National Assembly for Wales / Cynulliad Cenedlaethol Cymru
Health and Social Care Committee / Y Pwyllgor Iechyd a Gofal Cymdeithasol

Regulation and Inspection of Social Care (Wales) Bill / Bil Rheoleiddio ac Arolygu Gofal Cymdeithasol (Cymru)

Evidence from Justice for Jasmine Campaign Group – RISC 49 / Tystiolaeth gan Grŵp Ymgyrch Justice for Jasmine – RISC 49

Consultation on the Regulation and Inspection of Social Care (Wales) Bill

Submission to Health and Social Care Committee from the Justice for Jasmine Campaign Group

This submission reflects the events of a few families whose relatives sadly suffered significant abuse and neglect in [redacted] and [redacted]. Such abuse and neglect was the subject of an investigation known as Operation Jasmine. The police investigation was completed and subsequent criminal proceedings discontinued due to the incapacity of one of the defendants who suffered brain injuries during a burglary at his home.

In the wake of the collapse of the trial a few of the families have formed a group known as Justice for Jasmine. Our group has campaigned to find out and understand what happened to our relatives and to establish how it was possible for abuse and neglect to take place on such a huge scale and also:-

- To obtain justice in respect of the maltreatment of our loved ones.
- To ensure that those responsible are brought to account.
- To help to ensure changes are implemented both locally and nationally and similar tragedies will be avoided in the future.

We outline below just a few of the very many examples of the unbelievably cruel and abusive treatment suffered at the hands of those who ran and worked at these Nursing Homes. We hope that by highlighting the terrible pain and suffering of our loved ones we can provide additional background and impetus to the Bill, and emphasise the real and urgent need for the Bill radically to replace a system of care for the elderly which has failed in all respects, with a new model which places the welfare of its users at its heart. The terrible experiences of our poor relatives show not only what can happen when providers of services are not sufficiently accountable for their actions, but how the failures of the various responsible care services and regulators to monitor, detect and to take steps to prevent such abuse can itself have dire consequences.

[redacted]

[redacted] was diagnosed with Alzheimer's Disease [redacted]. Advised by doctors to place [redacted] in nursing home. [redacted] was admitted to [redacted] in [redacted] because there was a limited choice of nursing homes which accommodated EMI places. There were serious concerns during the weeks following admission.

- Staffing levels were very low and the level of hygiene was very poor. Her clothes were lost her glasses and even dentures. Excrement under nails. Incontinence pads not changed.
- Many failed attempts by family to contact person in charge regarding serious concerns.
- Unexplained injuries. Plaster over eye-brow, five falls not reported to family.
- Difficulty of communication. Many staff unable to speak English. Concerns over weight loss
- Very poor medical care. No disclosure of pressure sore even though family visited daily. Family were not aware of pressure sore until visited by police three years after [redacted]'s death.
- Nursing home who did not have staff qualified to take bloods. [redacted] had to be taken to local health centre for blood tests. When concerns were raised to care manager family were told "That's what you get for complaining".
- Failure by qualified staff to treat [redacted] with the appropriate care a POVA meeting was initiated by the family
- Tried to have [redacted] moved but failed due to availability of suitable homes. Contacted CSIW (as it was known then). Received no contact off this department.

[redacted]

- No disclosure of any bed sores, family were made aware by hospital staff upon [redacted] admission, of multiple pressure sores, one of which was reported by the hospital consultant as "the worst he had ever seen"
- Hideous stench in [redacted] room, family was informed it was diarrhoea but in fact was the stench from the pressure sores
- Lack of basic nursing care, eyes (sticky), nails(filthy) and oral care (dry mouth, black and filthy muck when carer attempted to clean following family request). Delay in care/action and a reluctance to act by qualified when family raised concerns when [redacted] deteriorated suddenly. [redacted] was admitted to hospital 6 days later following family liaising with the GP, POVA was initiated.
- Upon requesting nursing care daughter was told "I wish I was an octopus so that I can do all you want me to do for your mother "
- Lack of nutrition and blocked PEG tube, severe weight loss, loss of false teeth, which further reduced [redacted] ability to consume food.

[redacted]

- Unexplained injuries eg. Dad falling out of bed when he was physically incapable of moving.
- Dehydration and dads urine always cloudy resulting in dad eventually going into go hospital as an emergency admission with a blood sugar of 43 plus !

- Bad communication with the manager there at the time when addressing concerns. Always felt as if we as a family were being fobbed off with non exceptable answers to our concerns.
- Unexceptable staff language ie : family believed that residents dignity was not the utmost at [redacted] when it came to staff communicating with residents .
- Poor food given, very repetitive menus and cheap food .
- All in all a place where looking back I would like to think would not and should not be nowhere near to meeting the ccsiw standards, in my eyes very very low standard of care hence resulting in this investigation.

[redacted]

[redacted] suffered with late stage dementia and EMI care was recommended. No choice of Nursing home was given and a move to [redacted] was arranged in [redacted]. As the dementia progressed [redacted] became less mobile and by [redacted] had to be PEG fed and was more or less confined to her upstairs room with little or no interaction with residents or staff. By [redacted] cleanliness was questioned in particular the PEG feeding machine. [redacted] was hospitalised on the [redacted] with a seriously infected PEG site, described by hospital staff as "the worst they had ever seen". [redacted] did not recover from the infection and died of Septicaemia two weeks later.

- Concerns that the home smelled of waste, was generally very unclean and rundown.
- [redacted] was bedbound and in a room without a view and no means of stimulus.
- [redacted] lost the top of her finger in an accident at the home which was not advised to the family at the time or fully explained.
- Later developed MRSA in the injured finger which was not reported to the family.
- [redacted] was PEG fed and the machine was always grubby and not properly maintained.
- Later developed septicaemia at the PEG site due to inadequate cleaning routines and was not hospitalised early enough. This resulted in a very painful death.
- No palliative care made available.
- The home lost her wedding ring which had been put into safekeeping.

[redacted]

- [redacted] was bedbound and given airbed which had a faulty mechanism and the noise was continuous and very noisy and the bed ineffective. The home did not replace it.
- Family had to request food on many occasions. Staff had forgotten him.
- No disclosure of pressure sore.
- Patient had severe weight loss and family claimed he looked like a skeleton.

[redacted]

- Personal hygiene and simple aids immediately noticed as lacking at the Home.

- Complaints were listened to but not acted upon.
- [redacted] next of kin was fed the right words but was being lied to.
- Despite Social Worker presence at a review there was blatant non adherence to the truth.
- Measures of care required by Social Worker and next of kin not properly acted upon.
- Qualified persons ignored their duty of care by not calling an ambulance themselves, notifying the authorities or reporting to next of kin when seeing the deterioration of wounds.
- Qualified persons left decision to admit [redacted] to hospital to the matron and far too late.
- Governing bodies did not include or properly inform next of kin.
- Relatives and next of kin were not told of their right to be present at meetings.
- Next of kin first hand witness accounts were not taken into account by the NMC when investigating against the matron.
- Initial Police investigation not handled correctly and valuable time lost in interviewing staff.
- Police not giving all evidence to CPS led to the case not being prosecuted in the first investigation prior to Operation Jasmine.

[redacted]

[redacted] entered [redacted], where she was given sedatives without permission by members of staff resulting in her being transferred to [redacted]. She was discharged to [redacted] on [redacted], and further discharged to [redacted] in [redacted]. There were no signs of bed sores at the time she was admitted to [redacted].

- In [redacted] showing signs of distress and pain, could not speak, feed herself or converse by other means, informed by staff it was all down to old age.
- Staff showed no interest in the resident's wellbeing, calls for water ignored, food left at patients side uneaten (no help given by staff to residents to ensure they consumed some of their meals).
- Staff on duty noted to be in their rest area chatting, painting their fingernails or reading, ignoring resident's calls for assistance.

[redacted] was transferred to [redacted] with a chest infection, where she was found to be suffering from Malnutrition, Dehydration, and Severe Bed Sores. Her back was red and angry looking with two very large bedsores. The top B/sore was 15 centimetres long. The lower was 13 centimetre's long ducting into the bowels exposing part of the back bone. The infection of these areas were so bad that it was not possible for the surgeon to operate due to Septosis.

It is impossible to explain the amount of suffering and distress [redacted] felt and endured while in the care of [redacted].

Family observations included:

Insufficient places available in the area for the number of requirements.

[redacted] staff appeared untrained. Clients left sitting in chairs for too long a period without liquid requirements. Calls for help ignored. Staff lying about client's physical condition. No medical dressing or ointments etc to be seen available in [redacted] Bedroom. No pressure sore mattress on her bed. No member of Staff prepared to report the conditions at the home to the relevant authorities for fear of losing their job.

CONCLUSIONS

In light of our experiences, we fully support the principal aims of the Bill and in particular its intention to reform the regulatory regime for care and support services, including reform of the inspection regime. We also agree that the regulatory framework should be focussed on outcomes for service users and the placing of "well-being" at the heart of care and support.

What is most important in our view is that those who are responsible for poor, sub-standard care services, from those at the front- line delivering the care, to those responsible for supervising and regulating those carers, are all fully accountable for their failures, and that there is transparency at all levels. The provisions of the Bill appear to be aimed at delivering these important principles. However, in order to achieve these it is essential that there is sufficient funding to ensure that the quality of services keeps pace with the ever-increasing demands placed on them, and that there is a total shift of culture away from that of minimum standards and box-ticking to one where excellence and compassion are the norm.

Justice for Jasmine Campaign Group

24 April 2015