BREAKING THE SILENCE

PART THREE

HEALTH HAZARDS

SILENCE

DENIAL

COMPLACENCY

COVER-UPS

A REPORT BY EILEEN CHUBB
Of Compassion in Care
INTRODUCTION

My name is Eileen Chubb; I am the founder and Director of the Charity Compassion in Care. I am also a former Bupa care worker and Whistle-blower (Bupa 7). My work brings me into daily contact with both relatives and Whistle-blowers (Staff) who are concerned about the treatment of elderly vulnerable people in care.

I have always approached the investigation of care homes fairly, choosing to include a number of random homes alongside those homes where I have been informed of concerns.

Part of my work involves visiting care homes. In my efforts to be fair and not be accused of picking on their homes I realise I have given Bupa too much leeway. I have given them an advantage I would never give any other bad care provider. However it has become increasingly apparent that there are serious problems in Bupa homes with a disproportionately high number of concerns being reported compared to companies of a similar size.

As a former Bupa care worker who reported widespread abuse of vulnerable elderly people which was fully upheld by the regulator (See appendix for the inquiry report) my experience of Bupa is of a company that fails to learn from mistakes, where an ingrained culture of denial has led to abuse continuing unchecked. Such a culture in any company would be of concern but when it is a company that has responsibility for the care of the most vulnerable, it is a culture that can only result in suffering.

About the homes used in this report.

The homes are taken from the following sources,
- Tales of The Un-Inspected (See www.compassionincare.com)
- Media reports.
- Freedom of Information requests.
- Individual testimony.
Health and Safety prosecutions and compliance notices.  
The Nursing and Midwifery Council (NMC)  
Coroners Inquests
I have only used a couple of examples where the CQC have raised concerns. The reason for this is that in nearly all the homes where abuse and neglect occurred, the homes were judged to be compliant at the time the events took place. For this reason I have little faith in CQC inspections.

Apart from the homes used in this report I have more than 50 other Bupa homes where concerns have been raised with Compassion in Care but which I have not included as the information is confidential.

In total 115 of Bupas 290 homes have had serious and avoidable failures.

It should be noted that most abuse never makes the news, most of the available information about bad homes is kept from the public and not published in CQC inspection reports. It is only by obtaining such information as safeguarding alerts or death rates that the true scale of suffering is exposed. However there is one action that can prevent that suffering, protect whistle-blowers and break the silence that allows all abuse to take place.

In 1999 I blew the Whistle on the horrific abuse I witnessed in Bupas Isard House, 15 years later I am still trying to protect the people in their homes. Both residents and the brave Whistle-blowers. How many more vulnerable people have to suffer before action is taken?

Currently Whistle-blowers risk all to report concerns. It very often results in the whistle-blower being the one with no job or hope whilst the abusers go on to thrive, are often promoted and some even receive OBEs.

The Public Interest Disclosure Act has failed to protect Whistle-blowers and those they tried so hard to protect. I believe the only way forward is to scrap PIDA and create a new law that would protect the protectors, hold bad companies and their Directors to account and send out the message that it is safe to speak out. I would call this new law Ednas Law.

Eileen Chubb
This report is dedicated to all the victims at Isard House, but especially to Edna who had no family to speak for her, the first to suffer because of PIDA’s failure.
It is also dedicated to Agnus Nisbit of Pentland Hill, the last home in this report sadly not the last victim of a company that is seemingly beyond the law.
BUPA HOME 1.

ISARD HOUSE BROMLEY

April 1999 The Bupa7 whistle-blowers report widespread abuse at Isard House. Which is investigated and upheld by the regulator.

THE KENTISH TIMES. 21/6/02
BUPA CHIEFS RUBBISH ABUSE ALLEGATIONS.
In April Bromley Council extended BUPA’s contract to run six homes in the borough for two years on the recommendation of DAVID ROBERTS, Bromley’s Assistant Director for older people, he said “If BUPA had not been up to the job it would have been dealt with eighteen months ago in the investigation, we have tightened up the monitoring at Isard House and it appears to be working.

PRIVATE EYE, 3/8/04.
By Heather Mills.
BUPA finally seems to be getting to grips with the serious problems relating to the care of old people that have dogged Isard House care home in Bromley for the last five years. Since the eye last appeared more staff at the home have been sacked or suspended amid allegations of mistreatment and neglect, following the arrival of a hit squad from BUPA, investigations are continuing and more disciplinary action is expected. One sacked care worker is understood to have been one of those whom BUPA relied on five years ago to defend itself against claims from seven whistle-blowers of serious abuse and neglect in the home, which caters for up to 66 old people with high levels of dependency, it was alleged residents had been left in their own mess, were handled roughly and inappropriately drugged.
More recently reports from the new Commission for Social Care Inspection, have failed to spot the issues currently at the centre of allegations at the home, but the commission has found that the home has consistently failed to reach even the minimum standards in care needs and training. It also expressed concern about the high numbers of falls and accidents requiring hospital
treatment. Yesterday BUPA declined to give any details of the latest allegations, but said it was continuing to investigate “Concerns raised by staff.” To date five disciplinary hearings are due to take place, one staff member has been dismissed and one has been given a written warning. Eileen Chubb one of the original whistle-blowers said “The trouble is that by denying and fighting our claims five years ago, BUPA sent the wrong message to the core of the staff at the home and because of that, nothing has changed.” She may be right, advertisements have already appeared in the local paper for an unspecified number of staff, phoning up to enquire about a job as a senior care worker, an eye reporter was offered an immediate interview, she was not asked about any previous experience, qualifications, or if she had a criminal record, all mentioned as areas of concern in the last inspection report.

KENT ON SUNDAY 5/9/04
By Jamie McGinnis.
Shadow Home Secretary David Davis has backed a call from a group of former caseworkers to bring in better safeguards for Whistle-blowers. Mr Davis encouragement came as the BUPA seven hit back at their former employers dismissal of their claims of patient mistreatment. In an earlier article in the Kent on Sunday BUPA said “It encouraged Whistle-blowers to come forward” but Mrs Chubb said “She would feel safer informing on the Mafia” and she refuted BUPA’s assertion that none of the concerns raised in 1999 were ever substantiated, she showed the Kent on Sunday a copy of a report by Bromley Social Services which upheld allegations about patient care at Isard House. But Peter Ludford, Director of BUPA Care homes this week dismissed the findings of the report claiming that any failings identified were only “Minor.”

Private Eye 4/3/05, BUPA DON’T CARE HOMES.
By Heather Mills.
Former care staff who made serious allegations of neglect, potentially fatal doping and mistreatment of old people at Isard House, a BUPA run care home near Bromley in Kent, have at last learned what action police took in response to a dossier of evidence they submitted three years ago, it was all but ignored.
No statement was taken from any witness, no member of staff from the home was interviewed and BUPA itself was never even approached over the allegations. In fact police notes suggest that just a few hours after three bundles of documents, mainly complex medical records were submitted officers had already decided that “No crime had been confirmed.” This is alarming since on face value the medical sheets seemed to show that a number of elderly residents were given potentially fatal doses of powerful drugs. One resident E.P (Edna) had on four occasions been given a dose of tranquilliser that was Nine times the daily prescribed dose, 30mls and Six times higher then what is considered safe for an elderly person. Eye readers may also recall the case of Audrey Ford another Isard House resident who was taken to hospital suffering from the side-effects of a powerful Anti-psychotic which should only have been given to those suffering severe mental illness, like Schizophrenia. She never recovered and the Coroner recorded an open verdict

KENT ON SUNDAY 1/5/05
By Jamie McGinnis.  
A private healthcare firm has apologised over new figures appeared to show the number of falls at a care home it ran where higher than previously suggested. BUPA which ran the home until last month had maintained there were only 16 night time “Accidents”, but a newly unearthed report shows there were 34 night time falls in that period alone. Eileen Chubb requested the figures from Bromley council under the new, Freedom of Information Act. Mrs Chubb said she was disturbed to read minutes of a meeting between BUPA and Bromley council, which detailed an incident where a frail old woman at Isard house was found with a broken arm one morning in February 2004, in the minutes the manager of the home complained that staff had been found sleeping on duty. However this incident does not appear in the fall statistics for Jan to July 2004. Terry Rich director of Social Services said he did not want to comment on the falls figures saying that CSCI carry out regular inspections at Isard House.
THE NEWSHOPPER. 13/7/05
By Bede McGowan.
Whistle-blowers are calling for the resignation of a Social Services chief after a
damning report was published into care standards at six BUPA homes, Shaw
Healthcare took over the running of Bromley’s care homes for the elderly in
April 05, when the council’s contract ran out. Since the transfer 280 staff have
undertaken a training program on skills such as, the administration of
medication, adult protection and whistle-blowing. Members of the BUPA Seven
resigned as caseworkers from Isard house in 1999, alleging abuse as well as
potentially fatal drugging of elderly people.
Spokesman Eileen Chubb said “The care failings listed in this report show
elderly vulnerable people have suffered for six years and that suffering was
totally avoidable, we now call for DAVID ROBERTS’s resignation.” Mr Roberts
decided to comment...BUPA have always said there was no evidence to support
the BUPA Sevens allegations, a BUPA spokesman said “We strongly refute any
suggestion that the new provider inherited poor quality care.”

PRIVATE EYE. 16/7/05.
By Heather Mills.
Isard House, Bromley councils report on the successful transfer of six of its care
homes from BUPA to Shaw, makes very interesting reading, the homes included
Isard House where seven Whistle-blowers lost their jobs after making allegation
of abuse, drugging and ill-treatment,
The report said one of the major areas of concern, the large numbers of
admissions to hospital of elderly people through falls and ill-health had”
Significantly reduced.” This is good news for the residents as it was as long ago
as 1999 that the BUPA Whistle-blowers lost their jobs, ever since they have had
to fight tooth and nail to get the council and BUPA to act on their claims, the
council put out the contract to tender last year, BUPA however remains in
denial, spokesman Oliver Thomas said “We strongly refute any suggestion that
the new provider inherited poor quality care, the regulators were always
satisfied with the care we provided.”
I had accepted long ago that there could be no nice neat ending, the dramatic court scene I had once imagined where justice is finally done. I now know is something that only ever happened in the movies. But this story was much bigger for it showed what was at the heart of the system, it was not a question of how hard I had to fight to stop abuse, it was that I ever had to fight at all.

I had always joked that one day I would write it all down and now with my leg in plaster I am doing just that. It is only now that this story is finally told that I realise why I felt so driven to write it in the first place. This is the truth and if these words are read by another then the truth has prevailed.

The justice I had so long sought was not to be found in any court, nor was it forthcoming from any judge, but there is a higher justice when the truth prevails.

Thank you for bearing witness for Edna, Jessie, Dot, Reg, Lil, Florie, Ivy and all the others whose suffering was held so cheap, you are their justice.
BUPA HOME 2
WENTWORTH CROFT PETERBOROUGH.

The family of a resident had previously raised concerns with the home about the lack of basic care, which included dehydration, an untreated sore on their mother’s neck and a blocked catheter. Their relative had caught MRSA whilst in the home. Three months later the resident died from sepsis as a result of a grade four pressure sore.

Incident Report (Source Compassion in Care letter to CQC) In the summer of 2006, J removes her relative H from the home and makes a formal complaint. She would find H without food or drink, so saturated in urine it had soaked through the chair and pooled on the floor. H suffered drastic weight loss which was reversed once he was removed from the home. Haloperidol drugs were obtained in his name and not accounted for over a long period of time. J never had her concerns investigated and rang our helpline; she could not understand why the Safeguarding Adults Board (The Authority that investigates all allegations of abuse) did not take action. I obtained information that listed the members of the Safeguarding Adults Board, among them the manager from Bupas Wentworth Croft.

Incident Report (Source Media Report) 2006. The NMC strike off Nurse Bernadette Searle for abusing residents at this home. The incidents included medication abuse and tying dementia sufferers to chairs over a 4 year period (2000 to 2004)

Incident Report (Source FOI) 4th August 2006. A relative contacts the regulator saying her mother was left distressed on the toilet for over 2 hours with her call bell unanswered. Safeguarding ask the home to investigate themselves. Wentworth Croft concludes the resident chose to stay on the toilet for 2 hours.


Incident Report (Source FOI) 19th November 2007. An anonymous Whistle-blower rings CQC with concerns staffing levels are so low that residents care is at risk.
Incident Report (Source FOI) 5th December 2007.
A relative rings CQC desperate for help, says their loved one is dying of thirst.

A resident from Wentworth Croft rings the local authority to report a member of the night staff, saying he is very rough and shouts at her. This resident is so afraid she barricades herself in her bedroom whenever this care worker is on duty. The resident is concerned for the other residents also. The home manager is asked to investigate.

A second Whistle-blower rings CQC and says that standards have gone down in Wentworth Croft in the last two months and a lot of good staff are leaving. Staff morale is very low and a lots of people are going off sick with stress. Staffing levels are below an acceptable level. Where there should be 8 or 9 staff per shift there are only 4 or 5. There has been no laundry for 7 days, no clean sheets for beds, and the sheets that are available are threadbare and torn. There are no pillows except those with the name of a hospital printed on them which are filthy. The Whistle-blower says they are working a 72 hour week, residents care is suffering and they give the name of a resident who has developed pressure sores as a result. The Whistle-blower said they had told the manager of Wentworth Croft about these concerns and felt fobbed off as nothing had changed.
The CQC asks the Whistle-blower if they can pass on the concerns to the manager, which they do. The manager responds to the CQC stating their previous actions were sufficient.

Wentworth Croft informs CQC that a third Whistle-blower has made allegations about a member of night nursing staff. The Whistle-blower states various forms of abuse have taken place over time. The manager says none of the allegations involve assault. The allegations are subsequently noted to range from rough handling to physical assaults. CQC inform Safeguarding.
A relative informs CQC that they found their relative in bed in Wentworth Croft, there was a strong smell of urine and their relative was cold as the window was left open. There room was dirty with clothes and food strewn across the floor. The home manager was asked to investigate. The outcome was the resident was referred to the Community Psychiatric Nurse (CPN) But such a response is not dealing with the neglect.

Wentworth Croft informs the CQC that a resident in the home alleges they were verbally abused by a member of staff and that another staff member witnessed this. The staff member was suspended but subsequently reinstated as the witness said they did not see anything.

A relative raises concerns that his wife, who went into Wentworth Croft for respite care had been left in bed and she developed a grade 2 pressure sore. She had been found lying in faeces. She had lost weight and became poorly in the short time she was in that home. The husband says he had to work hard to get her back to how she was prior to entering the home. He is worried because she is due to stay there again; he does not want to complain but just wants her to be cared for.

A resident from Wentworth Croft is found on the floor with a large bruise on their forehead which is not consistent with a fall. There is also bruising on her arm consistent with being squeezed. It was concluded by the home manager that she was assaulted by another resident.

CQC is called by a member of the public on behalf of a fourth Whistle-blower who fears losing her job and wishes to remain anonymous. The caller says they were shocked when told of the concerns which relate to the welfare of residents and staff and how Wentworth Croft is being run. The whistle-blower has worked in that home two years and has seen the following,
A resident told the Whistle-blower that night staff had dragged her out of bed and that is how she sustained a broken thumb. The manager at Wentworth Croft told staff not to report this.
Residents have an allowance of £20.00 which should be used to buy what they need such as toiletries, this allowance is not being used for them and
the residents have no toiletries and the men have to be shaved with blunt razors.
Some residents are being put at serious risk of harm because they are being mixed with violent disruptive residents.
A female resident (Who was named) was sexually assaulted by a male resident and the manager told staff not to report this.
Call bells are ringing for up to an hour at a time as there are not enough staff to attend to residents.
The manager was said to have poor relations with staff and was unapproachable.
The rotas were completed according to which staff were liked or had been good to the manager they were getting the best shifts.
Staff were afraid of making a complaint or speaking out because it would go against those staff if the manager found out.

Incident Report (Source FOI) May 2009
A fifth Whistle-blower who works for an agency was concerned after working a shift at Wentworth Croft and reported her concerns to the agency who told her to ring CQC, which she did.
The Whistle-blower said staff had told her some of the staff hit the residents. She said hoists were not used correctly.
A resident who had MRSA was sitting with other residents with an open undressed wound on their hand.
Another resident with a pressure sore was in obvious pain.
She said hygiene in Wentworth Croft was appalling.
She had been told another Whistle-blower raised concerns but no action was taken apart from transferring a staff member to another unit within the home.

The Safeguarding Adults Board informed the CQC of concerns reported about the care of a resident at Wentworth Croft. That staff were not turning this person, their ear drops were not administered, and their blood sugars were not monitored and they did not receive the pain killers prescribed. The concerns were partially upheld.

My Full Report on Wentworth Croft Can be found on www.compassionincare.com Tales of the Un-Inspected (40)
The FOI document can be found in the appendix section at the back of this report.
Incident Report (Source Media Report) December 2\textsuperscript{nd} 2009.

Things got so bad in Oakhurst Grange it was reported in the local paper. A Bupa spokesperson said:
“We take the issues raised in the CQC inspection seriously. Following the inspection in October we immediately implemented an extensive improvement plan to ensure standards are raised as quickly as possible”

Incident Report (Source Media Report) 2010
NMC strike off Bupa senior nurse Violet Ruto. She went to work a shift in another Bupa home nearby and was reported for arriving at work so drunk she could barely stand. She was asked to carry out a medication round. She was later discovered slumped over the medication trolley. No one seems to have asked why she was told to do the medication in this state? The shift at Aston Grange occurred on December 1\textsuperscript{st} 2010.
However prior to this, in November 2010, whilst working at Oakhurst Grange the Deputy Manager noted she was so drunk she nearly fell of a chair twice and had to be escorted from the building. She was observed teetering up the path and falling into the bushes. This was not enough to stop Ms Ruto returning to work shifts at Oakhurst Grange. Other witnesses gave evidence of incidents at Oakhurst Grange, staff were unable to locate Ms Ruto on one occasion and on another Ms Ruto was found asleep in a cupboard.
What is more worrying is the fact that 28 days after she was reported as drunk on December 1\textsuperscript{st} 2010 by Ashton Grange, she was still working shifts at Oakhurst Grange, where on December 29\textsuperscript{th} she was noted to be so drunk she mistook a teddy bear for a baby.

Incident Report (Source Media Report) June 2013
It is announced that the council is moving 52 residents from Oakhurst Grange as their safety and welfare is at risk, three and a half years after the first media report on this home noted serious concerns about the welfare of residents. Bupa subsequently closed the home.
BUPA HOME 4
WEST RIDINGS CARE HOME  WAKEFIELD


Incident Report (Source Media Report) January 2009. NMC caution nurse after she obtained drugs from West Ridings care home and was selling them in the car park. The drugs were prescribed to residents who would not have received their medication due to it being stolen.

Incident Report (Health and Safety Case,) September 2009. Health and Safety prosecute Bupa after 80 year old Muriel Lindley fractures both legs after being dropped by a care worker who was working alone. This care worker had only started work at West Ridings care home a few days earlier. Muriel Lindley died a few days later.

My full report on West Ridings care home can be found at www.compassionincare.com Tales of the Un-Inspected (42)
Incident Report (See NMC v Priscilla Smith) 2008.
Nurse Priscilla Smith is struck off by the NMC for falling asleep on duty; she was allowing dangerous administration of medication over a long period of time.

Nurse I Haskins is struck off by the NMC for administering un-prescribed drugs to residents, falsifying medical records and carrying drugs hidden on her person. She took call bells away from residents. One care worker blew the whistle and said Haskins administration of the drug Temazapan was the last straw. Haskins had worked at St James Park since the 1990s yet in all the time she worked there many staff must have witnessed her behaviour. The Temazapan she administered to residents were not prescribed for those residents and were taken from the homes stocks but the missing drugs should have been noticed.

My full report on St James Park can be found at www.compassionincare.com Tales of the Un-Inspected (51)
Incident Report (Source Media Report) 2008. Care worker Zoe McGinn 18, is dismissed for posting vile comments about the residents at Claremont on the internet.

Incident Report (Source Media Report) 2008. NMC strike off Nurse Frederick Pearson for shoving an elderly resident who had dementia.

Incident Report (Source Media Report) 2009. Nurse David Rodger is convicted for slapping an elderly resident at Claremont.

Incident Report (Source Media Report) 2012. Janice Glover a senior care worker at Claremont is accused of abusing residents and staff between 2009 and 2011. Glover is said to have stuck a pen into one resident’s ear and left another to sleep on the floor. She continually banged on a window to torment one of the residents and used foul language. Staff were said to feel intimidated and bullied.

Incident Report (Source Media Report) June 22nd 2013. Nurse Zareena Khatun was reported to the NMC after a resident died on the night of June 22nd. Resident A was found on the floor with injuries to his face and forehead. He was administered Temazapan and no neurological checks were carried out.
Incident Report (Source Media Report) 2011
Whistle-blowers inform the CQC of widespread concerns about residents care at Donnington. The CQC inspect the home and finds a resident in a urine soaked bed as staff are too busy to attend to him. Residents are found to have been left without enough to eat or drink. The home was dirty and it smelt.
Bupa says they are putting an action plan in place to bring in new management and retrain staff. However, the staff knew that what was happening was wrong, and they took their concerns to CQC. It is not the staff that need training. There are clearly too few staff to care for people.

Nurse Barbara Kowalska ranted at elderly cancer patient Albert Inggall calling him dirty and filthy and rubbed faeces on his nose telling him “If you do that again you will be eating S*** cake” The care assistant who witnessed this reported it to a colleague as she was too afraid to say anything to Kowalska.

BUPA HOME 8
WARREN HALL TIVEDALE

Incident Report (Source Media Report) December 2010
In 2007 an 81 year old resident at Warren Hall, Ronald Kemble was found in agony by his daughter. It was discovered that four hours earlier staff had inserted a feeding tube into his lung. He died as a result of this. Bupa refused to admit liability and Mr Kemble’s daughter had to fight for three years before Bupa offered an out of court settlement.

A 25 year old care worker is arrested after allegations that he sexually assaulted an 85 year old resident at Warren Hall. He has been bailed pending inquiries.
BUPA HOME 9

WILMINGTON MANOR, DARTFORD.

The Deputy home manager who is also head of care at Wilmington Manor is convicted of assault. Nurse Kate Ugohugwu was observed on two occasions force feeding 102 year old Henry Hobbins. Other staff pleaded with her to stop but she dismissed their concerns.

Post 1
Incident Report (Source Comments Sunday Express Newspaper) 31/5/09.
“My mother died in a Bupa home in Wilmington, Dartford. The care she received was terrible and we were going to try and sue them. They never phoned us when she was dying till it was too late. When we asked for all the care plans she had died alone. Then when we read more into the paper work we discovered that some weeks before she was in terrible pain screaming out on ten occasions all they gave her was Paracetamol and they wrote still in pain. They never reported it to the Doctor or us for stronger pain killers. She also developed a pressure sore on her heel and two of her toes which went Gangrenous which was written by a nurse on the care plan but they never informed the Doctor. It was only ten days after my Brother noticed my mother’s toes and told them to call a doctor, also she had a small stroke and they said she was OK, it was only us that had to tell them to call a doctor. I could go on even more about all the other terrible treatment my mother received at this Bupa home”

Post 2
“My aunt was in a Bupa Home, she was severely dehydrated, malnourished and had rotting, gangrenous pressure sores. The CSCI (Now CQC) colluded with Bupa at every opportunity. Bupa believes (i.e. its directors and care workers) that it is unaccountable, what do old people do? They die. The list of elderly people with dementia abused and neglected in Bupa homes reads like a scroll of the war dead. There is a common theme of malnutrition, dehydration and pressure sores in most of the cases. Following my aunts death I wrote to Bupas chairman and CEO asking, either your care workers have full cognitive awareness and know what they are doing to residents or they are intellectually sub normal and do not. They could not reply. The day is coming when Bupa WILL be held accountable for the terrible suffering and worse they have inflicted on elderly vulnerable residents”
Post 3
“...I have worked in one of their homes and helped place my grandfather there. What a mistake that was. I feel he would have lived longer if we had not done so. The way he was treated was disgraceful, near the end of his life he was in severe pain and had not been encouraged to be mobile for a long time. He was left in his room most of the time and near the end he needed oral morphine to control pain. He could not take it he was choking on water never mind anything else. I know and will stand in a court of law to state he did not have it, as I had it in my hand they filled in the drugs register saying he had it. Therefore leaving him to die in pain. But for us complaining that is what would have happened. Further to our complaints I was forced out of my job by a regime of bullying and intimidation”

BUPA HOME 10
CLARE HALL  SOMMERSET

Incident Report ( Source Health and Safety ) 26th June 2002.
Health and Safety fines Bupa £23,000 as a result of a fatality at Clare Hall. Bupa did not control the risks of bed rails including the suitability of equipment, failure to provide Health and Safety information and written instructions for staff.

Bupa is fined £35,000 after a second resident dies after becoming in-tangled in bed rails at Clare Hall. Bupa were found to have the same poor risk assessment and inadequate staff training.
Two deaths in five years as a result of the same failings in the same home.
BUPA HOME 11

AMBERLEY COURT, BIRMINGHAM.

Incident Report (Source Media reports) 2005
Bridget O’Callaghan was admitted to Amberley Court for respite care, she was wheeled into her bedroom and should have been assisted to bed but was left fully dressed in her wheelchair. She was discovered dead the next morning. She had slid down in her wheelchair and been strangled by the lap belt. The nurse in charge the previous night had written notes saying Mrs O’Callaghan had been checked hourly, she left the country before any charges could be brought.

BUPA HOME 12

AMERIND GROVE BRISTOL

Three years after complaining about the care of his mother Iris Shepway received in Amerind Grove care home. Her son’s complaint is upheld by the LGO (Ombudsman). The local authority are ordered to pay £6,000 and the costs of removing Mrs Shepway to another home. Complaints were made to both Bupa and the local authority in 2008 by Mrs Shepway’s son, who found her lying in a soiled bed scratching her legs which were bleeding. She had obviously been left there a long time.
The Ombudsman said:
“ I find this particularly troubling in view of the number of serious safeguarding alerts (About Amerind Grove) the council were receiving throughout the time Mrs Shepway was a resident. Had more robust action been taken by the council then the poor standard of care she received may have been detected sooner”

Lesley Weir a staff member at Amerind Grove is found guilty of theft.
ABBOTSELEIGH MEWS  SIDCUP  KENT

93 year old Charlotte Woods is dropped from a hoist at Abbotsleigh Mews and dies from her injuries. Bupa are prosecuted by Health and Safety and fined £90,000. A Health and Safety spokesperson said:
“ Untrained and poorly supervised care assistant working alone used the incorrect hoist to transfer a resident who fell and died from her injuries. Lots of policies and procedures but they were not implemented, training schedule similarly not followed”

THE SIDCUP NURSING HOME  KENT

Incident Report ( Source Media Report ) 2003
78 year old Jean Bore dies in agony from multiple infected bedsores after spending four weeks at the Sidcup Nursing Home.

82 year old Irene Schoepff was found dead with a pillow over her face. Police officer attending the scene at the Sidcup home said; “That care assistant, Emily York, asked to speak to him alone as the home manager told the staff not to say much to the police.” The police believe it was suspicious. However it later emerged that Mrs Schoepff who was totally reliant on staff to turn her in bed, had probably suffocated. Recording a narrative verdict the Coroner said:
“ There was no satisfactory explanation for the position in which she was found. The precise circumstances of her position when found and the cause of death remain unexplained”.

ELM RIDGE  COULBY  NEWHAM

Incident Report ( Source Media Report ) 2004
Trevor Morris dies from burns sustained six months earlier when he was scalded in the bath at Elm Ridge care home.
Incident Report (Source Health and Safety) 2000
Un-named male resident with dementia falls from an upper floor window. A passer-by calls an ambulance as the staff at Kingswood were unaware of the fall. The man dies from his injuries a few days later.

Incident Report (Source Local Media Reports) 2004.
Bupa loses the contract for the Bromley council homes. Which are taken over by Shaw Healthcare. Shaw Healthcare give the Council a detailed report listing widespread serious problems inherited from Bupa in all the former Bupa homes including Isard House and Kingswood house.
Problems included
Staff with outstanding disciplinary action against them.
Poorly trained, un-supervised staff and some were not suitable to work in care.
A disproportional high number of residents suffering falls and injuries requiring hospital treatment.

Eleven residents die in a ten day period, six of the deaths were linked to flu.
HIGHFIELD CARE HOME    HALESWORTH

Incident Report ( Source Media Report ) September 2002
Joan Gadds a resident at Highfield care home is admitted to a local hospital suffering from infected bedsores and in renal failure due to severe dehydration. She dies a short while later.

BEDFORD CARE HOME    LEIGH

Standards at the Bedford care home are slammed by angry relatives after their loved ones suffered appalling conditions and lack of basic care. Residents had suffered hunger and thirst, were left soiled and at risk from pressure sores.

BEACON EDGE    CUMBRIA

Incident Report ( Source Media Report ) July 2014
William Bowman 22, Chevonne Benson 23, and Clare Strong 21 were all convicted of abusing elderly residents. Most of the abuse was listed during an earlier hearing and described as deeply disturbing by the judge. Only a few of the incidents at Beacon Edge were mentioned during the full hearing. Those incidents mentioned included:

Taking photos of residents in humiliating positions.
One resident stood sobbing as she had been told she needed £100 to sit in a chair.
Another resident had her hair yanked.
Others were assaulted and tormented.
A Whistle-blower Miss Burns, was working her first shift at Beacon Edge and was so disgusted by what she saw she immediately resigned and reported her concerns to Social Services.

The News and Star asked Bupa why the abuse had gone undetected for such a long time and would any managers be disciplined? Bupa responded by implying their robust whistle-blowing policies had been used which clearly was not the case.

If Miss Burns had not reported what she saw the abuse would have continued unchecked. The points I noted were:

The Whistle-blower felt they had to resign in order to report the concerns.

If this one person could see so much that was wrong happening in the space of just one shift, why did no other staff working at Beacon Edge come forward and raise concerns?

The Whistle-blower was new and yet the abusers felt complacent enough to carry out the abuse in front of her. This indicates a culture where the abuse of vulnerable people was carried out by perpetrators who felt safe to behave in this way.

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**BUPA HOME 21**

**ST DAVIDS HOME REDCAR**

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Resident Dorothy Robson dies after a fire at St David’s care home and the ceiling collapsed onto her. A Coroner’s Inquest hears evidence from staff at St David’s that the evacuation was chaotic and staff were not fully trained in evacuation procedures.
Incident Report (Source Media Report) December 2010

Three care workers from the Dales care home are jailed, Jolene Hullah 21, and Tanzeela Safdar 23. Recorded their abuse on mobile phones as they assaulted, bullied and tortured elderly residents. The other worker involved in the abuse was named as Hannah Parveen who is believed to have fled to Pakistan.

Several clips show elderly resident Mr Costigan being physically assaulted by laughing carers, his thumb pulled back causing considerable pain, hands pushed into his mouth. Mr Costigan holds his head in his hands and cry's in distress. The other resident filmed, Edith Askham, being bullied and assaulted as she sits on the floor crying "help me I am frightened".

The third care worker jailed, Paul Poole, did not take part in the abuse but is caught on camera watching, and not intervening. He told the court he was too afraid to report it. The abuse was only discovered as a cousin of Jolene Hullah saw the film footage on her phone and then reported her to the care home who called police.

Many staff in this home must have at some time witnessed what was going on and yet it was the family member of one of the abusers who raised the alarm. This case is noted to be one of the first cases brought under, The Mental Capacity Act. The first ever case prosecution was also a Bupa home. (See Home 23)
**BUPA HOME 23**

**BAKERS COURT   LONDON**

Nurse Romona Dublas, 41, has been convicted in the first ever prosecution under The Mental Capacity Act. Dublas photographed an 92 year old resident of Bakers Court, who had dementia. The un-named female resident was photographed held up by her wrists naked to the waist. A social worker at Newham Council was made aware of the photo and informed the police. A Newham council spokesman said: “We are pleased to play a part in this successful prosecution, which resulted from good partnership work between the Council and Police.

My full report on Bakers Court can be found at www.compassionincare.com Tales of the Un-inspected (35)

**BUPA HOME 24**

**ANCASTER COURT, HASTINGS**

Care worker Rebecca Reasbeck is charged with murder. She is alleged to have set light to the resident's bed. Irene Herring 85, died as a result of the arson attack. Reasbeck is bailed and banned from entering Ancaster Court pending trial. I checked to see if there was anything to stop her entering other care homes, there was not. Reasbeck was subsequently found guilty of manslaughter. She pleaded that she did not intend to kill Mrs Herring but wanted to raise the alarm for the attention of being the person to alert other staff that there was a fire.
Incident Report (Source Media Report) 13th February 2004
Maud Lever 94 died at Kestral Court. Kestral Court is not a Bupa home however the nurse in charge on the night she died at Kestral Court was a full time nurse at Bupas River View Court.
Maud Lever died from Hypothermia after being left sitting all night by an open window. Nurse Chandradeo Seeraton had worked all day at the Bupa home and all night at Kestral Court. He would be required to have a reference from Bupa for his second job. So each employer was aware that this Nurse was working 24 Hours shifts.
A Coroner ruled Mrs Lever died as a result of neglect.

Incident report (Source Media Report) 30th April 2009
91 year old Gwenoline Hoar died from horrifying bedsores; she was not the only resident in River View Court to suffer from such pressure sores was revealed at a Coroner’s inquest.
After the home was said to be improving by the regulator it was upgraded from zero to one star. The council lifted its embargo but soon after River View Court was found to have serious failures again.

Bupa care home manager, Karen Southern, is convicted under The Mental Capacity Act. Bupa were slammed by the judge who accused them of putting profits ahead of the care of residents.
During the hearing, a Whistle-blower who was a former manager gave damming evidence against Bupa. This evidence resulted in the successful prosecution. Nurses from the home said they had taken concerns to management but were ignored.
Joyce Farrow was a resident at Stonedale Lodge, her daughter Pauline Slaughter, kept a diary of what care her mother received, here are some of the extracts.

July 14 2010 “No glasses’, no teeth, no shoes or socks”

August 23 “Place is filthy, no one answered the door. There is a rat trap outside mother’s room, I saw a rat and told the nurse and she said it was because of the garden. More likely the stinking pile of rubbish out there. I am finding there is no such thing as an individual just a lady with dementia”

August 30th “Found mother naked sat on a bed with a quilt over her head”

September 7th “The day of Mrs Farrow’s death.
I have complained and written and moaned and visited daily. I have failed to protect my mother, she has passed away, this is not a nursing home, there is no nursing going on”

After the hearing Mrs Slaughter said;
“Care home staff in this country are underpaid and overstretched and are afraid to report abuse in case they lose their jobs.”

Bupa said much has changed at Stonedale Lodge since. A recent survey found over 80% of relatives rated the home good or excellent.

Liz Perry has removed her mother from Stonedale Lodge and taken her concerns to the police. She said her 89 Year old mother had four accidents in just ten days at Stonedale Lodge and suffered serious injuries to her arm. Her mother was only placed in the home for respite care. The home said at first she had banged her arm on a table but later admitted they did not know how the injuries occurred.

My full report on Stonedale Lodge can be found at www.compassionincare.com Tales of the Un-Inspected (55)
BUPA HOME 27

BEECHCROFT    HASTINGS

95 year old Kathleen Challis was given a beaker of corrosive dishwasher by mistake. Staff at Beechcroft realised what happened after Mrs Challis spat out the fluid. They wiped her lips but the skin came away. Staff tried to help her but she died in Hospital from a pre-existing heart condition. A post mortem examination revealed she had suffered burns to her mouth, throat, larynx and the burns had gone through to her stomach.

BUPA HOME 28

ASTON COURT     SUTTON COLDFIELD

Iris Teal 91, suffered an unexplained fracture of her leg in October 2011 at Aston Court, and was admitted to hospital where her condition deteriorated and she died. It was not until a year later, in October 2012, after lawyers intervened on behalf of Mrs Teal’s family that Bupa issued an apology for the first time.

The lawyers for the family said:
“That it is so frustrating that two years on Mrs Teals family do not know what happened to Iris and they feel that Bupa have not done all they could to be open about the failings in care.”
BUPA HOME 29

UN-NAMED BUPA HOME MANCHESTER

Incident Report (Solicitors Web Site) March 2012.
92 year old Dorothy Mason fell from her wheelchair on March 10th 2011.
She suffered cuts to her face and, over the next three days was unable to
walk and became progressively more unwell. After a week she was
admitted to Hospital where she died from aspiration pneumonia. Bupa
denied any responsibility.

It was not until the family took legal advice and obtained expert medical
evidence that Bupa finally agreed to compensation in an out of court
settlement.

BUPA HOME 30

CHASE VIEW ESSEX

A heartbroken son held a protest outside Chase View where his 82 year old
mother, Lily Pannell, had been a resident for three months. She developed
pressure sores that became infected and she was taken to hospital where
she died on May 29th 2006.
Her son, Paul Pannell, said:
“ That he hoped the protest might save any other family going through the
same ordeal”
Bupa said:
“ They strongly denied the allegations and said the regulator was happy
with the home.”
Chase View care home was issued a warning notice five years later, in
February 2012 as things were so bad.

If death from infected bedsores was not considered to be, “Natural causes”
then many others could have been spared from suffering and neglect.
BUPA HOME 31
ASHLEY CARE HOME     GLOSTERSHIRE

Horatio Spurrio, 86, died from the last of nine falls at Ashley care home.
At a Coroner’s inquest, a nurse from Ashley care home gave evidence, she said: “Because Mr Spurrio was a tall man he was difficult to manage and that he really needed one-to-one care.”
On the night of May 12th, after Mr Spurrio fell and he was examined by staff at Ashley care home and judged to be without injuries. The next day he was sent to hospital as he was struggling to breathe and an X ray showed he had multiple rib fractures. He died later that day. The Coroner ruled accidental death.

If the home knew he needed more care than they could provide, I would have asked what steps they had taken to get him transferred to a home that could provide the care he needed.

BUPA HOME 32
MEADBANK     LONDON

An elderly resident from Meadbank care home, 80 year old Jeanne Matthews was admitted to hospital. Her family went to visit her at Meadbank and were so concerned they called an ambulance.
A doctor at the hospital told the family that; “It was the worst case of dehydration they had ever seen.” Mrs Matthews died a week later.

Westminster Coroner, Dr Shirley Radcliffe said:
“Mrs Matthews had hugely high sodium levels, which suggest she was extremely dehydrated” she added: “I have been told Mrs Matthews had a bleeding cracked mouth and mouth ulcers. No one should be allowed to dehydrate to this level in a nursing home of any sort, let alone one run by Bupa”
The Pathologist said: “Mrs Matthews had died from a lung infection but dehydration could have weakened her immunity. Because we cannot say why she died we have to record death by natural causes.”
After the inquest Mrs Matthews Daughter said: “My Mother went into Meadbank, happy, bright and talkative, she came out in a coma. We visited three times a week and she was always thirsty, wanting to drink. I made complaints but nothing was done.”

See my full report on Meadbank at www.compassionincare.com Tales of the Un-Inspected (29)

BUPA HOME 33

DOVE COURT BURNLEY

A Coroner is to write to a medical supply company following the death of Margaret Grimoldby. Staff at Dove Court were adamant that the 69 year old was too weak to climb out of a cocoon bed, but after she was given tea by staff she managed to climb out of the device and became entangled in wiring under the bed and died from strangulation.
Recording an accidental verdict, the coroner said:
“It was believed there was no chance of her getting out of this bed, but she did get out and what happened next is difficult to explain.”

BUPA HOME 34

ASPEN COURT DERBYSHIRE

As part of a special investigation by the Times newspaper, an undercover reporter worked at Aspen Court and found cheap and nasty food being served. Several residents were sitting in front of uneaten food.
Bupa said; People liked that kind of food. The reporter was basing her judgement on what she thought was good food.
Incident Report (Source Media Report) 2007
A Coroner has ruled that neglect contributed to the death of diabetic Lesley Avenell who died after being given an insulin injection by Nurse Gisha Thomas. The dose that should have been administered was 8 units. But he was given 84 units. He died in hospital the next day from pneumonia. The Coroner said: “But we cannot dismiss that the overdose contributed to his death.”
The incident took place at Puttenham Hill care home.

BUPA HOME 36
BARTON BROOK MANCHESTER

Incident Report (Source Media Report) February 2012.
A nurse’s care of an elderly resident at Barton Brook just before he died was called by a Coroner “Minimal, unprofessional and ineffective”

War veteran Harold Massey 83 died at Barton Brook. Nurse Carmelita Castro ignored the pleas of two care workers to call an ambulance. Mr Massey was turning blue and was in great pain. The two care staff continued to check Mr Massey every half hour. Mr Massey died from a severe urine infection on December 28th 2009. The Coroner said: “He could see potential for his life to have been saved if action had been taken earlier.”
BUPA HOME 37

OAK LODGE SOUTHWATER

Oak lodge has been issued warning notices by CQC. A relative said: “They had raised concerns with staff at the home” The CQC said: “The home was not protecting residents from the risk of abuse, medication was unsafe and staff were using the wrong lifting equipment.”

BUPA HOME 38

BERRY HILL NOTTINGHAM

Incident Report (Source Health and Safety improvement notices) July 2013.
An improvement notice was issued to Bupa in respect of Berry Hill care home. Health and Safety said: “There was a failure to ensure that employees and service users were not exposed to Legionella bacteria.”

BUPA HOME 39

OLD GATES BLACKBURN

Abdulla Khan, a nurse at Old Gates was found guilty of five failures in care. An elderly resident who broke her neck was left sobbing in pain. Khan gave two paracetamol to the resident. Care worker Zuleka Namaji said: “The resident was screaming in pain.”
BUPA HOME 40

MILLVIEW       LANCASHIRE

A care worker at Millview saw residents nipped and squeezed by care worker M Maidi Nizeyimania. The care worker did not immediately report what she had seen but did so the following night to the Nurse on duty.

BUPA HOME 41

MANLEY COURT       LONDON

CQC visit Manley Court when informed of concerns. They find there are not enough staff and residents were left lying on soiled sheets. Some residents did not have a call bell. Another had not been given any food.

BUPA HOME 42

ADMIRALS REACH       ESSEX

Incident Report (Source Media Report) July 2014
82 year old George Mason, left Admirals Reach un-noticed and wandered into the night. Mr Mason had Dementia. His body was found the next day at 10.40am he had drowned in the river Chelmer.
The victim’s family attended a three day inquest last week their legal team said: “There had been 23 failures of care at Admirals Reach” Bupa had also failed to inform the authorities that someone was missing from the home.
BUPA HOME 43
THE ELMS       WHITTERSLEY

Incident Report (Source NMC v Rona Davis) 2012
The manager of the Elms care home Rona Davis was struck off the nursing register by the NMC. She was responsible for the care of residents at The Elms where nine residents wasted away from Malnutrition.

BUPA HOME 44
SHELTON LOCK     DERBYSHIRE

Incident Report (Source Media Report) 2009
Shelton Lock care home accepts that records were not kept correctly during a Coroner’s inquest into the death of Ivy Ross 79. A verdict of natural causes was recorded. Food and fluid charts had not been completed for Mrs Ross. After the inquest Mrs Ross's son, Antony said “It’s a shame this had to go to court before Bupa acknowledged there was a problem.”

BUPA HOME 45
STADIUM COURT     STOKE

Incident Report (Source NMC)
Deputy manager and nurse Maria Regala had conditions imposed on her after a resident died from an overdose of Midazolam, at Stadium Court. For my full report on Stadium Court, see www.compassionincare.com Tales of the Un-Inspected (46)
BUPA HOME 46

PARKLANDS                 BLOXWICH

Incident Report (Source Health and Safety prosecutions) 2007
Irene Evens 91 died ten days after falling from a hoist sling whilst being moved by staff at Parklands.

BUPA HOME 47

CARDERS COURT              CASTLETON

Incident Report (Source Media Report) December 2011
Barbara Oldham, 85, was discovered to have been given a sedative drug Promazine, on a near nightly basis for no reason. The inquiry also found that for a separate period of a week she was administered twice the prescribed dose.

Her son said: “He had concerns about his mother’s care since she moved into Carders Court” He added:
“His mother is now well cared for in another care home where it took six months to get the drugs out of her system, but she has not walked since”

The Safeguarding Adults Board voted to uphold the concerns by four votes to three. Concluding that Mrs Oldham was physical abused whilst at Carders Court.
The three members of The Safeguarding Adults Board who voted against upholding the concerns were,
Racheal Dodge, Safeguarding
Rose Elward, Bupa, Carders Court
Janine Kelly,  Bupa, Carders Court.

It simply beggars belief that those responsible for the abuse of a vulnerable elderly resident are allowed to make these judgements. To me it is like giving someone charged with a murder a place on the jury. It is small wonder Safeguarding is such a failure.
Incident Report (Source minutes of a meeting held at the Red House) 2009
HELD ON MAY 5TH 2009.

Residents and Relatives present 19 (I have used initials to protect the identity of those present)

Staff present. LS Manager, RD Deputy Manager, Activities Co-coordinator SP.

AGENDA - CARE STAFF. A relative RS asked the manager if she thought there was enough care staff as he was not happy to see just one member of staff on duty in the old house at certain times. MR (relative) said she was shocked to see residents were confined to their rooms on Easter day due to staff shortages.
The Manager LS said she was not aware of any shortages on Easter day, nor was she aware any residents had been confined to their rooms due to staff shortages.
AH (Relative) said he visited on Easter day and can confirm what MR claims.
LS (Manager) said she would look into this further.
AH (Relative) said he had read the CSCI (REGULATORS) guidelines on staff for care homes and he felt the Manager was not employing enough staff to cover day and night shifts. He felt there should be one member of staff per five residents and asked the manager how many staff were on each shift.
LS (Manager) said that if the home was at full capacity this would be the case if the staff were left as they were but there were staff to meet requirements.
The Manager pointed out that there were times when staff rang in sick prior to a shift change over and so inevitably there would be a shift which occasionally was short of one carer.
MR (Relative) said there was just four care staff on duty Easter Sunday for all the residents in the main building.
MM (Relative) Said she was upset her husband had to wait forty five minutes after his request to use the toilet and it had caused him a lot of distress.
LS (Manager) said if she could provide her with a date and time when this happened she would check it on the call bell recording system. MQ (Relative) said that he was fed up attending these meetings as nothing ever changed and he felt that LS (Manager) was just glossing over all the problems. He said she (Manager) had been repeatedly told that problems with her staff were always evenings and weekends when no manager was around but still things had not improved. MS (Relative) said his mother’s GP could not understand why the phone was never answered in the home when he rang to speak to her. MR (Relative) asked Manager if she was aware that carers disappeared at teatime, she had noticed on many occasions that certain carers went off for breaks or just stood around talking over residents. MR (Relative) went on to say that when the dining room has no care staff which is usually teatime and weekends why don’t the residents have access to the call bell in case of emergencies. AH (Relative) said that he had repeatedly brought this up and he felt it very unsafe for residents to be left on their own in the dining room without any way of contacting a member of staff. LS (Manager) said that a care staff member was usually with residents in the dining room to which AH (Relative) replied this was not the case whenever he visited evenings or weekends. AH (Relative) said it was quite evident that when he did turn up a member of staff would then appear and stay in the resident’s vicinity. Both MR and AH (Relatives) agreed that the kitchen staff were better with the residents than the care staff were. MR (Relative) said she was not prepared to give names but it was obvious to her that two or three of the care staff were just not suitable to the role of caring for the residents. RS (Relative) asked LS (Manager) if you are not as short staffed as you say then why do you work here some nights. To which LS replied that she covered nurse’s shifts whilst they were on maternity leave and that she enjoyed closer contact with her residents by working occasional shifts. RH (Relative) said that the manager could take it that most people here this evening are not happy with the staffing situation.
RH (Relative) said he had read a report on forty homes in the area; two were excellent, twelve were good and some had not been rated as yet and asked the Manager what this home was rated at. The Manager said it was adequate but she hoped for improvement at the next inspection.

AH (Relative) felt the results of the report were very worrying especially on medications being administered incorrectly this was putting residents at risk. LS (Manager) said she was well aware of what was written and that this issue had now been resolved and speaking to AH (Relative) she said that if CQC were concerned they would have intervened but this had not been the case. LS (Manager) said she personally ensured medications were now always delivered correctly.

RQ (Resident in the home) Said that an agency nurse had given her more tablets than she required at the weekend and had she not been conscious of the fact she could have overdosed by taking more than she needed.

AH (Relative) asked LS (Manager) if Company xxxx were happy with just an adequate marking for such a large home, to which LS replied they were quite happy with the way it was being run but of course we are striving to improve all the time.

AH (Relative) asked why care plans were no longer in resident’s rooms. LS (Manager) replied they have been kept at the nurses’ station for the last four years to protect resident’s privacy.

RD (New Deputy) asked AH (Relative) where he had looked up the CQC report as most relatives read these reports before putting their relatives in a home. AH (Relative) relayed that he had come across the report purely by accident a few weeks ago and was not aware of its existence before now.

RD (Deputy Manager) said she had been a manager and a deputy manager in care homes for many years and she had never sat at such a hostile residents and relatives meeting.

RS (Relative) Said that perhaps it was time to move on to the rest of the agenda and LS (Manager) said that if anyone has any problems they should always come to see her. To which RS (Relative) replied, I have been coming to you for the past two years but nothing appears to change.

HOUSEKEEPING AND LAUNDRY.

MR (Relative) said clothing had been returned in a shabby state.
RS (Relative) said several of his mother’s blouses had gone missing and even though she had been financially compensated it was not good enough as these were presents and one of which cost seventy pounds, he felt he should not have to go to Borough to purchase replacement clothing for his mother because they were going missing and they were not paying for his time or fuel only the cost of missing garments.

Several relatives asked if clothes were ironed as clothes were returned badly creased. LS (Manager) said that a steam iron was used so garments should not be returned creased.

At this point RS (Relative) produced a pillowcase returned to his mother that day which was full of creases.

RD (Deputy) said perhaps clothes were being tumbled dried for too long making them difficult to iron.

LS (Manager) admitted there had been problems in the laundry recently and would speak to them tomorrow to get things improved.

Both MM and S daughter said that for the money they were paying each month they should not have to take washing home to do and LS (Manager) agreed.

MS asked the Manager how often she held meetings with her staff, especially laundry and kitchen staff- LS (Manager) said that as a matter of course this was done at least once a month.

AH (Relative) asked if he could change the subject by asking if shift hours could be changed for care staff as changeover times 8am to 8pm meant that there was actually no care available on the floor for residents needs unless it was an emergency.

LS (Manager) said this was currently being discussed with care staff that seems to be keen to try a change.

RQ (Resident) asked what exactly is a key worker to which LS manager replied that a resident’s key worker has the closest contact with you; she is there to answer any problems and pick up anything from the shops you may want.

RQ (Resident) asked if she meant like a birthday card or present to which LS manager said yes.

MR Q said it might be an idea to put a photo of the key worker up with the name so residents found it easier to know exactly who their key worker is; everyone present thought this was a very good idea.
KITCHEN.
RS Relative said reading xxxx website gave the impression that the chef manager was responsible for fresh healthy choice meals and as everyone present here knows at xx home, this is just not the case. RS Asked Manager to explain to him why her staff were ringing him at home and telling him how bad the food is and could he bring food in for his mother. Mr. Q said the food on offer is institutional food is it not? Nothing like xxxx are portraying in their advertising. SL (Resident in home) said we just do not know what we are eating half the time as it’s so bland and awful, his daughter agreed. Mrs. S said it was not the meals so much more the way it had been cooked, the meat is so grisly that residents are unable to eat it. RS asked the Manager what the food allowance was per resident per day. LS said it was quite high. RS said that prisoners had Two pounds and twelve pence per day and he hoped his mother’s exceeded this" MR said she was shocked to see how food ran out and RS said that he had often had to purchase, porridge, soup and ham for his mother as they had none here. MR said she visited many care homes in the area and the food here and the standards are by far the worst she had witnessed. Mr. Q said that it was obvious that this home was being run on a shoestring budget which the manager denied. Mrs. S. Said to the Manager even your own care staff say that your kitchen staff are like the mafia you appear to let them run the kitchen with no oversight from yourself and sadly for the residents it shows. The manager replied this was not true. Mr. Q asked where all this fresh food comes from? And RS said it came in from a catering company called 3663. MQ replied that this was hardly local fresh produce. S daughter asked why there was still not any fruit provided for residents and AH replied that this was brought up at every meeting but was down to kitchen staff to provide, he had asked kitchen staff why there was never any fruit in the fruit bowels provided and they said because one resident would eat it all.
RS said a notice for relatives had not been updated it stated all written problems were to be addressed to area manager, KS, he asked if the sign could be updated as HB had now taken over from KS although he had written to her she did not reply.
LS Manager said HB would be visiting the home on May 21st and he could arrange to see her then.
RS asked Manager if relatives and residents meeting minutes were shown to area managers and LS Manager said they were not, to which RS said it was about time they were so that those above her could see for themselves exactly what was going on here.
LS Manager said she could send a copy to PC, to which RS said whose he?
LS said he worked in the company’s xxxx hotels department.
AH asked Manager if they could have a relative’s committee- to which LS said she saw no problem with this.
Several relatives felt six monthly meetings were too far apart and that perhaps an interim meeting could be held in three months’ time, August 2009 to which LS agreed to.

Incident Report (NMC) 2013
The NMC strike.... LOCAL NEWSPAPER REPORT DATED OCTOBER 2013
“A Nurse from The Red House, appeared before the NMC after telling a care assistant to give a sedative drug to a resident not prescribed it. Nurse Mwaka Nachilongo accepted the allegations. She did not call a GP or record the medication. There had been earlier incidents of concern about this nurse going back as far as 2004 on medication issues and in 2006 when she failed to provide care.”

See my full report on the Red House at www.compassionincare.com Tales of the Un-Inspected (61)
Incident Report (Source Coroners Report) April 2014

The Coroner sent a regulation 28 report to Bupa. This regulation is used when a risk of further deaths has been identified during an inquest. This happened in the case of Roy Godfrey, who suffered an unwitnessed fall at Seabrook Manor on the 23rd of July 2013. Paramedics attended and spent an hour with Mr Godfrey and the decision was made that he did not need to go to hospital as the care home agreed to take responsibility for Mr Godfreys care. Paramedics advised the staff to observe the patient overnight as external head injuries were apparent and if any signs of increased swelling, nausea or deterioration were observed an ambulance should be called.

The correct checks were not carried out by Seabrook Manor that night, no neurological checks were done at all. The next morning Mr Godfrey awoke at the usual time of 4.30am. He was taken to a lounge and a few hours later was found unresponsive.
He was taken to hospital where a CT scan showed subdural haematoma and a midline shift of the brain herniation. The Brain injury was deemed fatal. Mr Godfrey Died on July 24th. Mr Godfrey was on long term warfarin and elderly patients on warfarin are at increased risk of bleeding if a head injury is sustained.
At the inquest the deputy manager from Seabrook Manor, said: “That the staff on duty should have been aware of such a risk. The care staff should have carried out the instructions of the paramedics.”

The Coroner said: “I have heard a great deal of evidence from the London Ambulance Service in relation to a thorough investigation they had conducted into this case. They had the assistance of an independent clinical advisor and had identified all the relevant issues. They had taken all the action required to address those issues. Bupa care homes however had provided a one page document headed Summery of Investigation. This was the only investigation document. In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action”
BUPA HOME 50
BEREWEEKE COURT HAMPSHIRE

Incident Report (Source Media Report) August 2013,
Major concerns about the care of residents at Bereweeke Court were first
raised in March 2013. The CQC inspect the home and tell Bupa to rectify
the issues.
But since then little has been done to improve care. The residents tell
inspectors there are not enough staff.
Follow up inspections in April, May and June found continued failure to
improve the poor standards or increase staffing numbers.
Bupa said we have made significant improvements and we appreciate the
support of our partners.

BUPA HOME 51
SUTTON LODGE SURRY

Incident Report (Source Media Report) 2014
Care Assistant Susannah Carr 43, worked at Sutton Lodge for 11 years.
She suffered from mild schizophrenia but had not taken her medication
when the offence was committed. She took an elderly dementia resident
who was wandering around the home to the resident’s bedroom and tied
her to a chair. Fortunately Carr went on her tea break and told another
staff member what she had done and was reported.
She was prosecuted under the Mental Capacity Act.
Incident Report (Legal Web-site)
Bupa nurse Margaret Fenty slapped an elderly resident and called him a dirty bugger when she caught him molesting another vulnerable resident. The frail victim of the sexual assault was crying out in distress but Fenty just moved her out of the way and failed to report the incident.

Incident report (Source Media Report) 2013
A Coroner’s inquest into the death of 97 year old Phyllis Mulcahy, who died suddenly in December 2012 at Brandon Park care home, revealed she had been administered the antibiotic, Trimethroprim in spite of a red allergy sticker on her notes. Shortly after being administered the drug she became unwell with laboured breathing and paramedics attended. She was declared dead at the scene.
A post mortem concluded she died from old age and heart disease. Bupa said: “They had learnt important lessons.”

Staff Whistle-blowers from Peveral Lodge contact the CQC. They say that the staffing levels at the home are terrible and they are very unhappy. Bupa say they are reviewing the staffing levels as a result of the inspection. Were Bupa aware of the staffs concerns prior to CQC becoming involved? If so why did they ignore the staffs concerns?
Nurse Osironke Olugbile has been struck off by the NMC for removing residents call bells. Olugbile also left people fully dressed all night to save her time dressing them the next day. She also dragged an elderly resident to bed by her hair. The Whistle-blower who finally reported Olugbile said; “They hesitated to report her because she had told them that she would have them cursed by a witch doctor back home in Africa.” Olugbile had worked at Collingwood from March 2006 to February 2011. She registered as a nurse in 2005.

Bupa nurse Paula Fuller, has been struck off by the NMC. Fuller whilst working at Acacia Lodge left a dying resident in disgusting state. When Fuller was asked by a care worker to help the resident, she shut his room door and left him dying in great distress. Fuller later wrote false entries in the man’s care notes. During the NMC hearing she said: “She had panicked as she had just started work at Acacia Lodge and had not nursed for 2 years.” Why was she employed if she did not have the relevant skills?

A Relative said: “They had raised concerns about Oak Lodge earlier in the year.” Two subsequent CQC inspections found serious shortfalls in the care of residents.
Incident Report (Source Media Report) 2009
Phyllis Greasley, a 99 year old resident at Ashby Court was dropped when a care worker scooped her up instead of finding a colleague to help her use the hoist. Mrs Greasley suffered a broken hip and died five days later when broken bone caused a fatal blockage.

The care worker Bini Abraham admitted falsifying an accident report.
Mrs Greasley who must have been in dreadful pain, was not checked for injuries and her broken hip was only discovered the next day when she became unwell.

Source An FOI request made by Compassion In Care revealed three years of the same general concerns being raised by a succession of relatives and Whistle-blowers, about poor care at Heathbrook. These concerns were raised with the CQC and the Safeguarding Adults Board. The information revealed that some of the Whistle-blowers involved were disciplined by Bupa for insubordination. In one instance 45 allegations are made against a staff member who is suspended but later reinstated.

The main theme of the concerns relate to staffing levels, which are resulting in the poor care of residents. These concerns go on for two years without any apparent action being taken. However no sooner has the home been judged compliant than the same theme starts again. Numerous residents have needlessly suffered, and further Whistle-blowers are afraid to give their names.

Please see the appendix for a full copy of the FOI document.
Health and Safety issue Bupa with an improvement notice for failing to provide staff at Eastbank with training on moving, handling and for failing to provide lifting equipment which has placed staff and residents at risk of harm.

An 87 year old resident at Eastbank care home, Margaret Carroll, fell and broke her hip. Mrs Carroll had dementia and was unable to ask for help. Staff noted that she was limping but no action was taken. Mrs Carroll’s son, Jim who is a paramedic visited her and called an ambulance. Her son said: “He had visited his mother 24 hours earlier. When he returned he found her in agony and she had cracks in her glasses’ and a badly bruised elbow.” He called an ambulance and his mother was taken to hospital where it was discovered she had broken her hip. She was taken to theatre but died a few hours later. Doctors blamed the 12 hour delay. Bupa said; “They were confident she had received a high quality of care”.

78 Year old Margaret Hall was terminally ill and spent the last hours of her life left sitting in a crowded lounge in front of a TV screaming in agony. She had not received any of her pain relief for four days. The family had made a series of complaints since she went into Eastbank. Six months previously her daughter found her shivering in a bath of cold water as staff had forgotten about her. Her daughter had complained previously about her not having the Morphine she needed. She said: “I found her in a packed lounge right in front of the TV, I could instantly see the deathly colour of her. She was holding my hand tightly, roaring with pain and clutching her chest.”

A joint investigation into Bupa Care Homes In Scotland, by Compassion in Care and Private Eye Magazine in 2013 issue No 1352 (Which can be found in the appendix)
The investigation found of the 30 Bupa homes, there were serious failings at ten and nine gave some cause for concern. Only ten were rated consistently good and only one small home Balcarres in Dundee stood out as consistently excellent.
Since 2009 Eastbank has never been rated better than weak or adequate. The investigation has found that homes rated weak or adequate can actually mean misery and neglect for residents.

BUPA HOME 61

HILL VIEW        CLYDEBANK

Incident Report (Source Media Report) June 2010
Hill View has been criticised by the regulator who partially upheld two of three complaints made by the family of 82 year old Ann Kinloch, who died weeks after breaking her hip at the home. Her family received a bill for her care on the day of her funeral. They dispute the amount they have been charged. Bupa said: “The complaints investigated by the Commission found there was no question about the quality of the care she received”

Incident Report (Source Media Report) 2011
The NMC have suspended nurse Susan Thompson for giving alcohol to five residents at Hill View, including recovering alcoholics, to keep them quiet. She also told a resident that he should be ashamed of himself for wetting the bed.

BUPA HOME 62

HIGHGATE        LANARKSHIRE

Incident Report (Source Health and Safety) 2008
Bupa were fined £57,000 for failures after Mrs Elizabeth Stevenson 88 was dropped, sustained a broken neck and died. A care worker who had recently started work at the home was unaware that two staff were needed to move a resident.
NEWCARRON COURT     FALKIRK

Incident Report (Source Media Report) 2008
The NMC strike of nurse David McDade for restraining a resident by
twisting his arm behind his back and failing to record the incident. McDade
said: “if I wrote everything down I would be writing forever. “ He also
threatened to catheterise an elderly women who was going to the toilet
frequently.
Bupa sacked him and reported him to NMC. But whilst waiting for the case
to be heard, he obtained a reference from his last employer, Bupa and went
to work in another care home where he abused another pensioner.

DARNLEY COURT     GLASGOW

Incident Report (Source Media Report) July 2014
Darnley Court and Pentland Hill are among 14 care homes named as the
worst in Scotland. People were not washed or fed. There were mistakes
with medication and fears over staffing levels.
The inspection reports for all these homes feature years of people suffering
for the want of basic care.
John Collins 78 lost almost four stone in 11 weeks at Ailsa Craig. He was admitted to hospital badly dehydrated, had a mouth full of ulcers, two inch long toenails and his teeth were black. He was wearing a filthy old tea shirt, socks, pants and someone else’s dressing gown.
He had pneumonia and died three days later. His wife Catherine said: “She would find him soaked in urine, being fed solid food he could not eat and should have been given a soft diet. His teeth were not cleaned and medication was found under his tongue as he was not given enough fluid to swallow it.”
The regulator upheld the family’s complaints and told the home to improve, yet the next inspection found no improvements had been made.

Incident Report (Source Media Report) 2008
A media investigation found MRSA on the walls at Ailsa Craig.
An outbreak of vomiting and diarrhoea occurred during the investigation.
Dirty incontinence pads were stuffed down a toilet and strewn on floors.
Staffing numbers were so low staff could not cope.
A whistle-blower contacted the newspaper in desperation saying:
“Residents were paying huge sums of money and were kept like cattle.”
She added; “Residents had no one else to turn to. I can’t believe what is going on at Ailsa Craig”
Bupa denied there were any issues.
In my investigation into what was known about Pentland Hill, I have taken the facts from regulators reports, concerns, media reports and witness testimony. This report is the result.

AUGUST 2007.

Things were so bad in this care home that 19 relatives wrote a joint letter outlining their concerns to both BUPA and the regulator. They said many issues had been raised before and they no longer had confidence in the management.

The Issues raised were,
- Alarming staff turnover,
- Lack of qualified staff,
- Poor staffing levels,
- The cleanliness of the home and the residents,
- Torn sheets,
- Improper supervision at mealtimes,
- Poor food and a generally demoralizing atmosphere.

BUPA promised to implement an action plan as a result of these complaints.

When a relative raises a concern to the authorities it is usually as a last resort and I have always seen this as an early warning that should be acted on. When 19 relatives raise such serious concerns as a group it says things are so bad in this home people have already suffered harm and are at serious risk of further harm.

INSPECTION REPORT MARCH 2009.

1 Year 7 Months later.

Pages 6-7-8

States that there were issues with staff not reporting matters of concern.
There have been issues with poor quality food.
The regulator sent the home 40 questionnaires to give to relatives, only three were returned.

Pages 10-12
It is noted that there were seven people in a lounge but only three were given a drink and one of those three needed help to drink and was not given help.
There was an intolerance of a resident’s behaviour.

Page 15.
There is evidence that staffing levels are not meeting resident’s needs.
The home is graded as good.

INSPECTION REPORT MAY 2011
2 Years 2 months later.

Pages 19-20-21
Evidence from residents that staffing levels are too low.
Some people did not know how to raise concerns.
Three out of ten relatives thought there were not enough staff.
Three thought the home was not clean.
Four had issues about the food.
A person says the home needs a lot more trained staff and cleaners.
Another says the staff are constantly changing.
Another person said staff came on duty with hangovers.
Another person felt concerns were not acted on and there were issues with falls.

Pages 30-31
Evidence of low fluid and food intake.
Pressure mattresses were not set correctly.
Lack of investigation into unexplained bruising.
The paperwork is checked and the judgment made there are sufficient staff. There are serious issues with medication. Staff had altered the prescribed doses of medication. Medication was unaccounted for. Relatives say people are left alone in the lounge areas but inspectors do not witness this.

A relative says staff are all sitting together writing up care plans. Graded adequate in two areas and good in two.

The inspection history shows good grades are not maintained and drastic swings between good to weak are common. However the issues behind this are not addressed.

INSPECTION REPORT SEPTEMBER 2011
16 weeks later

Now the home is back to adequate and weak ratings. The resident’s dependency ratings that inspectors checked 16 weeks ago and relied on to discount the concerns of relatives are now found to be inaccurate.

States a relative raised a concern with the inspector.

Pages 23 and 26
A resident in bed lying on their side with their face toward the pillow was been fed by a staff member. Inspectors judge this to affect enjoyment of the meal but I would have though this could put someone at risk of choking. People were left at tables long after the meal was over. Pressure relieving mattresses were not set correctly.
There had been an incident that was not recorded correctly. Charts were being filled in advance. People were not given tea all morning.

Pages 30, 31 and 34.
Medication is still a mess. Staff are altering prescription doses. Medication is unaccounted for.
On one unit there were two relatives, two students and the usual number of staff struggling to serve lunch.
Inspectors ask staff, residents and relatives who all said there were not enough staff to care for people.
The inspectors decide to check the content of the dependency level check used by the company and find that dependency levels have been underestimated.
Therefore the QUEST documents for every home owned by this company are open to or complicit in the abuse. If staffing levels are set too low people will suffer. If this situation occurs out of ignorance it is neglect but if it is premeditated than it is deliberate abuse.

The home is not clean, dirty sinks, floors, windowsills and tables.

INSPECTION REPORT FEBRUARY 2012
5 Months later.

Pages 26, 28, 29

Pressure relief mattresses not set correctly.
One person was sat in a wheelchair for over two hours, a member of staff could not explain why.
Incidents were not recorded or action taken.
Medication was not given as prescribed.
People are at risk of pressure sores from sitting in wheelchairs.
Inspectors say the home is now staffed according to dependency levels and the Rota changed to reflect this.
Missing property not recorded.
Afternoon charts filled in during the morning.
A resident says they wait a long time for their buzzer to be answered and inspectors ring the buzzer and it took staff ten minutes to answer because they were busy, yet staffing levels are now judged sufficient.
Staff have been trained but it was not put into practice.
Concerns were not acted on.

INSPECTION REPORT JUNE 2012
16 Weeks later.

60 surveys sent out only 8 returned, residents with dementia the main client group for this company have not been included in the company’s participation strategy.
There was little for people to do and staff were busy attending to people.
Some people have a brush or comb and toiletry bags which were dirty.
There were not enough tables and chairs for people.
People were sat in the dining room up to half hour before lunch.
Some people were sat at the dining table from breakfast until after lunch before being moved.

Says the issues remain the same from last inspection.
The Quest document did not accurately reflect people’s needs.
One resident was calling out constantly, staff reassured but did not listen to what they were saying.
Staff did not see one resident fall asleep in their soup.
People were not given the assistance they needed to eat.
Call bells in rooms were disconnected.
These issues are not considered to be the result of staffing levels being too low and yet they are all evidence of just that.
INSPECTION REPORT NOVEMBER 2012
5 Months later.

Page 4.
The home still barely scraping an adequate rating.
The issues are the same as at last inspection.

WHAT HAS HAPPENED SINCE

The home was closed to admissions after widespread concerns and the police are into investigating the deaths of four residents. As a result of the press coverage further appalling information came to light. The regulator quickly down-graded the home.

INSPECTION REPORT JULY 2013
8 Months later.

Throughout the report the tragic consequences of ignoring failings year after year.
The home is now rated unsatisfactory weak. Not for the first time.
Now the home is threatened with enforcement action and then the company will promise yet another improvement action plan and the whole sorry saga will start all over again.

Pages 15, 16.
List the concerns of relatives and residents.
Of the 60 questionnaires that were alleged to have been sent out, only 8 were returned and for first time inspectors check if people received them and find they had not been forwarded by the home which explains the low returns for years previously.
The home is dirty and smells.
On a hot sunny day people were unable to go outside.
People were left in wheelchairs all day.
Immobile people sat distressed in a very noisy lounge.
People did not get help to eat and drink. One person was seen trying to eat soup with a knife.
Charts and care plans were lacking details.
Medication is still a mess.
The smells, was excessively hot, one toilet had a leaking soil pipe which had tape wound round it as a repair.
Call bells could not be heard when used.
Staff turnover was high.
People said they were afraid to complain
Accidents and deaths had not been reported.
There is clear evidence that staffing levels are too low.

PRESS COVERAGE.
20th November 2013...
A nurse who worked at Pentland Hill for more than two years tells STV she said; “That the staffing levels in the home put people at risk; she left the home because she could not work in the conditions. Despite previous inspections saying the home was adequate. The nurse said she never believed the staffing levels were safe. We were told the staff numbers were correct, it was impossible, there is absolutely no way that amount of staff could look after all those residents.
Nothing ever changed she said.”
BUPA has promised a robust action plan.

Compassion in Care and Private Eye magazine carried out a joint investigation into BUPA homes across Scotland and found all but one that did not have similar problems.
Among the emails,
“My father died in the home in 2009 and we complained and were told recommendations had been made. Too late for our father but we hoped others would be spared”

“I am one of three whistle-blowers who reported malpractice and abuse. We were set up and sacked; we lost our identity and nearly our home... Whistle-blowers must be prepared to lose everything for doing what they thought was right.”

“Another man thought the care inspectorate intervened to save his mother in time but was unaware that repeated concerns were being raised about the home going back to 2007.”

One lady worked at the home and her mother was a resident, her statement about her mother’s treatment is shocking as it tells us of a company where criminal activity is routinely concealed as a matter of policy.

On the morning of October 22nd 2009 I received a call from my place of work, Pentland Hill Care Home; the acting manager told me she had bad news, my mother Agnes Nisbit who was a resident in the home had been assaulted the evening before by an employee at the home, a care worker. Little did I know how this was going to change my life. I contacted my sister and we went down to the home to see our mum and find out what had happened.

When we saw our mum we were shocked, she looked battered. She had several obvious injuries, bruising to both her eyes, a swollen and obviously fractured nose, bruising to both temples, a cut inside her upper lip caused by her own lower tooth, bruises on her right arm and a bruised and swollen little finger on her right hand.

The care worker (Assailant) had been examined at the time and was found to have no sign of injury or bruising.

We were in shock. Staff members were visibly upset. Then we started to think why was mum left all night on her own in such a state?
Why were the police not called at the time?
Why were we not contacted?
It had happened at about 10pm the evening before. Things did not add up and were about to get worse.

I was called over to the office, there was a call for me. My brother accompanied me over to the office where there was a BUPA support manager waiting. She told me that the regional manager was on the phone and she put the phone on loudspeaker so we all could hear the conversation.

The R.M, who had been contacted after the assault by the nurse in charge of the home that evening and said how sorry she was but that she ,, had no idea that an assault had taken place,, and that she was under the impression that my mum had a bleeding nose. It was an angry discussion but she insisted that she did not know about the assault. It was a well-known fact that at that time that a senior manager had to be contacted for permission to call out the police.

I believe the night nurse involved had previously called out the police without permission believing there was an intruder in the building and she was reprimanded by senior management for not following BUPA guidelines. I myself questioned a manager about this and was told ,,I think all care homes do this,„

The next few months and years have been a nightmare. We contacted Alzheimer Scotland, the Care Commission etc., lots of interest but we did not seem to be getting our voices heard. We decided to ask the then named Care Commission for copies of their investigation of the incident. They had carried out an investigation at the time and later my brother had contacted them and asked them to look at the case again as we as a family were not satisfied that they had done a proper investigation. Nothing much came of any of these investigations. Much to my surprise they never interviewed myself or my sister about what we had experienced. They only spoke to BUPA people.
We waited several months but finally received some of the documentation. Much of it was not sent to us to protect the person interviewed. However what was clear was that the regional Manager knew there was an alleged assault by a care worker and she knew the other staff on duty did not believe this care workers story that my wheelchair bound mother had attacked her. The Regional Manager also admitted to the care Commission that she did not know why the staff had not believed this care worker.

A strange reaction indeed from a regional manager, she was obviously not interested. She told the nurse to send the accused worker over to another unit and a worker from there would take her place. She had sent a text to the acting home manager, who had not answered her phone on the evening of the assault, telling her there had been an incident at the home and could she deal with it in the morning.

We are not sure when management knew it was our mother who had been assaulted. With me working in the home and my mum getting daily visits from my father they couldn’t cover up what had happened. We strongly believe that their inaction on the evening of October 21st 2009, had an effect on the police investigation. The care worker went missing for a few days and of course my mum was cleaned up, the room was cleaned up and mums bloodied nightie that was to be kept as evidence went missing, never to surface again. We had been told the floor was blood stained, and the paper towels that the care worker had used to stem the flow of blood from my mums nose and mouth, all gone. My mum died on the 19th of April 2010 before the trial took place. A trial that would destroy all our faith in the fairness and justice we expected from a Scottish court.

It seems suffering from Alzheimer’s made my mums clear and frequently repeated accusations a subject for doubt.

We sat through three days of torture, it finished with the jury taking ten minutes to find the Care worker not guilty. We were so angry with the way the prosecution handled the case and lodged a complaint and subsequently had a meeting with the District procurator fiscal at the crown office. We were left even more angry and frustrated and have since lodged a further complaint to the lord Advocate of Scotland, we still await a reply.
Our mum was failed by everyone, Bupa, The Care Inspectorate, the police and the justice of the land. My dear fathers wish is that he lives to see some sort of justice, not only for our mum but for all the other elderly people in care homes, especially those with dementia, where is there protection? My mother got none.

As a care worker in the home Mrs. Taylor has seen residents left for hours after soiling themselves. The home was chronically understaffed and the company put profit before care. The home was an accident waiting to happen and it has happened.
SUMMARY

The list could go on forever but I have just given examples of the kind of issues that are raised again and again. I have used an editorial about Bupa from the Express newspaper written in August 2000 as I feel it says it all.

BUPA MUST ACT ON CLAIMS OVER RESIDENTIAL HOMES.

We reveal today a horrifying story of neglect and abuse at the privately run Isard House Residential home. Such stories are always deeply shocking. But what makes this one especially so are the allegations about the attitude of the owner Bupa, the largest private health and geriatric care company in the country. It failed to take proper note of these claims, or act to make sure that the culprits were brought to book. Even worse, it re-employed an alleged abuser in another home, Bupa contests these allegations. Most residential care for the elderly is provided in private homes. The greater part of it is, at the very least, adequate/some much better than that. It used to be that the old council run homes were more often than not a problem. But now there is an unpleasant undertone running through too many private homes, which make all sorts of promises about the standard of care they offer but which, when confronted with evidence to the contrary, simply do not seem to listen to employees on the ground. Bupa makes precisely these promises. Indeed, so fine is its reputation that one of its directors has advised the government. Yet our investigation reveals a profoundly worrying culture which runs throughout the company, from bottom to top. Bupa must act swiftly to ensure that its employee’s procedures are modules of good practice. If it continues to behave with such apparent contempt towards its whistle-blowers, the company will find itself at the centre of a national scandal which could, deservedly, destroy its entire market.
# APPENDIX

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LONDON BOROUGH OF BROMLEY
SOCIAL SERVICES & HOUSING

Isard House – Enquiry Into Care Practices

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1. Summary

1.1 On the 19th April 1999 at 10am, Ms Chubb and Ms Hook, care staff from Isard House, attended the Civic Centre offices and handed over written statements by seven members of staff concerning issues of abuse and neglect of residents at Isard House. The complaints were specifically regarding the conduct of the staff on Unit 3 of Isard House towards residents between June, 1998 and March, 1999.

The statements were received by Monica Hanscomb, Registration & Inspection Manager (Adults) and Richard Turner, Principal Registration & Inspection Manager. Relevant matters were referred to the police. A Social Services enquiry team were set up to investigate allegations about the care and medication of residents in Unit 3.

1.2 Carole Newton, Operations Manager for Care First Partnerships attended a meeting with Registration and Inspection staff later that day whereupon she was informed of the nature of the allegations.
2. Summary of Investigations Undertaken

2.1 A meeting was held at the Civic Centre at 11am on 20th April, 1999 in the presence of the Police Community Support Unit where WDC Judith Taylor and Detective Sergeant Ian Pegington were present. It was explained in detail the visit by two members of staff from Isard House and the concerns they had regarding residents there, especially on Unit 3. A small number of staff had apparently personally witnessed some degree of physical and verbal abuse and other people who had provided written statements had witnessed areas of neglect and general concerns regarding poor standards of care.

2.2 It was agreed that Police officers would interview those particular witnesses where physical abuse had been suggested, to determine whether a charge of common assault or actual bodily harm would apply and that the Registration & Inspection Unit would commence enquiries and begin to interview all members of staff in the home the following day about issues of neglect and poor care standards. It was agreed that if an incident of physical assault was identified during the interviews the discussion around that issue with the interviewee would be suspended and referred to the Police in order for them to conduct their own enquiries. It was also agreed that all relevant parties would be informed immediately, the Director of Social Services & Housing, Care First Partnership Ltd, Assistant Director for Community Care and the Contracts Section, London Borough of Bromley, indicating the nature of the enquiries to be undertaken and the serious nature of the allegations being made.

2.3 It was subsequently determined by the police (although no written confirmation has been received to date) that it was not possible to consider criminal charges as the allegations were technically out of time for the purposes of charging and issuing summonses.

2.4 As a result, the allegations of assault and the conduct of the staff have been considered by the enquiry team, under Section 17 which relates to the investigation of complaints and Section 9 which relates to the conduct of the home of the Residential Care Homes Regulations 1984.

3. The Enquiry Team and Methodology

3.1 The enquiry team consisted of Richard Turner, Principal Registration & Inspection Manager, Monica Hanscomb, Registration & Inspection Manager (Adults), Joan Ford, Registration & Inspection Officer, and Michael Tucker, Registration & Inspection Officer.

3.2 In view of the broad and serious nature of the complaints and the comprehensiveness of written statements by some staff it was decided to interview all members of staff in the home. This was done in privacy by Registration & Inspection Officers, one female and one male. Notes were taken. It was also agreed that statements would not be disclosed to
a third party except for those allegations where physical abuse had apparently been witnessed and Police enquiries would be required.

3.3 All those interviewed were asked specifically not to discuss the content of their interview with anyone.

4. Information

4.1.1 The Premises and Staff

4.1.2 Isard House is a home for elderly people in need of residential care. It is run by Care First Partnerships Ltd for Bromley Council on a five year contract. The Operations Manager is C N The Registered Home Manager is C J and the Deputy Manager is

4.1.3

4.1.4 Isard House is a purpose built sixty-five bedded home split into five separate units, registered as a residential care home for elderly people of whom thirty-five beds are registered for the elderly mentally infirm.

The home is located in a sub-district of Bromley with limited transport links. The home has a historic inability to attract staff.

4.1.5 Units 1, 4 and 5 are situated at the front of the building accommodating the physically frail but generally less dependent residents.

4.1.6 Units 2 and 3 are situated at the back of the building for elderly mentally infirm residents. Unit 2 accommodates those with varying degrees of dementia. Unit 3 is located physically at some distance from the main office.

4.1.7 The residents on Unit 3 are both physically and mentally frail with moderate to high levels of dependency requiring an intensive degree of personal care. These residents suffer with a high degree of dementia and are unable to readily voice their concerns or necessarily remember situations that have affected them. They no longer have the capacity to represent their own interests and can only make limited choices for themselves, they are in effect totally dependent on the care of those around them for their most basic daily needs, requiring help with toileting, eating, washing, dressing and social activities.

Unit 3, as all the Units in the home, require consistent supervision and monitoring and although a team leader or senior was apparently on duty for most of the working day, our enquiry suggests that adequate supervision had not always been provided. Such circumstances would heighten the risk of abuse or neglect, especially when less experienced staff are working alone on the unit.
4.1.8 The care and commitment of care staff at Isard House given to the residents on Units 1 & 4 & 5 and Unit 2 has not been an issue in this enquiry.

4.1.9 The care staff work in separate ‘unit designated’ staff groups with their own line management consisting of a senior care assistant and a team leader. When necessary staff from other Units cover shifts.

4.1.10 Complainants had formerly been key workers to some residents on Unit 3 which they subsequently considered were not being provided with proper care and they alleged a degree of neglect and abuse, e.g. leaving more ‘troublesome’ residents in the back lounge on their own.

4.1.11 A small number of relatives (5) have expressed their concerns about the treatment of residents on Unit 3 and have given statements regarding some specific incidents witnessed or concerns that they have had. These statements corroborate incidents of abuse or neglect.

4.2 The Allegations

4.2.1 The allegations fall into four groups:-

a) Physical and verbal abuse of residents which include a degree of assault;
b) The management of medication;
c) Neglect, lack of care and theft;
d) Failure of managers to investigate and respond to incidents of abuse and neglect.

These allegations are addressed in their respective groups as follows.

4.3 Physical and Verbal Abuse

4.3.1 Of the 27 allegations of abuse, ten were identified for consideration by the Police as a degree of physical abuse or assault was possibly involved. However the police were unable to bring criminal charges as the allegations were ‘out of time’ for the purposes of charging and issuing summonses.

4.3.2 Four members of staff have been identified by witnesses as allegedly assaulting, threatening or intimidating residents. These allegations include:-

a) pushing a resident up against a wall
b) putting a fist under a resident’s chin
c) kicking a resident on the ankle
d) pushing a resident in the small of the back apparently causing her to topple forward
e) pushing a resident’s head back against a wall with a fist
f) shouting at residents, especially when they were incontinent
g) flicking food in the face of a resident
h) wiping a resident’s face with a flannel coated with faecal material
i) spitting in resident’s face
j) swearing at residents
Of the ten incidents referred to above it has been identified that all save one occurred on Unit 3.

4.4 **The Management of Medication**

4.4.1 The Enquiry Team investigated the management of medication. An independent review of the accuracy of dispensing medication was also commissioned and undertaken by Mrs Betty Deshmukh, former community services pharmacist for Bromley Health Authority, who verified the findings of the enquiry team and identified a number of errors and omissions in terms of dispensing practice on Unit 3.

4.4.2 The Enquiry Team established the following that:

i) There is a confusing system of recording and verifying the medical needs of residents which should cross-reference with the doctor’s instructions.

ii) There are a number of doctors “log books”. Residents’ symptoms are identified but there is no reference to who has identified them, i.e. no signatures or signed authorised outcomes as to the treatment.

iii) The doctor’s “log book” is kept in the main office and there is a further one on each Unit in the form of an exercise book. This appears to lead to some potential confusion and the possibility of errors and omissions. Messages left in the unit log books are not signed or countersigned as to the outcome, or to indicate who had made the entries. There is no composite schedule of a resident’s medical condition (except in the GP’s own private medical notes). Entries are made in the various record books referred to in the above paragraph regarding symptoms. Residents do not appear to have an individual record card for staff to monitor the frequency of symptoms and the development of a pro-active system for the management of medical concerns, i.e. organising information in a clear and organised sequence.

Neither is there a schedule of outcomes or medical interventions listed to complement the understanding of the resident’s progress by senior staff or care staff generally.

iv) Regular audits of medication management and dispensing are not apparent. MAR sheets are not always clearly recorded and have been found inaccurate at times.

v) There have been reported to the enquiry team witnessed incidents of medication having been left out in pots and not given. Elderly, mentally infirm residents have been found in possession of their tablets. There has been unclear dispensing of Largactil (Chlorpromazine) involving inconsistent dosages for which there is no evidence of GP authorisation.
vi) Residents have not always been given their appetisers regularly on Unit 3 causing confusion and complications with the possible outcome of distress and discomfort, indicating a disregard of the residents' needs and neglecting the residents' medical condition.

vii) Where the visiting medical officer has said he would look into "psychic" history of a resident there is no recorded outcome. Staff have apparently been in the habit of taking verbal instructions to vary medication, on the advice of the GP over the telephone; a situation that should cease, unless it is the controlled application of a non-prescription drug.

4.4.3 The independent review of medication dispensing practices on Unit 3, supports the enquiry team's findings that inconsistent practices regarding the dispensing of medication or inaccurate recording of medication dispensed occurred on a number of occasions.

4.5 Neglect and Care Issues

4.5.1 Allegations of medical neglect, (other than medication) lack of care or emotionally abusing behaviour are cited as follows:

a) knowingly depriving a confused resident of her newspaper.
b) poor catheter management. A resident's catheter bag was repeatedly reported to be over-full which could have caused medical damage.
c) insufficient regard for 'first aid procedures e.g. when picking residents up from the floor after they had fallen having suffered serious injuries.
d) failure by senior staff to call the GP when real concerns of a medical nature were identified by junior staff.
e) residents left in bed, unwashed for long periods of the morning to await later shift staff.
f) sedated residents with their face in their food.
g) residents not cleaned appropriately after eating.
h) two residents, one of whom was aggressive and the other particularly noisy, were kept in a lounge isolated from the other residents on a regular daily basis.
i) inappropriate restraint of residents by gripping both their wrists causing bruising.
j) residents left in urine soaked clothing with resultant soreness.
k) lack of attention to dental problems, e.g. where resident was left in pain or discomfort for a number of weeks.
l) residents' biscuits and sweets were taken and offered or shared with staff without permission of the resident or their relatives.
m) one resident found slumped in a chair with an orange drink placed nearby covered in ants.
n) residents found dehydrated and not being assisted to drink regularly.
5. **Staffing Issues**

5.1 This enquiry has identified that at least six individuals who appear to have been aware of and responsible for the poor standards of care on Unit 3 during the period under consideration:
   
   a) **C** – registered care home manager
   
   b) **J** – deputy home manager
   
   c) **M** – team leader – unit manager
   
   d) **K** – care assistant
   
   e) – care assistant
   
   f) – care assistant

5.2 The six individuals referred to in 5.1 above are now considered in more detail.

5.3 **C J**, the Manager of Isard House, had been in post since November 1997, some 16 months at the time of the complaint. When she was appointed manager of the home she claimed the workforce was demoralised. The principal witnesses in this case are adamant that they had brought allegations of physical abuse, negligence and poor behaviour by staff (that they had seen occur) to her on repeated occasions and these are detailed in the witness statements.

5.4 The people making the allegations have not wavered in their conviction that **C J** as Manager was made fully aware of their concerns throughout the period that is under consideration, ie from June, 1998 to April, 1999. They claim that she deflected their complaints about **M K** and accused them of gossiping.

5.5 It appears that the allegations of physical abuse referred to **C J** by Eileen Chubb, team leader of Unit 2 and Linda Clark, a care assistant at the home, were either ignored or not considered sufficiently, nor were they recorded or recalled by **C J**.

5.6 If a true record of all the events reported to **C J** regarding the conduct of staff on Unit 3 had been recorded appropriately, indicating the manner in which she had dealt with them, this may have assisted the enquiry. However, it appears that no record exists of the times she was approached by staff about the conduct of **M K** and others, in terms of how they treated or cared for residents.

5.7 On a balance of probabilities it appears that the conduct of the home specifically on Unit 3, was unsatisfactory causing one Unit in the home to be in breach of S9 of the Residential Care Homes Regulations 1984.

5.8 **C J** repeated failure to satisfactorily investigate and record the concerns brought to her by staff regarding standards of care on Unit 3 were serious errors of judgement.

5.9 **C J** attended an intensive management course for two days a fortnight between October and December 1998 and in January and February 1999 she visited Kingswood House weekly to support the Acting Manager. This suggests that Isard House was considered to be in
safe hands of the designated responsible person, i.e. the deputy manager. Our enquiries reveal that this was not the case.

5.10 It is the enquiry team’s opinion that if C.J had remained in the home consistently between June 1998 and April 1999 this may well have allowed her to consolidate her management role. Unfortunately her managership was dissipated at a crucial time, i.e. when concerns over Unit 3’s practices heightened.

5.11 ... is the person who was responsible as Head of Care for the conduct of staff on Unit 3. It appears that did not effectively carry out that role in terms of managing Unit 3, placing total reliance on her friend, M Y, for monitoring care standards there. C. J decided to deal with ‘staff issues’ herself. This was in our opinion an unclear split of duties and responsibilities. C. J did not adequately or effectively investigate and record the allegations that were put to her by staff which were essential care matters which should have been determined by using basic investigative procedures. As a result, it appears that C. J became directly implicated in the continuation of these incidents by failing to deal adequately or appropriately with the concerns raised by the staff group about the care of residents at Isard House.

5.12 There is some suggestion in the statements made by C. J that she did not have confidence in her deputy manager’s ability to adequately manage the home in her absence. If this was the case, it should have been made clear to C. N, the Operations Manager and C. J line manager. The enquiry team has not been advised that this was the case. C. J understanding of the relationship between and M. K and its possible ramifications appear to have eluded her, although there are reported suggestions by staff ‘that things were not right in Unit 3’. No written record was held by the managers of Isard House to indicate why the problems erupted there after so many months of reported concerns by staff.

5.13 This enquiry has established that C. J made errors of judgement and relied too heavily on a line management structure which she was aware was no longer considered by care staff to provide adequate care for residents on Unit 3. Concerns about the poor conduct of staff on Unit 3 have been corroborated by the independent medical audit, personnel records and the statements made by witnesses who were not directly employed on the Unit. Also the statements of those who witnessed abusive or inappropriate behaviour confirm that the unit was not managed appropriately during the period June 1998 to April 1999. It is understood that C. J was, however, encouraged by her employer to be absent from Isard House during this period and that other units of the home were not directly affected. The decision that Mrs J should be absent from Isard House requires further examination.

5.14 C. J responses to the allegations and concerns put to her by care staff over a period of months were less than satisfactory, and she did not exhibit an adequately professional approach. She lost the confidence and respect of a significant proportion of her workforce. (Seven of the care staff employed there are now on sick leave, i.e. those who gave
should have strictly followed adult abuse and protection procedures. It is understood that Care First Partnerships Ltd have not fully implemented their procedures and practices of their parent company BUPA Partnerships. This does not excuse such a serious catalogue of allegations occurring without being recorded and adequately investigated.

5.15 However, the home in many respects was working well and the majority of the residents (72%), were apparently adequately cared for. It is C J influence that has helped to achieve this. It is not clear from the information received whether C J integrity as the registered Residential Care Manager is sufficiently flawed to support an application to de-register her from ever managing a residential care home again.

5.16 (Deputy Manager of Isard House). It is the view of the enquiry team that has failed in her role as “Head of Care” to satisfactorily administer safely and accurately the dispensing of medication.

She had direct responsibility for overseeing and monitoring the dispensing of medication. The external pharmacist’s report suggests that this in-depth monitoring has been absent and as a result it appears that failed to discharge this responsibility satisfactorily. On Unit 3 residents placed there suffered a degree of risk and discomfort as a result.

5.17 Drugs were not given to residents properly on Unit 3, and on occasions were found in communal areas loose in containers. The medication regime on Unit 3 did not ensure that Regulation 10 (1) (Q) of the Residential Care Homes Regulations 1984 which requires the registered person to ensure to “make suitable arrangements for the recording, safekeeping, handling and disposal of drugs” was complied with.

5.18 Accessing medical intervention was a responsibility undertaken as Head of Care, consideration for the welfare of the residents at Isard House appears to have been adversely affected. Reports by members of staff suggest that the visiting medical officer was unable to be present promptly, either because he was “too busy” or because his presence was considered unnecessary.

5.19 The time taken, apparently six to seven weeks, to ensure suitable dental care for an EMI resident on Unit 3 indicated a lack of urgency for the care, welfare and personal comfort of a resident who was totally reliant on the staff. The resident concerned suffers with severe dementia, is unable to obtain services for herself and she has no relative or close contact who visits who could assisted her in expediting the dental treatment she urgently needed.

5.20 A significant amount of residents’ clothing has gone missing. This was new clothing purchased for residents amounting to many hundreds of pounds. This has caused distress to relatives and physical hardship to residents and their families.
The losses have occurred either by ineptitude, indifference or intent. It is not the object of this enquiry to consider this matter in detail at the present time. The matter has been investigated by Bromley Police and referred to the Crown Prosecution Service.

5.21 It is however indicative of the general lack of care and inadequate management that such losses of clothing should have occurred. This matter was never dealt with. This aspect of the residents welfare is believed to have been the responsibility of as Head of Care.

5.22 claims that she "walked round the home". It is our belief that she did have knowledge of care staff working for her, but had insufficient detail of working practice to be aware of the frustrations of staff and their perception of management inaction ensuring the safety and well being of the residents on Unit 3. She claims to have been unaware of the continued difficulties that was encountering.

5.23 Due to her longstanding working relationship with M, she failed to supervise her effectively placing her total trust in her, without monitoring the unit's performance in a consistent and professional way.

5.24 -- As the Team Leader for Unit 3 bears the immediate responsibility and is the operational manager for that unit to safeguard the welfare of the residents and ensure the staff are managed appropriately. With 30 years experience, younger staff were placed with her for induction and training and she had developed a programme for this purpose.

Some of the staff who complained about standards of care on Unit 3 were trained or 'coached' by the Team Leader-manager of Unit 3 when they joined Isard House. They were not critical of her until they had become more experienced in their care practice. Once this had occurred they began to question the appropriateness of the personal care being provided to the residents on Unit 3.

5.25 She joined Isard House as a care assistant on Unit 3 in April 1997 and four months later was promoted to team leader. alleged that had suggested she joined Isard House as she had done similarly on previous occasions, when they worked for the London Borough of

5.26 From an early stage in her employment claimed she was unable to travel easily to and from her home and she was the only member of staff who was given permanent use of a bedroom on the first floor. The bedroom contains considerable amounts of clothing in black plastic bags that she has collected or bought during her stay there.

5.27 spent her break times on or around Unit 3 and in the evening she would spend time on the lounge of Units 1 and 4 where she would socialise with staff.
Until recently M K frequently spent seven days a week at Isard House until C J considered that she should spend her weekends, i.e. one in three, at home. M K

The presence of M K in the home was however of benefit to those running Isard House. She would readily do overtime and has averaged 50-60 hours a week during her employment. She would be available to switch shifts to help other members of staff or to fill in when the home was short of staff. In short, this was a mutually reciprocal arrangement but one which staff became aware was influencing the practical running of the home and aware of M K's close relationship with management. This arrangement made staff wary of reporting neglectful and/or abusive behaviour on Unit 3 earlier in a more consistent manner, to management.

Those staff who did complain, bypassed altogether and approached C J directly who subsequently agreed in recent months to deal directly with the complaints or "grievances" of Units 2 and 3 staff regarding M K whilst she was charged with the responsibility of dealing with operational matters of the day to day running of the home.

During the interviews with M K she insists her approach to the care of residents was not neglectful but she does admit to making errors over medication and increasingly being unable to manage younger staff. To her credit, she has presented her evidence in a straightforward manner but her responses suggest a person who has adopted patterns of behaviour which are no longer appropriate to the care of EMI residents to afford them dignity and respect.

M K's references are insufficient as are others we have reviewed. This shows that in this respect the home's administration is clearly flawed or at best lax. From an examination from personnel files, it appears the situation has existed both before and after Mrs J became manager.

M K has admitted that she was having considerable difficulties in managing young and inexperienced carers in her staff group and that Unit 3 was not the right place to train staff who had never worked with elderly people and especially those suffering from severe chronic disabilities.

As line manager should have been aware M K was being treated for blood pressure, which could be worsened by stress. It is the view of the enquiry team that M K was no longer able to cope with the management responsibilities of caring for EMI residents in such a stressful environment and should have taken appropriate action.

M K says she asked for help to manage the situation. It is the opinion of the enquiry team that she was not adequately listened to.
or "heard". Whatever the truth nothing was done to rectify the deteriorating situation.

5.36 M. K was responsible for a substantial breach of Section 9 of the Residential Care Homes Regulations 1984 has occurred and it appears that further breaches have occurred under Section 6, by failing to adequately maintain 'the records specified'; and sub-sections of Section 10.1 ensuring the provision of adequate facilities and services, i.e. failing to make adequate or appropriate provision under the following sub-sections 10(1)(a), suitably qualified and competent staff in numbers which are adequate for the wellbeing of residents; (p) arranging for residents to have suitable medical and dental services, (q) arranging for the 'recording, safe-keeping, handling and disposal of drugs'; (r) make suitable arrangements for the training, occupation and recreation of residents...'. It is also considered that Section 14 of these regulations have been breached, specifically (a) of section, of any event in the home which affects the wellbeing of any resident and 5.14(e) of any theft, burglary, fire in the home.

5.37 has some years experience in caring for the elderly, eight or nine years in total, both in residential and nursing home care settings.

5.38 The enquiry has identified ten specific incidents where it is alleged that was involved in inappropriate behaviour towards residents. At least six separate witnesses were able to corroborate that they saw these events; such incidents were not recorded at the time although apparently verbally reported to M. K or C. J.

5.39 During 1998, faced personal emotional difficulties for which she said she received counselling in April 1998.

C. J varied the rota to enable to attend counselling regularly on a Thursday afternoon every two to three weeks.

5.40 Although has experience, she has a poor work record. Her team leader, M. K stated that she worked too fast.

5.41 staff performance appraisal with C. J on her personnel file reinforces the statement that she was too fast a worker, i.e. "superficial" in carrying out personal care tasks for residents.

An incident in which a resident's incontinence pad was not changed at the right time, suggests this to be true and was corroborated by in the statement she gave.

5.42
5.43 Other members of staff have also stated that_pet was temperamental and needed to be taken out of the care situation when her behaviour deteriorated.

5.44 M_K_admits she could not manage_and asked for her removal or transfer to another unit when she discussed the matter with... 

5.45 The enquiry team recommend that Care First Partnerships Ltd request a review of _s health by an independent Occupational Health Physician who would need access to her psychological history from her GP.

5.46 Should it be subsequently confirmed that _is "unfit" to work with people requiring care, there is a general duty of care placed upon the Registering Authority to submit a report on conduct and health to the Department of Health Consultancy Service index. 

5.47 _is a care assistant on Unit 3. She does not however have a specific skill or training in the needs of the elderly mentally infirm.

5.48 The enquiry team has identified that she has been heard shouting at residents. Although those incidents may have been isolated it would seem appropriate for the Care First Partnerships to consider investigating these matters further.

If remains in post the employer should ensure that receives the required support and supervision, training and development that is necessary to ensure that she is capable of respecting the dignity of the residents for whom she is responsible.

5.49 Her employment as a care assistant with the elderly mentally infirm should be reviewed.

5.50 _is a care assistant on Unit 3. She has no specific knowledge, skill or training to work with the elderly mentally infirm. She was a former cleaner in a local hospital.

5.51 Although she is described as having a loving and caring nature she has a written warning on her personal file in Ward House because she shouted at residents. This has been witnessed by other members of staff. Her employment as a care assistant should be reviewed.

5.52 Personnel Records

5.52.1 Personnel records of five staff involved in this enquiry have been reviewed. These files were selected at random and were scrutinised in detail. Although a full review of all files has yet to be undertaken, files seen indicate that references are incomplete in a number of instances and some references contain insufficient information to ascertain the ability of the individual to carry out the task of caring for chronically frail elderly residents. There
were also inconsistencies in the sequencing of information provided on CVs and associated references.

5.5.2.2 The personnel file of one of the members of staff suspended shows that the content of her reference actually related to another person. This reference referred to an exemplary work record when her performance was considered to be only adequate by a former employer. This could have influenced her prospective employer, at that time Court Cavendish PLC, to appoint her. After considerable work by the enquiry team it was established this was likely to have been a serious administration error by the former employer, and not necessarily a forgery. Further clarification will be undertaken to ensure that this is the case.

6. Conclusions

6.1 Although the witnessed incidents of physical abuse are not recent, there are a significant number of witnesses, amongst care staff employed in the home, relatives and others who have been interviewed and who corroborate the original allegations.

6.2 A climate of complacency and laxness occurred in terms of the care of the residents particularly on Unit 3. Inappropriate behaviour towards them did occur in the manner suggested by the witnesses who have come forward and those subsequently interviewed.

6.3 The two statutory inspections during 1998, unannounced 16.4.98 and announced 5.11.98, had not revealed discrepancies in the home’s records on Unit 3 and the care of residents appeared to be adequate at the time of those inspections. It was only after detailed research by the enquiry team and the independent audit of medication that revealed the numbers of errors and omissions in dispensing medication.

6.4 The inspection Unit’s inspection format has been recently revised and unannounced themed inspections are to be introduced this year. This method will, it is hoped, assist in providing an opportunity to consider aspects of care in greater detail.

6.5 It has not been possible for the enquiry team to state categorically that the claims of physical abuse made by witnesses can be proved conclusively, i.e. beyond all reasonable doubt. There have been approximately 13 specific incidents where intentional abuse could have prevailed. The allegations are alleged to have been reported to their line managers who failed to record and investigate adequately.

6.6 Staff have been interviewed thoroughly with regard to their claims of abuse and/or negligent behaviour on Unit 3. The team leader for Unit 3 at the time, herself has admitted in her interviews, that she made mistakes on a number of occasions and was unable to manage or control staff.

6.7 Working long hours, M lived in the home and used the Unit lounges inappropriately for her recreational purposes. It is clear in our view that she was primarily responsible for allowing the climate of
abusive and neglectful behaviour to exist unchecked. This is represented by the inappropriate and allegedly abusive behaviour of who worked on this Unit. had a history of poor work performance. The number of incidents involving her are too many to ignore or overlook, but M K failed to deal with these appropriately or follow basic procedures regarding these allegations of abuse, e.g. essential examination and recording of concerns principally brought to her notice by staff.

6.8 M K claims she told she was no longer able to manage her staff group effectively.

6.9 New staff initially saw M K as a role model but subsequently became disaffected by her practices, as they became experienced in the care needs of the elderly.

6.10 M K and had formed a close relationship over a period of approximately 20 years when working in another Authority. The staff witnessed the close relationship which existed between them and it was their view that it deterred them from expressing concerns about M K through normal line management channels to

6.11 C J stated in her interviews that in the middle of 1998 she had made responsible as ‘Head Of Care’, (although staff seemed unaware of the arrangement in practice) and that she, Carol Jones would deal with the ‘personnel issues or any grievances’ largely emanating from Units 2 and 3. C J said that this was because there were difficulties existent at an early stage which she considered necessary to address by some form of structural change. Unfortunately the outcome of this new arrangement was to polarise the situation in that the management of the staff was divided and staff came to C J with their concerns rather than to their line manager in the correct way, i.e. to M K and . There was an assumption made by the two managers that much of the problem was mischievous gossiping between staff members on those units.

6.12 One notable aspect of this case is statement when initially interviewed. She had very little to say, except that she placed her implicit trust in her friend M K to run Unit 3. M K referred to in discussion a term afforded to her when she worked in the London Borough. The relationship between them was too close to ensure objective management practice or the satisfactory investigation of any complaints or concerns had staff felt confident enough to make formal complaint to about her management abilities.

6.13 M K claims she was repeatedly encouraged by to join her in the next home she worked in when they worked in and ultimately at Isard House. They had worked in various homes over a number of years, replicating the role of Deputy Manager and Assistant Officer in Charge and in respect of Isard House, Team Leader.
6.14 The enquiry has identified that M K had spent many hours in the office with this situation reinforced the view of staff that concerns regarding M K conduct could not be freely expressed to C J openly admitted in an interview that she had to bring M K social presence in the office to her attention but it appears this may have recurred when the manager had not been present.

6.15 To summarise, it is clear that repeated concerns regarding issues of care and possible neglect or abuse were never fully dealt with by in a structured and detailed way. Matters were being side-tracked and brought directly to C J, the Manager but again it appears that those reported incidents or concerns were not appropriately investigated.

6.16 The outcome of this enquiry concludes that on Unit 3 for a period between June 1998 and March 1999, a number of incidents occurred which were unacceptable in terms of the conduct and of staff and management of the welfare of the residents. As such, Section 9 of the Residential Care Homes Regulations 1984 has been breached in this respect.

6.17 The managing agents of the home, Care First Partnerships Ltd appear to have failed to ensure the effective line management of Unit 3 where the most highly dependent residents suffering with dementia are being cared for. Although it is accepted that the Operations Manager visited the home to the statutory requirements but was unaware of any shortfall in the care provided on Unit 3.

6.18 The outcome of this enquiry has been to indicate that the number of staff should be subject to disciplinary investigation. The operational management of work on the EMI units needs to be reviewed to ensure that basic care staff have some degree of job enrichment to prevent demotivation and de-skilling.

6.19 Training and development plans should be considered with the advice and support of the Registration & Inspection Unit who will make specific recommendations in this respect to ensure that no one employed to care for an elderly mentally infirm resident should do so with less than 6 months experience of caring for older people in a residential care home or nursing home. A recommendation can be found below for a modular programme of basic training to ensure that the concerning issues raised in this report do not occur again.

7. OTHER ISSUES

7.1 The enquiry has revealed underlying factors which have contributed to the problems on Unit 3:

- High levels of unskilled staff
- Staff working long hours
- A young and inexperienced staff group
- Difficulties in recruiting and retaining a consistent staff group
- Higher than average levels of dependency on Unit 3
7.2 It was identified during the course of the enquiry that Care First Partnerships Ltd had difficulty in recruiting and retaining suitable staff at Ixard House.

7.3 It has also emerged that there were a number of staff working on both Units 2 and 3 who were not suitably trained for the needs of this resident group.

The presence of inexperienced staff on Unit 3 is thought to have been a major factor which contributed to the difficulties and poor standards of care that occurred there. There should be suitable people to care for elderly residents, especially those with specialist needs.

7.4 Care First Partnerships Ltd must address the issues raised by staff of long hours and the resultant stress that they experience working on these units where high dependency exists.

When interviewed, a number of staff said that they were under constant pressure and stress as a result of the extremes of behaviour and high level of care required on Units 2 and 3.

7.5 In view of this information, Care First Partnerships Ltd must take action if it is to avoid a repetition of such events.

7.6 It is the enquiry team's view that a new role of General Duties Assistant should be created to support care staff in the running of EMI units to ensure a more adequate standard of care. This recommendation may not require additional staff if a restructuring of the existing ancillary cleaning staff could be achieved.

7.7 The duties of the General Duties Assistant would be:

(a) lay the tables before meal times;
(b) prepare breakfast and tea;
(c) wash up;
(d) make residents beds and clean residents rooms, together with the communal areas, e.g. kitchens and lounges;
(e) prepare and give out drinks.

7.8 During the course of the enquiry it became apparent that an appropriate designated responsible person was not always present in the home, specifically in the evenings and at weekends. The Revised London Guidelines clearly states in Sections 5.16, 5.29 and specifically in 5.30, that 'the persons delegated to run the home during the care managers absence must be a designated responsible person, who should be both a competent manager and a person well versed in the needs of the particular client group concerned.'

Care First Partnership Ltd is not always complying with this requirement and should rectify this omission.
7.9 Although staff team meetings took place fairly regularly, these were not always run appropriately. It is essential that issues arising from team meetings are clearly recorded and made available to senior management, for action on relevant issues.

7.10 Care staff stated in interviews that there appeared to be a lack of planning around holiday periods, especially with regard to cleaning staff which led to difficulties in providing appropriate care and ensuring the safety management and cleanliness of the home. This indicates a lack of adequate management.

7.11 It emerged during interviews and subsequent investigations that there were some omissions in basic information and knowledge that staff needed in order to undertake their work.

7.12 The enquiry team did not consider that the induction training provided for care staff was sufficiently comprehensive and recommends that induction training should be improved. Induction training should include the following:-

a) Fire procedures.
b) Policies and procedures.
c) An explanation of how residents are to be treated in a dignified manner.
d) Infection control procedures.
e) The use of incontinence pads and any toileting regimes.
f) The importance of recording significant events.

7.13 This enquiry further established that more specialist training is required for those who wish to undertake work with the elderly mentally infirm and a suggested programme of modular training is referred to below.

1. What is dementia? and an understanding of the HAFFLI principles (Revised London Guidelines 6.3) to indicate the basic care values which underpin the quality of life for residents.

2. A course on challenging and repetitive behaviours. A course of this nature is currently in operation.

3. A general course on understanding chronic disabilities which effect older people in addition to dementia, for example, Parkinson's disease, Cardiovascular disorders, etc. (Revised London Guidelines 7.2).


5. A course focused on the emotional aspects of dementia with special regard to understanding the background of the individual residents concerned, e.g. their social history, and previous occupational and social interests.
6. A combined course provided by Social Services and the Police to train care staff in identifying and accurately recording incidences of physical or emotional abuse and the various points of access that they should be aware of if they have concerns, together with an understanding of the recently introduced Public Interest Disclosure Act 1998, and Human Rights Act 1998 due to be implemented in the year 2000.

7.14 The enquiry team also noted the absence of an activity programme on Unit 3, and recommends that this should be developed immediately.

8. **Recommendations**

8.1 **Individual staffing issues**

8.2 The management should undertake a full investigation and take appropriate disciplinary action as a result of the findings of this report.

8.3 The recommendations regarding the allegations which have been the subject of this enquiry are as follows:-

8.3.1 C J (Registered Manager). It is the view of the enquiry team that C J should not be de-registered as a Residential Care Home Manager but should no longer remain as manager of Isard House. It is strongly recommended that C J be transferred to a smaller residential home where she would have the opportunity to develop her management skills in the managing of a Residential Care Home in a less pressured environment.

8.3.2 (Deputy Manager). It is the recommendation of the enquiry team that Deputy Manager of Isard House as she has failed to exercise the role as “Head of Care” adequately.

8.3.3 M K (Team Leader Unit 3). It is not possible to determine when M K abilities to manage staff began to deteriorate but there were failures on Unit 3 between June 1998 and April 1999. It is the enquiry teams view that she had become “worn-down” and she should no longer be a Team Leader.

8.3.4 (Care Assistant Unit 3). Careful consideration should be given by the management whether she should be a care assistant in the future. Sections above deal more fully with the enquiry teams views on this matter.

Physical and mental health has been brought into question resulting from this enquiry and an independent Occupational Health Physician's assessment has been previously recommended in S 5.45.
8.3.5 (Care Assistant Unit 3). Ability to work with vulnerable elderly mentally infirm residents has been raised as an issue in this enquiry report. It is recommended that the management review where would be best placed in the staff group.

8.3.6 Care Assistant Unit 3). The management have already found it necessary to discipline with regard to her behaviour towards residents. They need to consider whether she is suitable in her present role as a care assistant with vulnerable, elderly mentally infirm residents.

8.4 General Staffing issues

8.4.1 The management care shortcomings at Isard House must be addressed by Care First Partnerships Ltd to ensure the delivery of care is adequate on every Unit at all times. Care First Partnerships Ltd must review their procedures and ensure that staff and managers at Isard House are fully acquainted with implementing them.

8.4.2 References must be obtained before carers/cleaners start employment – a verbal reference must be immediately followed by written reference within 14 days. (Revised London Guidelines 5.8). Care First must satisfy themselves that the references adequately comment on the suitability of staff for this work.

8.4.3 Care First Partnerships Ltd must address the issues of recruitment, retention, and skills generally, and particularly in relation to Unit 3.

8.4.4 A new role of General Duties Assistant (G.D.A.) should be created on units for the elderly mentally infirm. Care staff should be relieved of ancillary cleaning duties to ensure the effective personal care of highly dependent residents.

Revised London Guidelines state ‘ancillary staff must be employed in sufficient numbers to meet the catering and cleaning needs of the residents’, section 5.25.3. It is further referred to in section 5.36 of the Revised London Guidelines that ‘ancillary staff should be employed to meet the catering and cleaning needs of the home’.

8.4.5 Care First Partnerships Ltd should consider employing more part-time staff, who could cover the busy periods of the day. (Revised London Guidelines 5.23.2). This should ensure suitably qualified and competent staff are provided in sufficient numbers, adequate for the well being of residents. (Regulation 10(1)(g)).
8.4.6 A Designated Responsible Person must be on duty both at weekends and evenings. That person should be supernumerary and have sufficient management experience to be available and answer any queries that relatives may have or assist in admission procedures. (Revised London Guidelines 5.29, 5.30).

8.4.7 The registered manager of the home must ensure that team meetings on each unit are held regularly and an agenda should be identified and minutes taken.

8.5 Medication

8.5.1 The management must nominate named staff members (a minimum of two) who must be responsible for checking medication in and out of homes and liaising with the GP. (Revised London Guidelines 7.19-7.30).

8.5.2 Negotiations must not take place between GPs and the home regarding the prescribing of medication over the phone. A prescription should be written and obtained by staff from the surgery. (Revised London Guidelines 7.19-7.30).

8.5.3 Medication must be given on time. (Revised London Guidelines 7.19-7.30).

8.5.4 Only designated care staff should administer medication to residents and all designated persons should receive appropriate training. (Revised London Guidelines 7.2).

8.5.5 Every night before going off duty the "On call" officer should check that all medication has been given and recorded. Any gaps in recording or explanations why medication was omitted should be recorded. (Residential Care Homes Regulations 1984, 10(1)(a)).

8.6 Training & Development

8.6.1 Management must ensure that all new staff have at least one day of induction training before caring for the residents as described in Section 7.12 above. (Revised London Guidelines 5.46).

8.6.2 The development of a structured activity programme is required. Consideration should be given to using both lounges on Unit 3. (Revised London Guidelines 6.66-6.67). (Home Life 2.52 p23 and p24).

8.6.3 Care First Partnerships Ltd must comply with Regulation 10(1)(a) with regard to the staff being suitably qualified and competent for the well being of residents. The Registering Authority strongly recommends that staff working on EMI units should have a minimum of six months experience in a residential care or nursing setting and that a training programme is made available to them and has been referred to in the previous section.
8.7 Care Issues

8.7.1 The Head of Care at Isard House must carry out a Care Audit every three months checking medication, care plans, Kardex reporting, to make sure that details of the individual needs of residents are being kept and recorded. (Revised London Guidelines 4.4-4.6), (Revised London Guidelines 6.27), and (Revised London Guidelines 7.19-7.30).

8.7.2 "Incontinence management, particularly at night, must be improved. The "on call" officer should be responsible for checking that the right amount of incontinence pads are available for night staff.

8.7.3 Risk assessment should be carried out on all residents and the findings noted in the residents care plan. The assessment should be carried out and care plans updated every 3 months. (Revised London Guidelines 6.44-6.47). Home Life 1.28.

8.7.4 The management must ensure that a person qualified in first aid is available to ensure cover throughout a 24 hour period. It is recommended that the Designated Responsible Person should always be a qualified First Aider. (Residential Care Homes Regulations 1984, 10.(1)(q)).
STATEMENT OF RICHARD TURNER
OF THE REGISTRATION AND INSPECTION UNIT, SOCIAL SERVICES
AND HOUSING, BROMLEY CIVIC CENTRE
STOCKWELL CLOSE, BROMLEY

WILL SAY as follows.

1. I am the Principal Registration and Inspection Manager employed by the London Borough of Bromley and have been employed in that post for the past 9 years. The Registration and Inspection Unit, whilst being part of the Directorate of Social Services and Housing is an "arms length" service undertaking the inspection and registration of residential care homes. I am overall responsible for monitoring the standards of care in those homes as well as carrying out similar responsibilities under the Children Act in relation to day care provision and children's homes.

2. Inspectors have to ensure that they are both independent and objective in their task which means that irrespective of whether it is a council, private or voluntary provided service, the same inspection standards apply. The Inspection Unit must show that it is "at arms length" from the Council's own direct service provision and not influenced by the objectives of other divisions of the department.

3. In the course of my duties as Principal Registration and Inspection Manager I also oversee the investigation of complaints and allegations made in respect of registered care homes and the provision of care in those homes.

4. In the Borough, we have 69 large homes in total providing residential care for both older people and adults with a learning disability.

All these homes are registered by the Registration and Inspection Unit for Bromley Council Community Care Division.

Six homes are contracted out by the London Borough of Bromley Community Care Division to Care First Partnerships Limited and Care First Care Homes Limited. The premises of five of the homes are still owned by the London Borough of Bromley and one is now owned by Care First Care Homes Limited, but is providing care to Bromley residents under contract to London Borough of Bromley, making a total of six homes which provide care under a contract to the London Borough of Bromley.

All the care homes in Bromley in this sector are managed and owned by independent service providers and as such the Unit deals with all
the homes on an equal basis, making no distinction in terms of its regulatory responsibility towards those that have been contracted out by the Council.

5. Under the regulatory system two statutory inspections are carried out each year; one announced and one unannounced for each home. The Registration and Inspection Unit also do follow up visits as a result of these inspections where necessary. Where there are concerns about a particular establishment we will undertake as many visits as required.

6. There are on average 30 or so complaints a year regarding service provision in adult care homes. These vary from specific small scale complaints to larger matters. Normally these complaints just relate to one individual and they are usually raised by relatives, visitors, staff or ex-staff.

7. In addition to Registration and Inspection visits the Council has a rota of visits by Councillors to contracted out homes. Sometimes the Registration and Inspection Unit receives information on issues from Councillors if they are concerned about the standard of the premises or the care offered.

8. The London Borough of Bromley has contracted out its responsibility to provide care in residential homes since 1995. The contract is now within Care First Care Homes Limited after a series of company restructurings.

9. The Registration and Inspection Unit can recommend that a home is de-registered if they:
   i) Employ people who are not fit persons to be employed to care for the elderly or staff are not provided in sufficient numbers.
   ii) If the premises are not adequate to provide suitable accommodation for those being carried out.
   iii) The way they carry on the business would indicate an inability to provide a secure and sustainable service with integrity e.g. someone who was backing an organisation was an undischarged bankrupt or in prison for fraud for example or dishonest and did not maintain records.

10. In this role I was approached by Eileen Chubb and Karen Hook in April 1999.

11. On 19 April 1999 Eileen Chubb and Karen Hook came to see Monica Hancoom, Registration and Inspection Manager for adults at the Civic Centre, (the operational location) for the Inspection Unit. I was invited to join the discussion and was made aware that there were concerns of quite an extensive nature with regard to the care of residents at Isard
House particularly on Unit 3 which provides care for elderly mentally
inform residents suffering from chronic dementia.

12. Eileen Chubb and Karen Hock gave us hand-written statements of
members of staff alleging a range of abusive and inappropriate
behaviour, towards residents by certain members of staff.

13. This first meeting went on for at least an hour and a half. Ms Chubb
and Ms Hook stated that the 7 staff were upset and concerned about
the residents whom they had been looking after. They told me they
were coming to us because they had reported their concerns to
management at Isard House and nothing had been done. I asked for
time to read their statements. At this point they went and had some tea,
subsequently returning to meet with me and Monica Harriscornb once I
had finished reading their statements.

14. They repeated that there were difficulties relating to management at
Isard House. They had spoken to their Line Manager but their
concerns had not been dealt with and that is why they were coming to
us.

15. I said I was very concerned about the nature of the allegations, and the
seriousness as it involved a large number of people, residents and staff
and the line management at Isard House. I stated we would have to
involve the Police, given the nature of the allegations. I said I would
arrange a meeting as soon as possible with the Police and our staff
and conduct an investigation in conjunction with them to examine the
allegations more fully.

The "whistle blowers" seemed content with this and it appeared that
they thought we were taking matters seriously. I told them I would be
in touch when I had arranged a strategy meeting for the following day.

16. On 20 April 1999 there was an inter-agency strategy meeting with
Bromley Community Support Unit at 11.00am. This involved two Policia
Officers and Social Services. This meeting examined the allegations
brought to the attention of the Registration and Inspection Unit by the 7
applicants. WDC Judith Taylor and Detective Sergeant Pegington
were the Police Officers involved.

17. At the Strategy Meeting, it was agreed that we would seek suspension
of Maria Kavanagh immediately the main person implicated in the
allegations.

18. The Police Officers also agreed that they would interview witnesses
and would look into the allegations of possible theft from residents, and
criminal abuse. And would in parallel with Social Services staff begin
an inquiry to establish the facts of the matter.
19. It was further agreed that all the staff at Isard House and any other relevant parties, including the residents if they were capable of being interviewed and possibly some of the relatives would be interviewed. It was acknowledged however that most of the residents were EMI (Elderly Mentally Infirm) and the likelihood of attaining useful evidence from them was fairly remote. All the relevant parties were notified. The Director of Social Services and Housing, Care First Partnership Limited, the Contracts Division. Proposed placements of residence to the home were temporarily suspended pending an assessment. Once the assessment had been completed and the Unit satisfied that the safety and well-being of the residents would be assured, I would advise the Social Services and Housing Community Care Division of the outcome.

20. On 21 April we set up an enquiry team consisting of Joan Ford, Registration and Inspection Officer, Mike Tucker, Registration & Inspection Officer, Monica Hanscomb, Registration & Inspection Manager, (Adults) and myself. The Team attended at Isard House to begin the enquiry.

21. The Manager, Carol Jones provided us with accommodation on the first floor where we undertook the interviews.

22. Two Officers were present at each interview, one male and one female and often two interviews were running concurrently. We started the interview process on 21 April and continued over a number of weeks including weekends and visiting in the evenings to see night staff. Some members of staff would have been interviewed perhaps on two/three occasions depending upon their involvement. We interviewed anyone who was closely involved. We had a set of questions for each member of staff which was common to all.

23. We asked each person questions about their current role, previous experience, training and if they had seen anything as Isard House which made them feel uncomfortable, did they have any concerns about the ways in which residents had been treated.

24. At the outset of the interviews we asked people if they felt happy to talk to us which the majority agreed. If they were unhappy with these arrangements, we asked if they would like somebody with them.

25. On 5 May, Eileen Chubb telephoned me for assistance because she was being 'chased' around Isard House by Carol Newton, Care First Partnerships Area Operations Manager and Eileen Chubb had locked herself in a bedroom of one of the residents to get away from her.

26. As this breakdown in the relationship between the members of staff and their Managers was affecting the running of the Home, Monica Hanscomb and I attended Isard House immediately. Eileen Chubb contacted us in order to try to keep the peace and avoid too much.
disruption. An interview then took place between Eileen Chubb and Carol Newton in the conference room in Isard House on the first floor with both myself and Monica Hanscomb present.

27. This meeting was for Carol Newton to establish what the problems, had been and it appeared that she saw Eileen Chubb as the 'ring leader'. Eileen Chubb was too distraught to go on working. I felt we were mediating in an internal employer – employee situation which could not be resolved easily, and not the Units role. Carol Newton asked why Eileen Chubb had gone to the Registration and Inspection Unit when there was a BUPA Help-line for Care workers. Monica Hanscomb pointed out that there was no Help-line at the time and when they had brought concerns to the Management nothing had happened.

28. Eileen Chubb indicated to Monica Hanscomb that she could not go on working under the circumstances and Monica Hanscomb told Carol Newton she agreed with this.

29. Mr Kelly was Care First Partnerships Limited Operations Director. Carol Newton was the Area Operations Manager Mr Kelly was therefore Carol Newton's Line Manager. I suggested to him that he should attend a meeting with the 'whistle blowers' as a way of reducing their tension and distress. I told him that I believed that the staff group had come to us in good faith, I was concerned if this disruption was going to continue at Isard House, it would affect the residents.

30. I arranged an impartial venue and discussed this with Eileen Chubb and Karen Hook. I said they would be able to present their own case. I said I would be there just to listen and facilitate the discussion.

I arranged the meeting for 14 May at one of the Council's special sheltered housing units. The meeting was attended by all 7 'whistle blowers', Mr Kelly and myself and Monica Hanscomb joined us later. It was a constructive meeting in the sense that the 'whistle blowers' were reasonably calm and very professional. They presented their concerns on a flip chart which clearly identified the circumstances of their allegations and some of the residents most affected and the staff hierarchy which they suggested had inhibited the present resolution of their concerns in Isard House.

31. Mr Kelly listened to what the staff group had said and thanked them and talked about training and development and how this could be improved at Isard House. However he said that BUPA could not do anything until the Registration & inspection Unit had completed its investigations.

He emphasised with the staff group and told them about his own care background in Residential Care Homes and that he understood their concerns. Care First Partnerships or BUPA were keen to ensure that care would improve and improved training was the key to this. It was
an informative meeting on both sides and I felt was the beginning of a
dialogue would continue between the respective parties.

32. Mr Kelly presented his own credentials and told the staff group about
books he had written i.e., his academic background. He did not identify
any clear objective to resolving the issue at Isard House but he said he
would rely on the outcome of the Registration & Inspection Unit's
enquiry and that he would make sure that everything was OK in the
sense of the residents care.

33. In summary Mr Kelly explained his professional background, his
knowledge of residential care matters and tried to give some
reassurance. I felt that Mr Kelly had listened to what the staff had said
and that he would take some action. He did say he would take
responsibility for the situation. The “whistle blowers” were really upset
about the lack of care to residents of whom they were particularly fond.

They were frustrated, upset and angry that they had not been able to
achieve any change for the residents in terms of the care they had
been receiving. All the people who attended had an opportunity to say
something. The meeting went on for approximately 2 hours.

34. I got the sense that there was a management vacuum at Isard House,
5 residents in particular seemed to have suffered particularly and there
was a real problem of under staffing on Unit 2. The “whistle blowers”
were adamant that there had been physical assaults and verbal abuse
towards residents in the year preceding April 1999 principally on Unit 3
Isard House.

35. The staff group were also concerned about communications with the
GP which had apparently been blocked by Maria Green, the Deputy
Manager, at Isard House. They claimed that this had prevented early
treatment of a variety of residents’ health conditions and concerns.

36. Lee Elkin, one of the staff that made allegations claimed that he had
been harassed to return to work by repeated telephone calls with the
Manager of the home, Carol Jones.

37. There was underlying distress at the meeting. Linda Clark in particular
became very emotional. All the staff attending the meeting at Durham
House were tearful at times except Margaret Roity.

38. On 24th May I arranged for the “whistle blowers” to have counselling
through a voluntary agency Council and Care for the Elderly. I was
conscious that my lines of responsibility were becoming blurred. I felt
sorry for the “whistle blowers” who had come to us in good faith wanting
to help them but I also wanted to avoid their concerns being treated as
gossip. There was a need to ensure their own emotional needs were
receiving help from and external source and that their health was
39. The enquiry team had prepared and interim report in May and held a meeting on 13th May at the Civic Centre with Mr Kelly and Carol Newton present from Care First Partnerships Limited and we discussed the interim findings in full. Mr Kelly met with the staff group at Durham House the following day.

40. Carol Jones, the Manager at Isand House, then went off sick and subsequently left in July 1999. Maria Green, the Deputy Manager at Isand House, had been moved to another home in the area pending the outcome of our inquiry.

41. Throughout the summer of 1999 I was in frequent contact with Eileen Chubb and the staff would drop in to the Civic Centre from time to time. They wanted to know what was happening and also expressed their concerns that they were not receiving payments from BUPA in a regular and consistent manner; there were apparently shortfalls in the money sent to them but they were all to the best of my knowledge, off sick with stress during that period. I wrote a letter on one occasion on behalf of Lee Elkin to his housing landlord to say that he had been helping with our inquiries and therefore his drop in income was due to the fact that he was doing this. Although he was unable to fully pay his rent, I made a plea on his behalf for leniency with regard to possession.

42. Meanwhile we continued to monitor Isand House constantly. We would visit weekly or fortnightly unannounced and announced to ensure that the staffing levels were right.

43. Agency staff were employed but it was understood that this was the only option open to the company although these arrangements were not ideal as it did not give consistent care in the long-term to residents. The "whistleblowers" all felt guilty about what was happening to "their residents".

It was clear that the relatives of the residents thought highly of the members of staff, especially those from Unit 2 i.e. the "whistleblowers.

I felt optimistic in general terms that the staff group would be able to maintain links with their employer after our meeting of 14th May, and I imagined they would all return back to work in due course. I continued to remain in touch with the staff group throughout the summer.

44. On 27th May I again met the staff group together at the Civic Centre. They handed in further written statements to me.

On 4th June, Renee Warwick came in to discuss her financial situation including payment of arrears of earnings on 16th June Maggie Roffy came to see me at the Civic Centre, with a further written statement setting out her additional concerns about the attitude of management.
towards her.

45. I met again with the staff group on 29th July when they came into the Civic Centre again and reported to me that they had not received their Statutory Sick Pay. I then wrote to Des Kelly on their behalf.

46. On 27th August, I received information via one of the manager’s of another residential care home in the Care First Partnership Limited group who reported to Monica Hanscomb that Maria Keenaghan was to be re-employed at Anne Sutherland House another home in the group in a similar capacity to that she had had at Isard House. It was on or around that date that I had also received a call from Eileen Chubb to say that Maria Keenaghan was to be re-employed at Anne Sutherland House as a team leader their on a Unit for the elderly mentally infirm. At that time, Maria Keenaghan was under arrest and on police bail whilst they were making further inquiries regarding theft from residents.

47. We managed to ascertain that Maria Keenaghan was due to start work first thing on Tuesday, 31st August after the Bank Holiday Monday. On the evening of Friday, 27th and over Saturday, 28th and Sunday, 29th I contacted Mr Kelly at his home and said that the re-employment of Maria Keenaghan at Anne Sutherland House was unacceptable to us, essentially as she was firstly on bail with regard to allegations of theft and secondly, that in our view she was implicated in both abuse and neglectful behaviour either by herself and members of her team that she was managing on Unit 3 at Isard House. He ultimately agreed to prevent her from commencing employment at Anne Sutherland House on the morning of 31st August, which I understood that he did because I phoned Anne Sutherland House to confirm that this had happened.

48. On 1st December 1999, Eileen Chubb and Karen Hock came to the Civic Centre and spoke with Monica Hanscomb and Carl Sewell, the Chief Executive’s Monitoring Officer and informed them that Maria Keenaghan had been at Faircroft, a home in the management of Care First Care Homes Limited and not under direct contract to the London Borough of Bromley.

49. Faircroft is owned by Care First Care Homes Limited which did not have the same Directors Care First Partnerships Limited and operated separately as an Limited Company within the BUFA Care Services Group. Faircroft is a privately registered Care Home, registered in Bromley specifically for Elderly Mental Infirm Residents.

50. I rang and asked to speak to the Manager of Faircroft, Mrs Lydia Esmond and I asked if she had Maria Keenaghan working in the home. She said no. I then asked her if she had anyone called Maria which she denied. I was not satisfied with her reply so I visited the
Home that evening with Monica Hanscomb at around 9pm to coincide with the possible changeover of staff for the night shift.

51. We looked at the records at Faircroft from which it appeared that the rota had been altered and the name Maria had been 'flip-exed' out on at least one of those that I had seen. This rota was hanging up in the office upstairs. Further rota were held in the Manager's office in the basement which we did not have access to that evening.

We returned at 8.30am the following morning and waited for the Manager to arrive at 9.15am. We interviewed Mrs Edmonds at that time and she finally agreed that Maria Keenaghan had worked there since September.

52. Mrs Edmonds said that she knew Maria Keenaghan was on bail for theft. She was however, at that stage unaware of the allegations of verbal and physical abuse which had been made against her. Maria Keenaghan herself had told her about these some weeks later. The Manager was under the impression that Maria Keenaghan had been discriminated against for race reasons. She felt sympathetic towards Maria Keenaghan.

53. Carol Newton had brought Maria Keenaghan to Faircroft at a time when the Manager was not on duty. We subsequently ascertained that this had occurred on 31 August immediately after she had been prevented from working at Anne Sutherland House. Mrs Edmonds had not raised the issue of Maria Keenaghan with anyone else. Her view was that there was not a shred of evidence to back up the allegations which had been made against Maria Keenaghan.

54. I wrote to Mr Ludford the Operations Director of Care First Care Homes Limited. He did not reply. I drew attention to the fact that Maria Keenaghan appeared to have been re-deployed at Faircroft. The matter was subject to lengthy correspondence between myself and the company. I also said that Maria Keenaghan was on Police bail and this information was included in detail in my letter to Mr Ludford on 21 December 1999 but I now understand that from June this year, Maria Keenaghan was re-suspended once again and that she was no longer working at Faircroft at the present time. There are elderly mentally infirm residents at Faircroft for whom she was responsible.

55. My letters were passed on to Mr Kelly for a reply without any acknowledgement from Mr Ludford of Care First Care Homes Limited

56. I received replies from Mr Kelly to my letters who stated that Maria Keenaghan had been re-deployed at Faircroft, because he had insufficient evidence to continue her suspension due to the fact that the written allegations made by the 'whistleblowers' had not been able to be released to him and therefore he felt that the balance of evidence against Maria Keenaghan was insufficient to keep her from being
employed. I made it abundantly clear in correspondence that I did not agree with this view. She had been on bail at the time of her re-deployment for theft and that with the other allegations of such a serious nature that we had received we demanded that her suspension continue.

57. I undertook company searches and found that Mr Kelly was not a Director of Care First Care Homes Limited between the 1st December and the beginning of February. He is however, on the BUPA Management Board. He subsequently became a Director of Care First Care Homes Limited on 24th February.

58. It was always clear in my correspondence to both Care First Care Homes Limited and Care First Partnerships Limited, that Maria Keenaghan was on police bail and it was inappropriate to employ her and it was not appropriate for her to work with elderly mentally infirm residents.

59. The Manager, Mrs Edmonds had breached regulations under the Registered Care Homes Act. There was also an issue of tampering with records which reflected on her fitness and also the fitness of the Area Operations Manager, Mrs Newton. It was purely by chance that we discovered that Maria Keenaghan was working at Faircroft. Placing Maria Keenaghan at Faircroft was in breach of Statutory Regulations.

60. Care First Partnerships Limited received the first draft of the completed inquiry report on 3rd August 1999 and the final version after correspondence between us by 5th November 1999. We considered that we had made our position abundantly clear with regard to all those members of staff who were implicated. It was also made clear at the time when attempts were made for Maria Keenaghan to be employed at Anne Sutherland House, that this was not appropriate and Mr Kelly finally agreed that this was the case. I have a full record of the communications that took place between myself over the weekend of the 28th August and Mr Kelly over the possible re-deployment of Mrs Keenaghan at Anne Sutherland House.

Signed: 

Dated: 30th June 2000
### Summary of Concerns for Heathbrook House

**Information Request CQC IAT 2012 0260**

**Key:**
- HH – Heathbrook House
- CPN – Community Psychiatric Nurse
- GP – General Practitioner
- WCC – Worcestershire County Council

<table>
<thead>
<tr>
<th>Concern No</th>
<th>Date</th>
<th>Description</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Mar 2009</td>
<td>Notification received from HH regarding allegations of verbal, physical and sexual abuse and failure to adhere to manual handling procedures. Alleged abuser suspended pending investigation.</td>
<td>Safeguarding Alert raised with Worcestershire Local Authority</td>
</tr>
<tr>
<td>2</td>
<td>Jun 2009</td>
<td>Notification received from HH regarding a relative being verbally abusive and aggressive towards staff at HH. Police were called and requested the relative to leave.</td>
<td>Safeguarding Alert raised on receipt of further information from the Police. Minutes and copy of statement for meeting held on 16/4/09 received. Further meeting arranged and Police involved.</td>
</tr>
<tr>
<td>3</td>
<td>Sep 2009</td>
<td>Anonymous letter received in relation to HH raising issues with staffing levels, management of the home, staff morale and residents being afraid to complain.</td>
<td>Letter sent to HH by the Inspector with a summary of the concerns asking for them to be investigated. This was followed up with the home manager with a second letter in October 2009. HH informed CQC of a delay to this investigation in mid October and HH provided rota as evidence of staffing levels. CQC received a letter from HH with the findings. It recognised there were issues between staff which continue to be addressed but could not substantiate the claims around infrequent toileting.</td>
</tr>
<tr>
<td>4</td>
<td>Sep 2009</td>
<td>Telephone call from a doctor at a local hospital. Concerns were raised with the doctor by a concerned member of staff at HH. The concern related to residents not being toileted frequently. This was reported to management and the response was not helpful. Other staff are also not being civil to each other.</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Nov 2009</td>
<td>Phone call from residents relative. Wanted copy of Su care plan as concerned care home not complying with it. Also had concerns care standards had deteriorated, lack of care staff in the communal areas, poor communication</td>
<td>The information of concern was used by CQC as part of our ongoing monitoring of the essential standards of quality and safety.</td>
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<td>Summary of Concerns for Heathbrook House</td>
<td>Information Request CQC IAT 2012 0260</td>
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<td></td>
<td></td>
<td>and Staff shortage in relation to feeding of service users.</td>
<td>Minutes received from safeguarding team regarding service user death in hospital. Referred to coroner as concerns death resulted from prior fall in care home. General concerns with dementia unit were raised.</td>
</tr>
<tr>
<td>6</td>
<td>Dec 2009</td>
<td>Notification received from HH regarding death of a resident in hospital following a seizure at HH.</td>
<td>HH contacted the tissue viability nurse for advice.</td>
</tr>
<tr>
<td>7</td>
<td>Apr 2010</td>
<td>Notification received from HH following the admission of a resident from another nursing home who was found to have pressure sores</td>
<td>HH contacted the tissue viability nurse for advice.</td>
</tr>
<tr>
<td>8</td>
<td>Apr 2010</td>
<td>Notification received from HH following the admission of a resident as an emergency who was found to have pressure sores</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>May 2010</td>
<td>Notification received from HH following a resident developing pressure sores.</td>
<td>GP informed an monitoring and HH are awaiting swab results</td>
</tr>
<tr>
<td>10</td>
<td>Jul 2010</td>
<td>Notification received from HH following concerns raised by 2 CPN's during an unannounced visit to HH. On the 1st of July 2010 2 CPN's arrived at the home to investigate an AP allegation. Service user transferred from another service. Service user was admitted for respite. The manager does not know where the allegation came from. SU died 2010. Issues being looked into: 1 why the specific medication was not given 2 Pressure relieving equipment not working 3 issues around palliative care medication.</td>
<td>HH provided with the notification was able to provide detail that the medication and mattress issues were correctly addressed and that the end of life pain relief would be investigated by the home manager.</td>
</tr>
<tr>
<td>11</td>
<td>Jul 2010</td>
<td>Notification received from HH regarding inappropriate behaviour of a male resident to several female residents</td>
<td>The incidents were reported to the local Access Centre for Vulnerable Adults. Once contacted by the social worker the home will interview staff.</td>
</tr>
<tr>
<td>12</td>
<td>Jul 2010</td>
<td>Notification received from HH regarding 45 allegations made against a member of staff by other colleagues. These included allegations of bullying, physical abuse, refusing residents food and drink, not following correct procedures and fraudulent completion of records.</td>
<td>The allegations were reported to the local Access Centre for Vulnerable Adults and they requested copies of the concerns. The Vulnerable Adults Lead advised HH to contact the police. The police advised the home to conduct an internal investigation and to keep</td>
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<th>Date</th>
<th>Event</th>
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<tr>
<td>Oct 2010</td>
<td>Letter received from HH employees who raised concerns about the home and felt they had been treated unfairly as a result. Further emails originally sent to BUPA were forwarded to CQC by the employees union representative</td>
<td>The police informed of the outcome. Staff member returned to work, safeguarding advised of this. Strategy meeting arranged. The inspector rang the home manager, and recorded “Gave assurance that initial complaints were investigated, &amp; by police. One complaint upheld. Accused Care Assistant received further training. Whistleblowers not attending meetings with management, now under investigation for insubordination &amp; not following BUPA policy on whistleblowing. Several also already under investigation for allegedly sleeping on night duty.” Inspector contacted union rep by phone, recorded “He remains concerned that he has had no response from Manager of HH regarding allegations of bullying of staff.” On 24 November 2010 a Safeguarding alert was sent to Worcestershire County Council about the allegations in the letter.</td>
</tr>
<tr>
<td>Dec 2010</td>
<td>Letter received from the relative of resident detailing concerns about care. Concerns were about the running of the home, staffing levels at the home, feeding of residents, not cleaned patients who have soiled themselves and treatment of employees.</td>
<td>The information of concern was used by CQC as part of our ongoing monitoring of the essential standards of quality and safety.</td>
</tr>
<tr>
<td>Feb 2011</td>
<td>Investigation report received from HH into a resident who was restrained by a care worker to prevent the resident assaulting the care worker.</td>
<td>HH concluded that Care Worker had no alternative but to hold resident's arms to prevent any assault in a confined space.</td>
</tr>
<tr>
<td>Apr 2011</td>
<td>Letter received from the relative of resident detailing concerns about care. Concerns related to the understaffing of the home.</td>
<td>The information of concern was used by CQC as part of our ongoing monitoring of the essential standards of quality and safety.</td>
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<tr>
<td>No further action required by CQC.</td>
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<tr>
<td>20 October 2011. CQC reported to safeguarding. Strategy meeting outcome: Aspects of the concerns were not proven, ie bullying, swollen lips and gums, inappropriate placements, and privileges. However there were issues re training on communication, information sharing between staff, and knowledge of the residents. Health needs of the residents. Service were required to update care plans. Also to inform the Care Services Quality Team to update them on the outcomes. Service subject to monitoring and further review to be arranged for November 2011. CQC visited 18 November 2011 to review—none compliant.</td>
<td></td>
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<tr>
<td>15 December 2011. Care Services Quality Team feedback to CQC— to discuss how the organisation is supporting improvements: 1) Well supported by external managers who are also providing training and care planning instruction. 7 days per week from these managers which will be sustained in the interim until new manager appointed. 2) BUPA pharmacist input in the light of the meds errors. 3) Dementia unit-specialist dementia training with WCC commenced. Another place to be sought. 4) Service Improvement Plan to be written and shared with CQC, Care Services Quality Team.</td>
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<tr>
<th>Summary of Concerns for Heathbrook House</th>
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<tr>
<td>Information Request CQC IAT 2012 0260</td>
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| 17 | Sept 2011 | Service user taken to hospital, no bone injury, hospital advised HH to review medication with GP. |
| 18 | Oct 2011 | Anon WB made a number of allegations about the care provided: |
| | | • Service user bullied by care worker |
| | | • Doctor not called when service user taken ill, caller felt illness was serious however HH did not agree. |
| | | • Use of stand aid overnight on service user who caller did not believe required it resulting in injury to service user. |
| | | • Service user alleged covert medication used on them by care worker, caller reported this but no action was taken. |
| | | • Allegation some service user have swollen lips/gums and that nothing is done in relation to this. |
| | | • Allegation that 2 service users do not have dementia and have special privileges. |
### Summary of Concerns for Heathbrook House

**Information Request CQC IAT 2012 0260**

1. and other interested bodies.
2. They are not admitting at present and will inform us when they are to re-start.
3. Care Services Quality Team will also be providing Dignity training in Jan 2012.

CQC Compliance review visits 31 January 2012 & 1 February 2012. To review: Improvements noted in staffing, medication, training. Care plans being updated. Reduction in level of concerns. Further review to take place.

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<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Details</th>
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<tbody>
<tr>
<td>19 Nov</td>
<td>Notification received from HH service user medication ran out, note left in diary but not on MAR chart so one med missed. Medication ordered as soon as this was realised. No ill effects to the service user.</td>
<td>HH Reported to Safeguarding, In reach team and Next of Kin. HH investigated incident.</td>
</tr>
<tr>
<td>20 Nov</td>
<td>Notification received from HH Carer reported service user given medication 1 hour late due to no hand over between carers. GP contacted and advised continue meds as per MAR chart.</td>
<td>HH has implemented full handover to avoid repetition.</td>
</tr>
<tr>
<td>21 Nov</td>
<td>Service user found with skin tear. Dressing applied, care plan in place.</td>
<td>HH informed Safeguarding team. CQC review visit 18 November 2012, to check compliance as a result of recent care practice concerns.</td>
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</table>

20 December 2011. Adult protection meeting. The home advised that they called the GP and the wound was dressed. They informed CQC and WCC and have double checked the bedside protectors and moved the bedside table.

Service Improvement Plan to be written and shared with CQC, Care Services Quality Team and other interested bodies.
<table>
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<tr>
<th>Date</th>
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<tbody>
<tr>
<td>Dec 2011</td>
<td>Notification received from HH service user released from hospital without meds, so unable to administer them. HH faxed prescription twice to pharmacy but service user without meds for 5 days. Doctor was informed and service user observed.</td>
</tr>
<tr>
<td>20 December 2011</td>
<td>Adult protection meeting-outcome. Service to provide information regarding medication errors. Voluntary suspension may now need to be formalised. Arrange case conference to follow up concerns.</td>
</tr>
<tr>
<td>Jan 2012</td>
<td>Notes of discussion with service provider re whistleblower concerns. 1) Staffing levels and turn over 2) Rough handling of service user by some staff 3) Service user not turned regularly to prevent skin damage.</td>
</tr>
<tr>
<td></td>
<td>Provider investigating staffing and toileting issues, and will undertake further investigations into allegations of rough handling and put in place reviews of service user at risk of skin damage then report to CQC in 1 week. Manager will be carrying out 1-2-1 and staff training over month. Manager provided update to Commission. Weekly service improvement plan from HH to reflect actions taken. HH have assigned a lead Nurse for wound care and tissue viability who will lead and support with this area within the home to improve care in this area. Compliance Review follow up 31 January 2012 and 1 February 2012. Improvements noted but not reached compliance. Further review to take place.</td>
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## Summary of Concerns for Heathbrook House
### Information Request CQC IAT 2012 0260

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<tr>
<th>Date</th>
<th>Event Description</th>
<th>Action Taken</th>
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<tr>
<td>24 Jan 2012</td>
<td>Notification received from HH. Nurse on duty was asked to contact GP to review service user medication, but failed to do so until the following day. Meds were changed following day.</td>
<td>Provider action to rectify error.</td>
</tr>
<tr>
<td>25 Jan 2012</td>
<td>Notification received from HH. Care plan advises service user should only be moved by 2 carers using a hoist, however relative lifted service user and may have caused slight bruise.</td>
<td>Safeguarding informed, HH discussed needs of service user with family member, care plan updated.</td>
</tr>
<tr>
<td>26 Jan 2012</td>
<td>Letter to CQC from service user relative referring to unspecified concerns with Ch and requesting copy of recent inspection. Notification received from HH. Family member raised concerns re care of service user. Profiling bed failed, service user distressed and had to wait several hours for replacement. During this time service user not repositioned correctly despite being at risk of pressure sores.</td>
<td>Care home met with family member to discuss issues. CQC passed bed failure concerns to safeguarding. HH requested by CQC contingency plans in place for such failures, and that such equipment has been regularly serviced/maintained. Response received from HH confirming audits/maintenance in place. Compliance visit to monitor progress 31 January and 1 February 2012. Improvements noted: temp experienced care manager in place, significant ongoing staff recruitment, staff training to underpin safe practice in M/H SiG and dementia care. BUPA QC in home x 2 weekly to oversee care plans/risk assessments and carry out audits on plan updates for quality. Although there have been improvements the outcomes for people still need to improve. HH is not compliant in essential standards 4, 9 and 13.</td>
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Summary of Concerns for Heathbrooke House

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<tr>
<th>Date</th>
<th>Incident Description</th>
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<tbody>
<tr>
<td>27 March 2012</td>
<td>Letter to NHS funding team from service user relative re above concerns, (occ. to CQC). Unhappy with outcome.</td>
</tr>
<tr>
<td>28 Feb 2012</td>
<td>Notification received from HH. Care user sitting on preds to lift service user, however care proceeded.</td>
</tr>
<tr>
<td>29 Feb 2012</td>
<td>Notification received from HH. Care user admitted wrong doses of medication due to format of MAR sheet.</td>
</tr>
<tr>
<td>30 March 2012</td>
<td>Notification received from HH. Mattress failure c15 mins.</td>
</tr>
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Strategy meeting held on 06 January 2013 to discuss wider safeguarding issues. Social worker to make further unannounced visit.
Summary of Concerns and Complaints re Wentworth Croft

On 3rd August 2006 CSCI received an email from the Adult Protection Unit

This was to inform us of a complaint that had been made by a relative of a deceased service user and the investigation that followed.

The service user was admitted to Hayward House at Wentworth Croft on 10.03.06, initially as a two-week respite period, but that was extended. Her skin was intact at that time, according to the social care assessment. She was admitted to hospital (I think on 14.05.06) from Wentworth Croft.

Part of the problem was that she had developed a pressure sore on her sacrum, and by 22.05.06 this is described as a grade 4 sore. The service user was discharged from hospital to Wentworth Croft on 28.06.06 and on 16.07.06 returned to hospital.

On 25.07.06 the service user's daughter wrote to GPPCP to make a formal complaint about her mother's care at Wentworth Croft. In summary she alleged that:

- The development of the sacral pressure sore was related to a faulty pressure mattress and an occasion when her mother had slipped off the hoist during bathing.
- With the provision of appropriate basic nursing care the pressure sore should not have developed at all.
- The staff did not have the skills to bathe her mother.
- The staff said that in preparation for having a bath they could not protect her modesty as they would have to wheel her past male residents.
- A sore on the service user's neck was left untreated.
- In May 2006, because of a lack of basic nursing care at Wentworth Croft, the service user developed MRSA and became dehydrated, leading to admission to hospital.
- In July 2006, because of a lack of basic nursing care at Wentworth Croft, the service user was again dehydrated and her catheter was blocked, leading to re-admission to hospital.
- There were at least two occasions when the relative's sister (who is a nurse) had to prompt the staff at Wentworth Croft to call the GP to see the service user, otherwise they almost certainly would not have done so.

On 29.07.06 the service user died. She had been admitted to Ward 6 Isolation Ward because of (I think) Clostridium difficile.

The relative received the Death Certificate for her mother which stated the cause of death as sepsis secondary to sacral sore and hypertension. She felt that this added weight to her complaint that the quality of care may have been a contributory factor in her mother's demise. This was provided to the AP Unit.
Summary of Concerns and Complaints re Wentworth Croft

On 4th August 2006 CSCI received a call from a concerned relative

The caller’s mother was a resident at Wentworth croft for two to three weeks. The daughter is not happy with the care she received whilst at the home particularly on the 17th July when her mother says she was left on the toilet for two hours. Apparently she kept using the call bell but the staff did not come. It was a very hot day and she became very distressed. The relative complained to the home which apologised and said they would investigate.

She has now received a letter from the home saying that her mother refused help. The daughter feels this is not a true reflection of the situation. The service user has a care manager but when mentioned to them they said they would put a note on the file – but did not offer to take it any further. The relative would like to know the outcome of any investigation. The caller advised that her mother was no longer at the home. This was forwarded to the Regulatory Inspector for action. These concerns were reported to the safeguarding authority for investigation.

Concerns, Complaints and Allegations Form dated 1st October 2007 taken from a Regulation 37 notification

On 29th September 2007, a service user was found on her floor by bedroom door with oxygen on. CPR was performed and 999 was called but she later died. The bedrails were found to be in situ and frequent checks were carried out prior to the event. The safeguarding authority was notified by CSCI.

Concerns, Complaints and Allegations Form dated 19th November 2007

The Customer Service Unit received an anonymous call re a complaint concerning staffing levels at the home. He alleges that there are only 2 members of staff during the night and he also has concerns that there are insufficient day staff to cope.

Concerns, Complaints and Allegations Form dated 5th December 2007

The Customer Service Unit received a call from the brother of a service user. He alleged that his sister is being neglected as she is being “dehydrated to death”. He needs action to be taken as he is “desperate” in knowing what to do. CSCI completed a safeguarding referral.

CSCI received an email from the Adult Protection Unit on 4th September 2008

The APU advised that a service user reported that there was a particular night carer who she was concerned about regarding his behaviour towards herself. She explained that he was an awful carer, very rude and rough; he shouts at
Summary of Concerns and Complaints re Wentworth Croft

her, uses bad language and lies to her. She explained that she asked for a bowl of cereal one night and he told her that she couldn’t have it as it was all locked up. Also that he came to her one night after shouting at her and apologised, saying he lost his temper and she ignored him when he said this to her. The service user indicated that when this carer is on shift she blocks her door with the large water container (and other items) that she uses for the water machine in her room. She stated that he has not been working long there but she is very concerned about his behaviour and that he is not fit to care for vulnerable people. The service user said she has not mentioned this to anyone before today and she did not want to tell her granddaughter to worry her. I assured her that it would be looked into by the home.

There may also be concerns around this care worker’s behaviour towards other vulnerable residents. The Registered Manager was asked to complete an investigation into the allegation and to provide the name of the care worker for the police to complete their checks. These concerns were reported to the safeguarding authority for investigation.

Concerns, Complaints and Allegations Form dated 23rd September 2008

The Customer Service Unit received a call from a current member of staff indicating that the standards of care have gone down in last month or two. Staff morale is low and there are a lot of staff members leaving, especially trained staff. A lot of staff have been ringing in sick because of stress.

The staffing levels are below the lowest legal limit. Where there should be 8 or 9 staff on a morning shift there are often only 5 and 4 staff for night duty for 36 residents.

There has been no laundry for the last 7 days because laundry staff are on leave and the manager forgot to book any other staff. Staff have not been able to put clean clothes on residents when they get them up, significantly cardigans and bottom half of pyjamas. There are also no clean sheets to put on beds, those that are available are threadbare and have holes in them. There are no pillows and those that are available have PDH stamped on them, are dirty and cannot be cleaned.

Caller says he is working 72 hours a week to help out in all areas, but feels there has been a steady decline in last 1-2 months. Particularly on Yeoman, where there are most dependent people. One person on Yeoman has recently developed bed sores because staff are not able to give correct care.

He said he had told the manager of his concerns and the manager said it would be looked into. The caller feels he was just fobbed off as there has been no change. He is happy for us to contact the service provider. That day the Regulatory Inspector wrote to the provider asking them to investigate this matter. The provider reported back to CSCl and it was felt that the explanations provided were sufficient.
Summary of Concerns and Complaints re Wentworth Croft

Concerns, Complaints and Allegations Form dated 26th September 2008

The Customer Service Unit received a call from the registered manager who is also sending in a Regulation 37 notification.

A care worker has made allegations about one of the nurses. Both staff work on night duty. She alleges that various forms of abuse have taken place with several residents involved over a period of time. The manager said that none have any current indication of assault.

He has already contacted the safeguarding team who I phoned to verify that they had received the call. The phone was not answered after a long time and so a message was left with details on how to contact myself but at the time of completion no response had been received.

The manager also said that he intended to contact the police. He provided the names of 4 residents involved. He said that the allegations ranged from rough manual handling to physical assault. He said that he intends to suspend the nurse concerned immediately. Safeguarding referral completed and the Link Inspector was emailed. These concerns were reported to the safeguarding authority for investigation.

On 7th October 2008 CSCI received and email from the Adult Protection Unit

During a visit to the home on 2nd October 2008 a relative found a service user in bed where he had been incontinent and there was a strong smell of ammonia. The window was open and it was cold. Clothes and food were strewn across floor. The relative spoke with a junior staff member to ask for help and he indicated that he was working alone and only junior members of staff were available. The incident was reported to adult protection and the provider was asked to investigate the matter.

This service user was seen by the CPN and Consultant Psychiatrist. His relative also visited on 3rd October when she discussed this service user's care plans with the unit manager and was briefed accordingly. She is fully aware of his care needs and has been satisfied with the care plans that are in place in meeting his care needs. The home manager has also instructed staff to ensure this service user is now kept in the lounge to ensure his dignity is not compromised. He is also on a behaviour assessment chart and a referral has been requested to the CPN.

On 10th October 2008 CSCI received and email from the Adult Protection Unit

The alert came from the home manger around an allegation made by the service user that on Sunday 5th October 2008 a care assistant was overheard
Summary of Concerns and Complaints re Wentworth Croft

by another care assistant to swear at this service user while assisting her to eat a meal.

The home manager spoke with Human Resources and suspended this care assistant pending investigations by an independent investigator. He found incidents of this care assistant using colourful language to staff but that there have been no concerns around the care she provides.

The service user is unable to remember incidents even immediately following events and has limited communication due to dementia.

At this point no other incidents have been reported by staff and it was felt that residents would be unlikely to be able to recollect incidents but enquires will be made. These concerns were reported to the safeguarding authority for investigation.

On 27th October 2008 CSCI received and email from the Adult Protection Unit

This related to an alert of an incident on 25th October 2008 where a service user slapped another resident on the face. The service user was sitting next to the resident in the lounge that had fallen asleep in his arm chair. The service user was trying to wake him up as she was trying to talk to him. She has often called him by her husband’s name and when he did not respond she slapped him as in trying to wake him up. The staff intervened and have amended the service user’s care plans to prevent any further incidents. Both of the service user’s next of kin were informed of the incident and the measures put in place to prevent any future incidents.

The Teams responsible for commissioning the service user’s placements were notified for each of them to follow up as were the other relevant professionals.

On 24th December 2008 CSCI received an email from the Adult Protection Unit

During a visit to a service user’s home, the husband raised some concerns about her respite care while at this facility. He indicated that she had spent longer in bed while there than when she was at home, resulting in a grade 2 pressure sore on her sacrum. She lost weight and was left in a faecal soiled incontinence pad the day she left the service.

On several family visits the service user was found to be remaining in bed and staff were challenged regarding this. On the first instance they said that she had been unwell. On the second occasion the daughter was advised by staff that she had no clothes. The husband states that there was a wardrobe full of clothing. Contact with the daughter was made to ascertain accuracy of
Summary of Concerns and Complaints re Wentworth Croft

statement. They have spoken to the District Nurse who advised that the sore was grade 2 on return home but is now Grade 1 and improving.

On arriving to collect the service user at the usual time of 2pm, the husband found that she had not been dressed appropriately in warm clothing to return home and none of her clothing had been packed up ready. He proceeded to carry out this task.

On taking her to the car/taxi the husband identified that she smelt soiled and on return home was found to be soiled with faeces. The husband does not feel that this had just occurred but that the pad had not been checked or changed that day. Her carers were required to shower her on the return home.

The husband also is concerned regarding if she was supported with eating meals as she seems frailer on return and whilst he acknowledges her appetite can decline whilst in respite care he is worried regarding the support she is having.

These concerns are affecting the husband as a carer. He has found that it has taken him at least a week to promote the service user's physical well being to try to bring it back to how it was prior to respite. This service user is on a rolling respite programme and he now feels he will not be able to take full advantage of the carer break if he is constantly worrying about her whilst she is in respite.

Neither the husband nor the service user wish to complain but I have explained my duty to investigate their concerns. While the husband did not wish to make a formal complaint he was concerned to receive feedback from the investigations as the service user is next due to go to back to respite one 16th January 2009.

A meeting was held with the home manager regarding recent concerns raised about respite care from 15th to 29th November 2008. This meeting was partly attended by the Yeoman unit manager.

The home manager was advised of the need for the following:

- to monitor and record pressure area care on a daily basis to ensure the service user is repositioned on a regular basis to minimise risk to skin integrity in the future.
- to ensure the service user is offered an appropriate diet which will not cause swallow difficulties. He will liaise with both his chef and the service user with regard to this.
- to ensure that staff are aware of time of collection to return home and therefore should be able to ensure the service user's continence needs are met prior to time of husband's arrival.

The Adult Protection Unit made some further suggestions regarding safeguarding for both the individuals and the home. These were:
Summary of Concerns and Complaints re Wentworth Croft

- to weigh the service user on admission and discharge which would evidence any weight loss or stability during stay.
- To note skin integrity on admission and at the end of the respite period note by photograph any injuries.
- To note in the daily recording whether the service user has declined meals, drinks and at what time of day personal care tasks are carried out. Recordings could be more frequent and more extensive in the support that has been given.

On 20th January 2009 CSCI received an email from the Adult Protection Unit

A service user was found on lying on floor with large bruise to her forehead and one eye, not consistent with fall. There was also bruising to her right forearm consistent with squeezing. This was caused by another service user staying at Wentworth Croft on respite. The placing authority has been advised that he can no longer be accommodated.

On 23rd March 2009 CSCI received an email from a member of the public on behalf of a member of staff

This individual wrote on behalf of an employee at the home who wished to remain anonymous through fear of losing her job. He raised concerns regarding the treatment and welfare of both staff and residents at the home.

This employee has worked at the home for 2 years and has told me some truly unbelievable stories about the standards of care given and the way management are choosing to run this home.

These are the concerns:

- An 'investigation' had taken place in the 'woolsack' area of the home with regard to a resident whose thumb was broken during the night. The resident in question said that the night workers pulled her vigorously by her hands while helping her out of bed. The manager has recently informed members of staff not to say anything to anyone including family and other residents and to falsely believe that she did it herself on the commode. The complainant indicated that this incident was being reviewed by 'POVA' at that time.
- The allowance of £20 that residents have to spend on toiletries is not being spent on the residents. They frequently go without suitable attire and washing properly. Members of staff frequently had to use the same blunt razors on residents. 1 man feared having his stubble shaved due to the pain inflicted over using worn razors.
- Within the Woolsack area of the home, residents classed as 'residential' were being mixed with violent and disruptive residents. It was reported that a lady suffering from dementia was being influenced
Summary of Concerns and Complaints re Wentworth Croft

by a male resident to believe she was his wife and was witnessed taking this lady into toilets and indecently touching her inappropriately. It was alleged that management again had told staff to not say anything to anyone.

- Residents were often left waiting up to an hour after ringing bells due to staff being too busy to attend to their needs. Residents who needed the toilet are often left until it’s too late and they could not hold it in any longer.

- Staff members were assigned their own group of residents to care for. However this has made no difference because staff and residents have been learned up together who did not get on well or who failed to have good relations with each other.

- The manager had very poor relations with her staff and did not involve/motivate or stimulate the staff to do better. Staff found the manager unapproachable, undermining and consistently uses favouritism within the work place. The manager often made decisions regarding rotas on the basis of how well she gets on with certain staff and if they have been ‘good’ to her. A lady who worked within woolsack has been indirectly threatened that if she didn’t do the shifts she’d been given she would be moved to a different unit. Staff were worried about speaking out and making a complaint because it goes against them when the manager finds out.

These concerns were reported to the safeguarding authority for investigation.

On 7th May 2009 CSCI received a fax from the home manager

Mrs G alleges a male person tried to get into bed with her while she was asleep. On another occasion she was punched in the stomach while sitting in the car on a day out with her husband. There are no dates for these occurrences, or descriptions of the perpetrators. These concerns were reported to the safeguarding authority for investigation.

On 15th May 2009 CSCI received a phone call from an agency care worker

An agency care worker called to raise the following concerns about infection control and some care practices but also to advise that she had been told by a member of night staff that service users living in Hayward Unit have been slapped and hit by staff member(s). She had no other details than this, but was told by her manager to inform CQC.

Worked one night shift and saw care practices (in Hayward House) that she felt were not appropriate.

Staff used hoist inappropriately - was not able to give description of this. One resident is MRSA positive, but was sitting with other residents with open wound on back of her hand.
Summary of Concerns and Complaints re Wentworth Croft

Another resident had a pressure sore but had no dressing on it and was in obvious pain.

Hygiene within the unit/house was appalling - again not able to give description.

A permanent staff member has gone to the night manager of the unit with these concerns but this has had no effect other than to transfer one permanent night staff member to days.

Information provided by the individual raising concerns gave very little detail and therefore was treated as information to be used to guide the next inspection. ASR in May 2009 identified there were increased concerns and that key inspection was to be brought forward. Key inspection carried out 10 Sept 2009.

On 18th May 2009 CSCI received a fax from a member of staff

A service user punched another service user in the side of her face. She fell over and sustained a fractured hip. The ambulance service was called. The other service user has been moved to another care home. These concerns were reported to the safeguarding authority for investigation.

On 17th August 2009 CSCI received a fax from a member of staff

A service user was shouting in a foreign language as he approached a member of staff. He then poured a cup of tea over another service user. Both residents became confrontational and bumped into each other. The service user sustained a small bruise on the left side of his forehead and eye. Staff intervened.

Observations carried out on both service users, next of kin were informed, POVA informed, referral to CPN made.

Alert referred to Peterborough PCT by service on 13/08/09

These concerns were reported to the safeguarding authority for investigation.

On 22nd September 2009 CSCI received an email from the local authority

The following concerns were reported:

1) Ear drops not given causing wax build up and deafness.
2) Turning not provided to manage pressure areas.
3) Staff not providing cream as required.
Summary of Concerns and Complaints re Wentworth Croft

4) Blood sugars not checked causing erratic blood sugar levels and risk of hypoglycaemia.
5) Medication to stop nausea allegedly not given, causing poor appetite and weight loss with an already low weight. This has also affected her blood sugars.
6) Allegation that pain killers are not always given when she is in pain.

This was investigated by safeguarding. A strategy meeting decided the following outcomes:

- allegation of neglecting wound care – unsubstantiated.
- allegation of failing to administer ear drops – unsubstantiated.
- allegation of failing to administer nausea medication correctly – unsubstantiated.
- allegation of failing to administer pain killing medication – not substantiated in context of neglect.

Incident on 31st December 2009

A service user alleges that another service user slapped/hit her on face/nose which resulted in a nose bleed. The matter was referred to safeguarding by the service. The service user was put on 1:1 observation. These concerns were reported to the safeguarding authority for investigation.

Incident on 23rd June 2010

On 22nd June 2010 an allegation was made by service user regarding theft of £20 from the pocket of a jacket in their wardrobe. Social services, police and safeguarding were all notified. The police will speak to the service user. These concerns were reported to the safeguarding authority for investigation.
Dear Ms Chubb and Ms Hook

Re: Isard House

I have received a copy of your correspondence of 12th September from a councillor indicating your concerns regarding Bupa. Your letters imply that the Council may be “playing down” issues concerning allegations of abuse at Isard House reported to Members at Social Services & Housing Committee on the 11th September in the Registration & Inspection Manager’s Annual Review to that committee.

I must stress that the Report presented to the Committee on 11th September, was as stated a report reviewing the work of the Unit over the previous year.

I have discussed this matter fully with the lead officers in the case, Dick Turner, Principal Registration & Inspection Manager and Pauline Robertson, Senior Solicitor, and the Council’s position on this matter is based on the following facts.

You are already aware of the following:-

1. When you and five other staff brought this matter to the attention of the Registration & Inspection Unit on 19th April 1999 and an inquiry was undertaken immediately and with the Police and a final report produced in July.

2. The inquiry team interviewed all the staff in the home, relatives and residents, with approximately 40 individuals having been interviewed and an independent pharmacist’s report was commissioned which substantiated that poor care practices did occur on Unit 3 where the focus of your allegations had been placed.

3. Resulting from the inquiry within a very short period after the inquiry commenced two individuals closest to the care of those residents on Unit 3 and implicated in the allegations were suspended.
4. The line managers directly responsible for unit 3 were either transferred or left Isard House prior to the inquiry report being published.

Recommendations were given regarding the conduct of all those involved and the Inquiry teams view as to the reasons for this decline in standards on that particular unit.

5. Members had been informed prior to 11th September by Mr Turner on two previous occasions, giving a full summery as to the progress made in the matter of both the Inquiry and following up on the recommendations with an 'action plan' to ensure that care practices in the Home are improved generally.

6. On the 7th September you came to the Civic Centre to see the Director of Social Services & Housing who was not available, but you were seen by Mr Turner and Mrs Robertson on that occasion. You stated to them at that meeting that you had been passed a further twelve allegations of poor care practice from the Daily Express via a former member of care staff who wished to remain anonymous. These allegations referred to matters occurring after the inquiry had been concluded in July last year.

Mr Turner and Mrs Robertson gave an undertaking that these further allegations would be investigated immediately by the inspector designated to Isard House at the present time. You were given further assurance that Mr Turner and Mrs Robertson would contact you as soon as the inquiries were completed to arrange a meeting in order to clarify the outcome.

I understand that the hearing of your Employment Tribunal has been adjourned to March, 2001. It is important to remember that the content and outcome of the Unit Manager's reports have been restricted by those proceedings. You must understand that this Authority cannot become or be involved in matters relating to the Employment Tribunal hearing.

Mrs Robertson has had contact with your solicitors Bolt Burdon, who are aware of the Authority's position. You will recall that assurances were given to BUPA by the Tribunal Chairman in July that the Inquiry Report would not be disclosed in those proceedings.

The Council remains committed to investigate any allegation of abuse.

Yours sincerely

Jeremy Ambache
Director of Social Services & Housing
FURTHER INFORMATION

Breaking the Silence Part One
Breaking the Silence Part Two
Available at www.compassionincare.com

Beyond The Façade by Eileen Chubb ISBN 9781847476333

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