safeguarding adults at risk
a cumbria partnership

# Safeguarding Adults Review Beacon Edge

## Report Author – Margaret Flynn

## March 2016

## A Serious Case Review[1] concerning Beacon Edge Specialist Nursing Home

Margaret Flynn, 31st March 2016

### About this Serious Case Review

1. The review focused on the period January 2013 - December 2013 and the agencies associated with it were invited to answer the following questions:
    - *How was the abuse allowed to happen? – recruitment/competence of staff, induction, supervision, training and monitoring and appraisal of staff should be considered*
    - *What other agencies were involved in the day to day running of Beacon Edge and did all agencies work together to ensure the best outcomes for residents?*
    - *Were there any warning signs that would have allowed the abuse to be picked up sooner? Why did it take a new member of staff to report it?*
    - *Were there governance/quality assurance arrangements between the local authority/CCG and the provider sufficient to safeguarding the residents effectively?*
    - *Were safeguarding alerts raised at the appropriate times and did the process contribute to safeguarding the victims concerned? If not, why not?*
    - *What steps did all agencies take immediately after the incident to address the situation and what was the impact?*
    - *Could any action have been taken to prevent these incidents?*
2. The expectation that agencies would submit answers to these questions and describe the key events at the nursing home was unevenly realised. For example, the "completion due date" of December 2015 appeared to add no urgency to the task. Also, since the nursing home's owner, BUPA Ltd, did not answer all of the questions posed during 2015, more questions were asked and further delay resulted. Although some consideration was given to establishing contact with former employees, this would have encompassed a process of negotiation against the backdrop of concern about the duration of the review.
3. Since the Care Quality Commission no longer provides written submissions to reviews, two meetings were arranged with the inspector with principal responsibility for Beacon Edge and the area's regional manager.
4. The review was largely based on documents of mixed quality. One contributor spoke of "the acceptance of mediocrity as normal." This cogent description of Beacon Edge Nursing Home was borne out by the written submissions and the meeting with relatives during March 2016.

### Introduction

5. Beacon Edge Nursing Home in Penrith is owned and run by BUPA Care Homes (CFChomes) Limited[2] (referred to as BUPA) as a specialist dementia home providing care and support *for up to 37 people with dementia type illnesses*. It is registered with the Care Quality

[1] This review was commissioned during January 2015, that is, it pre-dated the implementation of the Care Act 2014

[2] The homes owned by this company are listed at http://www.cqc.org.uk/provider/1-116865215 (accessed 1 March 2016)

Commission (CQC). At the time under consideration by this serious case review the registered manager was DB and the Responsible Individual was Andrew Cannon[3].

6. During September 2013 a new member of staff began her first shift at the home. She reported witnessing cruelties perpetrated by three care workers. Those members of staff were subsequently convicted for ill-treatment and neglect under Section 44, Mental Capacity Act 2005. The male employee was further convicted for a sexual offence.
7. Even though the home had a policy not to permit the use of mobile phones by employees and the three involved, BB, CB and CS had all received up to date training in relation to this policy,[4] many thousands of incriminating texts, photographs and videos were recovered from their phones during the police investigation. These showed actions which were disrespectful, frightening, physically painful, degrading and humiliating for the residential patients.
8. There had been "a high level of safeguarding alerts" at Beacon Edge during 2012 with 41 alerts received between 1 January and 20 August 2013[5] concerning the home received by Adult Social Care (ASC).[6] The patient who was principally the subject of these alerts was an individual who's first language was not English.[7] As a result of the nature and frequency of the safeguarding alerts, regular "clinical support" meetings were held between Health[8] and Social Care professionals from ASC, Cumbria CCG (Clinical Commissioning Group), Cumbria Partnership Foundation Trust (CPFT) and the Registered Manager.[9]
9. The Older Adult Community Mental Health Team provided most of the support for Beacon Edge.[10] This team consisted of Community Mental Health Nurses, Occupational Therapists, Psychologists, a Psychiatrist, Assistant Practitioners and Support Workers. It provided support for behaviour, reviews, dementia mapping and medicine reviews for example. Care Home and Education Support Services (CHESS) was provided by mental health workers from CPFT to raise awareness of dementia and the specialist knowledge required to care for people with dementia. There seems to be no record as to whether staff from Beacon Edge attended these courses. Training was offered on a monthly basis by Tissue Viability Nursing in relation to pressure area care, wound assessment and appropriate choice of dressings. No staff from Beacon Edge attended these courses during 2013, irrespective of the regulatory

[3] Managing Director for Care Services with BUPA from January 2013 to August 2015

[4] A letter from BUPA's Area Manager, 17 March 2016, states *BUPA has a strict mobile phone policy as well as a social media policy that incorporates the taking of photographs within the care home. All staff must sign upon commencement of employment. It is clear that staff must switch off their phones and are only permitted to use on designated breaks*

[5] 77 in total during 2013

[6] Adult Social Care noted that these were *predominantly 'resident on resident' assaults*

[7] Once it was arranged for this person *to be able to listen/watch radio/TV* and read newspapers *in her first language*, *the behaviour changed* resulting in *a reduction of safeguarding alerts*

[8] Appendix 1 outlines the commissioning structure at the time

[9] It had been determined that for 18 months, monthly meetings were to be *held with Beacon Edge to discuss all residents' needs,* yearly reviews were to be undertaken *by ASC and Health* and *extra support/ assessments/ strategies* were to be provided

[10] Cumbria Partnership Foundation Trust noted, *as Beacon Edge is a nursing home and employs Registered Nurses, CPFT would not have provided district nurse support*

expectation and contractual obligation to ensure that staff are trained to undertake the work.

10. The Continuing Health Care (CHC) Team recalled that "early warning meetings" had prefaced "a high level of concern" about the care delivered at Beacon Edge, and perceived Adult Social Care's level of concern to be lower and the Care Quality Commission's (CQC) lower still. A number of patients had pressure ulcers.[11] When challenged by the CHC, the home would assert that since the CQC were happy with the care provided it was not under any obligation to improve.[12]
11. The CQC had misgivings about the home with regards to governance and poor internal communications. "The Registered Manager was inexperienced in managing staff…There was a notice board which was covered by a curtain which no one read. Care plans were hand written and if they were amended they were redrafted by hand…A senior carer required training in how to understand facial expressions."

## Pivotal Events

12. **2012**

During **July** the Speech and Language Therapy (SALT) Team raised certain issues in relation to staff at Beacon Edge not following its recommendations (they had done similar in July 2011). This matter was raised with the line manager of the SALT Team, who sent a letter to the Registered Manager of the home. The response of the manager at that time suggested that the service was "defensive and not receptive to the challenge."[13] There was a sense that neither this manager nor BUPA's managers had a "finger on the pulse." There was, apparently, a hierarchical structure in relation to the Registered General Nurses who, it was reported, spent a substantial amount of time in the office with the door closed, writing up records in long hand with only one or two carers left to look after the patients. The qualified staff would not, therefore, have had oversight of the quality of care that was being delivered or of any activity within the home. It was reported that there appeared to be a "them and us" culture.

During this period, it was known that some carers referred to patients as "feeders."[14] Record keeping and documentation was identified as an issue from the SALT perspective. Practitioners reported that there was often an offensive smell when they entered the building. The monthly clinical support team meetings[15] appeared to have had little impact in terms of changing practice or the number of safeguarding alerts raised.

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[11] When pressure against the skin is greater than the pressure of blood delivering oxygen and nutrients, then skin cells and tissues are damaged. Pressure ulcers are extremely painful and they require urgent clinical treatment

[12] Beacon Edge made a complaint about the Continuing Health Care Team, *accusing* it *of micro managing. Accordingly the home implemented a policy where CHC members were only allowed onto the premises with appointments and always escorted when there*

[13] Cumbria Partnership Foundation Trust

[14] Cumbria Partnership Foundation Trust noted, *when there appeared to* be a *lack of leadership the carers organised themselves and became very task orientated*

[15] Cumbria Partnership Foundation Trust noted, *At the clinical support meetings there was reporting of concerns by the Beacon Edge manager and highlighted by the multi-agency team however there appears to be no record of actions taken to support change,* that is, *assurance was given but no real change had taken place*

In terms of the home's layout, it was described as having "narrow corridors." The dining area was subject to change "on several occasions" and in some areas, most particularly the front lounge and upstairs, patients were not supervised.

During **August**, a number of safeguarding alerts were raised about Beacon Edge.[16] These resulted in a process of monthly multi-agency clinical support meetings. The meeting purpose appeared to be supporting Beacon Edge around identified issues in relation to the number of safeguarding alerts and how they were being managed, for example, the number of falls.[17]

On **7 November**, the CQC made an unannounced inspection of seven standards:[18] *respecting and involving people who use services; care and welfare of people who use services; meeting nutritional needs; safeguarding people who use services from abuse; staffing; supporting workers;* and *records.* The home was judged to be meeting every one of these standards. The following quotations from the Inspection Report indicate some concerns:

*The provider may wish to note that on the day of our visit there were fewer staff available than the staffing rota identified as necessary…we had noted…that the home supported people who would occasionally exhibit aggressive or agitated behaviour…The manager had kept both the CQC and the local safeguarding authority informed…there had been occasions where people living at the home had been aggressive towards other people living there…We spoke with staff who told us that they often felt there were not enough staff on duty…the manager had recently appointed four new staff…On a previous inspection we noted that staff required more training.*

During **December**, a GP made a referral to the Out of Hours district nursing service. A patient was identified as being dehydrated and subcutaneous fluids were prescribed. Two visits by two different practitioners were carried out.[19] Information was not shared within the CPFT nor with the multi-agency team.[20]

## 13. 2013

On **13 March**, a clinical support meeting was held at Beacon Edge[21] described as "safeguarding and MDT case discussions…good practice multi-agency discussion concerning all residents*."*[22]

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[16] Cumbria Partnership Foundation Trust noted, *safeguarding investigations were undertaken internally, however, there appeared to be little impact on improvement on the outcomes for the residents as the same concerns were recurring*

[17] The Clinical Commissioning Group noted that *General Practice did not always attend meetings regarding their patients at the home…*of *patients' records, nothing particularly unusual* was flagged. *There were some falls, pressure ulcers and patient bruises but all were explained by the home and accepted by the Practices*

[18] The CQC did not inspect all standards at the time and, in Cumbria, it was "dealing with two failing trusts"

[19] Typically, the Cumbria Partnership Foundation Trust (CPFT) *would not have provided district nurse support*

[20] Cumbria Partnership Foundation Trust

[21] This was one of the series *instigated by ASC Eden Team following the high level of safeguarding alerts at Beacon Edge in 2012 and early 2013*

[22] The Clinical Commissioning Group noted that *the Continuing Health Care team's concern* about *the care standards at Beacon Edge began in Spring 2013*

On **8 April**, a further clinical support meeting was held at which all patients and safeguarding episodes were discussed.

On **25 April**, a woman care worker witnessed colleagues (CB and BB) engaged in the unsafe lifting of a patient and overheard heard the patient being verbally abused, that is, she was described as *a fucker* and was told to, *just fucking fall out*. The care worker was physically intimidated by BB when she offered to take over. An employee immediately reported this incident to the senior care worker.[23] The Registered Manager suspended staff, informed families and the CQC, and advised that she was taking direction from BUPA.[24] The latter stated that the incident was "fully investigated by an independent investigator, and due to insufficient evidence, on balance of probability, was unable to proceed to disciplinary…the investigating officer would have needed to have consistent accounts by all staff interviewed and this was not the case…She did however make recommendations in respect of training, supervisions and a discussion with the Home Manager to reflect on the use of inappropriate language…"[25]

The Registered Manager gave assurances to the CQC that BB and CB would not work together at Beacon Edge. However, during subsequent inspections it was noted that they continued to work together. This was because the incident "had been signed off by safeguarding."

On **29 April**, an alert was raised with Adult Safeguarding.

On **1 May**, a strategy meeting was held.

On **8 May**, a safeguarding planning meeting[26] was held at which it was reported that CB and BB had only been employed within the previous six months. At this stage both denied the allegations. The Registered Manager had interviewed six staff members but was unable to establish the facts. However, she agreed protection for the whistle blower. She agreed that the staff had undertaken safeguarding procedures awareness training.[27] She agreed that an Occupational Therapy referral was required in relation to moving and handling.[28] It was agreed also that CB and BB would receive challenging behaviour training and 1-1 support for a month with a skilled, senior member of staff.[29]

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[23] The police noted that whistle blowers subsequently reported experiencing bullying by CB and BB. In the letter from BUPA's Area Manager, 17 March 2016, it is stated that *BUPA were only made aware at the trial that the member of staff had been bullied by the two staff members*

[24] Adult Social Care; the CQC noted that the Registered Manager was not accompanied by senior BUPA managers at any of the safeguarding meetings

[25] Letter from BUPA Area Manager 17 March 2016, in which it is also stated that *BUPA's internal policy is that all staff undertake bi-monthly supervisions*

[26] No information is available about this meeting

[27] Letter from BUPA's Area Manager, 17 March 2016 states *In respect of safeguarding reporting, attention and re-training has been an area of focus in respect of staff reporting concerns at the time both internal and local policies have been re-issued and staff are clear that any potential safeguarding alerts are to be raised immediately*

[28] Adult Social Care noted that there was no evidence that this referral was made

[29] BUPA asserted that *supervisions* were *undertaken as recommended…for both staff*

BUPA noted that, "our HR policies and procedures were followed, however, due to insufficient evidence the staff members were brought back to work. This was with the cooperation of the local safeguarding team."

BUPA initiated an independent review by an internal quality manager. This noted that, given the seriousness of these allegations, particularly in relation to swearing, it was unusual that this alleged abuse did not proceed to a disciplinary hearing.[30]

An additional internal review of the Human Resources process conducted by an independent BUPA manager stated that the Registered Manager was arguably acting as "judge and jury." Senior personnel at Beacon Edge all acknowledged their surprise and shock when these allegations came to light. They had been "unaware of any wrong doing or allegations of any type of abuse or abusive behaviour". It was claimed that both staff were "well liked."

BUPA state that the "Probationary period for all staff is 6 months. All staff were recruited through local advertising, all three came from another local care provider and recruited following our internal recruitment processes including the gathering of references and Disclosure and Barring Service (DBS) checks (all reviewed and in place at time of incident)."[31]

On **14 May**, a clinical support meeting was held at which all patients and safeguarding episodes were discussed.

During **June** it was noted that a patient said "I am not liked and I am not wanted." A patient also said "I don't like that bugger." Such remarks were viewed in isolation and did not appear to have been considered in relation to other issues which were being identified at the home.

On **13 June**, the CQC made an unannounced inspection of five standards: *consent to care and treatment; care and welfare of people who use services; staffing; supporting workers; and assessing and monitoring the quality of service provision.* The home was judged to be meeting all of these standards. The following quotations from the Inspection Report, however, indicate some concerns:

[Re the Mental Capacity Act 2005] *We were told that they* [the staff] *felt some extra training may be required in that area…capacity assessments were not reviewed on a regular basis…we noted that staff were often task orientated…mealtimes were not a social occasion…prior to our inspection we had received information that there was not enough staff to meet people's needs, particularly when the home was busy…The provider may wish to note that though there were sufficient staff on the day of our inspection staffing levels must reflect the needs of people using the service.*

On **18 June**, a clinical support meeting was held at which all patients and safeguarding episodes were discussed.

[30] This is quoted from information submitted by BUPA. BUPA did not share any of its internal reviews, noting that *All of our HR cases are reviewed by our Manager Advisory HR Service and are overseen by the Area Manager to support impartiality throughout the process.* The Area Manager elaborated in her letter of 17 March 2016, *BUPA are unable to share the reviews as they hold confidential information in respect of other cases and service users and are legally protected*

[31] Letter from BUPA's Area Manager, 17 March 2016

On **11 July**, Adult Social Care held an internal meeting at which concerns were documented and forwarded to the ASC contracts team on 25 July.

On **25 July**, a clinical support meeting was held at Beacon Edge at which all patients and safeguarding episodes were discussed.

On **26 July**, concerns were raised with Adult Social Care's contracts team about "the high number of falls and safeguarding in comparison to other homes."

On **1 August**, an NHS early warning meeting was attended by ASC and contracts staff in relation to Beacon Edge.

On **22 August**, CB and BB were observed by a second whistle blower engaging in the unsafe moving and handling of a male patient.

A two-day audit visit by the ASC Contracts' Team began.

On **23 August**, a safeguarding alert was raised with Cumbria's adult safeguarding team. This hinged on the moving and handling issues raised by the second whistle blower. CB and BB were seen pulling a patient from a chair by his arms and pulling his neck to place pillow behind him. CB and BB were put on light duties, that is, neither were to engage in moving and handling patients. One to one support had been in place during May and moving and handling training was in place for CB and BB. An Occupational Therapist visited the service user with a social work practitioner to assess moving and handling needs and equipment requirements. The Contracts' Team were advised of these concerns. The safeguarding team advised that "taking a case management route was more appropriate to address the moving and handling concerns rather than safeguarding."

The audit found the home was not contract compliant around "staff not signing that they had read individual residents' care plans" and some records and charts were illegible.

On **2 September**, a woman[32] commenced employment at Beacon Edge Nursing Home. During a subsequent police interview she reported that, when she started there was no senior member of staff to assign tasks; she was shown around by a woman care worker (CB) who introduced patients in a verbally disrespectful and hurtful manner; subsequently, she worked alongside a male care worker (BB) who physically hurt two patients by "yanking" their hair; the same patients became distressed when he simulated masturbation in front of them and their new colleague; finally, another woman care worker (CB) disclosed to her colleague and the male care worker (BB) that she had been "caught" using her phone by the head nurse. This worker had panicked since the head nurse "could have seen the videos." She explained that these included one of a patient being scared in her bedroom and another of the male care worker getting into bed with this patient. The new employee told her colleagues that these were cruel acts. The response was "It's just a laugh."

On **4 September**, Adult Social Care received three safeguarding alerts relating to the abuse of three known patients of Beacon Edge by named staff members.[33] BB and CB were suspended from duty.

[32] BUPA noted that she had previously worked with these three staff members who thought she would be "one of them"

[33] Draft report - ASC

On **5 September**, the woman whistle blower verbally resigned after working a single shift. She informed the Registered Manager that the reason for her resignation was the ill-treatment of four patients by her colleagues. The Registered Manager reported the ill-treatment to Adult Safeguarding and following a strategy meeting, which included the police, CQC, Contracts and Health. A full criminal investigation began. The potential victims were identified (only one of whom could be interviewed) and officers began to take witness statements from patients' relatives and from Beacon Edge staff.

Multi-Disciplinary Team case discussions, clinical support meetings, good practice multi-agency discussion concerning all patients were then held with BUPA's staff.

It was acknowledged [during the first multi-agency strategy meeting] that actions required at Beacon Edge were not always completed nor adequately followed through;[34] that Beacon Edge shared only incomplete information; that a whistle blower was not protected from bullying; and that the nursing home's whistle blowing events occurred "either in front of the nursing office or in the lounge."

On **6 September**, concerns were raised by Adult Social Care concerning Beacon Edge to BUPA's regional manager. A voluntary suspension of admissions to the home was agreed.[35]

BUPA noted that the "home manager"[36] at the time attended the home immediately and suspended the staff involved and informed the police and the safeguarding team.

On **10 September**, a meeting was held between BUPA, the CCG and ASC. The BUPA representatives listened to the examples and areas of concern and agreed that additional support would be provided to the home and that they would "monitor the situation."[37]

On **12 September**, BB and CB were arrested on suspicion of offences under Section 44, Mental Capacity Act. They were interviewed and bailed. In addition to the five known patients who were victims of their physical and verbal cruelty, their mobile phones identified a further seven victims. Messages from their mobile phones highlighted the use of gender-specific profanities; disrespectful descriptions of patients; the disclosure of (i) verbal threats made to patients (ii) anticipated assaults and (iii) the disclosure of retaliation towards a colleague who had reported their cruel behaviour. One of the care-workers noted via a text message: "I think they are calmer when you provoke them."[38] The photographic images recovered from their mobile phones showed patients being provoked; a male care worker wearing a woman care worker's uniform and separately looking up the nightie of a patient; a naked woman resident; and the statement written in a deaf patient's notebook, "We are going to kill you."

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[34] Letter from BUPA's Area Manager 17 March 2016, states: *The only concerns raised…was that the Home Manager was defensive, on occasions did not share up or below…felt she was stressed and needed more support at meetings, once this was raised the Area Manager and Quality Manager attended all meetings*

[35] This stemmed from the County Council's *Poorly Performing Provider Procedures*

[36] BUPA Ltd refers to the Registered Manager as the "home manager"

[37] However, no improvement was evident and a decision was made by ASC and the CCG that a formal suspension of admissions to the home was required

[38] The CQC noted that *the senior carers had ancient mobile phones and it is unlikely that they knew how to text*

BUPA advised that the personnel files of all three were reviewed, appropriate recruitment checks had been made, including Criminal Records Bureau checks, and satisfactory references were received:

*The rotas for Beacon Edge…for 2013* confirmed that *the three staff members worked together on many occasions (either two or three of them on duty on the same shifts). This was not disproportionate in…a small, single site home with one team rota…staff working together often is to be expected.*

BUPA noted that two of the three members of staff had been assaulted by patients, who were not normally considered to be a risk, on two and three occasions respectively. "These assaults may have been an indicator of interactions with residents with dementia which were not therapeutic." The assaults were not considered to be significant by the Registered Manager:

*Despite a thorough induction, both staff had not undertaken Managing Behaviours That Challenge training…we feel the abuse could not have been picked up sooner.*

On **16 September**, CB resigned from Beacon Edge.

On **22 September**, BB resigned from Beacon Edge.[39]

CS remained suspended from Beacon Edge and "was dismissed after the Court Case."[40]

On **24 September**, a patient's body was found beside her bed.[41] (During **March 2016**, BUPA Ltd entered guilty pleas to two charges brought by the Health and Safety Executive: (i) failing to provide care and support for people with dementia type illnesses or to ensure that people not in their employment, including this patient, have not been exposed to risks; and (ii) failing to ensure all its staff using beds and bedrails were given adequate health and safety training.)

On **3 October**, the second multi-agency planning meeting was held.

On **11 October**, a clinical support meeting was held at which "all residents and safeguarding episodes were discussed."

On **17 October**, the ASC Contracts team made an unannounced, follow-up visit.

On **21 October**, a third suspect, a woman care worker (CS) was arrested on suspicion of offences under Section 44, Mental Capacity Act. She was interviewed and bailed. Her arrest was the result of the examination of BB's mobile phone. Although 15 victims of abuse were identified in total, the Crown Prosecution Service decided there was insufficient evidence concerning two of these patients.

BUPA Ltd stated that Human Resources clinics were held following the arrests and staff were encouraged to report any concerns and discuss any issues. No one came forward with any knowledge of abusive behaviours.

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[39] In the letter from BUPA Area Manager 17 March 2016, it is stated that had the pair not resigned, *both staff would have remained suspended and dismissed from the business and in all probability a referral made to the DBS for consideration*

[40] Letter from BUPA Area Manager 17 March 2016

[41] http://www.newsandstar.co.uk/news/BUPA-admits-care-home-safety-failings-after-death-of-woman-91-9cf8a3f3-fe24-4c35-b30e-c96daa15ac4c-ds (accessed 5 March 2016)

On **23 October**, a formal notice of suspension was served by the County Council.

On **24 October**, BB and CB were interviewed and bailed once more.

On **25 October,** the third, multi-agency planning meeting was held with North Cumbria Public Protection Unit.

On **28 October** and **13 November,** North Cumbria Public Protection Unit identified more possible victims and seven safeguarding alerts were raised.

Each of the 15 victims' families had person to person contact with the detectives involved in the investigation. They "listened to the needs and concerns of the family and worked with other agencies to fulfil their requirements. Each victim and their family were assessed based on individual needs in order to determine which agency was the most appropriate to update them as to the status of the investigation. Some families chose to communicate directly with the police, others…with Adult Social Care. Once the investigation was complete both Police and Adult Social Care met with each family to disclose the outcome of the investigation relevant to their own family member and the Court process that was to follow.

The one victim…who had capacity was communicated with directly. At first, because of her vulnerability this was carried out in the company of Adult Social Care and/or close family…as the investigation progressed and the victim gained confidence in the Police, detectives met with the victim on a one to one basis and… [each] statement was recorded."[42]

On **7 November**, the CQC carried out an unannounced inspection in response to concerns that one or more of the essential standards of quality and safety were not being met. The standards were: *care and welfare of people who use services; safeguarding people who use services from abuse; and staffing.* The home was judged to be meeting each of these standards. The following quotations from the Inspection Report refer to some post allegations actions:

*Staff were aware of what to do if they suspected abuse was taking place and had been well trained and supported following the allegations made…staffing could be increased if people needed extra support…Some* [relatives] *were positive about the home some less so…we used the Short Observational Framework for Inspection…we did not observe any negative or poor interactions between staff and people living there…All staff had completed mandatory training in the safeguarding and protection of vulnerable adults…(BUPA) had provided additional training sessions. The Local Authority safeguarding team had also been to the home to speak with and train staff. The home manager had been meeting with…staff and assessing that staff had understood the training they had undertaken. BUPA's human resources representatives were visiting the home weekly to support staff and ensure that they were aware of the home's whistleblowing policy*[43]*…there was a dedicated telephone number for staff to ring if they had any concerns…*In the wake of the suspensions of three

[42] North Cumbria Public Protection Unit

[43] Letter from BUPA's Area Manager, 17 March 2016, states *'Speak up' is BUPA's name for its whistleblowing policy. The policy is applicable to all of BUPA's businesses globally. It is a meaningful term for BUPA's people and represents our culture. The policy has been called 'Speak up' for some time and it is a generally recognised term in BUPA which is more meaningful than 'whistleblowing'*

members of staff, Beacon Edge *had recruited extra members of staff…there were always two qualified nurses on shift.*

On **13 November**, the police investigation identified more possible victims resulting in five safeguarding alerts.[44]

On **18 November**, a clinical support meeting was held at which "all residents and safeguarding episodes were discussed."[45]

On **22 November**, CS was interviewed and bailed once again.

On **10 December**, the police investigation identified a further victim and a safeguarding alert was raised.

On **13 December**, a meeting was held at which "all residents and safeguarding episodes were discussed."

On **14 December**, the fourth multi-agency planning meeting was held.

## 14. 2014

On **24 January**, BB was charged with 8 counts of ill-treatment and wilful neglect and a sexual offence; CB was charged with 10 counts of ill-treatment and wilful neglect; and CS was charged with 3 counts of ill-treatment and wilful neglect.

On **27 January**, a multi-agency review meeting was held regarding safeguarding adult concerns raised in relation to whistleblowing from Beacon Edge staff and the police investigation.

On **7 February**, CS entered a guilty plea.

On **28 February,** the police started an investigation into the death of a Beacon Edge patient.

On **6 May**, BB and CB entered guilty pleas. BB pleaded not guilty to the sexual offence charge.

BBC coverage[46] of the trial noted that "BUPA, which runs the home, described the behaviour (of the three ex-employees) as "deplorable" and apologised to the residents and their families…It said in a statement that everyone at the home was deeply shocked, and other carers had reported the abuse so action could be taken."

On **10 July**, the CQC carried out an unannounced inspection of five standards*: care and welfare of people who use services; safety, availability and suitability of equipment; staffing; supporting workers; and assessing and monitoring the quality of service provision.* The home was judged to be meeting all but the care and welfare of people who use services and

[44] Information concerning the scale of the abuse came to light gradually as the police secured evidence from the phones of three members of staff

[45] BUPA noted that *throughout 2013, regular, minuted meetings were held with Beacon Edge that included the local authority/ Clinical Commissioning Group…to discuss all safeguarding referrals and plan future care and strategy. Therefore, it is evidenced that the home manager was working closely with local partners to monitor care provision…during 2013*

[46] http://www.bbc.co.uk/news/uk-england-cumbria-27296123 (accessed on 2 November 2015)

staffing standards where it judged that action was needed. The following quotations from the Inspection Report indicate some of the concerns:

*We found that care and treatment was not planned and delivered in a way that was intended to ensure people's safety and welfare…because care plans were not based on up to date information and had not been read by all…staff…there was insufficient staff available during busy periods throughout the day…did not have sufficient time to interact with people who used the service…we had received information prior to our visit that pressure mats at the home were not working or being used properly* [this was not evident during the inspection]…*There were clearly more people who required support than there were staff to assist them.*

On **14 August**, the CQC carried out an unannounced inspection in response to concerns that one or more of the essential standards of quality and safety were not being met. The standard was: *management of medicines* and the judgement was that action was needed. The following quotations from the Inspection Report indicate concerns:

*We found that people who used the service did not receive their medicines in a safe way…We saw medicines administration records for creams signed by nursing staff but we were told creams were applied by care workers and this was recorded elsewhere…the records did not show that the creams were applied as instructed by the doctor…we saw two medicines mixed together before administration but could find no evidence…that this was appropriate.*

During **17 September - 7 October**, there were 14 safeguarding alerts, most of which hinged on the neglect of eight women patients. Five alerts concerned one woman, that is, her chair was turned to a corner; she did not have a pressure cushion or sensor mat; she was dragged and spoken to nastily; her medication was not administered; she sustained weight loss, and care plans not updated following lost dentures. Two alerts concerned two women: one was left in a wheelchair and her medication was destroyed; the other was subject to inappropriate moving and handling on two occasions. Individual alerts concerning the remaining five patients stated that they were forced to shower; non-qualified staff were completing moving and handling; a nurse administered core drugs intra muscular as opposed to liquid form; a patient had not showered for 31 days; and nutritional status neglected.

It was during **September** that the CQC introduced new methods to their inspection process. Prior to this date, inspection methods were being piloted.

On **20 October**, a report of the trial[47] noted that BB stated "I am disgusted and ashamed of myself for it. It was just silly photos of each other to start off with and it just spiralled and spiralled and spiralled and got worse."

15. **2015**

On **19 June**, the CQC undertook an unannounced inspection. The service was given an overall rating of good since in relation to the following questions: *is the service effective,*

[47] http://www.bbc.co.uk/news/uk-england-cumbria-29696897 (accessed on 2 November 2015)

*caring, responsive and well-led?* The rating was *"good".* However, with regard to the question, *"Is this service safe?"* the answer was "*requires improvement*." It noted that:

*The amount of staff on duty was inconsistent over the period of time that we looked at.* Also, *a total of seven creams for four people were out-of-stock.*

The report noted that *the manager…was clear that incidents in the past would be learned from and not repeated…There was evidence in staff supervision records that showed the manager used supervisions as an opportunity to empower staff and give them confidence to work in a person-centred and inclusive manner. Some staff had undertaken new roles as champions and leads within the service and been given greater responsibilities…the activity coordinator had been enabled to develop the environment…the service nominated a 'resident of the day' on a daily basis…The manager carried out regular audits and checks…The provider had a corporate system of quality assurance in place…Quality metrics were monitored by the provider's quality team…senior members of the management team regularly visited the home.*

On **10 August**, PT, a new home manager was appointed. [No action was taken against his predecessor who ultimately left BUPA.]

On **12 October**, Beacon Edge's new manager described work at the home since his appointment:

*Staff continue to have a five-day induction before starting BUPA and cannot commence working on the floor until they have completed the full induction, two references have been processed and the DBS has been completed, the new team member must be buddied with an experienced, competent member.*

*Regular training updates are in place which is completed by the BUPA area trainer who has been allocated office space at Beacon Edge, I have and I will be having regular meetings to ensure training is appropriate to each individual resident and staff are competent in carrying out the daily routine in a person-centred way.*

### Reflections of the agencies contributing to the Review

16. **BUPA Ltd** asserted that the three ex-members of staff:

*…went to great lengths to cover their tracks and to avoid being caught out. They worked together on night shift and typically focused on residents who were not able to speak about their treatment…it is very difficult to see how this could have been uncovered sooner*[48]*…through discussion with…BUPA Area Manager at the time that the arrests were made, Cumbria Police stated that they believed that these three employees were acting as a closed group and no other person was aware of, or involved in, their alleged abuse. Therefore, it would have been very difficult to pick up their abuse sooner.*

In terms of the prevention of such behaviour, the Area Manager notes that *It would be beneficial within small communities that any concerns in respect of carers that are known to other providers and stakeholders are shared, however I know that this may not be possible*

[48] The Registered Manager contributed to monthly meetings at Beacon Edge Nursing Home and concerns were escalated to the Regional Manager during September 2013

*due to data protection laws that we are invited to case reviews so that we can respond to concerns at the time.*[49]

In addition, the Area Manager notes that, *from the investigation records I can see that supervision was undertaken with* [a nurse] *who was the nurse in charge on the day of the incident with SB and BB. However, as BUPA were unaware of the abuse that was going on during that time I can see no evidence of what action was required to be taken, the off duty nurse who was contacted by the carer about the abuse reported the incident to the Home Manager reported it immediately.*[50]

17. **Cumbria Partnership Foundation Trust** noted that:

…the referrals to the Older Adult Community Mental Health Team *were not over and above what would be expected for the number of residents…Practitioners identified some good practice…for example, when the Speech and Language Therapist visited,* they observed *staff skilfully manage residents who were complex to manage; they demonstrated good rapport and knew how to pace the feeding. Some carers were very knowledgeable about the residents…carers also asked for support in relation to feed thickening and asked the SALT to speak to the qualified nurses…the Activities Coordinator was very helpful…Generally residents were in their own clothes…were clean and well presented…requests for medication were not being asked for by staff…There is evidence that staff had* an *understanding of the Mental Capacity Act, Deprivation of Liberty safeguards and the use of Best Interests meetings.* The Team noted that individually they were welcomed into Beacon Edge which they described as *homely, not stark or institutionalised.*

The Trust also referred to indicators that all was not well at Beacon Edge:

*Lack of leadership was identified by several practitioners…There were reports that there appeared* to be *a lot of new staff…high turnover of staff…on one occasion one of the carers swore in front of the manager of the Older Adult Community Mental Health Team who told the carer that* it *was inappropriate…The SALT team had an open referral system where any…homes could phone in…a number of Beacon Edge staff would leave a message but with no resident identified and when the SALT rang back, no one appeared to know the reason for the contact…The medicine round took two hours to two and a half hours…*that is, the nurses *would not be available to support with any care.*

*Record keeping and documentation was identified as an issue…it was reported that* the SALT *found it difficult to find information…about a resident's medical history,* which is important *in relation to assessing the aspiration risk.* The dietary recommendations of the SALT team were inconsistent with *information in the kitchen.* Also, *nursing staff lacked understanding of the impact of end-stage dementia*[51]*…the SALT team had to advise the nurses to contact the GP* and involve families *in decisions…staff* were not *proactive in this area.*

When Beacon Edge accepted a new patient it was noted that although the staff were supportive, the risks, impact and staffs' capacity appear not to have been considered, not least since that in some areas of the home, patients were unsupervised.

[49] Letter from BUPA's Area Manager, 17 March 2016

[50] Letter from BUPA's Area Manager 17 March 2016

[51] General Practice was aware of *poor care planning at the home…for end of life care*

18. **Adult Social Care** noted that:

…among the professionals involved in the regular monthly meetings there was a lack of confidence in the management of the home. Its failure to engage was reflected in its failure to take *action in relation to specific care staff members…specific names regularly emerged and it was the opinion of health and social care professionals that* the Registered Manager[52] *was ineffective in addressing the concerns raised.*

After the safeguarding alerts of April, August and September 2013, Adult Social Care stated that *alerts continue to be made on a regular basis predominantly in relation to medication errors*[53]*…there appears to be different staff groups who display animosity towards one another in the home and this can result in 'tit for tat' allegations being made against staff members. There is little evidence that the management team…have been able to address the acrimonious cultures…it does not appear to be a positive environment.*

19. **Cumbria Clinical Commissioning Group** noted the acceptance of General Practice that:

*…Registered Nursing Care homes…were able to provide the level of care expected…they made assumptions that BUPA was monitoring the home effectively and if it was not then CQC would be.* GPs noted that *as a dementia home,* Beacon Edge *had greater demands upon it* but also, *they had to make the best of what they had in Penrith* where *there were no market forces at play.* Although General Practice *recognised some poor working* at Beacon Edge and requested the intervention of the Community Mental Health Team, *no real change to practice was noted.* The CCG noted that since Out of Hours provision is no longer a General Practice responsibility, *this has limited the view practices have of their patients* and the homes at which they are receiving care.

Concerns were raised by the Continuing Health Care Team regarding the number of unregistered care staff at Beacon Edge, who appeared "to know each other very well on a social level, some of whom were thought to be related to each other." The CHC Team believed that "the unregistered carers were in control of the home" rather than the registered nurses or home manager, not least because "duties appeared to be organised by them, depending on their needs rather than those of the home."

The CHC Team were aware of the *relatively high turnover of registered nurses* at Beacon Edge; that they were "rarely witnessed to be on the patient areas of the home;" and that they were disempowered. It was "concerned that BUPA managers were moved around the local BUPA homes following concerns being raised. Beacon Edge staff had received training after a care plan audit…which found that records training, falls training and meds training could all be improved…however nothing appeared to change."

The Clinical Commissioning Group also highlighted the fact that some staff had *poor knowledge of English.*[54] This had been discussed during safeguarding meetings.

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[52] The letter from BUPA's Area Manager, 17 March 2016, states that *The home manager at the time was transferred and following a period of managing…another of our care homes…left the business soon after. I am unable due to data protection provide any further information*

[53] Cumbria Clinical Commissioning Group noted that there was *little visible support from General Practice or medicine managers to address this*

[54] How might staff with a limited command of English understand and be understood by older people, some of who suffered from sensory loss, and whose communication skills might be compromised by dementia?

20. The **Care Quality Commission** acknowledged that this nursing home's nurses did not provide leadership to the staff team and that the practice of the senior carers was wanting. Families with relatives at Beacon Edge were concerned that it might close and some "sided with staff."
    Ultimately, 13 members of staff were suspended, including the Registered Manager. It appeared to the regulator that BUPA's senior managers "changed every five minutes" and favoured BUPA's in-house training over that of externally sourced and accredited training.

21. The **trial** came to the conclusion that the behaviour of the three former members of staff was premeditated. Furthermore, their behaviour thrived in a home in which there was inadequate training and little management support. The ex-staff members themselves described their behaviour in terms of "a laugh" and cathartic "release" from the challenges of working at Beacon Edge. That is, there was a sense of being overwhelmed by the number of patients and their support needs against a backdrop of poor management at the home. They were the youngest members of staff at a home which appeared to neglect its contractual duties and thereby reinforced their unlawful behaviour.

### Analysis

22. It cannot have escaped the attention of other staff working with BB, CB and CS that the three were distracted by their mobile phones during working hours. They were sending *many thousands* of texts, receiving texts and taking photographs when they should have been providing care and support to elderly patients. A fellow-worker's attempt to rein in their behaviour during April 2013 was not followed up. It does not appear that either the existence of a BUPA policy prohibiting the use of mobile phones or having peers who did not use mobile phones was sufficient to halt their behaviour. It is striking that the trio made no attempt to modify their behaviour before a new member of staff, particularly since they too were novices in terms of their experience as care workers.
23. BB's reported explanation was that it was "just silly photos of each other to start off with and it just spiralled and spiralled and spiralled and got worse." However, the trial determined that the photographs and videos showed that patients' safety and wellbeing was threatened. Patients were observed to have been mocked, humiliated and harmed by BB, CB and CS. The photograph-takers took no account of the suffering and distress of older people as they took images without permission and where they would reasonably have expected to be granted privacy.
24. BB suggested that it was a shared appetite for taking photographs and videos and sending texts that got out of hand, that is, "it just spiralled and spiralled and spiralled and got worse." So much worse that it became excessive and progressively more harmful. Glimpses of the content of the texts from BBC coverage and a police report would suggest that the trio boasted about their behaviour and goaded each other to engage in further cruelties.
25. The CQC gave Beacon Edge the benefit of the doubt in terms of staffing during November 2013. That is, although on the day of its visit "there were fewer staff available than the staffing rota identified as necessary" and that staff informed the inspectors that they often "felt there were not enough staff on duty" the home was judged as having met the necessary standard in this respect. This was principally due to recent recruitment. The home

was also judged to have met the necessary standard in terms of the "Care and welfare of people who use services." During June 2013 and November 2013, that is after the whistle blower had described her first shift at Beacon Edge, the inspectors judged the home to be meeting both the care and welfare of people who use services and the staffing standards. It was only during July 2014 that the CQC determined that action was needed in terms of these standards.

26. Concerns about practice at Beacon Edge were incubating before 2013. The home appeared to give more credence to CQC inspection reports than to:
    i. monthly clinical support meetings with practitioners from the CQC, Adult Social Care and Cumbria Clinical Commissioning Group, specifically focusing on safeguarding
    ii. ongoing contacts with primary care and Continuing Health Care clinicians
    iii. health-led training opportunities.
27. Irrespective of such considerable professional input and scrutiny resulting in promises of change, neither substantive improvements nor decisive action resulted. It would appear that undue reliance was placed on the fact that there were a lot of professionals visiting the home. Inadvertently, such professional contacts, which included the deployment of nursing and social care staff, propped up this failing nursing home.
28. Neither BUPA's in-house training nor the training provided by health professionals in Cumbria made a difference to practice at Beacon Edge.
29. Almost half of the patients at Beacon Edge Nursing Home did not live in a safe, secure or pleasant environment when BUPA employed BB, CB and CS. Despite having health problems and high levels of need for assistance in their daily lives, at least 15 patients were harmed and exposed to physical assaults, disrespectful language and behaviour.
30. There is no 'market' of providers in Penrith, Cumbria competing on quality. This rendered the CQC and local authorities impotent. According to Kennedy (2014):

    *As a market, the care sector has some quite unique characteristics:*

    - *the purchase* [of a place for an older person] *is distressed and emotional, usually made in a time of crisis*
    - *switching provider is a tough decision*
    - *supply is geographically restricted as people want to be near their neighbourhoods, friends and relations*
    - *barriers to entry to the market are high*
    - *some markets are monopsonistic (similar to a monopoly, but a large buyer, the local authority[55], controls much of the market and drives prices down).*

    *…Private care homes can be excellent but they need to operate in a functional market – one that is not just set up to compete on price; this is dangerous. If a care home is under financial pressure, there is a significant danger that corners will be cut and quality reduced.*

    *The basics of the market need to be functional to promote competition based on quality. We need to be more open and honest about profit, about what is reasonable and set up the market to include minimum tariffs and functional commissioning practices to ensure that good care homes can be viable. We need to regulate the market in the truest sense…*

[55] At the time of the review c.75% of BUPA's care home residents in the UK received state funding.

*…the opportunity cost of an impoverished care sector is huge for the NHS and the economy…The market is one that we have created but it doesn't work. The market should be managed to create what we want – good, viable care homes in the right places; crucially too, care homes with the skills and capacity to support our ageing communities and our NHS.*

**Learning Points**

31. Three members of Beacon Edge's nursing home's staff incriminated themselves by using their mobile phones. They took unauthorised images of patients with the intention of sharing them and ignored the distress of the elderly patients.
32. It is possible that the trio had no appreciation that the police could and would access the incriminating digital images, videos and texts. However, the information stored on the phones of these former members of staff, which they shared with each other, allowed police to reveal the full extent of their cruelty.
33. The employees who were prosecuted defined their behaviour in terms of "banter…just a joke…just a bit of fun between the two of them" (that is CB and BB) and… "only a joke". However, their jokes reflected extraordinarily potent and disrespectful views of older people, for example, using the terms "cabbage" and "vermin" in relation to certain patients.
34. Since context is crucial to understanding the hostility of jokes and their meaning, the contexts in which the trio's jokes were told cannot be clear from digital-exchange evidence alone. It is difficult to argue with a joke since, typically, those hearing it do not wish to be seen as devoid of humour. However, the defence of "a bit of fun" at Beacon Edge demonstrates insensitivity at best and outright hostility at worst towards older people.
35. Monthly professional meetings, the provision of training opportunities and meetings associated with safeguarding processes are suggestive of a lot of scrutiny and monitoring. However, the meetings did not identify common ground or adopt an explicit overarching purpose. The safeguarding concerns did not diminish since there was no credible "operational grip" on the failing work culture at Beacon Edge Nursing Home. This was the responsibility of BUPA Ltd.
36. The Area Manager's assertion that 'Speak Up' is *more meaningful than 'whistleblowing'* is surprising (see, for example, CQC, 2013). Moreover, the claim that 'Speak Up' *is a meaningful term for BUPA's people and represents our culture* requires unpicking, not least since its "culture" was described as "acrimonious" by Adult Social Care. Reference to the observations of patients' relatives (see Endnote) bears this out and suggests that their concerns were downplayed.
37. The fact that BUPA Ltd favours the term "Home Manager" over "Registered Manager" would appear to downplay this critical role. It is not a term used by the CQC.
38. Even though its internal training was not working, Beacon Edge's Nursing Home staff did not access training which was available locally. It appears that this nursing home elected to remain outside the Cumbria Care Sector Alliance and its patients were not advantaged by such isolation.
39. Beacon Edge's complaint about Continuing Health Care "micro-managing" resulted in the dates of subsequent visits being agreed by the home and professionals being accompanied by the home's staff. In the light of the continuing thread of concern about inadequate

numbers of staff and insufficiently skilled staff, it is remarkable that CHC professionals acquiesced.

40. Finally, BUPA Ltd is a private, global company and there are weaknesses in the current legal position concerning such companies. That is, irrespective of the public interest associated with the care of large numbers of people and the public sponsorship involved, there are no obligations in terms of corporate governance (Griffiths *et al* 2015). Events which triggered this Review pre-date the introduction of the Criminal Justice and Courts Act 2015. Sections 20 and 21 of this Act provide for "care worker" and "care provider" offences, the latter of which is capable of covering both individuals and bodies corporate. The designated "Responsible Individual" directors BUPA UK Foundation, BUPA Care Homes (Developments) Ltd, BUPA Care Homes (GI) Ltd, BUPA Care Homes (Ans) Ltd, BUPA Care Homes (Cfg) PLC and BUPA Care Homes (Cfchomes) Ltd. It is not known how this role is enacted across these companies (which feature in the CQC's "Market Oversight" sample.[56]) It is known that this role failed Beacon Edge Nursing Home's patients and their families.

### Conclusions

41. It is regrettable that BUPA Ltd.'s contribution to this review has been partial. It has responded belatedly and erratically to requests for information and clarifications. This has been exacerbated by the continued turnover of senior staff at Beacon Edge and within BUPA Ltd.
42. During June 2015 Beacon Edge Nursing Home received an overall rating of "Good" by the CQC. It is not known how it achieved this rating and there is merited concern that such endorsement may allow it/BUPA Ltd to claim, once again, that it has overcome the shortcomings which prevailed during 2012-13. Nothing is known generally or specifically about BUPA's approach to recruitment, induction, staff training, supervision and appraisal at Beacon Edge during 2012-13. It is unlikely that a small provider would have survived the negative media attention BUPA received during the trial.
43. There was a wide discrepancy between the hopes of families and the experience of their relatives at Beacon Edge Nursing Home during 2012-13. We are left to speculate that BUPA is not engaged by either: "values based" recruitment,[57] or the social care commitment.[58]

### Recommendations

i. That this "case study" of Beacon Edge Nursing Home features in the safeguarding training of Adult Social Care, BUPA Ltd, the Care Quality Commission, Cumbria Care Sector Alliance, Cumbria Clinical Commissioning Group, Cumbria Constabulary,

[56] The purpose of the CQC's new regulatory duty of Market Oversight is "to protect people who may be placed in vulnerable circumstances due to the failure of a 'difficult to replace' adult social care provider. The CQC's monitoring of the "financial sustainability" of a sample of providers would enable it to determine "where we believe business failure is likely and that service delivery may be affected to the extent that Local Authorities may need to step in to ensure continuity of care, we will notify the relevant Local Authorities of this"

[57] www.hee.nhs.uk/our-work/attracting-recruiting/values-based-recruitment (accessed on 23 February 2016) and http://www.skillsforcare.org.uk/Recruitment-retention/Values-based-recruitment-and-retention/Values-based-recruitment-and-retention.aspx (accessed on 23 February 2016)

[58] www.thesocialcarecommitment.org.uk (accessed on 23 February 2016)

Cumbria Learning Improvement Collaborative, Cumbria Partnership Foundation Trust and Healthwatch Cumbria;

ii. That the commissioners associated with the clinical support meetings at Beacon Edge and some of the lead professionals meet to address the identified failings and document how, and in what ways, they would respond differently to concern about poor practice in the residential and nursing home sector. The commissioners may wish to involve the CQC in this meeting;

iii. That the CQC advises Cumbria's SAB of the actions it is taking in relation to the governance of Beacon Edge Nursing Home and BUPA Ltd, in the light of, Regulation 20: the duty of candour,[59] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014;

iv. That the Department of Health ensures that future guidance concerning Safeguarding Adult Reviews includes an expectation that the nominated individual (under Regulation 6 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) is personally responsible for the registered care provider's contribution to the process;

v. That Cumbria's commissioners embark on a sustained form of reckoning, setting out what it is that is expected in terms of *inter alia,* governance and a home's "windows" so that residents and patients may look out, communities, including can look in and there is scope for people to be and to feel part of their neighbourhood;

vi. That BUPA Ltd informs the Safeguarding Adults Board of the measures it has taken to assure commissioners that Beacon Edge's engagement with patients and relatives, its recruitment practices, its development of rotas, its supervisory and appraisal practices, for example, are supportive of learning and improving practice;

vii. That Cumbria's SAB and commissioners write an open letter to the current responsible individual at BUPA, or nominated individual, to express concern about BUPA's circumscribed responses to the questions raised by this Review, and furthermore, ask him to account for the changes which he will instigate as a result of this Review and, in particular, the Endnote;

viii. That BUPA Ltd joins the Cumbria Care Sector Alliance;[60]

ix. That BUPA Ltd undertakes to access external training opportunities in Cumbria, including those available via the improvement collaborative;

**References**

Care Quality Commission (2013) *Whistleblowing: Guidance for providers who are registered with the Care Quality Commission* https://www.cqc.org.uk/sites/default/files/documents/20131107_100495_v5_00_whistleblowing_guidance_for_providers_registered_with_cqc.pdf (accessed 18 March 2016)

Griffiths, A.W., Hodgetts, C. and Ni Thuama, R. (2015) The legal context of residential care and corporate governance. In M. Flynn, *In Search of Accountability: A review of the neglect*

[59] http://www.cqc.org.uk/content/regulation-20-duty-candour (accessed on 11 March 2016)

[60] An employer-led, membership organisation made up of more than 200 charities and private organisations providing social care in Cumbria

*of older people living in care homes investigated as Operation Jasmine,* Cardiff: Welsh Government

Kennedy, J. (2014) *John Kennedy's Care Home Inquiry* York: Joseph Rowntree Foundation and Joseph Rowntree Housing Trust

## Endnote

On 17 March 2016, a meeting was held with the relatives of people who had been harmed at Beacon Edge. The discussions ranged over a number of themes, some of which had not been revealed during the course of the review:

- **Complaints**[61] - BUPA's complaint's process was experienced as unhelpful and disrespectful at Beacon Edge Nursing Home. It is not known whether some expressions of concern, which were serious, were escalated within BUPA Ltd or even investigated. All relatives were concerned about the potential backlash if they made complaints, not least because the communication of their relatives was compromised:

*We questioned the expenses and were told that our relative was paying to see a hairdresser four times a week! How many people see a hairdresser four times a week?*

*We asked them not to spend* [their relative's] *money without checking with us. We never saw the purchases – even though they spent £100.00 without any authority*

*Re the fees – I think there was some fraudulent activity*

*We used to buy* [our relative] *nice clothes. Really good quality clothes went missing*

*I saw some staff wearing items which belonged to the patients – fleeces for example*

[My relative's] *glasses went missing. They had cost £400.00 and I was told to "claim it on insurance!"*

*Same for us – expensive glasses lost and not replaced*

*Packets of new, unused socks vanished*

*They never looked after their clothes and belongings*

*Clothes were damaged because they weren't washed carefully*

*I did suggest that…housekeeping [might] compare [relative's] inventory of clothing in personal file with those clothes in [resident's] room to see what was missing in the laundry to help reunite [my relative with] labelled clothing*

*We would just politely try to bring concerns to the attention of management when seeing them face to face e.g. at "Relatives' Meetings." Though when someone has your loved one in their care you try not to rock the boat for fear of repercussions so tend to brush over a lot of things as you don't want to be seen as a trouble-maker*

*Often, concerns or suggestions, although recorded, are not actually followed through. I've had to repeat on each visit my concern about some issue…and although the nursing staff/ carers have been able to go back and find the diary entry, no one has taken ownership of seeing it through*

*[Our relative sustained a broken limb] by an "agency" employed staff and [was] in hospital for over a month…not only did we receive no apology or compensation [Bupa] continued to*

[61] http://www.BUPA.co.uk/complaints (accessed 18 March 2016)

*issue not inconsiderable monthly bills for…care and upkeep…[Our relative was] treated just as a profit-making commodity*

- **"Resident of the day"**[62] according to BUPA this is *an initiative that helps care home staff to really understand what is important to each resident and to review in depth what would make a difference to them. Each day, in homes across the region, the resident of the day programme enables all staff, whether carers, nurses, housekeepers or gardeners, time to get to know one service user so that we can personalise their care and provide an environment for them to enjoy as much stimulation as possible.* This is not the way in which 'resident of the day' was experienced by patients' relatives at Beacon Edge Nursing Home:

*It was a waste of time because you couldn't rely on their records. It was supposed to be a review and it meant that the resident could have their favourite food cooked for example*

*They ignored people's histories. We told them many times* [a single, significant fact] *about our relative and because we had to repeat it at every 'resident of the day' event it was clear there was no point. In the end we didn't bother going – we just rang*

*What was the point in inviting me to a non-existent meeting? For the process to be beneficial then…more planning or offering choice of dates to relatives so they can select the most convenient (especially if they have to arrange time off work) – when the resident's team is actually going to be available…would be beneficial all round*

*I took time off work and arrived to find that no one was available. Neither the staff who usually worked with* [my relative] *nor the manager were on duty. When I complained I was told, "I take your point!"*

- **BUPA Ltd** – families did not realise that they were relinquishing the care of their relatives to a nursing home in which there was no evidence of the promised "person first"[63] or "person centred" care.[64]

*The senior managers are very interested in their public image – not what happens to the people they're looking after*

*There was never any consistency of attendees at meetings so you'd have to go over the same ground at each meeting*

*There were never enough staff and they weren't trained - yet they were supposed to be looking after patients*

*They must have made a least £1m a year in that home and yet it wasn't clear what they were spending the fees on. Surely they could afford to have more staff and pay them adequately?*

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[62] http://BUPAcare.newsweaver.co.uk/newsletter/nh1euxobdvb?opc=false&s= (accessed on 18 March 2016)

[63] http://BUPAagedcare.com.au/staticfiles/BUPACare/Images/choosing%20a%20care%20home/choosing-a-care-home.pdf (accessed on 18 March 2016)

[64] http://www.BUPAagedcare.com.au/portal/site/BUPACare/menuitem.d132f798fc01d63b0bbe80d7685420a0/?vgnextoid=04caa68f8a71c310VgnVCM1000000c0a400aRCRD (accessed 18 March 2016)

*Staff were working 12 hour shifts – that's too long for any carer - and the pay is atrocious*

*There were three members of staff on at night. How would they get people out if there was a fire?*

*The senior managers were always changing*

*The meetings they organised were always at their convenience, not ours*

*BUPA's minute taking was poor – they contain factual errors - but this was to their advantage because they never corrected them!*

*You could never rely on their records, not even the records of care arrangements*

- **Looking back at Beacon Edge Nursing Home**

*There was a lot of complacency and no planning*

*A lot of the staff were mates – they socialised together*

*It was like anyone could be a carer there*

*[The staff] know their names and what their duties are but we don't*

*Patients' histories were ignored*

*Things weren't sorted out and no one had a grip – the manager would make polite requests as though they wanted to be friends*

*Friday afternoon the manager was always "on a course" or "in a meeting"*

*There was a lot of bullying and back-stabbing*

*Our relative used to be* [a clinician] *and if* [they] *had seen what some staff were getting up to* [they] *would have given them hell!*

*Where's the accountability?*

*What about the duty of candour?*

- **The harms at Beacon Edge**

*I learned about the abuse on Radio Cumbria*

*We feel we've been totally disregarded*

*Why did it take BUPA months before they wrote to us?*

*There was no understanding of what relatives were going through and still are*

*BUPA hasn't even apologised properly. It's as though they didn't accept responsibility and they're scared to say "sorry"*

*When we visited my relative used to say "Something bad happened to me last night and I can't remember what it was." We used to reassure* [our relative]. *The guilt I feel now is like a knife in the gut*

*My relative started to flinch when approached*

*There was another unexplained fall…due to lack of supervision [staff] thought she may have been pushed over…but allegedly no witnesses amongst the carers*

*Lessons haven't been learned. They've blamed the staff even though they weren't properly vetted and they didn't train or supervise them*

*They have the nerve to claim that CCTV would infringe people's human rights – after all our relatives have been through*

*We'll never forget what happened. It's long lasting*

*I couldn't bear to have any who worked at Beacon Edge Nursing Home at my relative's funeral*

*BUPA managers even lied to us at one meeting claiming that they'd written to us – then they couldn't find the letter they alleged that they'd sent!*

*It's like they've shoved it under the rug*

*[Our relative] was tormented and abused by members of [BUPA's] staff…we have yet to receive either a personal apology from BUPA or the management at Beacon Edge itself*

- **If only BUPA Ltd would…**

*…understand that a heart-felt apology would make us feel less guilty*

*…see that 'resident of the day' is a waste of time*

*…take a lead in fielding an "agent provocateur" as a new member of staff – then they wouldn't have to rely on new members of staff to whistle blow*

*…understand that 12 hour shifts are too long*

*…spend more of the fees – which are considerable – on training and supervision and paying staff a decent wage*