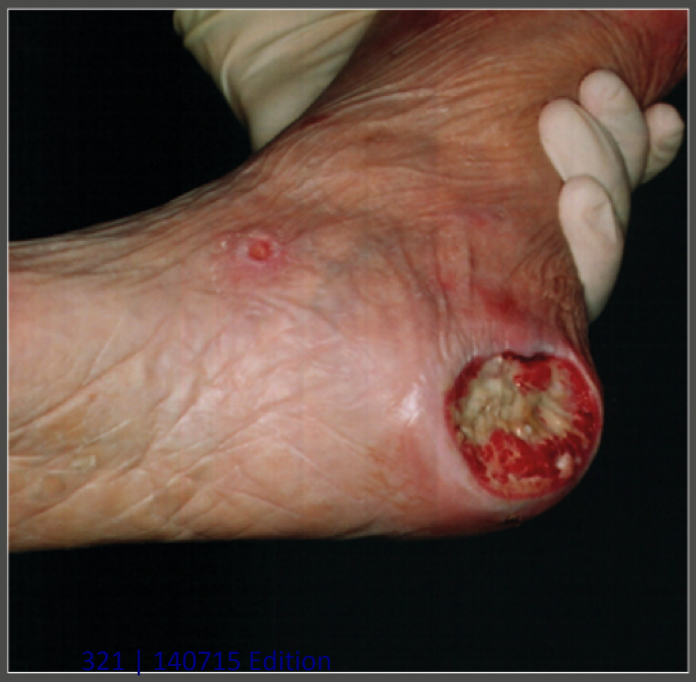
there are photographic images following that may be upsetting

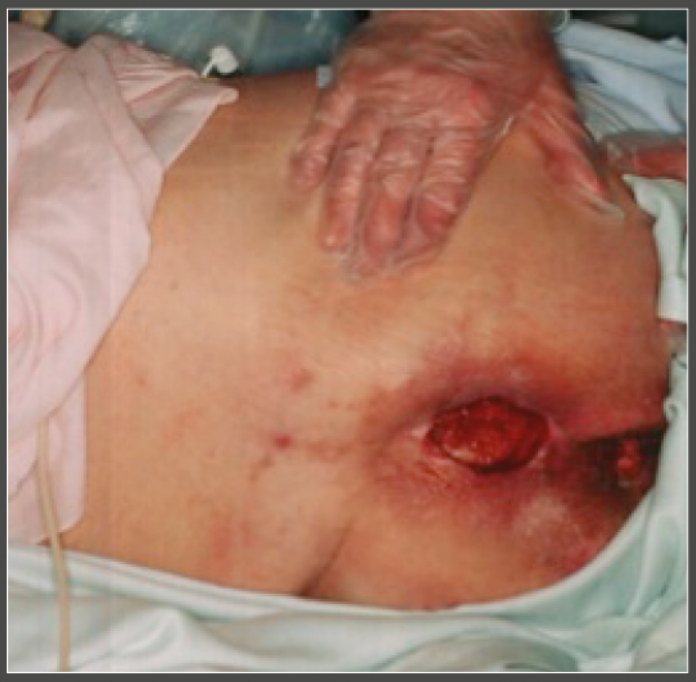












Operation Jasmine Review
Led by: Dr Margaret Flynn

From: Dr Margaret Flynn

Rhian Thompson
Secretary to the Review
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By e-mail only

Date: 19 December 2014

Dear First Minister

Re Operation Jasmine Review

Recommendations arising from the Operation Jasmine Review for the *Regulation and Inspection of Care and Support (Wales) Bill*

Discussions with the families of older people and professionals across disciplines confirm the importance of elevating safe and effective care which is not only **person-centred** but also **relationship – centred** i.e. incorporating an acknowledgement of care which reinforces people's history/sense of who they are/ and ensures that considerate attention is given to their individual support needs - as well as to the primacy of relationships. A shift from an emphasis on what is quantifiable to a critical gaze on **outcomes** would be welcomed.

1) **Legislative expression should be given to the primacy principle of the welfare and wellbeing of people receiving care**[1] and it should be explicit that the needs of *the person cared for* **must include their health needs**[2]

[1] Just as a child's welfare is paramount when making specified decisions, so the best interests of people receiving care should be the supreme principle and reflected in statute

[2] There were persistent failures in securing and delivering effective nursing care and primary health care for older people in the six homes within the purview of Operation Jasmine in terms of: ensuring adequate numbers of nurses; accurate risk assessment and care planning to prevent pressure ulcers; failures in recording and in taking action to prevent/ manage infections; inattention to clinical guidelines and to professional regulation; inattention to expressed pain and pain relief; inadequate hygienic standards; there were delays in seeking external medical and nursing advice re malodorous discharge from wounds and necrotic pressure ulcers; failures concerning adequate nutrition and hydration; repositioning regimes; updating residents' clinical files; the condition of PEG

2) Similarly, it should be explicit that the needs of *the person cared care for* **must include their need to be protected from harm and danger**[3]

The UK's 'care market' is large, competitive and prone to scandal. However, Directors are typically spared civil and criminal sanctions when residents are harmed, even though their employees may be prosecuted. It matters that there is **accountability** and that Directors and shareholders invigilate their own corporations and are held accountable for doing so. It cannot be right that companies and their owners may walk away from the consequences of their profit-related policy and decision-making. Further, although the need to ensure credible corporate safeguards is a long-term goal, greater **transparency** is required

(i) about the private companies responsible for delivering residential and nursing care
(ii) concerning the annual performance of a residential service

3) If the provider of a regulated service is a corporate body or a holding company, **there should be a Fitness of Provider/ Owner test** e.g.
   - **transparency about the legal status of the applicants**
   - **information about the history of other Directorships held and the number of companies – holding, subsidiaries - owned individually and collectively by the applicants**[4]
   - **information concerning the applicants' failed companies/ receivership**[5]
   - **information concerning the criminal records of the service provider/ Directors, including whether or not they have been disqualified under the Company Directors Disqualification Act 1986**

   There should be **a presumption that the burden of proof is on the corporate body, holding company and Directors that they are fit to provide or own**

4) A certificate of registration should be prominently displayed **specifying the name and contact details of the Responsible Individual and this person should be a Director and Board Member of the company.**[6] Arguably the digital age and the computer literacy of many families should be recognised with account taken of families who may require assistance to access such information. A regularly updated website featuring the structural chart of an organisation/ contact information would be helpful.

5) It is recommended that **in the event of the responsibility of the Responsible Individual being delegated, the period of delegation should not exceed three months, after which there will be a legal presumption that registration is no longer valid**

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sites; medication administration and recording; acting on the concerns of relatives and/ informing families of their relatives' deteriorating health

[3] Poor and inadequate healthcare placed residents in harm's way; the inadequate maintenance of homes and their fittings placed residents in danger; and there were no systems in place to ensure the safety and welfare of residents and staff including, for example, the failure to renew safety certificates; train staff re *inter alia,* moving and handling practice; and fire safety

[4] Dr Das and Mrs Dr Das' pattern of ownership alternated the roles of Director and Secretary as they created new companies. They owned all the shares of each company

[5] 15 of the homes of Dr Das and Mrs Dr Das went into receivership

[6] Dr Das fielded unsuitable people

6) It is recommended that if the provider is a corporate provider, **certificates of registration should state the names of the Directors and the registered address of the company**[7]

7) The process of registration **should involve confirmation of consent from the Responsible Individual and the Registered Manager for their names to be put forward**[8]

8) There should be *Annual Returns* prepared by providers and it is recommended that these should include information about the number of staff; their qualifications; and the diversity of the workforce; the total number of sickness absence days; the number of days and nights worked by agency staff; the number of disciplinary actions; the tax paid by the service provider; whether or not HM Revenue and Customs have issued a winding up petition against the company in respect of unpaid taxes;[9] the VAT registration number; the returns to Companies House on 31 March of each year; and the insurance paid *in the event of the persons receiving support being harmed*.[10] **It should also state** the number of residents on 31 March, the number of admissions during the preceding 12 months, the number of deaths which occurred at the home and those following admission to hospital. **Finally**, **it should summarise its responses to complaints, inspections and compliance issues**

9) It is recommended that **information about the dates when professionals visited (such as GPs, District Nurses, Tissue Viability Nurses, Dentists, dental hygienists, Chiropodists and pharmacists, opticians - and the names of the residents they saw during these visits is gathered) is reflected in the Annual Returns**[11]

10) It is recommended **that there will be a legal presumption of registration cancellation in the absence of good cause if the Annual Return is not completed within two months following the end of each financial year**[12]

11) In the event of there being no Responsible Individual for a regulated service, it is recommended **that there is a legal presumption of (registration) cancellation if**

(i) a Responsible Individual cannot be identified

(ii) there are recurrent problems concerning the appointment of the Responsible Individual

12) It is recommended that **a limit is placed on the number of places at or from which the provider provides a regulated service for which a Responsible Individual is registered**[13]

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[7] At least one family did not know that Dr Das owned Brithdir

[8] Dr Das nominated personnel without their knowledge/ consent e.g. a nurse was unaware that she was the acting manager at Brithdir and a woman who did not apply to be a manager was described as the *acting manager* (see published decision of the Care Standards Tribunal re Puretruce Healthcare Ltd, Holly House, The Beeches, September 2006); also, Dr Das nominated Responsible Individuals who were unsuitable and declined to reconsider his nominations. Dr Das was himself the Responsible Individual for Brithdir – even though he had insufficient understanding of the role and his referees were either not contactable or declined

[9] Dr Das did not disclose to the CSIW that HMRC's 2005 winding up petition arose from unpaid taxes, unpaid PAYE contributions and unpaid NI contributions. As a beneficiary of tax-funded contracts with the LHB and local authorities, Dr and Mrs Dr Das should have contributed fairly to tax

[10] An insurance bond – if the home fails this would fund the appointment of emergency manager/ staff and/ or pay for the NHS care of people with penetrating and infected pressure ulcers for example. Why should the public sector fund the medical treatment required to repair preventable pressure ulcers? In the absence of transparency about where the risks for failures lie, the financial consequences are otherwise borne by the taxpayer

[11] Such information would contribute to an assessment of the failure to request medical assistance and failures of treatment

[12] Dr Das and Mrs Dr Das were not compliant with (a) the CSIW/ CSSIW or (b) their corporate responsibilities i.e. they did not, *inter alia,* file accounts with Companies House between 2002-04

The simplistic binary of *compliant vs non-compliant* does not serve residents well since an ostensibly compliant service may disguise a host of operating concerns and fail to identify the necessity of urgent intervention. **Improvement** should hinge on openness to a service's vulnerabilities based on outcomes for residents– taking account of the **involvement** of residents, their families and friends.

13) Cancelling registration must be the final act of the CSSIW following graduated responses to a provider's non-compliance with standards and regulations and inattention to outcomes for residents
14) It is recommended that **improvements which are attributable to the documented efforts of Inspectors, NHS and LA employees *do not* constitute grounds for satisfying Welsh Ministers that (registration) cancellation is no longer necessary**[14]
15) It is recommended that **there is no provision for a succession of repeated improvement notices concerning pressure ulcer prevention and treatment**[15]

Since the tasks of registration are considerable service providers should **contribute to the registration regime** by paying fees.

16) It is recommended that **part-payment, erratic payment or payment out of time of registration fees are sufficient grounds for registration cancellation**[16]
17) It is recommended that **there is a presumption against single Director/ husband and wife Director-companies and/ or an expectation of independent members of the Board i.e. except for smaller companies, at least half of the Board, excluding the Chair, should comprise non-executive directors determined by the Board to be independent. A smaller company should have at least two independent non-executive directors**
18) It is recommended that **in relation to the residential and nursing home care of older and vulnerable people, a critical corporate safeguard is that no one individual should have unfettered powers of decision**[17]
19) With reference to penalties, it is remarkable that fines *not exceeding £50,000.00*[18] are proposed. The actions of private care sector companies have wide ranging public consequences and Wales is in a strong position to demand that these companies do not solely serve Directors and shareholders. With a capped fine limit which reflects only the sum of the original capital that Directors and shareholders invest, there is no incentive to inculcate proper caution into decision-making which adversely impacts on residents e.g. limiting incontinence pads to one per

[13] This will require negotiation with large provider companies since some UK-wide providers have a single Responsible Individual/ Nominated Individual
[14] Dr Das and Mrs Dr Das sought to claim credit for the temporary improvement of conditions at Brithdir but this was not the result of their efforts or those of the manager, but rather the wider NHS community and the tenacity of the CSIW. Such improvements can only be short-lived
[15] The longer the process takes the more compromised the regulator's position becomes. A decisive stance concerning pressure ulcers would be a fitting legacy of Operation Jasmine in Wales
[16] Dr Das *decided not to pay the registration fees safe in the knowledge that cancellation of a registration for such default would be regarded as disproportionate* (see published decision of the Care Standards Tribunal re Puretruce Healthcare Ltd, Holly House, The Beeches, September 2006)
[17] It was believed – erroneously – that Dr Das had absolute discretion when, in fact, Mrs Dr Das was a director of all the companies she incorporated with her husband
[18] To register as a public company there is a minimum capital requirement – the authorised minimum which a public company must have is £50,000.00 (Companies Act 2006)

resident per day, reducing the milk delivery to a home with 60 residents by two thirds per day and removing bulbs from light fittings to save electricity.[19] It is recommended that **penalties**

(i) **are commensurate with those of other regulatory bodies such as the Health and Safety Executive**

(ii) **reflect the public interest associated with care of vulnerable people and the public sponsorship involved** [20]

Inspections should result in a clear, **focused evaluation** which reflects the provider's Annual Account and captures outcomes for residents, the adoption of best practice or risk reduction activities and enforcement actions for example.

20) Since it is too easy to cite the Data Protection Act 1998, it is recommended that **there is a presumption of information disclosure and that the responsibility lies with the person/ service to show that they do not have to disclose**[21]

21) It should be a requirement of registration that providers/ the Responsible Individual should attend a PACE interview requested by the CSSIW. It is recommended that the service risks being de-registered if they fail to attend[22]

Yours sincerely,

Dr Margaret Flynn

[19] These behaviours were described by a former employee of one of Dr Das and Mrs Dr Das' homes

[20] Irrespective of the hundreds of hours invested in prosecuting the owners of Belmont Residential Home, Mr and Mrs Bentley – who pleaded guilty to almost 50 offences – were fined a mere £28,833.00

[21] The LHB refused to share safeguarding information with the CSIW re Bank House

[22] Mr and Mrs Bentley refused to attend