



Practice review report: Operation Jasmine

These case studies are intended to raise issues in a practical application; bringing together the critical factors, particularly around multi-agency working. They will help to contextualise risk factors and raise questions about prevention within situations of known abuse, neglect and harm. They have been summarised to assist in this process, but more information is available in the actual review reports.

Context and background of review

Residents of some care homes in the Caerphilly County Borough and Blaenau Gwent County Borough were subject to a widespread and sustained level of abuse which caused horrific injuries and premature deaths. The Gwent Police commenced an investigation under the code name of Operation Jasmine.

In December 2013, the First Minister of Wales Carwyn Jones announced he was setting up a review of Operation Jasmine and the events associated with it, so 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.
4. Set out key lessons for the future alongside recommendations regarding policy or legislation, regulation and operational practice, for the various parties involved.

Circumstances of, and challenges faced by, the individual

The families of older people described the wrong and indifferent care home practices that 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 that 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.



What happened?

Despite the weight of evidence produced, the Crown Prosecution Service failed to bring forward a prosecution against the company and representatives of the care home due to the inadequacies of current legislation. Subsequently, proceedings by the Health and Safety Executive did not go ahead, but were “left on file”. There may be a possibility that these could be re-instated sometime in the future.

Why it happened?

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 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 Care and Social Services Inspectorate Wales 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.



Selected report 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.

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 to inform strategic planning for health and social care.

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

- (i) the significance of deep pressure ulcers is elevated to that of a notifiable condition
- (ii) senior clinicians, including registrars, general practitioners and tissue viability nurses, assume a lead role in preventing avoidable pressure ulcers 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:

- (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.

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

Citation *In Search of Accountability: A review of the neglect of older people living in care homes investigated as Operation Jasmine*, Welsh Government, May 2015

<http://gov.wales/docs/dhss/publications/150714ojreporten.pdf>