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In Search of Accountability

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

Executive Summary

A Review by Margaret Flynn

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In Search of Accountability: A review of the neglect of older people living in care homes investigated as Operation Jasmine

In this executive summary…

> *…are the background and terms of reference of the Review, an insight into the people and organisations involved, an overview of the findings and analysis plus the recommendations. It concludes with six 'lessons for the future' of older people's residential care as requested by the First Minister.*

The Background

Operation Jasmine was a major Gwent Police investigation which started in November 2005 and has been estimated to have cost around £15m. It concerned 63 deaths which were a cause for concern in care homes and nursing homes for older people in south east Wales.[1]

There were many victims, some of whom were resident in homes owned by Puretruce Health Care Ltd. The sole directors and shareholders of this company were two General Practitioners, Dr Prana Das and Dr Nishebita Das.[2]

In January 2010, the Crown Prosecution Service (CPS) formally advised Gwent Police that there was insufficient evidence to support a reasonable prospect of prosecution for either gross negligence manslaughter or wilful neglect.

During 2011, responsibility for leading the investigation was transferred to the Health and Safety Executive (HSE). Charges were then laid against Puretruce Health Care Ltd, Dr Prana Das, and the Chief Executive, Paul Black under the Health and Safety at Work 1974. Dr P Das was also charged under the Theft Act 1968.

The trial was halted in March 2013 because an assault took place in September 2012, during which Dr P Das sustained head injuries. Had the trial proceeded, it might have led to a conviction for crimes of fraud and breaches of health and safety in a single nursing home, Brithdir.

The charges were placed 'on file' on the basis that the case might be revived should Dr P Das recover sufficiently to stand trial at a future date.

The trial, had it taken place, would not have been able to take into account the sum of harms endured by older people in the care homes investigated since it would have hinged on six specimen cases. It would not have resulted in justice for all the families involved but it might

[1] Two homes – **Brithdir** and **The Beeches** were owned by Dr P Das and Dr N Das; **Mountleigh Bryngwyn** was owned by APTA Healthcare UK; **Grosvenor House** was owned by Dr and Mrs SM Uzair Subzwari and Dr and Mrs SK Narang of Lightend Ltd; **Belmont** was owned by Mr and Mrs Bentley; and **Bank House** owned by Mrs Syal and Mrs Lal

[2] Dr P Das and Dr N Das owned two of the six particular homes considered by the Review and feature substantially because of the much larger number of homes they owned at various times across south Wales

have accomplished something less damaging than the current impasse. The absence of a judgement or legal resolution compounds the families' grief and sense of grievance.

The Operation Jasmine Review

In December 2013 the Rt Hon Carwyn Jones AM, First Minister of Wales, announced that he was setting up a Review of Operation Jasmine and the events associated with it *in order that we may learn for the future.*

The purpose of the Review was to:

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

In particular, the Review examined:

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

The Challenges

Necessarily, the Review required the assistance of such agencies as the Crown Prosecution Service (CPS), Gwent Police, the Care and Social Services Inspectorate Wales (CSSIW), local authorities, NHS staff and the Health and Safety Executive (HSE).

The principal agencies associated with Operation Jasmine were invited to contribute to the Review by:

- Identifying the pivotal events and explaining their context
- Drafting an account of their activities with reference to policy and legislation
- Reflecting on what might have made a distinctive and positive difference.

In looking back, as well as looking forward, it was envisaged that professionals would share their own agency's self-scrutiny, as well as bring matters of general concern about the

provision of support to older people to the attention of the Review – having heard from the families of older people about their experiences.

Concern was expressed by most agencies over the governance of the Review: its legal appropriateness; its procedural safeguards; its power to require that evidence be submitted; and whether or not contributors, including family members, would sign confidentiality agreements, for example.

A document dated *2002-current day,* entitled *Protection of Vulnerable Adults Practice Improvement* (also referred to as *106 lessons),* was described to the Review as *evidence of learning.* In fact, it is not clear from its content how this document provides assurance of improved conditions favourable to handling future crises.

There is an uncomfortable comparison with historical child abuse investigations where, for example, the retirement of key individuals has not been regarded as a barrier to pursuing inquiries. However, it has been put forward as a rationale for limiting information shared with this Review.

Although most agencies asserted their commitment to the Review, the hope that individuals and agencies would engage and problem-solve with courage and creativity was compromised. For example, critical information was forwarded by two agencies only within weeks of the due date of the end of December 2014. It was agreed with the First Minister that the publication of the Review could extend into 2015 to take account of this information.

Key Events for the People and Organisations Associated with Operation Jasmine

The families of older people described the wrong and indifferent care home practices which harmed their relatives. The organisational practices they witnessed were inadequate in terms of attending to older people's frailty, chronic illnesses, deteriorating health, mental distress and pain. The *nursing* which some older people were promised proved to be false.

If in an era of *patient choice* a family's experience of identifying a care home is reduced to that of *take it or leave it* - that is not a choice; health and social care commissioners should therefore desist from using the vocabulary of consumerism. Care home residents associated with Operation Jasmine were not *happy shoppers* who could move to alternative providers. Their dementia was too advanced, and/or they were physically very frail with chronic health needs and for the families, proximity to their relatives was a paramount consideration.

Their families were not aware of the poor reputations of some of the owners and managers or of the homes where the relevant regulations were repeatedly tested and breached.

The families perceive the inattention to such *basics* as hydration, nutrition, physical comfort, personal hygiene, unexplained injuries and deep pressure ulcers which their relatives suffered as the abandonment of common humanity and a reflection of the unchecked greed of those businesses which own the homes concerned.

The funding of care is a critical consideration, since a growing number of people are paying in full or in part for their residential or nursing care. However, they do not benefit from consumer legislation should they be harmed or even die as a result of their treatment. Refunds are unheard of in the care sector and yet as self-funders' resources are exhausted, they fall back on diminishing state funding. Nor does the state utilise company or consumer law to either promote safety and quality or to halt the imprudently excessive rewards of company owners and the betrayal of the public interest. This is most particularly the case in situations of quasi-monopoly where the incentives for cost-effectiveness and public benefit are blunted.

Those responsible for the homes in question appeared impervious to the needs of older people and the growing concerns of their families. The homes' staff had neither the skills nor the knowledge to care competently for frail older people. Although care-giving tasks are demanding, staff were neither supervised nor trained nor properly equipped with medical supplies or safe equipment.

The business interests and practices of two **General Practitioners**, Dr Prana Das and Dr Nishebita Das, have a long history. Concern about their ownership of homes for older people featured in a television programme in 1995 in which older people's relatives and former employees described harmful practices and the rationing of such necessities as food and incontinence pads.

Concern was also expressed that nursing home patients were sourced from the Das' general practice lists. Fifteen of their homes went into receivership, the registration of five of their homes was cancelled and one of their homes (Holly House) was the subject of two Care Standards Tribunal hearings.

There were two further adverse television programmes about the Das' homes which were broadcast during 2005 and 2013.

The prosecution of Dr P Das was halted in March 2013 due to his medical condition which resulted from the assault during 2012. The CPS decided not to proceed with a prosecution against Puretruce Health Care Ltd or its Chief Executive.

The **Crown Prosecution Service's** correspondence with the Review stated that *It may have been possible to say…that bed sores were attributable to a failure to turn the patient often enough. However, the task of turning patients was shared by many people and we could not say with any certainty which individual had failed in their duty of care…the charges of gross negligence manslaughter could never be proved on the evidence available…The CPS accepts that there were insufficient resources deployed from the start of the investigation.*

Aspects of **Gwent Police's** investigation were described by a North Wales Police review team in 2009. Since *the number of deaths within Operation Jasmine grew rapidly in the early weeks of the investigation,* the parameters and priorities of the investigation were subject to adjustment.

Operation Jasmine secured Special Grant Funding from the Home Office. Since it was decided that the Gwent Police would: *investigate the circumstances of all the deaths where there are or have been concerns* and *all allegations or suspicions of abuse*, the actions of partner agencies were compromised.

The setbacks for Gwent Police included the outcome of the early trials of staff of Bryngwyn Mountleigh in 2008; the removal of the Senior Crown Prosecutor; and advice from the CPS that there was *insufficient evidence* to secure a successful prosecution, that is, to identify named perpetrators and accrue sufficient evidence against those individuals.

The lead responsibility for the Operation Jasmine investigation was transferred to the **Health and Safety Executive** in August 2011, after it was *presented with evidence of the grossness and scale of the injuries and on the understanding that there was not any other regulator able to secure justice in respect of the organisational failings by Puretruce.*

The HSE had regulated the Puretruce homes in terms of their generic health and safety arrangements such as manual handling, inadequate equipment provision, the maintenance of work equipment and accident records. Between 1994 and 2006 the HSE had issued 12 improvement notices to the Puretruce homes.

The six Operation Jasmine homes were located in Blaenau Gwent County Borough Council, Torfaen CBC and Caerphilly CBC. **The local authorities** had contracts with the Puretruce homes and until 2002 they were responsible for registering and inspecting all care homes.

The Welsh Government's guidance *In Safe Hands* raised the profile of adult protection in 2000 and placed new responsibilities on local authority social services departments to investigate Protection of Vulnerable Adult (POVA) referrals.

Multi-agency adult protection arrangements were expected to dovetail with regulatory inspections, disciplinary processes, professional regulation, complaints and clinical governance.

POVA referrals about concerning practices at Holly House (which was owned by the Das') and Brithdir included the failure to prevent deep pressure ulcers.

In 2004, Caerphilly CBC and Puretruce Health Care Ltd commissioned a report from *a policy adviser and representative for Care Forum Wales and an independent consultant* to *identify whether the contractual standard of care* at Holly House was being met. This consultant's assessment of standards of care did not tally with those of the regulator.

The decision of the Care Standards Tribunal in 2005 enabled Holly House to remain operating. Caerphilly CBC's Director of Social Services at the time confirmed that he would not place a loved one there because the home did not meet minimum standards *in all respects…the first and best option is to make* a failing home *better.* Holly House was de-registered in 2005 and Brithdir in 2006.

Before 2002, the inspection of nursing homes had been the responsibility of the **National Health Service**, that is, Caerphilly Local Health Board (LHB) which had contracts with the Puretruce homes and in which three of the Operation Jasmine homes were located.

Caerphilly LHB was aware of frequent POVA referrals to Caerphilly CBC concerning Holly House, one of the Puretruce homes, which included concern about residents' deep pressure ulcers for example.

An embargo on placing older people in Holly House at the end of 2003 was lifted in early 2004. Caerphilly LHB provided training in older adult mental health to Puretruce homes and provided qualified nurses to improve care planning and the standards of care over a four week period at Holly House.

District nurses assessed all Brithdir residents on three occasions, noting *the limited input of registered nurses on upper floors and defensive staff.* However, in March 2005 a senior LHB nurse reported on the home's *considerable improvements,* albeit with merited concern about their sustainability.

The **Care Standards Inspectorate for Wales** (CSIW) was set up in 2002 as the single inspection and regulatory body. The CSIW and, after 2007, the **Care and Social Services Inspectorate Wales** (CSSIW), had power when issuing a certificate of registration to impose conditions.

Of particular relevance is the fact that the inspectorate was required to demonstrate that reasons for deciding to close a home remained compelling at the point of closure – particularly pertinent where health and social care agencies had already 'stepped in' to shore up failing practice since this masked the failures of the registered provider.

The legal advice to the CSIW was that the efforts of the social services and LHB to raise standards could be a barrier to issuing an order to cancel the home's registration.

The regulations made under the Care Standards Act 2000 imposed requirements on care homes. An individual or organisation running more than one care home must have separate registration for each home. The legal advice to the CSIW was that if there was concern about two homes in a group of homes, Inspectors were to take action on a home by home basis.

This meant that Inspectors had to prioritise action against those Puretruce homes which showed the greatest number of breaches of standards and regulation, that is, the regulator was compromised since it could not adopt a corporate, contextual approach to enforcement.

Actions Taken in the Interim

Not all agencies provided an account of their actions. It is significant that the CSSIW is more responsive to concerns about the circumstances of residents and no longer engaged with providers' promises of compliance. Its reports are clearer and more concise than those which were prepared by its predecessor. Also, the CSSIW is proactive in ensuring that actions with commissioners and other regulators are coordinated. Caerphilly CBC deploys *all qualified social work teams* and has developed a *Provider Performance Monitoring Protocol* to address

potential and actual contract breaches. The Aneurin Bevan University Health Board (which replaced the Caerphilly LHB) similarly recognised that there was no case for persisting with an approach that did not work. Contracts have been developed which pay greater attention to the circumstances of older people, albeit within *a market* offering limited choice.

Findings and Analysis

Mistakes and errors of judgement characterise the organisations associated with Operation Jasmine.

The Crown Prosecution Service's assertion that the Operation Jasmine case would have fallen on the basis of lack of evidence of causation should have been tested before a jury.

Some of the early cases known to the Operation Jasmine investigation should have been brought to the attention of the Coroner.

It cannot be right that individual criminal liability and corporate criminal liability are regarded as mutually exclusive. *Only prosecuting business representatives as individuals provides corporations with incentives to scapegoat their employees, whereas a unique focus on the corporation allows individuals to avoid their own moral responsibilities by pointing to the surrounding corporate structure* (J.G. Stewart).[3]

The legal context of residential care and corporate governance[4] shows that the provision of care homes by non-listed private companies is not subject to the UK Corporate Governance Code and legislative provisions that apply to listed public companies.

Better corporate safeguards are required to ensure *good governance*. For example, in spite of the public interest associated with the care of frail older people, providers with large numbers of care homes have operated and continue to operate with one or two directors.

In law, directors have separate and collective responsibility for the management of their companies. The corporate history of the Puretruce portfolio confirms that Dr N Das' involvement was not minimal, contrary to the judgement of the CPS and the police.

The reported poor standards of care provided by the Das' companies may have rendered them liable in contract to public and individual commissioners of services; their companies could have been held vicariously liable for the civil wrongdoings of their employees; and proceedings could have been taken under the Company Directors Disqualification Act 1986.

There is a compelling case for: locating breaches of care standards regulations in the context of the disqualification of directors; considering whether or not the corporate social responsibility provisions of the Companies Act 2006[5] require additional teeth given the clear public interest in the provision of health and social care; the presumption of director disqualification where there is a history of insolvency; considering whether or not the

[3] Wells, C. *Corporate criminal liability: a ten year review* [2014] Crim L.R. 849-878, citing J.G. Stewart

[4] The Review report contains a section on: *The legal context of residential care and corporate governance* written by AW Griffiths, C Hodgetts and R Ni Thuama

[5] Section 172

definition of an *unnatural death* should include individuals who have died with deep pressure ulcers and evidence of possible neglect; and basing corporate criminal responsibility on corporate conduct across an organisation.

The care of frail older people was being severely compromised ten years before Gwent Police's Operation Jasmine began. The NHS took no credible action and the indisputable build-up of problems from the time of the first television programme was still awaiting resolution in 2005.

Extensive media coverage and *frequent POVAs* proved insufficient in securing a fair and legally sanctioned resolution. Insofar as the adult protection outcomes for residents at the six homes are known, they had no discernible impact on people's untreated, deep pressure ulcers. There were too many occasions when the homes did not secure medical treatment and report deep and multiple pressure ulcers to the regulator and the local authority. Reporting such wounds to local authority POVA personnel is an anomaly, since local authorities cannot advance or provide the urgent clinical interventions required.

No single profession or agency assumed a lead role in addressing breaches of trust, neglected contractual duties or the harms endured by older people. Discussion concerning which agency should investigate and prosecute – involving considerations of duties, powers, capacity, capability and urgency to protect, for example – was not held.

It appeared that the roles of the regulator, the Local Health Board (now the Aneurin Bevan University Health Board) and the commissioning local authorities were reduced to that of feeding of information into the police investigation.

The parameters of the Gwent Police investigation were too broadly drawn: for example, *to investigate the circumstances of all the deaths where there are or have been concerns* and *to investigate all allegations or suspicions of abuse.* This played a part in the duration of the investigation. A peer review by North Wales Police in 2009 questioned elements of the Gwent Police investigation.

Agencies lost some autonomy of action as activities which were normally within their powers became restricted because Gwent Police had primacy over how the investigation should be conducted. The exclusion of the CSIW from the investigation was remarkable. It was remarkable also that such a high profile police investigation was advised by a retired inspection manager. From the perspective of the professionals who had sought to effect improvements in failing homes, they ceased to be witnesses and some became suspects.

Inter-organisational cooperation was overshadowed by ambiguity and suspicion as the police investigation extended and the potential trial of Dr P Das, Paul Black and Puretruce Health Care Ltd had an ever receding start date.

An expert panel comprising clinicians and a social care expert was commissioned by Gwent Police in 2006. Initially it was invited to produce combined reports and, subsequently, individual reports. The prosecution of a number of Bryngwyn Mountleigh nursing staff

became a distracting diversion but was seen by certain panel members as an assertion of their duty to report individuals to their professional bodies.

The inspection reports of the CSIW in relation to the Operation Jasmine homes contained excessive numbers of *requirements.* It is not clear how an *urgent requirement* differs from a *good practice recommendation* for example. Crucially, there did not appear to be any consequences for failing to act on *requirements.*

The CSIW Inspectors had to deal with such challenges as the Das' homes being threatened with the disconnection of gas and/or electricity due to unpaid bills; seeing and smelling older people's necrotic, deep pressure ulcers for which they had received neither treatment nor pain relief, in homes owned by local GPs; bailiffs visiting the Das' homes; the angry resistance of families, whose relatives may not have been harmed, to the prospect of a home being closed; the transfer of frail older people from one failing home to another; and the setback arising from the Care Standards Tribunal decision in 2005.

The inward migration of labour to the south east valleys of Wales presented communication challenges. The fact that the first language of some care home employees was neither English nor Welsh was a major concern for residents' relatives.

The ownership of residential and nursing homes by GPs operating as business men and women is no guarantee of timely and attentive healthcare for residents and patients. Similarly, a GP partner of an owner does not guarantee that residents will receive the healthcare that they require.

Having GPs associated with the ownership of residential and nursing homes can lead to a conflict of interest, particularly where they are sourcing residents from patient lists and/or are responsible for the primary healthcare of residents at such homes.

Aspects of palliative care such as the management of pain and the provision of emotional comfort were remote from the experience of the older people known to Operation Jasmine. The use of opiates and access to palliative care teams, for example, did not feature at the end of their lives.

The Review confirmed that people with dementia were less likely to receive pain control than their cognitively intact peers. Recent research suggests that this situation has not improved.[6]

The compatibility between *person-centred care*, *relationship centred care* and palliative care suggests that a new direction needs to be sought when care planning for frail older people in Wales.

[6] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3817007/ (accessed 25 May 2015)

Recommendations

The Review provided input to the *Regulation and Inspection of Care and Support (Wales) Bill,* through (i) meetings with civil servants responsible for its development. These considered how emergent findings might be reflected: by ensuring that those who own and gain from the provision of services, that is, Board members, are held accountable; by allowing regulators to take action against a corporate body rather than a single service; and by ensuring that information about services providing care and support is accessible to individuals receiving care and to their families; and (ii) a letter to the First Minister and the Deputy Minister for Social Services in December 2014. This was acknowledged to be an ambitious list of ideas such as: *the best interests of people receiving care should be the supreme principle and reflected in statute; there should be a presumption that the burden of proof is on the corporate body, holding company and directors that they are fit to provide or own; improvements which are attributable to the documented efforts of Inspectors, NHS and local authority employees do not constitute grounds for satisfying Welsh Ministers that (registration) cancellation is no longer necessary;* and *no one individual* (Director) *should have unfettered powers of decision.*

In addition, it is recommended that:

1. the residential and nursing care home sector:

- **(i)** becomes a sector of primary national strategic importance for Wales, recognising that low investment in the social care system means higher costs for the **National Health Service** and affects economic potential by failing to support a modern and trained labour force;
- **(ii)** is shaped by explicit policies to regulate and allow intervention in the social care market to improve the quality of care by directly addressing issues such as pay and working conditions, staffing levels and the knowledge and expertise of commissioners of publicly funded services;
- **(iii)** care home managers are registered and are members of a professional body which sets professional standards, has disciplinary powers and provides them with a voice on national policy; and
- **(iv)** develops credible quality indicators[7] to inform strategic planning for health and social care [see J. Kennedy (2014) John Kennedy's Care Home Inquiry York: Joseph Rowntree Foundation and Joseph Rowntree Housing Trust]

2. the Welsh Government, in association with **Public Health Wales**, ensures that:

- **(i)** the significance of deep pressure ulcers[8] is elevated to that of a *notifiable condition*

[7] For example, from the demeaning experiences of frail older people illuminated in this and other reviews, it is possible to build on frameworks of valued care and support such as, for example, the 'Senses Framework' [M. Nolan, U. Lundh, G. Grant and J. Keady (2003) *Partnerships in Family Care: understanding the caregiving career* Maidenhead: Open University Press McGraw-Hill Education]

[8] That is, a focus on the severe, deep tissue injury and *unstageable* pressure ulcers

(ii) senior clinicians, including Registrars, General Practitioners and Tissue Viability Nurses, assume a lead role in preventing avoidable pressure ulcers[9] and in developing a National Wound Registry, assisted by the **Welsh Wound Innovation Centre**

(iii) senior clinicians are made responsible for notifying **Public Health Wales** of deep pressure ulcers and

(iv) where **Public Health Wales** has been informed of the existence of deep pressure ulcers, a process is identified whereby that information is communicated to the **Care and Social Services Inspectorate Wales** or the **Healthcare Inspectorate Wales** and appropriate commissioning authorities as well as to people's families

3. **Safeguarding Adults Boards** should ensure that the **Protection of Vulnerable Adults** (POVA) process:[10]

   (i) defines more narrowly and more specifically its functions

   (ii) strengthens protective outcomes for individuals where there is an allegation or evidence that harm has occurred, by ensuring that either a care assessment or a review of that individual's care plan is undertaken. The outcome of the process should be specific action rather than simply a determination of, for example, *institutional abuse*

   (iii) ensures that the NHS is accountable for fulfilling its lead responsibility for investigating such major and potentially lethal conditions as deep pressure ulcers in the residential and nursing care sector

4. Inquests should be held, notwithstanding the fact that the deaths of **Stanley Bradford**, **Megan Downs**, **Edith Evans**, **Ronald Jones** and others known to the Coroner have already been registered

5. **Gwent Police** provides the families of older people in the six homes included in Operation Jasmine with the information prepared by members of the expert panel and ensures that they are supported during and after this process

6. **NHS Wales** considers how the responsibility for reporting hospital deaths to the Coroner is undertaken by senior clinicians and considers the need for a legal presumption in favour of reporting the deaths of residential and nursing home residents to the Coroner

7. the **General Medical Council (GMC):**

   (i) collaborates with **NHS Wales** to identify ways in which conflicts of interest can be managed that arise from the admission of patients of **General Practitioners** and

[9] Although clinicians estimate that 90% of pressure ulcers are preventable there is a well-documented disparity between clinical practice and research evidence

[10] Although there are many ways in which individuals may be harmed, the process of responding has three elements, (i) prevention – setting up a well ordered service and paying attention to recruitment and training (ii) secondary prevention – being alert to signs and symptoms so that concerns are picked up quickly and inquiries made and (iii) taking action to support and protect those who are known or believed to have been harmed

other **GMC registrants** (hospital consultants for example)[11] into residential and nursing homes in which such doctors are company directors, or are related to the directors of these homes

(ii) ensures that all **General Practitioners** and **other GMC registrants** are informed about what constitutes a conflict of interest[12] and how to manage this in practice. Given that declaring a conflict by itself would have been an inadequate safeguard given the findings of this Review, the GMC may wish to consider the specific example of clinicians owning nursing and care homes

(iii) considers in its review of the Medical Register the potential for recording information on declared conflicts of interest

8. the **General Medical Council (GMC)** and the **Nursing and Midwifery Council (NMC)** consider the need for continuing reform[13] to ensure that fitness to practise proceedings are conducted as quickly as practicable, while maintaining their primary purpose of protecting the public

9. the **Director of Public Prosecutions** refers the Operation Jasmine investigation to the Special Crime and Counter Terrorism Division (formerly known as the Special Crime Division) of the **Crown Prosecution Service**

10. the **National Police Chiefs' Council (NPCC)** ensures that the primacy of a police investigation delivers the ability of (a) the **Care and Social Services Inspectorate Wales** (CSSIW) and the **Healthcare Inspectorate Wales** (b) professional regulators, such as the **GMC**, the **NMC** and the **Care Council for Wales** (CCW) to take forward civil and criminal action; and address concern about alleged fitness to practise within a defined time frame

11. the **National Police Chiefs' Council**, the **Health and Safety Executive**, the **Care and Social Services Inspectorate Wales** and the professional regulators share what has been learned as a result of this Review, collaborating further to specify and confirm the components of a framework for undertaking timely team and parallel action in future

12. the **Law Commission** reviews the current legal position in relation to private companies with particular relevance to the corporate governance of the residential and nursing care sector[14]

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[11] And by extension, registrants of the Care Council for Wales – the social care workforce regulator. The CCW has a Memorandum of Understanding with the Health and Care Professions Council which registers social workers in England

[12] GMC (2011) *Conflicts of interest: what* our *guidance says* London: GMC; and GMC (2013) Financial and Commercial arrangements and conflicts of interest (http://www.gmc-uk.org/guidance/ethical_guidance/21161.asp (accessed 7 April 2015)

[13] In the light of the Law Commission's (2014) *Regulation of Health and Social Care Professions Etc Bill*

[14] Given the clear public interest in ensuring the well-being and safety of residents, the Law Commission may wish to consider whether or not corporate criminal responsibility should be based on corporate conduct across an organisation, rather than the current practice of pinpointing responsibility on individuals

The Lessons

- scandals fix nothing permanently
  The answer cannot reside in an exhortation to read *106 lessons,* in rare and piecemeal interventions or a plan to avoid mistakes. It lies in understanding the complexities of the care home infrastructure and the associated business models - as well as in employing talented and competent managers to recruit, supervise and train staff to support frail older people in homes that are their workplaces[15]
- citizens cannot rely on the conscience of care home owners to deliver valued care and support to frail older people
  Good governance is critical to quality and safety in homes for frail older people as well as residents being and feeling embedded in relationships - with their relatives, friends and advocates and with health and social care practitioners and the wider agencies - of which they are a part. All should insist on participating to ensure that there is *a window* so that residents can look out, the community can look in[16] and there is scope for residents to be and to feel part of their neighbourhood
- it is assumed, without evidence, as acceptable practice, to group older people with dementia together in particular homes, without sufficient staff who are inadequately managed, trained and supervised, on the grounds that they all have similar needs
  Since the growth of the sector has preceded reflective research to guide its structure, function and direction, the investigatory attention of the media has been instrumental in highlighting the consequences of the deficient practices (including planning processes which advantage developers), it is up to (i) commissioners to engage with the reality of the impoverished lives of too many residents with diminishing capacity and (ii) the sector to demonstrate the effectiveness of their interventions and support arrangements, including how a culture of valued relationships may be nurtured, for example.
- older people's injuries, pain and life-threatening deep pressure wounds were unobserved, unreported, reported inaccurately and/or reported belatedly – and yet, in this case, no crimes were identified by the Crown Prosecution Service
  The rhetoric of concern has to be matched with credible action. It is essential that all necessary clinical care is provided alongside timely processes to identify ways of preventing further harm – which must include prosecution
- the public sector should not under-write companies which have produced considerable rewards for the few at the expense of the many

[15] Roger Clough writing for the Wagner Committee in 1988 and talking then of reports of abuse and neglect that go back more than 30 years stated: *it is not only in exhortation, not only in planning to avoid mistakes, it lies in in understanding the complexities of residential work and of the systems in which people work and live – and then working out the best system to promote the well-being of the residents.*

[16] See R. Elkan and D. Kelly (1991) *A Window in Homes: links between residential care homes and the community*, Surbiton: Social Care Association

This means that local authorities and the NHS have to demonstrate long-term prudence, pool their learning from older people, families and research, build on their knowledge of the strengths and weaknesses of the whole sector and combine their purchasing power. Being explicit about what they will commission and why - should herald a new relationship with older people, their families and providers

- private interest pursued at the expense of others has a long history, however the public interest cannot be subordinate to the short term personal gains or even the criminality of a minority of directors of care homes

  The external scrutiny of the care and support of older people by commissioners, care managers and regulators should be matched by ensuring that companies in this sector open their boards to independent scrutiny. A lasting achievement of Operation Jasmine has to be a readiness to adopt a long term view. Companies which have demonstrably failed older people should be allowed to fail and their directors should be disqualified. They have depleted public trust. The needs of frail older people cannot be subordinate to those financially sophisticated businesses and/or powerful directors; if that situation should prevail we will remain ***in search of accountability*** indefinitely.