COMPASSION IN CARE

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To Hatchers Solicitors
You're Ref XMCR/25.ER.MSX

Re Your Client, Morris Care Centre

Dear Sir,
In response to your letter to us of 9th March, received on March 12th at 3pm, We ask you to note that you have given us barely two working days to respond and given that time frame and the fact we are a small Charity with no salaried staff, we have had to delay attending to help-line calls on our very busy help-line. We have also not been able to give as full and detailed response as we would like to have done due of the threats of a two day ultimatum.

Firstly we ask that you note that our series of reports "Safeguarding Shambles" is part of our evidence for changing the law. This series of reports primary aim is to highlight the extent of failures of Local Authority's Safeguarding Adults investigations. As these failures are UK wide we have to include the details of both the concerns reported and the investigation outcome. Morris Care Centre has not been singled out but is one of many cases we are using demonstrating these issues.

Secondly our evidence on the care home re registration loophole is currently part of an investigation by the Health Department and the Minister's letters regarding this are all published on our website with all the relevant links to our robust evidence.

Morris Care Centre had a number of previous inspection reports which evidenced very serious concerns about the care provided and these reports have likewise been archived. I deal with this evidence in more detail on pages 4 to11, and will be bringing our report "Safeguarding Shambles Case 2 "to the attention of Jeremy Hunt The Secretary of state for Health.

To deal with the other points you raise as follows,

You refer to Safeguarding Shambles Case 2 being tweeted.
All our reports and correspondence is published and tweeted in exactly the same way, we are a charity that campaigns in the public interest and are open and transparent in the work we do.

You refer to your client being named.
Again you will see that we have named hundreds of care provider's in our published work all of which has been formally presented to Government as evidence for law change. This is the first time that our work as a small charity has ever been threatened with legal proceedings.

You state that I have not checked the accuracy of the signed witness statement sent to us and that your client fully disputes the content.

My comments are based on the following evidence provided to us,

Fact One. The Death Certificate.
Cause of Death Septicaemia bilateral infected foot wound.

Fact Two. Hospital Video footage. We took the decision not to publish this because the footage is so graphic.

Fact Three. The family's log of events and photographic evidence. We took the decision to publish the picture we did because that picture is the least graphic of all those we were provided with.

Fact Four. Maggots were in the wound. Our research on this issue has looked at all the accepted good practice in wound care. Wound care dressing would not allow for insect larva to enter an open wound.

Fact Five The individual was taken to surgery to have her wounds cleaned out under general anaesthetic and this again is a matter corroborated by hospital records.

Fact Six. The individual was hours from death when the family arrived at the home and called the ambulance. The ambulance then made the assessment the person needed hospital treatment. The expectation that a trained nurse would have equally been aware that **hospital treatment** was required is a reasonable expectation in all the circumstances. Especially when it is considered in light of the degree of Hospital treatment that subsequently had to be provided and that the individual died as a direct result of the infection in her leg wounds.

Fact Seven The individual was administered immediate pain relief at the hospital because the level of pain being suffered was recognised to be severe. Anyone who suffered such a level of pain for even one hour would agree with us that urgent medical intervention for this individual would have reasonably been expected to have been provided days earlier given that the individual was so able to express their level of pain to staff. Furthermore the degree of infection should have been prevented from progressing to a life threatening condition.

Fact Eight Had the family been aware of the archived information on this home they would not have placed their mother there.

I note your clients concern for their reputation and what their family and friends think. At no time has the slightest consideration or regret been expressed for either the individual who suffered nor the family who saw this happen to their much loved mother.

I also note that your client seeks to use the Safeguarding process as a defence, however it is the safeguarding process that has resulted in this particular case be chosen as one of many to demonstrate the failures of such safeguarding investigations in the first place.

I consider my comments on the above facts to not only are fair comment but I consider I have a duty of care to state these facts in the public interest. What should not be forgotten for a second is the suffering endured by a vulnerable person.

If we as a charity are to be sanctioned for highlighting that suffering then something is very wrong indeed.
I stand by my comments on the facts for to do otherwise would be to contravene every aim and objective of Compassion in Care as a Charity.
There are somethings that we cannot remain silent on.

The next section lists evidence from the archived reports which is highly relevant. I also ask that you note that the current inspection process used by the CQC has resulted in 90% of our helplines contacts relating to care homes currently rated good by the CQC. Which is exactly why it so important that all a home's history is available to the public and not archived when there is a poor history.

The inspection history of Morris Care Centre consists of a total of **135** pages, of which **106** pages of evidence on this history has been archived by the CQC as belonging to another provider, **leaving the public with just 29 pages**.
This is why we have worked tirelessly to expose the situation across the country in relation to this misleading practice.

Report 1 19th March 2010 Rated Zero Star. 43 Pages

Page 7
" We also looked at information which we had received from other agencies, including the local safeguarding adult's team. The inspection was triggered following a significant number of referrals which had been made"

Page 8.
" This key inspection identifies a considerable amount of failings and shows that the home is not functioning well and people are being placed at risk of harm. These failings suggest the home has not been managed or monitored Effectively"

Pages 16 to 17
" Of particular concern was that there was nothing in this person's care records to inform staff how to care for a part of this person's body which has sustained an injury reports this to the attention of the acting manager and Company representative on the first day of our inspection.

We returned on the second day and saw that some information about the injury have been added to the care plan but it's still lacked detailed guidance to ensure staff knew the care which needed to be given until there was a full recovery from the injury. We spoke with the nurse involved in this person's care and they told us that this person has attended appointments at the hospital to review the injury however we established that information about all the appointments had not been recorded in the care records."

POOR WOUND CARE

"We found poor recording in respect of wound care and management, such as gaps in recording to show that wounds have been redressed, measured or monitored. None of the care records we saw have photographs of the wounds, which is considered a good method to use as a means of monitoring progress.
Observation of the homes wound management policy shows that it expects its staff to carry out this task.
In care records we saw there was nothing to suggest that the home had contacted wound care specialists for advice or guidance on wound management. We saw that people have been assessed for the risk of deterioration to the skin or where we saw that the plan of how to reduce the risk of pressure sores occurring was limited in information and did not fully reflect the level of care and equipment needed. "

" Staff were administering medication to people who were using the service but were not recording exactly what medicines they had administered. We therefore found that the medication records were not robust enough to demonstrate that people using the service were having their medicines administered as prescribed"

Page 21

"We also found evidence to show that staff will sign in the mar sheet to confirm that administration had taken place when in fact the medication had not been administered "

Page 25

"People are not protected from the risk of harm and abuse because processes such as recruitment ,care planning, assessment of risk and administration of medication are not robust "

Page 31

"We looked at 5 staff personnel files to look at how the home recruited staff. We found the home has not insured the staff had all the necessary pre-employment checks undertaken to ensure they are suitable to work with vulnerable people.

One member of staff started working at the home in 2009 without any references been obtained. Other staff only had one reference which was not always from their previous employer which it should be.

The staff had started working before their full criminal record Bureau checks CRB have been obtained. We saw emails confirming that as a POVA first check which are checks against a national list of people considered not suitable to work with vulnerable adults have been completed by the company and informing the home that they could start working under supervision however the staff should not have started working until the company was certain that all other checks such as references have been completed and was satisfied with them. "

Page 33

" Morris Care Centre does not have effective arrangements in place to promote the health, safety and welfare of people who live there this means people cannot be confident they will be protected from harm ."

Page 34

"Our observations made at this inspection and evidence throughout this report indicates the home has not been managed or monitored effectively by the company for some time.

For example there is no evidence to suggest that medication administration records are audited for their integrity or that care records are checked to ensure that people have received the care they need.

Representatives of the company were present on both days of this inspection. On conclusion of our first day, we gave the acting manager and Company representative a feedback summary of our findings from that day.

Near the end of our second day of inspecting the home we attempted to give feedback to the acting manager and two company representatives. We informed them that we had identified many concerns including serious concerns with the management of medication. Despite our request to inform them of our findings the company representatives declined which suggested a lack of

commitment by the company to respond promptly to improve outcomes for people and protect their health safety and welfare. We met with the director of the company a week after the inspection who acknowledged that they should have received our feedback at the time of our inspection."

Page 35
"As identified earlier in the report we were concerned regarding an incident and respect of bed rails as we saw it in in a person's care records notes describing how they had been found trapped between bed rails.
We looked for further information about the incident on the first day of our inspection but an incident accident record could not be found and the acting manager confirmed they were not aware of the incident. There was nothing written within the person's care records to say whether the bed rails were viewed or changed after the incident.
We had also not been notified of this incident. The acting manager subsequently notified us in writing about the incident after we had identified it. This indicates that staff have not followed good reporting all the recording practices after the incident. We also established that the home have not kept us informed when a person needed admission to hospital."

Inspection report dated February 2011. Total of 44 pages

Overall there is improvement in the home but it was still not fully compliant with all the standards .

Page 14.
"Care staff we spoke with expressed concern about the lack of information made available to ensure the safety of a person concerned and of themselves"

Page 20
"Since our last visit a new housekeeper has been appointed and other agencies have visited the home and undertaken audits on infection control. Numerous recommendations were made by one agency and our findings evidence that the home are working towards meeting these"

Page 21
"Some staff Express concern about the lack of hand hygiene gel being made available to resident's, staff and visitors "

Page 22
" We found a was very little information in the person's care plan about how medicines were to be administered and how certain medical conditions were to be managed and monitored"

Page 23
"We then looked at the way the nursing staff were managing the medicines of people who use the service on Wreken Court unit, we again found that on the whole the medicine administration records show that people we looked at were having the majority of their medicines administered as prescribed. We did however find a small number of anomalies and with some medicines that had not been packed into the monitored dosage system suggesting that these medicines have not been administered to the person concerned as prescribed"

Page 29
"We received a report from another agency that visited the home and reviewed several staff records and found some shortfalls in recruitment practices for example written references been obtained from former colleagues and not the applicants manager as required ,the manager has since addressed this issue "

Page 31 and 32
"People told us that staff work hard and are very nice. Some expressed concerns about the number of Staff deployed on the intermediate care unit, comments we received from people using the service, visitors and staff include,

Staffing levels stay the same despite an increase in the dependency levels of people living in the home.

Staff are too busy and task orientated.

A more flexible approach is required based on dependency levels.

We could do with more staff

Sometimes I'm left waiting in my room for up to an hour waiting for staff to come

There is not enough staff, people are often left unsupervised in the lounge therefore there is a lack of supervision.

It's an accident waiting to happen

Sometimes staff are very stretched especially in the evenings.

People are encouraged to go to their room after tea as there's not enough staff to supervise them in the lounge.

We found that the staffing levels remain the same despite the dependency levels of people being admitted to the service. The management team fully acknowledge our concerns and committed to reviewing the situation "

<u>Inspection report August 2012 Total of 19 pages</u> .

The home is judged fully compliant .
Page 12
"There have been a recent referral into safeguarding procedures. We saw that the Home co-operated fully with the investigations and accepted any recommendations for improvement that arose from them

(According to CQC. This is the last inspection report under the ownership of the Morris family. These reports are archived under an old provider and the public are told the Morris family no longer own the home.)

<u>Inspection report May 2013. A total of 14 pages</u>

(Please note this is the first inspection under the alleged new provider the Morris family)

"This inspection is taking place as concerns have been raised about the care and welfare of people who use the services staffing and supporting workers"

(CQC appear not to have upheld the concerns but we are not told what the concerns are.)

Inspection report February 2015 Total of 6 Pages

(Please note this inspection is under the new CQC inspection regime the CQC new regime)

The home is rated good on all five standards

The home is not inspected again for a period of 2 years and 3 months.

Most recent inspection May 2017 Total of 9 pages,

"Rated good in all areas"

(However it is important to note that the events that took place since this report was published 7 months ago, that no further inspection has taken place in relation to those incidents. I also note that the CQC website as of yesterday displayed no banner to show any intent to carry out an inspection)

We have many other points and evidence that we have not included due to the time limits you have imposed. This document will, like all our evidence be sent to the Government and published. Neither the Government nor the CQC will act on our reports unless we publish the names of the homes.

To summarise we have evidenced our concerns on the practice of re-registration in the documents,
CQC an On-going Concern,
CQC A Likely Story,
You can find these on our website along with the internal emails between senior officials at the Department of Health and the Chief Inspector for social care for England, Andrea Sutcliffe. These emails

confirm that the concerns we have raised about this practice are judged as valid concerns.
Our work in exposing both abuse in social care, the failures of regulators and safeguarding is widely acknowledged. For example our work has featured in over 52 issues of Private Eye magazine, BBC Panorama and many other media outlets.

We have shown Morris care has a past history of failures that relate exactly to the concerns raised by the family of resident A.

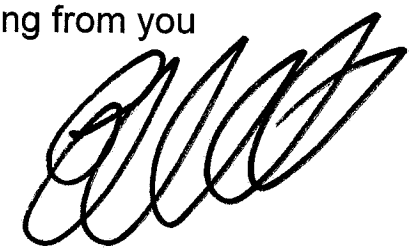
We have shown that our comments and publication of events is a fair comment given the established facts and is in the public interest.

We ask that you note we are not attacking the staff at this home many of whom do their best to deliver care. We are clearly raising concerns about Nursing standards and management.

We have provided evidence that this provider is intolerant of any criticism.

We have explained fully in the time allowed us why the report was published. We have evidence from CQC and the Health Department to prove their on-going stance of refusing to investigate care home provider's where the names of those care home provider's are not disclosed.
Whilst we guarantee the whistle-blowers and other sources absolute confidentiality unless they wish to be named, we do this because whistle-blowers are known to suffer serious harm for making disclosures.

We look forward to hearing from you



Eileen Chubb

CC Jeremy Hunt
Shadow Minister
Health Select Committee
Family of resident A