# COMPASSION IN CARE

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## Compassion In Care

## Investigation Into *FAILURE* TO INVESTIGATE

**PARKVIEW RESIDENTIAL & NURSING HOME**

**BOLTON**

**PART ONE**

**Who Knew What and How Long Ago?**

**Extracts from Care Quality Commission reports**

**with Comments by Eileen Chubb**

### Section One: Inspection Reports

The following selection of CQC Inspection reports highlight what the authorities knew, when they knew it and how persistent were the issues involved.

**May 2012 Registered for Nursing**

Overall judgment is that the home was not meeting one or more standards.

Page 8 states "we were told by some people who use the service that sometimes the majority of staff were hard to understand as their first language was not English".

Page 10 "Care plans were disorganised, this made them difficult to read and it was not easy to understand the current care needs and risks of people who use the service."


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**COMMENT: If you cannot read the care plans and understand the needs of the people, how can inspectors judge whether there are enough Staff to meet their needs?**

Page 11 "All care plans and assessments were written by the same member of Staff. This made it difficult to determine whether other Staff were able to assess the care needs of the people who use the service."

"We did not see any documented evidence when people who had been nursed in bed had been turned to prevent the development of pressure ulcers."

"We did observe that one person was turned at regular intervals and that all pressure care and general nursing care had been appropriately undertaken."

"We noted that some of the people who use the service looked dehydrated."

Page 12 "The care files reviewed had a basic nutritional assessment tool but there was no guidance of actions recorded that demonstrated appropriate steps were taken when any nutritional risk has been identified. We did not see any food charts in use and we only saw one fluid chart in use despite several people looking dehydrated."

Page 13 "The feed was to be administered by percutaneous endoscopic gastromy (PEG)."

**COMMENT: Clearly this home is registered to provide nursing care and there is evidence that people have conditions that require nursing care. Please note this in relation to further documented evidence in relation to staffing ratios.**

Page 16 "One room was quite isolated, as there were no other people in their rooms at all during our visit and we did not see any Staff in that area. One person was in bed with the door wedged open. In the event of a fire there would be no protection against smoke. Numerous doors were wedged open with either chairs, wooden wedges or other equipment throughout the home."

Page 18 "We looked at the staff establishment of the home, which provides both nursing and personal care. We found that on every shift, both covering days and nights, a registered general nurse (RGN) was allocated on duty. On the day of the visit the manager was also the RGN on duty. We saw that the ratio for Staff was good. The off duty rotas were completed at least two weeks in advance. It was difficult to determine the number of hours worked per person on some rotas, as duties were recorded as ON or on others as 8=8."

**Comment In other words nobody knows what the needs of the Residents are in relation to setting the Staff ratio, compounded by the fact that even the inspectors cannot understand what is written on the rotas. Throughout this report there is no reference to a nurse working on the floor. This raises the question, are homes registered by the CQC for nursing care actually being staffed by nurses, and if not why have they kept their nursing registration?**


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**Compassion In Care has previously reported on another unconnected home, where ten people died from infected bed sores in a seven day period. It was clear from our examination of the inspection reports about that home, which was residential, that it had no nurses on duty but it was allowing people who required nursing care to reside in the home, ultimately resulting in the deaths and appalling negligent circumstances that persisted in the following years. The CQC noted that people required nursing in bed but did not check that their needs could be met in a residential home. I will comment on this in more depth at the end of the inspection report section.**

Page 11 "The manager told us the deputy manager of the home had been seconded to another home belonging to the provider to oversee the management of that home until a manager was appointed."

**COMMENT: Why on the CQC website, regardless of whether this provider has two homes open or not, is the inspection history of each home not accessible to the public? I can find no single reference to the name of the other home. This information is very important because if this provider had another home then it would assist the public in choosing a care home if they could see the culture in both. This applies also to any provider with multiple homes.**

Page 22 "During the sampling of care files we found that records were being completed about nursing and personal care delivered that were dated and timed hours before. For example, on a daily progress sheet for 14 May 2012 when read at 3.30pm said "6pm. Care as planned. Medication given as prescribed. Protol water given as directed by Dietician. Toileted every 2 hours – PAC position changed. Water 200ml given prior to commencing Jevity promote 1000ml". This constituted a false record and was discussed at length with the manager and provider. The manager said she had done this because an agency nurse was on duty and it gave her guidance."

Page 22-23 "We saw that a copy of the complaint procedure was displayed around the home. This gave conflicting information, in places it referred to the Commission for Social Care Inspection and in others to the Care Quality Commission (CQC). It also advised people that CQC would be happy to investigate complaints. The manager was advised that the CQC did not investigate complaints and that all complaints would be referred back to the home or social services."

**COMMENT: We will be giving full information regarding a subsequent Coroner's inquest in which a Police Detective Inspector stated that he could find no evidence of the home falsifying records. We will provide full details of a culture of repeated falsification of records, which is evidence that both the Police and Coroner should have considered had a proper investigation been conducted, as would have been done under Edna's Law.**


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Page 9 "When we arrived a radio was on in the lounge area tuned to a popular station with music blaring out. The choice of music did seem inappropriate for the majority of people sitting in the lounge at the time. Bhangra music (popular music associated with Punjabi) was playing in one person's bedroom and later in the afternoon, the radio was tuned to an Asian speaking station. The person's first language was English. The care plans indicated that this person's preference was to listen to classical music."

"Overall judgement. The provider was not meeting this standard. We judged that this had a minor impact on people using the service."

**COMMENT: The music issue is NOT minor, this can have a very damaging impact. I have witnessed firsthand this being done to someone in a care home. It should not be assumed it is done out of ignorance, sometimes it is done as a deliberate "punishment". For someone who enjoys classical music to be subjected to the noise this individual was subjected to can have a major impact, eg such tactics are recognised in prisoner of war situations as a pre-interrogation technique to break people's spirit.**

**COMMENT: Re "***CQC do not investigate complaints"* **- I rest my case. As for the difference between CSCI and CQC, please note that David Behan was in charge of both regulators**.

**COMMENT: There have been various reports where the home has been rated as compliant despite plaster falling off the walls, filthy dirty skirting boards, heavily stained furniture and carpets. Other serious issues found to have been non-compliant are suddenly judged compliant and then non-compliant, which raises the question: if the plaster has been falling off the walls and they go back and still find it falling off, how could it ever have been rated compliant in the intervening periods?**

**<u>July 2015 The home is judged Inadequate</u>**.

Page 6 The inspection was brought forward from the date they had originally scheduled due to information received.

**COMMENT This means they were told the home was inadequate and they had to come in after the harm had been done.**

Page 7 "We found areas of Parkview that were unclean and presented a risk to people in relation to infection prevention and control. There was a staircase leading to the 2nd floor and we saw that there were several spillages in this area, which were not cleaned at any point during the day. Many of the toilets, baths, and bathrooms that were accessible to people were dirty and there were stains on the floor and on the toilet. One of the baths we saw had a dirty cushion from a wheelchair in it, another bathroom contained personal hygiene products including a bar of soap, flannel and towel. There was a smell of urine that was present in both the communal areas and


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some people's bedrooms. Carpets were dirty and in need of replacement. We also saw stains on the wallpaper and what appeared to be old food and drink on the walls and floor in two of the bedrooms we looked at."

"The registered manager told us the standard staffing levels were four care Staff in the day and two care Staff on the night shift. If the registered manager was working during the day they were included as one of the four care Staff."

**COMMENT: This home is registered and described by CQC in this inspection report as Parkview <u>Nursing</u> and Residential Home. Where are the nursing Staff and how many nursing homes in England has CQC wrongly registered as "Nursing"? I will go into further detail on this in our summary section.**

Page 7: "Some people living at Parkview require two staff to assist them with tasks such as visiting the toilet. This would leave two Staff to support the remaining thirty people. We also saw one person living at Parkview was frequently involved in tasks such as moving furniture, picking up rubbish and getting cushions for people."

**COMMENT: This is a Resident they are talking about, someone that *needs* care being used to provide care.**

Page 7 "During the inspection we had concerns with how the service managed risk, for instance, one person who lived at the home was judged to be at high risk of falls. However there was no record of any prevention measure in place to help keep this person safe. We observed this person during the day and noticed they were very unsteady on their feet. They had fallen at the home two days prior to the inspection. As a result the manager said that in order to prevent this happening again, this person had been placed under constant supervision by Staff, however we observed this person being assisted to walk by another Resident because there were no Staff present. This placed this person at risk of falling again."

**COMMENT: This placed the other Resident at risk also. Please note how people at high risk of falls are cared for in this nursing home. I will deal with this issue in more detail in the summary.**

***Page 8 "One member of Staff told us when they had raised safeguarding concerns with the registered manager that they felt the information had not been acted upon initially and had not been taken seriously."***


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Page 9 "The registered manager told us two satisfactory references would be obtained for all Staff before they started work. However, we found there was only one reference in one of the Staff member's files we looked at. The registered manager told us the other reference was probably in an email but had not been printed. After the inspection the provider sent us a copy of a second reference that had been obtained. This was dated two days after the inspection".

**COMMENT This home tells lies and yet still the regulator allows the manager to remain in post.**

Page 10 "At one point during the inspection we observed a person become agitated and grab the wrist of one of the two Staff members supporting them. The Staff asked another person living at Parkview for help and this person intervened to remove the person's hand from the Staff member's wrist".

**COMMENT Clearly neither the Staff ratios nor skills in this home can meet the needs of the Residents. If that is happening in front of the inspectors then what is happening every day when they are not present?**

Page 12 "One person told us *some Staff are kind, they can be grumpy but they're alright*. Another said *On the whole there are those who will do that little bit more but others who will do just what they have to do and no more*."

"We also observed some people were wearing soiled clothes."

"We found there were not many clothes in some people's rooms. A relative told us clothes were rarely hung up."

"We saw the service had installed CCTV in areas of the home including the lounge and communal garden. The cameras were not obvious in the communal areas and we could not see a sign advising of the presence of CCTV until this was pointed out by the registered manager. The sign was addressed to Staff and informed the Staff that it was present for the purposes of crime prevention, training and monitoring. We were told people had been consulted when it was first installed, however there had been no consultation since its installation over a year and a half ago."

**COMMENT: Re CCTV our report Reality (CCTV) Check shows that crime prevention, training and monitoring are the last things CCTV can achieve and that those homes which are installing it without consulting the Residents sum themselves up by that very fact.**

Page 13 "One person we spoke with told us they had spent most of the day in bed as there was nothing to do."


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"It became apparent that the registered manager did not allow people to watch television before 4pm. The registered manager told us this was to encourage people to interact with each other and to take part in activities".

**COMMENT Prohibiting people from watching the television until a set time shows an institutional attitude to care and complete disregard for Residents' choices and rights. I also note that people were not allowed to sleep in, they had to be up for breakfast at a certain time. Most people had to be out of bed by 8am in the morning. Again this reflects an institutional approach and lack of care.**

Page 15 "We received a mixed response when we asked Staff if they liked working at Parkview and if they felt they were treated fairly. One member of Staff told us *Everybody is friendly and gets on* and another said *The registered manager looks after their Staff*. However two Staff said they were not treated fairly and were not happy……they had raised issues in relation to staff welfare. They said their concerns had not been taken seriously…… the registered manager after the inspection ….said they were unaware of any particular issues".

**COMMENT: This is clearly not a home where Staff would raise concerns lightly or where any concerns would be responded to appropriately.**

**<u>September 2015: Inadequate rating.</u>**

Page 2 "Overall we found eleven breaches of the Regulations. These related to safety of the premises, safe management of medicines, infection control, assessment and management of risk….meeting nutrition and hydration needs, Staffing, training and assessment of needs and preferences, records and systems in place to monitor the safety and quality of service, and requirements relating to the registered manager. We are considering our enforcement options in relation to the regulatory breaches identified. We will report further when any enforcement action is concluded."

"Parkview Residential & Nursing Home is a large property built on three levels with a passenger lift to all floors. The home provides accommodation and nursing care for up to thirty-three people. The home did not provide and was not registered to provide nursing care at the time of our visit. The provider has requested that their name be changed to reflect this."

**COMMENT: The CQC are saying this home *did not provide and was not registered to provide nursing care at the time of their visit*, however they actually state in this report that this is a residential and nursing home.**


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**The report does not touch whatsoever upon these issues:**

- **at what point was this home changed to a residential home?**
- **what Residents were moved from this home who had nursing needs?**
- **what continuing care funding has been refunded to the NHS?**

**The home is saying they have no residents who require nursing care, however I can find no evidence that this was checked.**

Page 2 "We had concerns that the manager did not have the required skills to manage the service effectively".

**COMMENT: As far as I am aware, this manager has been in post and registered by the CQC as a fit and proper person for at least ten years. Raising the question if the person has not got the proper skills, why did the CQC register them as a manager?**

**Page 2** "We found a door in front of a steep staircase to the basement was unsecured on several occasions. We looked at records of maintenance which had shown the electric system to be unsatisfactory. Several faults had been identified by an electrician as requiring urgent or immediate action." The provider had not taken action to ensure the people living in the home were safe.

"Medicines were not managed safely. We found stocks of medicines that were not on people's medication records and found missing signatures on the records. We found two people had not received their medicines as prescribed. The home was not following it's documented procedures around medicines and stock control was poor."

"We observed a paddling pool that was set in the bath of a bathroom, accessible to people using the service that was not cleared up properly. The rationale for using this item was not clearly recorded."

**COMMENT: Commonsense would not be asking about the rationale, it would be to say: What on earth is this doing in the bath with urine and how long has it been there?**

Page 2 "We found not all Staff were providing support with moving and handling or had received the appropriate training. We also observed unsafe practice in relation to moving and handling. The service supported people with a wide range of needs, however no specialist training had been provided, for example in supporting people with mental ill health or drug addiction".

Page 3 "Whilst referrals had been made promptly to other health professionals, the records did not always demonstrate that advice in relation to food and nutrition was being followed. Staff


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told us they thought the records were not accurate. We looked at one person's records which appeared to have been amended between the first and second days of our inspection".

**COMMENT: Another clear item of evidence that records were being falsified, yet again the Police and Coroner did not consider this long history of evidence of past falsification.**

**Also, the home has now started to admit younger people with various health and mental ill health needs, to live alongside the frail elderly people with dementia. This should not be allowed. People with various different needs should not all be mixed into one care setting. It is neither fair on the younger people nor those with dementia and often can lead to a situation where Resident on Resident assaults take place. For example I have seen people with dementia wandering in a lounge where there are younger people with mental health needs who have lashed out at the older person when they have started to touch them. This home now seems to be pursuing a policy of fill the beds with anybody with care needs, regardless of what training Staff have in looking after people with drug or alcohol addiction alongside people with dementia. The staffing levels in this home add to the mix of a highly risky situation which is likely to lead to catastrophic consequences.**

Page 7 refers to "An external professional who was working with the service part-time on a temporary basis." The information we have received indicates this might be the current manager.

**COMMENT: We will return to this point later.**

Page 9 "However three of the six people we asked about Staffing levels told us there were not many staff on the night shift".

**COMMENT I will return to this point in my summary.**

Page 10 "Those staff members said it would be difficult to support people in an emergency situation, such as a fire. We asked the registered manager who would provide support to people requiring 2:1 assistance to people at the same time as ……or whilst one of the night Staff was conducting the medicines round. They replied *At the moment, no-one but we're open to suggestions.*

……on the 2nd day of inspection.....person fallen out of bed, this had occurred due to the person wanting to get to the lounge to sit with their friend. We asked why.....the manager replied *I've no idea, the night staff must have been busy."*


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Page 11 "One person's moving and handling risk assessments did not match the support currently being provided to them. Another person had moved to the home over two months prior to our visit and had no risk assessment in place."

**COMMENT: There are people being admitted to this home, the inspectors have no idea what their needs are, they just take the word of the home that nobody requires nursing care.**

Page 14 "From looking at care plans, and speaking with Staff we were aware that the home provided support to both younger and older adults and also people with a wide range of support needs. This included people living with dementia, people with drug and alcohol addiction, people with physical support needs and people with mental ill health. We asked the manager what training the Staff had received to assist…….. The registered manager told us Staff had not had much training but these people did not require much in the way of support."

**COMMENT: So CQC are aware what category of care this home is providing only when they inspect and look at care plans and ask Staff. Surely when a home registers to provide care, CQC should register it for providing that category of care. It should not be the case that inspectors turn up and discover by chance that this home is providing that category. In other words, the home is admitting whoever it wants, in order to make money, and then telling CQC afterwards. From looking at care plans and speaking to Staff, it is not what is on the CQC website. It gives the public a definite statement that this home provides specific categories of care so is another example of misleading information given to the public.**

Page 14 "On several occasions we observed poor practice in relation to moving and handling, such as people being lifted under their arms".

**COMMENT: I will deal with this in my summary.**

Page 16 "Some people living at Parkview had a high level of independence. We saw these people were free to access the community and free to come and go as they please."

**COMMENT: How are these people's addictions being managed? While this independence should be encouraged, this is a home where frail elderly people are living alongside younger people who freely come and go from the home, there is a clear risk to frail people living in the home but also to Staff who are not trained to deal with these issues. Drug or alcohol addiction should be a category of care that is totally separate. Letting people come and go is not caring for them.**


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**At no point throughout this report can I find any evidence that those Residents who had been residing in the home for some time, had been consulted about the changes the provider had decided to accommodate, and nor were their families consulted. If they had been, they may have had objections – unlike the CQC.**

Page 20 "Care plans, risk assessments and other documents were difficult to read due to the legibility of the handwriting in them. We found records of food and fluid intake indicated low levels of fluid intake that staff believed had been recorded incorrectly. On the first day of inspection we looked at one intake chart that indicated a low level of fluid intake and made the registered manager aware of our concerns. When we looked at the same record on the second day, it appeared that some of the numbers had been altered. We asked the provider to investigate this and report back to us. They told us…….no-one took responsibility for this and would provide training around record-keeping."

**COMMENT: Firstly this is not about training. This is deliberately falsifying records and the fact that it can be so blatantly done in front of inspectors indicates a culture where altering records is the norm. Asking the manager to investigate this shows a culture within the regulator of taking assurances at face value even when they discover irrefutable evidence themselves of serious criminal falsification of medical records.**

**No-one will take responsibility at the home or within the regulator so it will happen again and again.**

**Page 21 The CQC make a fuss saying it is no smoking, when in fact someone does smoke in the home, rather than the big issue of the home taking inappropriate categories of people and having no nurses.**

**<u>April 2016 Requires Improvement (ie it is not safe).</u>**

Page 4 "We found care plans did not always provide relevant information for staff……this includes missing information about epilepsy, diabetes and turning regimen".

"A new manager had started working at the home since our last inspection and registered with us in January 2016 although they were not present during this inspection."

Page 9 "We also saw no evidence of appropriate risk assessment being carried out by the service to mitigate such risks."

Re risk assessments: ".....generic statements copied and pasted.....In one, a male Resident had been referred to as female with the wrong name..... At the time of the inspection there were 20 people living in at the home and only 9 PEEPS were in place."


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Page 10. We also saw no evidence of risk assessments being conducted relating to falls and Waterlow. A Waterlow chart would identify the potential risk of a person developing pressure sores. We saw there were blank Waterlow documents in care plans, however these were incomplete. The deputy manager told us falls risk assessments had not been completed but would do so immediately following the inspection. According to the accidents and incidents records, one person had fallen from bed on four occasions."

Page 10 "However we found further on ongoing concerns with regard to other aspects of medicines handling of all eleven people whose medication records we looked at".

Page 11 "The stock levels and usage of controlled drugs, such as morphine, must be recorded.....we found such drugs were not recorded in the controlled drug register.....legal requirement."

"We found there were enough staff working at the home to care for people safely. The home was unable to take new admissions and as a result there were only twenty living in the home."

**COMMENT: In other words an embargo had been placed on new admissions.**

**The report goes on to say the home has improved in other areas whilst being inadequate regarding safety. However I can find no evidence of any improvement and in fact enforcement action should have been taken on serious concerns long ago. Example: Is the service effective? The inspectors say the home has improved, however on the same page we find the following quote:**

Page 13 " ....which had also been raised as an issue at the last two inspections."

**COMMENT: The home is not safe, and even though the other areas have been rated as improved, the overall rating has gone from Inadequate to Requires Improvement.**

**However this is often the case at the points where CQC should take enforcement action to close a home that is suddenly rated as improved with little evidence, then subsequently harm is suffered by people because of the CQC's lack of action.**

**<u>April 2016 Rated Good all areas</u>**

**COMMENT:**

**This is incredible given the number of things that were wrong and I find it hard to believe a home can improve that much in eight months. Looking at the evidence for this, people said they were happy, which they also said in the reports which were dire.**


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**At the time of the inspection there were seventeen people living at the home, it was still only half full. They have a safeguarding and whistleblowing policy in place but I do not regard that as evidence of improvement.**

**COMMENT: The biggest abuse is putting people at risk through mixed dependencies when there are neither the skills nor the Staffing to provide for mixed categories.**

**On page 8 one of the five people whose medicine was checked by inspectors, did not have their medicine available. I fail to see how this is evidence of good management, just because the manager rang and obtained them after this was raised by the inspectors. What if the missing medicines were painkillers and the person remained in pain – how long for? Until the next CQC paid a visit and noticed?**

**There is a cosmetic paper trail of guidance for "what if" situations to satisfy the easily satisfied CQC.**

**The main body of the report is page 6 to 18, around twelve pages about policies and procedures. Policies and procedures were in place on the Herald of Free Enterprise but people still died.**

The following information was passed to us by a source who may have been a member of the public, a Staff member, or a relative as we receive information about care homes from many sources, and given the past history of this home the information chimes to be truthful.


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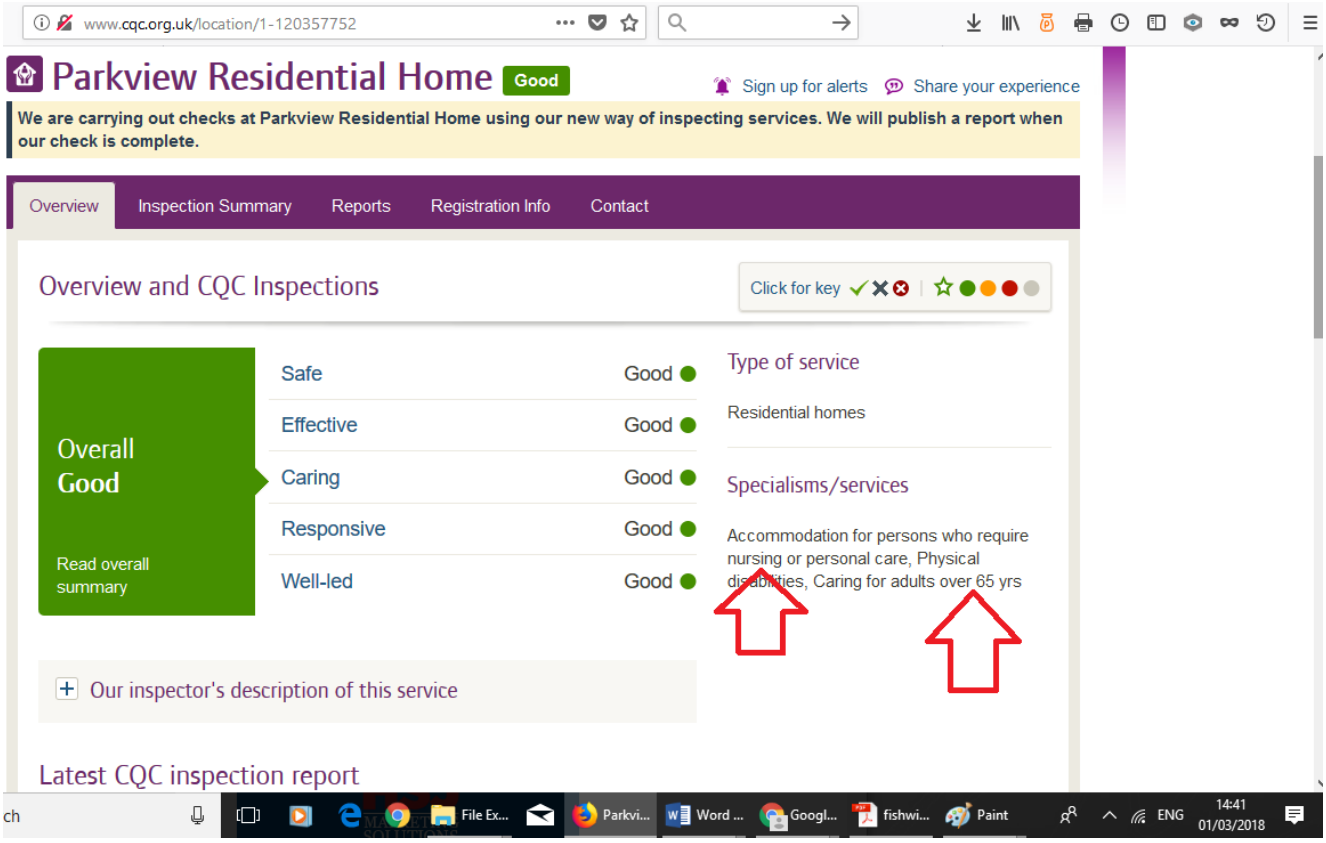
## Section Two: The Current Situation

**CQC website screenshot taken 01.03.18:**





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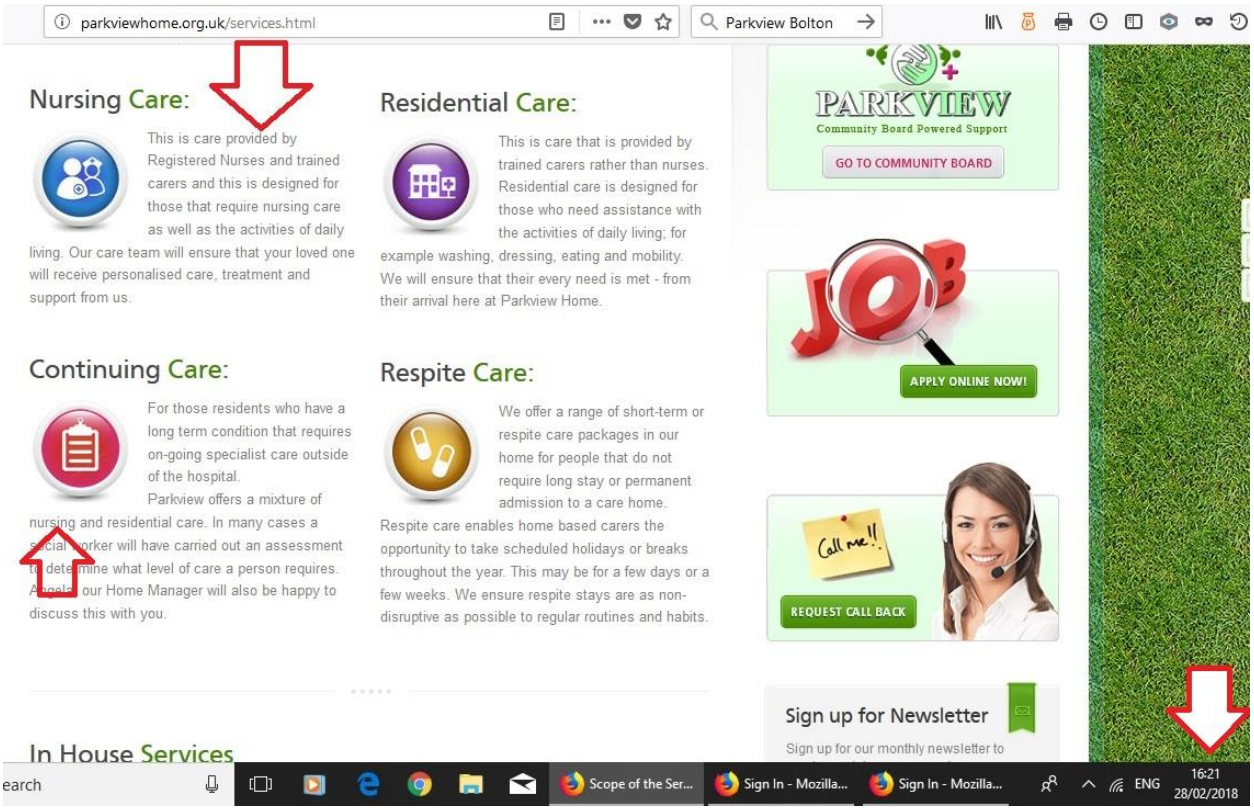
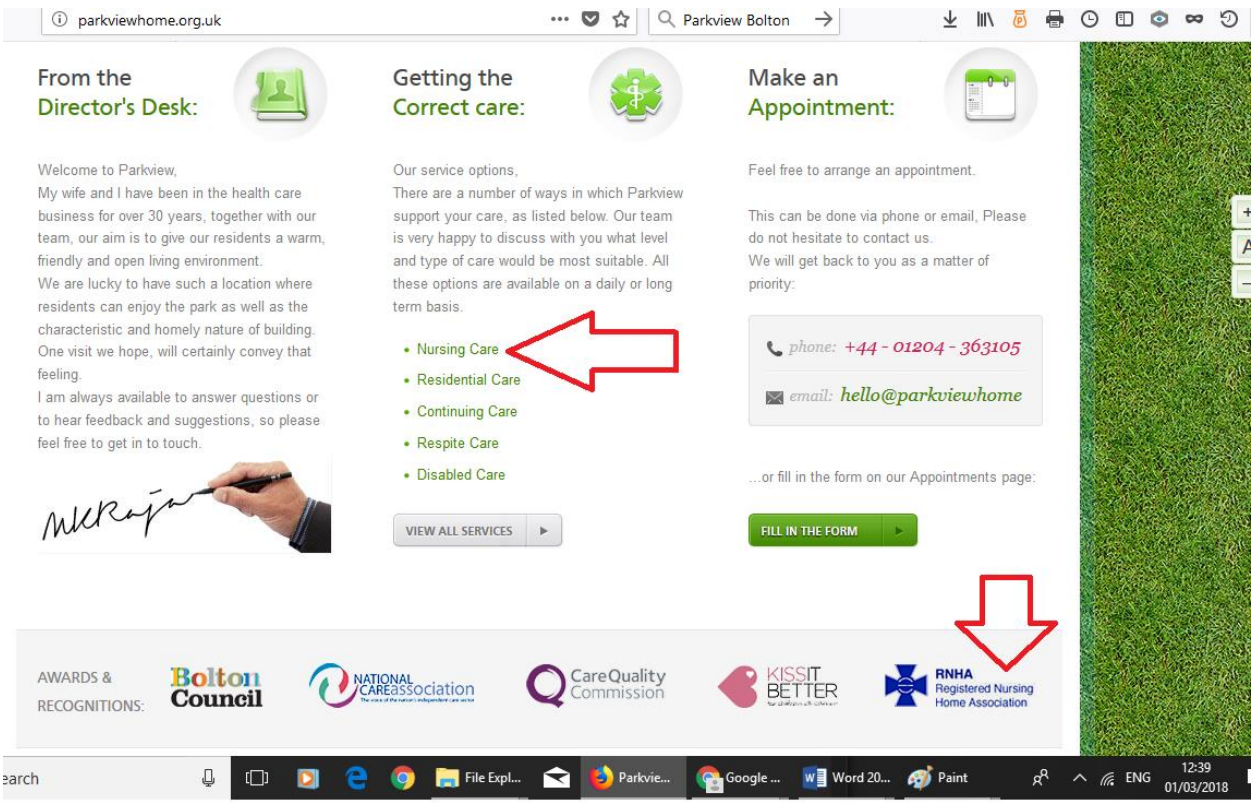

parkviewhome.org.uk/services.html
Parkview Bolton
Nursing Care:
This is care provided by Registered Nurses and trained carers and this is designed for those that require nursing care as well as the activities of daily living. Our care team will ensure that your loved one will receive personalised care, treatment and support from us.
Residential Care:
This is care that is provided by trained carers rather than nurses. Residential care is designed for those who need assistance with the activities of daily living; for example washing, dressing, eating and mobility. We will ensure that their every need is met - from their arrival here at Parkview Home.
Continuing Care:
For those residents who have a long term condition that requires on-going specialist care outside of the hospital.
Parkview offers a mixture of nursing and residential care. In many cases a social worker will have carried out an assessment to determine what level of care a person requires. Alternatively our Home Manager will also be happy to discuss this with you.
Respite Care:
We offer a range of short-term or respite care packages in our home for people that do not require long stay or permanent admission to a care home. Respite care enables home based carers the opportunity to take scheduled holidays or breaks throughout the year. This may be for a few days or a few weeks. We ensure respite stays are as non-disruptive as possible to regular routines and habits.
PARKVIEW
Community Board Powered Support
GO TO COMMUNITY BOARD
JOB
APPLY ONLINE NOW!
Call me!!
REQUEST CALL BACK
Sign up for Newsletter
Sign up for our monthly newsletter to
In House Services
Scope of the Ser...
Sign In - Mozilla...
Sign In - Mozilla...
ENG
16:21
28/02/2018


parkviewhome.org.uk
Parkview Bolton
From the Director's Desk:
Welcome to Parkview,
My wife and I have been in the health care business for over 30 years, together with our team, our aim is to give our residents a warm, friendly and open living environment.
We are lucky to have such a location where residents can enjoy the park as well as the characteristic and homely nature of building. One visit we hope, will certainly convey that feeling.
I am always available to answer questions or to hear feedback and suggestions, so please feel free to get in to touch.
Getting the Correct care:
Our service options,
There are a number of ways in which Parkview support your care, as listed below. Our team is very happy to discuss with you what level and type of care would be most suitable. All these options are available on a daily or long term basis.
Nursing Care
Residential Care
Continuing Care
Respite Care
Disabled Care
VIEW ALL SERVICES
Make an Appointment:
Feel free to arrange an appointment.
This can be done via phone or email, Please do not hesitate to contact us.
We will get back to you as a matter of priority:
phone: +44 - 01204 - 363105
email: hello@parkviewhome
...or fill in the form on our Appointments page:
FILL IN THE FORM
AWARDS & RECOGNITIONS:
Bolton Council
NATIONAL CAREassociation
CareQuality Commission
KISSIT BETTER
RNHA Registered Nursing Home Association
File Expl...
Parkvie...
Google ...
Word 20...
Paint
ENG
12:39
01/03/2018

## Section Three

### What Compassion In Care Discovered

We sent the following email to the Coroner's court, Greater Manchester Police and Bolton Safeguarding. The inquest was attended by Compassion In Care. The accompanying statements have been provided by us with permission given by the Fishwick family to publish.

**20th February 2018**

**To the Coroner**

**Bolton**

**(Sent by email)**

**An inquest is to take place this Friday 23rd February 2018 regarding the death of Millicent Fishwick who died at Park View Residential Home in Chorley Bolton BL1 4AP.**

We are a registered charity which supports whistleblowing staff who have concerns, as well as relatives of people who have concerns about care. We also receive concerns via visitors to the home and others and it is in this capacity that we have been contacted today by someone who does not wish to be identified, who has passed to us the following detailed information which we are bringing to your urgent attention as we believe criminal offences have been committed and that people currently residing in this home are at serious risk and we have the express permission of the source to have this evidence entered for the inquest.

I will also be contacting the Police to whom I have permission to pass this information.

We are quite happy to go on the record as a charity regarding the information but we will not disclose the source.

The information is as follows:

The manager of the home has asked Staff to falsify care records to be presented at the Coroner's court on Friday 23rd February 2018. Staff have been bullied into going to court to back up the manager.

The following information shows the circumstances in relation to Millicent Fishwick's death are continuing and causing high risk to other vulnerable people in this care home.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The following examples of such risks have been highlighted to us:

The manager sleeps in the home up to six days a week around the clock. People in the home are at high risk of falls and are suffering falls on every shift. Many of the Residents are covered in bruises, others are in pain either from ongoing conditions or from injuries incurred by a fall.

There is corroborating evidence in numerous Bruising Charts which Staff have completed.

Staff raising concerns that an ambulance should be called have been ignored.

There is also corroborating evidence in a cleaning book which is located in the laundry/linen area of the home, showing examples of care Staff being asked to do cleaning and highlighting just one of the recent serious falls, where an ambulance was not called, but where the home manager had logged that the carpet in room 9 needed to be cleaned because it was covered in blood.

Staff have been texted and called at all hours when off duty to be told what they will be allocated to do when they come in, ie admin and cleaning duties out of the care hours, and there are written records available to show that Staff are being asked to do cleaning, administration, leaving one member of Staff to care for all the 33 residents.

The falls that are happening on an hourly basis are not being reported to the authorities, most of the people in the home are covered in unexplained bruises.

Two cleaners recently left the home and need to be interviewed, because they intervened.

Also a deputy manager of the home recently left in similar circumstances.

One resident was in serious pain and constipated for ten days because medication that he was prescribed had not been ordered.

Many people prescribed pain relief or other medication do not receive it because the manager says they do not need it.

Moving and handling is putting people at serious risk of harm because of the staffing levels, for example a lone carer should not be using the hoist.

The Staff are all good but many are too frightened to whistle blow.

One Resident for example has brittle bone disease and Staff have been told routinely to draglift her.

Call bells continually ringing, people falling because Staff cannot get to them in time.

One Resident was described as "vomiting faeces".

One woman has a huge lump on her back as a result of a fall.

Another person is falling three or four times on each shift.


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Seven people are bedbound but there are not enough Staff to attend to their needs, so they are often soaked in urine, not turned to prevent pressure sores.

The male Residents have had the chargers removed from their electric razors by the manager, who has arranged for some person to come in and then shave the men at £10 a time.

People are not washed properly and not bathed.

No temperature checks have been done on the hot water in the bathrooms.

**The investigator needs to look at the Staff handover book located in the office**.

In around December 2017 the manager stitched the head (not butterfly stitching) of a Resident instead of taking them to hospital.

Many people are crying in pain, not given pain relief.

Staff are bullied constantly, and are being bullied and harassed if they try to call for a GP or an ambulance.

Some care Staff have been told by the manager to clean people's rooms in the middle of the night.

It is a dangerous high risk situation. Staff do not trust CQC. Staff felt they would not be believed because the home is rated "Good" by the CQC.

**The manager told Staff that "the CQC won't do anything about concerns because I trained the local inspectors myself."**

Some Staff have no contract. The manager has been having Staff handover talking about the Millicent Fishwick case and trying to influence Staff who are going on Friday.

I note as in 90% of the concerns we receive re care homes that the homes are rated "Good" by the CQC, as is Parkview Care Home, and in my view has led to the situation where the Staff do not trust the CQC as a consequence.

The manager has repeatedly refused Staff requests to call for ambulances. One woman who was seen to have had a serious fall and was bleeding badly, the manager refused to call an ambulance.

Yours faithfully

**Eileen Chubb**

**Founder & Director of Compassion In Care**


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**Failures in investigation by the authorities**

Unfortunately the evidence given by Compassion In Care to the authorities was not properly investigated, firstly by the **Police**, or otherwise they would have discovered the same evidence of falsification of care records which was a longstanding inherent culture within this home.

The investigation undertaken by CIC has uncovered clear evidence in public documents of an inherent culture in Parkview involving the falsification of care records. Had the concerns passed to Police been investigated they equally could have uncovered this evidence. Alas this was not the case, therefore there will be clear procedures in Edna's Law for the investigation of such issues in future.

The following pages contain statements to the inquest and our comments.


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**The Police investigation into the concerns raised by Compassion In Care**

RESTRICTED (when complete) MG11

Page 1 of 4

**WITNESS STATEMENT**

CJ Act 1967, s.9; MC Act 1980, ss.5A(3)(a) and 5B; Criminal Procedure Rules 2005, Rule 27.1

URN

RECEIVED 21 FEB 2018

Statement of: **Matthew Fraser Moore**

Age if under 18: Over 18 (if over 18 insert 'over 18') Occupation: Detective Inspector

This statement (consisting of 3 pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything in it, which I know to be false, or do not believe to be true.

Signature: ..... Date: 20/02/18

Check box if witness evidence is visually recorded ☐ *(supply witness details on last page)*

I am Detective Inspector 08162 Matthew Moore of the Greater Manchester Police currently stationed at Wigan Police Station.

It is the policy of Greater Manchester Police that deaths deemed to be a Specia Procedure Death will be investigated by operational detectives. Special procedure deaths are defined as:

- Death of a person under the age of 18 years
- A drug related death
- Apparent Suicide
- Death resulting from an accident, which is not as a result of a road collision

Investigations into such deaths will be dealt with by the duty Detective Inspector unless there are exceptional circumstances that prevent this when a suitably qualified Detective Sergeant under the direction of the Detective Inspector will carry out enquiries. In relation to these investigations appropriate enquiries will be made to ascertain if there are any suspicious circumstances surrounding the death.

This statement concerns the death of Millicent Irene Fishwick b.30/05/1940 and who died at Royal Bolton Hospital on 5th December 2018. At the request of HM Assistant Coroner I have today carried out a review of the circumstances of Millicent's death to establish if there any suspicious circumstances or third party involvement.

I have reviewed of the statements already provided to HM Coroner, the post mortem report and copies of Millicent's care notes from the care home in which she was resident at the time of her death. I have also been provided with a copy of an e mail from Millicent's daughter Joanne raising concerns about the standard of care at the care home along with an email from Compassion In Care a charity that assist people raising concerns

Signature: ..... Signature witnessed by: .....

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about the standard and quality of care in residential and nursing homes in which there are allegations that the manager has asked staff to falsify records to be presented at Coroner's Court and bullied staff into going to court to back her up.

From my review I note the following Park View 54 Chorley New Road Bolton provides both Resident'al and Nursing care. Millicent and her husband Gordon had recently become resident. Gordon has dementia and Millicent had been in hospital and the family had been looking for a care home where they could be together. Millicent was discharged from hospital on the 17th October 2017 and went to Park View she was welcomed and appropriate assessments of her needs were documented. The requirement for residential care was because Millicent required assistance with day to day care though she was assessed as being independent. She used a Zimmer Frame to assist in moving around and her risk assessment indicated that if she was going further than 15 metres she would require the assistance of one member of staff. She was capable of going and using the toilet herself.

The documentation I have seen has highlighted some problems with the ordering of medication for Millicent after her arrival at Park View and it also documents a changeover of staff senior staff between the time of Millicent's arrival at Park View and just prior to her death. Examining the documentation I could find no evidence that it had been altered or falsified in general it was a contemporaneous record of Millicent's daily life at Park View.

I note that in general Millicent was checked on hourly however there are gaps in the Resident Hourly Check sheets. These are mainly during waking hours and I have not seen them for the month of November.

My investigation however focuses on the reason for Millicent's death and from the witness testimony and further enquires that have now been made with an additional witness Risha Chapman I am satisfied that Millicent had a fall whilst returning from the toilet to her room which was just across the corridor. At the time Risha Chapman was attending to Gordon Fishwick and hearing a scraping noise looks up to see Millicent fall and bang her head. As a result Millicent sustained a bruise to her right lower leg, the bridge of her nose and bit her lip. Staff at the home tended to Millicent's immediate needs and informed her family. They monitored Millicent through the night and at about 03.45 finding her to have deteriorated called 999 for an ambulance. Records also indicated that following Millicent's fall staff contacted 111 and received a call back from a GP




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who provided advice. Sadly after admission to hospital it was found that Millicent had a large left sided subdural haematoma with significant mid line shift that was not survivable. This was confirmed at post mortem with the provisional cause of death being given as 1a Subdural Haematoma 1b. Fall and Head Injury. There is a comment from the pathologist that "it is recognised that the head injury causing the subdural haematoma may relatively minor in elderly people".

I am satisfied that there are no suspicious circumstances or third party involvement in the death of Millicent Fishwick. The fall was accidental and most likely resulted in the subdural haematoma. In respect of third party involvement I have considered whether any person or organisation was in breach their duty of care in such a way as to be grossly negligent. Millicent was assessed as independent and could move short distances on her own with a Zimmer frame and could go to the toilet herself. This is documented in her care notes and she does this on a daily basis. At this time of her fall this is what she was doing and therefore there was no requirement for her to be assisted. The care staff on site where abiding by care plan in place for Millicent. Following the fall whilst the documentation is brief as to what actions were taken it is clear that observations of Millicent were done as she was found clammy and unresponsive by staff carrying out those checks. I therefore find that no one person has been grossly negligent in their duty of care.

In terms of the home again plans, policies and procedures are in place to ensure residents wishes and needs are respected and fulfilled. Therefore I find there is no grossly negligent breach of a duty of care on behalf of the home.

I conducting my review I have also taken account of the concerns raised by Millicent's family about the standard of care provided to their mother and I considered whether any person working at the home or the home itself are liable under section 20 or 21 of Criminal Justice and Court Act of Ill Treatment or Wilful Neglect I can find no evidence of this either.

Finally I note the families wider concerns have already been forwarded to the Quality Team at Bolton Council and I have raised the matter with the Public Protection Investigation Unit at Bolton Police Station for them to progress appropriately under Adult Safeguarding Procedures.




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**COMMENTS on Police investigation:**

1. Why did the Police and Coroner not ask for nursing observations charts, which would be standard documents to present to an inquest following a death in a nursing home and are conspicuous by their absence in this case?

2. *"At the time Risha Chapman was attending to Gordon Fishwick and hearing a scraping noise looks up to see Millicent fall and bang her head."*

What is the basis for Detective Inspector Moore's statement? Because Risha Chapman very clearly **did not** state she had seen Mrs Fishwick *"bang her head",* quite the opposite in fact: Risha Chapman stated*: "**I did not see Milli bang her head…."***

3. DI Moore stated "*Parkview……provides both Nursing and Residential care*" so he has mistakenly assumed that 24 hour nursing care was being provided when in fact it was not.

4. DI Moore stated: *"I therefore find that no one person has been grossly negligent in their duty of care."* NB The duty of care in a nursing home staffed by trained nurses is not the same as in a residential home staffed by care assistants with no clinical qualifications.

5. Edna's Law will investigate not only "suspicious" deaths but also neglect in care settings and elsewhere.


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**Joanne Fishwick's statement:**

RESTRICTED (when complete) MG11

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**WITNESS STATEMENT**

**Criminal Procedure Rules r 27.2; Criminal Justice Act 1967, s.9: Magistrates' Courts Act 1980, s.5B**

**URN :**

Statement of: **Joanne Claire Fishwick**

Age if under 18: **Over 18** (if over 18 insert 'over 18') Occupation: **School Teacher**

This statement is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything in it, which I know to be false, or do not believe to be true.

Signature: Date: **25/01/2018**

J C Fishwick

RECEIVED 31 JAN 2018

Check box if witness evidence is visually recorded *(supply witness details on last page)*

I am Joanne Claire Fishwick and I reside at 18 Martin Avenue, Farnworth, Bolton.

I make this statement in relation to the death of Millicent Irene Fishwick who died on 5 December 2017 at The Royal Bolton Hospital, Minerva Road, Farnworth, Bolton.

Millie Fishwick was my mother and I would like to take this opportunity to tell you a little about her life.

My mother, Millie was born on 30 May 1940 in Bolton. Her maiden name was Gregory. Her parents were Edwin and Alice Gregory, unfortunately Edwin never returned from the war as he passed away in a prisoner of war camp. From this marriage they had 4 children, Mavis, Bob, Sylvia and Millie. Alice remarried on 17 March 1951 and her new husband was Edward Murphy, who brought up the children as his own. They then had a further child together, Tony.

My mother married Jack Cooper on 21 June 1961 and from this marriage had 3 children, my sisters Sharon,, Gillian (who is deceased) and Tracey. Jack passed away and Mum then married Gordon Fishwick date of birth 07/05/1933, on 4 March 1970. They then had a further two children, Julie and myself, Joanne. Gordon adopted the three other children.

My mother was a retired Baker and my father a Foreman Resin Worker.

Up until 2009 life was normal, she was fit and healthy. She enjoyed dancing, rock and roll, jive, this kept them both fit.

RESTRICTED (when complete) MG11


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In 2009 my mother was diagnosed with breast cancer and my father with dementia. Due to health problems they moved to warden controlled living, Weavers Court in Bolton.

My mother had chemotherapy treatment for the breast cancer and went into remission. Later the cancer returned, this time in her ear. Again she received treatment and went into remission. She had two strokes but her speech and movements were not affected.

Life continued, they would spend time with family and enjoyed days out. My fathers dementia was progressing slowly and mum was doing well. She did have recurrent chest infections for which she needed hospitalisation on several occasions. Each time our family had to become a carer for my dad.

In early 2017 it was felt that carers were needed to assist them. Carers came in twice a day at first but this increased to 4 times a day to care for both mum and dad.

In July 2017 mum had a fall off a pavement and fractured her neck of femur. She underwent an operation to fix the fracture and she recovered really well from this.

In September mum developed another chest infection and tests showed it was an abscess on her lung. She was hospitalised again. We all rallied around to look after Dad, we had been looking for a residential care home which would take both mum and dad together. An opportunity came up at Park View Residential Care Home, Chorley New Road, Bolton. They would take both mum and dad.

Dad moved into Park View on 25 September 2017 and mum moved in on 17 October 2017 when she was discharged from Royal Bolton Hospital.
We had some teething problems at the beginning with medication and with Dad still being very dependent upon Mum, staff should have intervened. Wendy Baker Dickinson, Director of Services had a meeting with us to sort though the issues, it became clear through that meeting that Jill Booth and her had underlying issues.

We trusted that the issues were going to be resolved but sadly that was not the case. We permanently had ongoing issues. Wendy always promised they would be sorted. We felt that paperwork was being forged and completed either before the evening or after, much later.
We feel that we were not informed of all incidents at the home, or if we were only given partial information.

Jill Booth, was the manager at this point but left in December prior to mum's fall.

On 4 December 2017 I was contacted by Wendy Baker Dickinson at 22.45 to advise that mum had had a bit




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of a fall. Mum had overbalanced whilst walking back to her room from the toilet when she had reached for her room door handle. Wendy said I didn't need to worry that mum was fine just a bit shaken, she had fallen onto her knees and that she had banged her shins and lip on the zimmer frame. She would ring 111 to be on the safe side but she did not think that mum would need to go to hospital.

She reassured me that she would keep a close eye on mum and monitor her closely. She asked not to let mum know that I knew she had fallen because according to Wendy mum had requested that she did not tell us that she had had a fall. She didn't want mum to hide things from her if she broke her confidence. In the same conversation she asked if we had put in an official complaint regarding the medication and also in relation to the way she had spoken to one of my sisters.

I told her that we hadn't as I thought we had worked though everything. Ended call on a positive note saying she would monitor mum and not to worry.

I received a call at 3.53hrs and that was from Wendy asking me to go to Park View as mum's condition had deteriorated. I told Wendy to ring am ambulance and I would get there as soon as I could.

I then received a further call from Wendy at 03.59hrs telling me to get there quick as mum was deteriorating. I asked had she rang for an ambulance and she said she had. I told her I need to get off the phone to carry on getting ready to go down to Park View.

Stuart my partner rang my other sister, Julie, and told her to get down to Park View. I called Sharon to let her know as well. Sharon then rang our other sister Tracey in Cornwall.

When I arrived at Park View my sister Julie had arrived. My mum was unconscious on her bed and she had been incontinent of urine and a fast response paramedic was with her. Wendy and my sister Julie took my father to the dining room to stop him becoming distressed. Wendy stayed with dad and Julie returned to the room. Talking to mum, reassuring her we were there. Her eyes fluttered briefly and she took one sharp intake of breath and then appeared to stop breathing. We assisted the paramedic to get mum on the floor and the ambulance crew arrived and we left them working on mum whilst we made or way to the Royal Bolton Hospital.

Mum was in resus for a while and when we were allowed to see her she was on life support and we were told she had suffered a massive bleed on the brain. The doctors were consulting with the surgeons at Salford Royal Hospital to see if the bleed was operable. Eventually they confirmed it was inoperable and they would be turning off the life support machine.

We asked if we could wait for my sisters to arrive before turning off the life support but we were told this




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was not possible.
Myself, my partner Stuart and my sister Julie were with mum when she died but my other two sisters Sharon and Tracey couldn't be there which was very distressing for them.

At the time mum died we accepted Wendy's explanation of what happened but in light of recent events with dad we now suspect that mum's fall was more serious than we were led to believe and that the fall caused the bleed which led to her death.

We have also since learnt that no one actually witnessed mum falling so we don't know how long she was on the floor for or how closely monitored or even whether 111 was actually called to assess her. We just have Wendy's version of events.

We entrusted our precious mum into your care, expecting her to be looked after and to have her basic care needs met. She wasn't just a resident – she was our mum and we feel badly let down.

Millie is dearly loved and dearly missed by all her family and friends. She was like a second mum to a lot of people. She was unselfish and always put other people first often to the detriment of her own wellbeing. She was fun loving, funny, a great cook, a great wife and a great mum, grandmother and great grandmother. She overcame some enormous obstacles in her life with a great sense of humour. She will be forever in our hearts.




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**COMMENT**

**I share the concerns of the Fishwick Family that the events relating to the two falls and hospitalisation of Mr Gordon Fishwick was relevant evidence into the circumstances of Mrs Millicent Fishwick's death. However the Coroner did not allow this information.**

**Also the Coroner did not deal with the current information supplied by Compassion In Care that falls and lack of medical treatment are an issue at this care home currently.**


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**Statement of Senior Carer Risha Chapman:**

RECEIVED
21 FEB 2018

MG 11

RESTRICTED (when complete)

**WITNESS STATEMENT**

(CJ Act 1967, s.9; MC Act 1980, ss.5A(3)(a) and 5B; MC Rules 1981, r.70)

URN

Statement of: Risha Chapman

Age if under 18: Over 18 (if over 18 insert 'over 18') Occupation: Carer

This statement (consisting of 3 pages each signed by me) is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated anything in it, which I know to be false, or do not believe to be true.

Signature: ..... Date: 20th February 2018

Check box if witness evidence is visually recorded ☐ *(supply witness details on last page)*

I am Risha Chapman and on the 10th June 2016 I was hired as a Senior Carer at Park View Residential Care Home based on Chorley New Road, Bolton. I would normally work nights at the care home working from 8pm till 8am and have been a Carer for the past 12 years.

I have been asked to make a statement in relation to the death of Mrs Millicent Fishwick who I knew as 'Milli' and sadly passed away on the 5th December 2017.

Milli became a resident at the care home in October 2017 shortly after her husband Gordon Fishwick. Gordon Fishwick came into the home suffering with dementia and both he and Milli shared a room together which was either Room 12 or 12A.

They later moved to a bigger room which was room 18.

On the 4th December 2017 I was working nights at the care home working from 8pm to 8am. At the time we had two other members of staff on duty called Ellise Magan and Nioma (can't remember her surname). The manager Wendy Dickinson was also present. The care home was almost full with approximately 26 to 28 residents.

I was on my 'Med's' round at approximately 10pm when I was giving medication to Gordon Fishwick in room 18. Milli wasn't in the room as I was giving Gordon his tablets. As I was just finishing I heard the door handle

Signature: ..... Signature witnessed by: .....

2004/05(1) MG11

MG 11 (cont)

RESTRICTED (when complete)

URN

Statement of: Raha Chapman

turning to open and then the scraping of metal on the door as it swung open. As I turned to look what it was it was clear that Milli had fallen on entering the room and had fallen onto her Zimmer frame. The scraping sound on the door was clearly the Zimmer frame as Milli fell over through the door. I did not see Milli bang her head but it was close to the wardrobe when she landed on the floor. She was face down on the floor and stuck in the middle of the Zimmer frame. Milli was screaming in pain so I immediately went over to her and saw that Elise was walking past and asked her to get Wendy Dickenson the care home manager who is registered nurse. Wendy must have been close by as she was with me after a few seconds as I started to do a top to toe survey of Milli.

I noted that Milli had blood coming from her lip that may have been from her biting her lip as a result of the fall and she also looked as though she had bruised her shins as she hit the frame of the Zimmer. Wendy came and gave Milli some reassurance and checked her over as well. Wendy asked me to assist her in getting Milli to sit up and then assisted in getting her into a chair.

Elise then put Milli to bed whilst I started completing paperwork in relation to the accident.

Wendy then asked me to ring 111 and ask for advice as it was possible that she had a head injury due to the fall and the fact that she had also been sick. NHS direct informed me to monitor Milli who was sat up in bed.

I then continued to complete the paperwork for the accident until in the early hours of the morning when Wendy informed me to ring for an ambulance as Milli had lost consciousness and was unresponsive. I called for an ambulance and was told to wait at the front of the care home to show the paramedics to her room. After only a short wait I showed the Fast response paramedic to her room and was asked to contact Milli's family. I rang one of her daughters and informed her of the accident and she stated that she would tell her other sister and be straight over. I then waited for the ambulance and showed them to Milli's room. The family also arrived very quickly.

I could now see that Milli was being given CPR and Wendy took Gordon her husband out of the room so that he would not get distressed at what was happening. I was later asked to get a wheelchair for the paramedics

Signature: ..... Signature witnessed by: .....

2003(1) MG11 (cont)

MG 11 (cont)

RESTRICTED (when complete)

URN

Statement of: Risha Chapman

in order to get Milli out to the ambulance. I photocopied Milli's Medication Administration Records and her Careplan and handed them to the paramedics before they left.

It was approximately 4am when Milli left the home and I was informed at about 8.45am that Milli had passed away. I completed the accident documentation and handed it to Wendy.

In January 2018 I left Park View Residential Care Home and started a new job at another care home.

I am willing to attend coroner's court and give evidence.

Signature: ..... Signature witnessed by: .....

2003(1) MG11 (cont)


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**Key points noted by Eileen Chubb which should have been obvious also to the Coroner and Police:**

Ms Chapman's statement refers to her going to work at Parkview in 2016. I query if she was aware it was meant to be a nursing home and whether she was aware that there was supposed to be nurse on duty at all times.

1. I note she makes clear reference to blood coming from Millie's lip and "*Wendy asked me to ring 111*." She makes clear reference to Wendy Dickinson asking her to ring 111 even though Ms Chapman was not clinically qualified to understand the advice and Wendy Dickinson as a clinically qualified nurse should have undertaken this task.

2. Another important point is that Ms Chapman makes clear reference to the fact that Millie had been sick prior to this call. Her statement includes clear reference to Wendy Dickinson being fully aware that there is a possibility of head injury due to the fall.

3. It is clearly established that the possibility of a head injury has been acknowledged prior to that first call. (Wendy Dickinson's statement is below the falls protocol which follows).

4. Risha Chapman stated "*On the 4th December 2017 I was working nights at the care home, working from 8pm to 8AM. At the time we had two other members of Staff on duty called Ellise Magan and Nioma (can't remember her surname). The manager Wendy Dickinson was also present*."

**COMMENT:** This care home is listed by CQC in the most recent reference to care staff numbers as having three care workers on duty for the night shift. Ms Chapman quite clearly states her duty hours and states that two other named staff were also on duty with her. She then makes reference to the manager Wendy Dickinson being present. It would have been more usual to say Wendy Dickinson was on duty as the nurse for this shift but she does not say this, she just states she was there.

When an incident like this occurs, whether running either a nursing or residential home, it would be usual to name those staff who were on duty officially because if someone was present such as Wendy Dickinson who was not officially on duty would that not raise questions about the home's liability insurance and clinical accountability regarding which named staff were making clinical decisions, as Wendy Dickinson was? There are also implications regarding the Working Times Directive.

In a situation like this it seems that no-one knows exactly where the accountability lies, or who should be doing what tasks, and we ask also, who is providing nursing cover on nights when Wendy Dickinson is not sleeping overnight on the premises?


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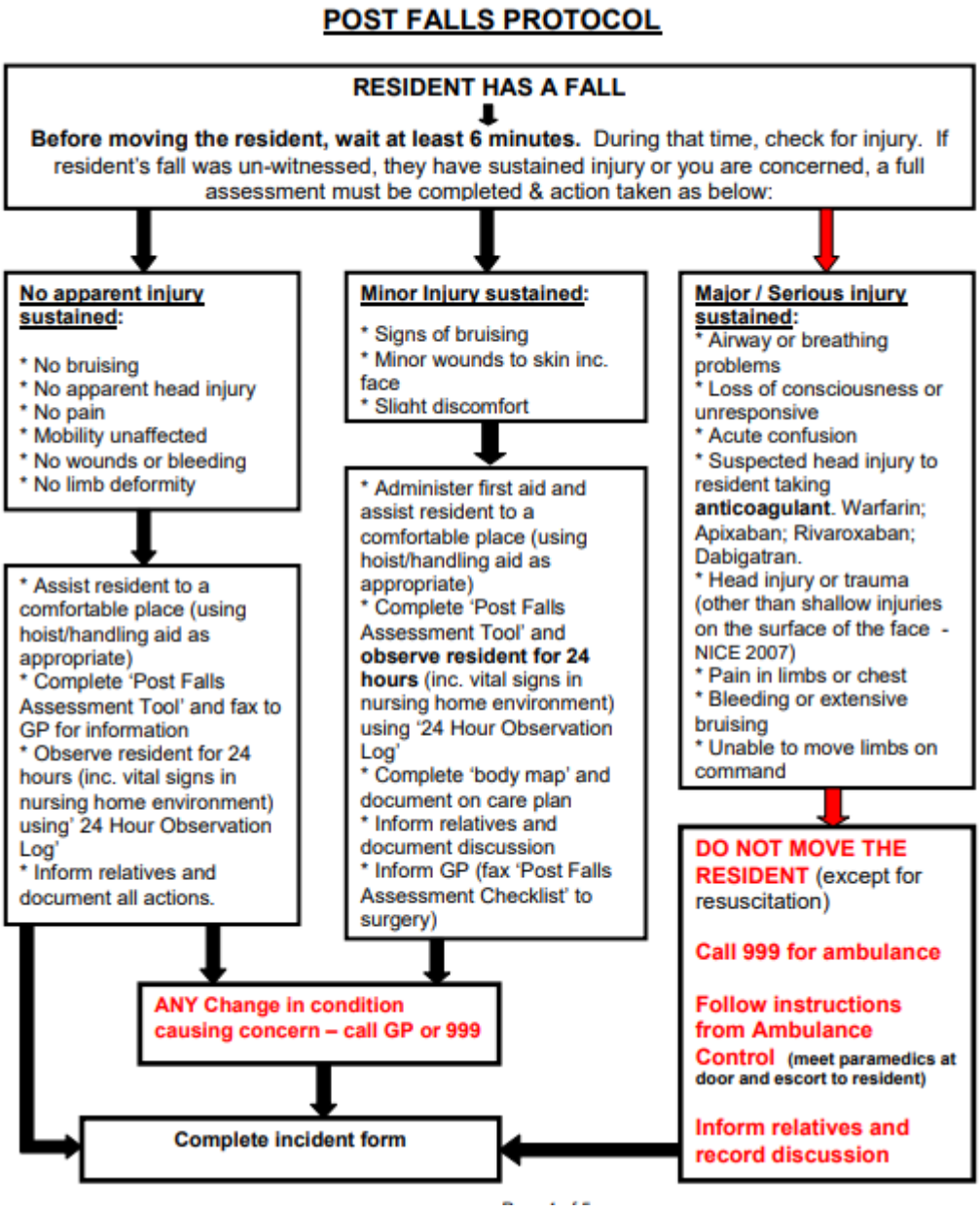
The following documents are from our online search for guidance for care home Staff re monitoring basic observations for suspected head injuries. They clearly define the protocols for post-fall observations in nursing homes. Please note that at no time are these observations undertaken by HCAs but the guidance defines nursing observations.







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**Duty Officer / Nurse Action Checklist (response to falls)**

| | | |
|---|---|---|
| **DANGER** | check for dangers, seek advice | **999** |
| **RESPONSE** | unresponsive | **999** |
| **AIRWAY** | compromised airway | **999** |
| **BREATHING** | absent or difficulty breathing | **999** |

- UNCONSCIOUS **999**
- REDUCED LEVEL OF CONCIOUSNESS **999**
- HEAD INJURY AND TAKES ANTICOAGULANT **999**
  (Warfarin, Enoxaparin, Dabigatran, Rivaroxaban, Apixaban)
- HEAD INJURY / TRAUMA **999**
- MAJOR HAEMORRHAGE **999**
- CHEST PAIN **999**
- OTHER SEVERE PAIN **999**
- LIMB DEFORMITY (inc shortening and rotation) **999**
- EXCESSIVE SWELLING AND BRUISING **999**
- DIZZINESS / VOMITTING (after fall or head injury) **999**
- FALL GREATER THAN 2 METRES **999**
- CONDITION - causing serious concern for staff **999**

**ADMINISTER FIRST AID AND RESUSITATION APPROPRIATE TO NEED**
Do not move the resident and follow the emergency treatment and instructions given by Ambulance Control

**IF NO REQUIREMENT FOR AN EMERGENCY AMBULANCE RESPONSE**

- Administer first aid as appropriate
- Complete the post falls assessment with resident (blood pressure and blood sugar - Nurse only)
- Assist resident to a comfortable place (using a hoist and manual handling aids as required)
- Inform relatives and document the discussion in the care plan
- Fax the completed post falls assessment to the GP Practice
- Observe resident for 24 / 48 hours using the post fall observation log (blood pressure - Nurse only) - keep in care records
- Complete body map - keep in care records
- Complete incident form and follow incident reporting procedure

**IF AN AMBULANCE CLINICIAN HAS ATTENDED THE RESIDENT, THERE IS STILL A REQUIREMENT TO FULFILL THE FOLLOWING ACTIONS**

- Complete post falls assessment documentation and body map
- Observe resident for 24 / 48 hours if remaining in HCC care
- Inform relatives and document the discussion in the care plan
- Complete incident form and follow incident reporting procedure

**IN ALL CASES WHERE THE RESIDENT REMAINS IN THE CARE OF HAMPSHIRE COUNTY COUNCIL, THE POST FALLS ASSESSMENT TOOL SHOULD BE SCANNED TO THE RESIDENT'S GP PRACTICE**




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**POST FALL ASSESSMENT TOOL SCAN & SEND TO RESIDENT'S GP WHEN COMPLETE**

| | | | |
|---|---|---|---|
| Name of resident | | | |
| Date and time of fall | | | |
| Place of residence | | | |
| Name and signature of person assessing | | Time and date of assessment | |

| | | √ Tick and sign |
|---|---|---|
| **Level of consciousness** | Responsive as normal | |
| | Less responsive than usual | |
| | Unresponsive or unconscious (call 999) | |
| **Pain or discomfort** | No evidence of pain or discomfort | |
| | Showing signs of pain or complaining of pain | |
| **Where is the pain?** | | |
| **Injury or wounds** | No evidence of injury, bleeding or wounds | |
| | Evidence of swelling, bruising, bleeding or deformity/shortening/rotation of limb | |
| **Where is the injury or wound/s?** | | |
| **Movement and mobility** | Able to move all limbs as normal for the resident | |
| | Able to move limbs but has pain on movement | |
| | Unable to move limbs as normal for the resident or there is a major change in mobility | |

Observations including neurological observations (nursing homes only)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Pulse** | | **Blood pressure** | | **Blood sugar** | | **Neuro-Obs chart** | Tick & sign |

| Conclusion of assessment | | Tick and sign |
|---|---|---|
| **No apparent injury or minor injury** ☐ | Give first aid treatment | |
| | Commence observations (use post falls assessment chart and complete body map) | |
| | Inform relatives | |
| | Complete an incident form | |
| **Major injury** ☐ | Give first aid / resuscitate and **call 999** **DO NOT MOVE THE RESIDENT** | |
| | Commence observations (use post falls assessment chart and complete body map) | |
| | Inform relatives | |
| | Complete an incident form | |




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Observations including neurological observations (nursing homes only)

| | | | | | | | |
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| | Complete an incident form | |
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| | Commence observations (use post falls assessment chart and complete body map) | |
| | Inform relatives | |
| | Complete an incident form | |




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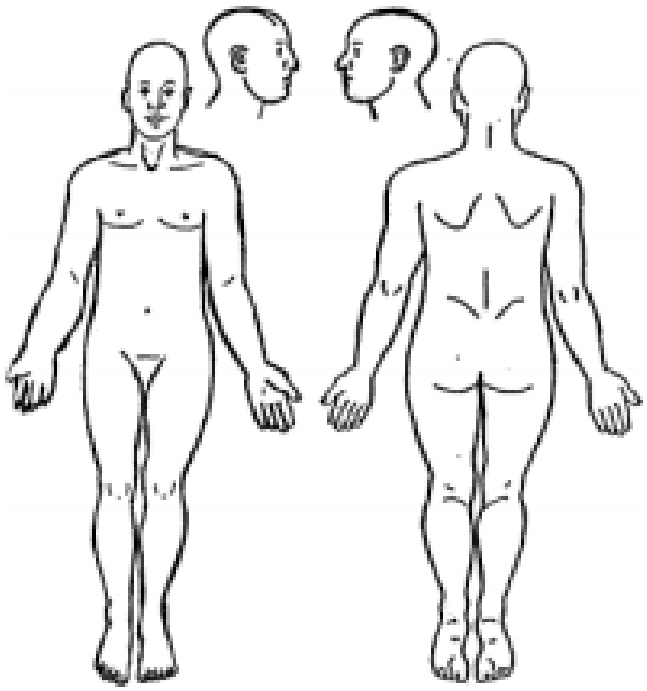
**Body Map – Assessment of Injury (keep in resident's care plan)**

| | | | |
|---|---|---|---|
| Name of resident | | Date of Birth | |
| Residence | | Date and time of fall | |



**Marks or bruising on resident's body (describe, mark on map above with date observed)**

**Residents description of any pain/s or non-verbal signs of residents pain with date**

| Day number following fall, Date & Time | Action taken and Date | Signature |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

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**24-48 Hour Post Fall Observation Log**

| | | | |
|---|---|---|---|
| Name of resident | | Date of Birth | |
| Residence | | Date and time of fall | |

**Observations should be done as soon as possible after the fall, then:**

- **Every 15 minutes for one hour**
- **Once half an hour later**
- **Once one hour later**
- **Once two hours later**
- **Every four hours until 24 hours post-fall. Wake the resident up to do the checks. *Do not assume the resident is simply asleep.***

**Fill in the time observations are due in the 'Time' column on the chart**

| Date | Time | Reported Pain/ signs | Wounds/ Bruises | BP Pulse + Neuro obs chart | Comments | Signature |
|---|---|---|---|---|---|---|
| | ASAP | | | | | |
| | 15 min later | | | | | |
| | 15 min later | | | | | |
| | 15 min later | | | | | |
| | 15 min later | | | | | |
| | 30 mins later | | | | | |
| | One hour later | | | | | |
| | 2 hours later | | | | | |
| | 4 hours later | | | | | |
| | 4 hours later | | | | | |
| | 4 hours later | | | | | |
| | 4 hours later | | | | | |
| | 4 hours later | | | | | |
| | | | | | | |



This also raises the question of the conduct of Wendy Dickinson in following her own professional code. It is quite clear that the recommended observations should be done and recorded at set intervals by a qualified nurse for up to 48 hours after the injury occurred. It also clearly states what steps should be taken in the observation protocol. As a nurse and clinical practice facilitator who we understand from a press report has trained other nurses on an accredited training course, Wendy Dickinson would have been well aware of the head injury observation protocol.


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**Wendy Dickinson's statement:**

19 FEB 2019

**WITNESS STATEMENT**

**Criminal Procedure Rules r 27.2; Criminal Justice Act 1967, s.9: Magistrates' Courts Act 1980, s.5B**

**URN :**

Statement of: **Wendy Dickinson**

Age if under 18: **Over 18** (if over 18 insert 'over 18') Occupation: **Care Home Manager**

This statement is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence. I Shall be liable to prosecution if I have wilfully stated anything in it, which I know to be false, or do not believe to be true.

Signature: Date: **16/02/2018**

Check box if witness evidence is visually recorded *(supply witness details on last page)*

I am Wendy Dickinson and I am the Director of Services at Park View Residential Care Home, Chorley New Road, Bolton, BL1 4AP. I have been in post since October 2017. Park View is a Nursing and Residential Home, it can accommodate 31 residents living in individual rooms. We have facilties for couples to stay together and to continue living together whilst benefiting from the care and support we offer. On the 13 December 2017 I took the additional role as Registered Manager.

I make this statement in relation to the death of Mrs Millicent Irene Fishwick who sadly died on 5 December 2017.

Millie became a permanent resident on 17 October 2017. Her husband Gordon Fishwick moved in on 25 September 2017 but Millie couldn't at that point as she was in hospital having developed a chest infection.

On the 18 October 2017 the standard comprehensive risk assessments for new residents where carried out, including mobility and risk of falls. Millie was able to walk around the home, however due to her frailty and weight loss over the last 12 month she was to be assisted over 15 metres then 1.1 assistance was required as assessed by discharge team. Millie had had a left hip replacement and a bad knee injury due to a fall. The risk was deemed as medium.

It was noted that Millie had two previous falls in her own home which resulted in hospital admissions. Confirms that Millie mobilises with a zimmer.

We did have some issues surrounding a delay in obtaining Ensure drinks for Millie. However, Jill Booth the

RESTRICTED (when complete) MG11


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Manager at the time and I met with Joanne and her sisters to iron out the initial issues.

Jill Booth left Park View in December 2017 and I acted up as Care Home Manager.

On 9 November 2017 the District Nurse attended to Millie as she had a skin break on her bottom for which cream was prescribed. The next visit was on 24 November when the GP attended to review Millie's poor appetite.

The care provided to Millie was very directed by her family who provided regular care on a daily basis to Millie and Gordon. All family were very involved in decision making within the care being provided at Park View.

Millie and Gordon had a large family and different family members attended on a daily basis. There were lots of celebrations at Park View in which Gordon and Millie and their family were involved.

On 4 December 2017 at approximately 22.15hrs Millie was walking from the toilet, which is off the main corridor, back to her room she shared with her husband, Gordon. Millie was using her zimmer frame, she opened the door and as she approached the door to go though it she lost her balance and fell on her knees and banged her lip/mouth on the bar of her zimmer frame. This was witnessed by Risha Chapman, Senior Night Carer who was assisting Gordon at the time. Millie advised Risha and I that she had lost her balance.

On examination Millie had a small swelling to her upper central lip, no loose teeth and no bleeding. Millie had a pale blue bruise on her right calf below her knee. Millie's next of kin, Joanne Fishwick was contacted and informed of the incident. We dialled 111 for further advice. A GP returned our call straight away and advised that we observe Millie throughout the night in case their are any changes. If Millie deteriorated during the night then to call 999 immediately.

Millie had a cup of tea and had her medication prior to going to bed. Checks were made on Millie throughout the night, 22.50hrs, 23.00hrs, 00.00hrs, 01.00hrs, 02.00hrs, 02.45hrs, 03.45hrs which raised no concerns.

One the last check we did Millie was checked and appeared pale, clammy and was having difficulties breathing. We immediately dialled 999 and they attended at approximately 04.05hrs. We contacted Millie's family and they arrived at around 04.20hrs.

Millie was taken to the Royal Bolton Hospital.

I have provided a full copy of Millie's file, however I attach to my statement:


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1.Admission Risk Assessments
2.Accident/Injury Record Sheet.
3.Statutory Notification to Care Quality Commission
4.Daily Report completed after the fall
5.Bolton Council Integrated Discharge Team

I was devastated to hear that Millie had passed away. I had got to know Millie and Gordon very well and Millie will be missed.

I attended the funeral of Millie and it was comforting to note that the family had stated in acknowledgements on the service card, We are so grateful to Wendy and all the staff at Park View for their continuing care and compassion. The celebration of Millie life was held at Park View and all attended with photos of Millie around there home it was an honour to do this for such a lovely lady.

Following the death of Millie, the family celebrated Christmas with Park View and all the family attended. Approximately one month later her family felt that the care that we continued to provide for Gordon was not to the standard they now expected. It became apparent on the day Gordon was unwell and admitted to hospital. A report was received regarding the care and support provided to Gordon. I was devastated to read this report with such allegations as at no point had any complaint been raised through the complaints procedure displayed at Park View. On 24 January 2018, Gordon Fishwick moved to another care home. We are sorry this happened as we miss Gordon and his family who were very involved with Park View.

1. Ms Dickinson states that she is the director of services as well as the care home manager at Parkview. She states that Parkview is a nursing and residential home.


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2. On page 2 she states that there was no bleeding when examining Mrs Fishwick which is an obvious contradiction to Ms Chapman's statement. Also Wendy Dickinson fails to include the significant fact that Mrs Fishwick "…*had been sick"* as Ms Chapman stated.

3. Ms Dickinson states that checks were made throughout the night commencing 22.50 hrs, 23.00 hrs, 00.00 hrs, 01.00 hrs, 02.00 hrs, 02.45hrs and 03.45 hrs but observation charts do not appear to have been presented, showing recording of the recommended observations to be carried out in these circumstances.

It is reasonable to conclude that Compassion In Care has uncovered a clear failure in duty to conduct and record the standard observations and it is quite clear that this should have been apparent to the Coroner at the inquest.

We will be writing to the Chief Coroner asking for better training in inquests into care home deaths to ensure that no injustice occurs in future.

**We consider this an alert by Compassion In Care that there is an ongoing failure in investigating such deaths. We are in effect issuing the equivalent of a Regulation 28 (Prevention of Future Deaths) notice**.

**We will also forward this report to the Nursing and Midwifery Council asking for a full investigation into Wendy Dickinson's actions that night.**

**What is clear to us from the evidence we have uncovered and from the relevant protocols is that the 111 service would have given different advice to a nursing home as opposed to a residential home, and given all the evidence that we have put forward, showing that this care home while being registered previously as a nursing home by CQC, did not in fact have any 24 hour nursing cover.**

We have been informed that Wendy Dickinson is sleeping in this home during the night so she is therefore not a working Staff on the floor, that she would have worked the previous day and the subsequent day following the events of that night, and that this whole arrangement is placing Residents at risk of harm.

**In our view there currently is a clear and present risk to Residents living in that home.**

Ms Dickinson is exceeding the remit of her role in acting as a nurse when it suits but neglecting to carry out the duties of a nurse working the floor.

**Please note that this is what we have uncovered in a few days as a small charity with very scant resources compared to the CQC and Police with their vast resources and support Staff. We**


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**have to ask if this is a widespread situation where CQC are listing homes as Nursing and allowing homes to list themselves as a nursing home when it is clear they are not providing nursing care.**

**When it is a matter of life and death this is an important question.**

Another issue Is that the home is admitting people from 18 years plus, whereas the CQC says it is registered for caring for people "*aged over 65 years*".

**NB Wendy Dickinson knowingly made a sworn statement to the Coroner's Court that Parkview is a Nursing and Residential home, therefore the implication was that a level of nursing care was provided when it was most definitely not. This was deliberately misleading the Court.**

**COMMENT:** Parkview has been open for around twenty years. CQC has not published reports prior to 2009 but a nursing home without 24 hour nursing cover has been allowed to continue operating all that time and it was only in September 2015 that CQC asked the question, *What training have you had as a nurse?*

Also it is quite clear there is no nursing cover at night and this has not been picked up, only substandard nursing cover during the day. This is directly linked to the set of circumstances that we will discuss next.

As we have said before, and Compassion In Care has been the only charity to do so, at a time when there is massive debate about the lack of investment in social care supposedly leading to the crisis in the NHS, why is nobody gathering the data (which we have requested previously by Freedom Of Information) asking how many people are admitted to hospital *from* care settings?

Our experience is that people are repeatedly admitted to hospital from care settings as a result of the poor care they have received. Our view is that the debate should be not about investment in social care, instead it should be about tackling the poor care homes and poor providers that exist in social care.

**The first issue that must be addressed is the poor care that results in hospital admissions, in other words elderly care should be taken back into public ownership instead of continuing to pour millions of pounds into private companies which are beyond the law. Post Carillion and Southern Cross we are still not learning lessons but continuing down the route of pouring public funds into private profit-making organisations.**

**NHS Continuing Care funds will have been claimed by this home for a number of Residents over many years. There should be a full investigation into how this fraud could have been allowed to continue under the eyes of the regulator CQC.**


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**Compassion In Care wishes to make clear that we know there are a number of caring and devoted Care Staff at Parkview who should be given the chance to speak in confidence to any new, competent investigators, which should not include any Safeguarding Board member but an external Police force should investigate.**

We will be returning to the issues about Parkview in a follow-up report as there are a number of avenues of inquiry and evidence of which we are aware, which will be published in our next report about Parkview.

**EILEEN CHUBB**

**5th March 2018**

Cc

The Fishwick Family

Jeremy Hunt

Chief Constable Greater Manchester Police

Chief Coroner

NMC Professional Standards Committee

Bolton Council

Public Accounts Committee

Alison Holt BBC News

Private Eye


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