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"FILE ON 4"

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ACTUALITY OUTSIDE COURT

URRY: A care worker from Portsmouth has just been jailed for abusing elderly residents in the home where she worked. Two other staff were also convicted. File on 4 is here at the courts to see them sentenced and to investigate this, the latest in a series of disturbing cases which raise serious questions about the failure to care for the frail and the mentally ill in residential homes. Last month a parliamentary committee found more than 20% weren't even reaching basic minimum standards laid down by the Government.

FINN: I miss him. It's left me with the guilt that I put him in there. I blame myself now, because if I'd have seen how bad his foot was and how thin his body was and all these sores, I perhaps could have got him out of there and took him to hospital, but I didn't know. I have to live with this every day.

URRY: But how is she supposed to find out if her 92 year old father really is being looked after in his care home? Shouldn't she be able to rely on the scrutiny of those who regulate and inspect such places? In the cases we've examined

URRY cont: for this programme, we've uncovered a shocking series of failures. An elderly man beaten to death by another resident in a home because there weren't enough staff on duty to protect him. And neglect so bad, an elderly dementia sufferer died of infected bedsores, described by an experienced nurse as the worst she'd ever seen. Problems the authorities failed to spot, despite numerous inspections. Now, following our investigation, a Government minister says he'll review the way individual complaints are handled.

LEWIS: This is one of the issues that we'll have to consider – the way that people feel they're getting proper redress in terms of legitimate grievances and complaints against individual care homes.

SIGNATURE TUNE

ACTUALITY OUTSIDE COURT

URRY: Hello, we're from the BBC.

WOMAN: No comment.

URRY: You wouldn't happen to be from Cornelia Lodge?

WOMAN: No comment.

URRY: You can't tell us anything about what's gone on inside the court?

WOMAN: No comment.

URRY: Outside the courts in Portsmouth last week, not everyone wanted to talk about what had happened at Cornelia Lodge, a nursing home in neighbouring Southsea. Three care workers there were convicted of abuse. One was jailed, two others received community service orders and were banned from caring for vulnerable people for two years. They walked free and one of them, Ting Ting Zhu, left court with her interpreter, still protesting her innocence.

ACTUALITY OUTSIDE COURT

URRY: I've just heard the magistrate in there saying that you lost your temper.

ZHU: I still insist I'm innocent, I do.

INTERPRETER: She still insists that she was innocent on this case.

URRY: That you didn't assault anybody?

ZHU: No.

URRY: Why did the court think that you did then?

ZHU (VIA INTERPRETER): One of the witnesses, she said so, or she claimed so that I did it.

URRY: Zhu was found guilty of assault for throwing a cup of tea at a woman in her eighties who wouldn't get up from her chair in the residents lounge. The prosecution said Zhu and another foreign care worker couldn't understand English very well and therefore couldn't communicate properly with those in their care. Instead, the court was told, they were following the example laid down by another, more experienced colleague, Zonke Nzimande. Her idea of an appropriate daily regime for the elderly residents she looked after, many of whom suffered dementia, was to use casual violence to get them to comply with her strict routine so she could take her breaks and complete her shift on time.

MAVUSO: It was unbelievable and even you yourself was watching it, it was really scary. It was physical abuse, verbal abuse, those are the things really.

URRY: I mean when you say physical abuse, what was going on?

MAVUSO: Clients being punched and slapped in their faces.

URRY: Punched?

MAVUSO: Yes.

URRY: When was the first time you saw her hit someone?

MAVUSO: It was the very first time I worked with her, first day.

URRY: Nqobile Mavuso, another care worker, witnessed what was happening at Cornelia Lodge on the very first day she started working there. To make matters even more difficult for Nqobile, she had known Zonke Nzimande socially before then, and she regarded the more senior carer as her friend. One of those assaulted by Nzimande was 80 year old Sheila Liddell. Her daughter, Nicke Bentley, didn't know her mum was being knocked around and roughly handled. Because she was elderly, Sheila's skin was thin and she marked easily. Nicke had become concerned about bruising she'd seen when she visited, but had been reassured by the explanations she'd been given.

BENTLEY: When Mum was in Cornelia first of all, she had bruising on her. I assumed it was because she was so frail.

URRY: What sort of bruising?

BENTLEY: On her arms, on her hands. In hindsight perhaps I should have been more concerned about this bruising, but I was told that she'd knocked herself on the bed or on the corner of the chair that she was sitting in.

URRY: You were given plausible explanations about the bruising that you saw?

BENTLEY: I asked various workers there and they said, 'Oh Mum's probably knocked herself.' I assumed that this to be the case, yes.

URRY: Is it difficult to make complaints when you're in a situation like this?

BENTLEY: It is difficult, because you don't want to think that there is going to be this type of assault going on. And also you don't want to make a lot of fuss because it might have repercussions for your relative.

URRY: With families being fobbed off with excuses, and those who'd been assaulted unable to make a formal complaint because of their dementia, it fell to Nqobile Mavuso, an employee, to blow the whistle on her friend. A survey published last month by the charity Help the Aged found that 60% of nurses they polled were reluctant to report abuse because of fears they might have misinterpreted the situation. But 35 year old Zonke Nzimande was found guilty of nine charges. The judge told her they were among the worst type of common assaults which could be imagined. She was jailed for six months.

ACTUALITY AT CARE HOME

MAN: Harry, that's your tea. Watch, it's hot. I'm just doing your toast, I'll just get you some toast. And some marmalade, yeah?

HARRY: Please.

MAN: Okay, I'll just get that.

URRY: This is Cornelia Lodge today, a year on from the regime of casual violence, and a place now of much higher standards, according to the company.

MAN: There you go. Is that all right?

HARRY: Thanks very much….

URRY: Owner Stephen Geach insists he did all the necessary background checks on his three former employees and that they came up clean.

URRY cont: But background checks are only part of what's needed to protect residents with dementia. It's clear from inspection reports by the regulator that Cornelia Lodge hadn't been meeting all the good practice guidelines laid down by the Government, known as national minimum standards.
Nursing and care staff, they said, lacked training to deal with dementia, mental illness and learning disabilities, which is really what you specialise in here, isn't it?

GEACH: Yes, absolutely. I mean, there, there was limited training in the dementia care and there were weaknesses in, in certain areas that have been brought to account now.

URRY: People were being knocked around here, weren't they? That was pretty clear. People had bruises, black eyes, they had other physical signs of injury. What were the explanations given?

GEACH: We need to explain each individual one on an individual basis. I couldn't possibly get into generalising such as you've just done. Elderly people fall more than younger people, they bruise easily. I don't like to call it battered around or bullied in any way. I mean, every single bruise that happens is logged and identified in a care plan about justification of what it was and how it was caused.

URRY: And yet when police seized the records, they say there was no record of the specific injuries that subsequently led to the charges, that these things weren't written down, whether anyone was to blame or not.

GEACH: Well, as I say, there was an administration error. We have put our hands up about it not being administered particularly well or written down exactly according to our procedure, and that exactly ….

URRY: They weren't written down at all, never mind procedure.

GEACH: Well, that's why we've made the changes we've made.

URRY: Sheila Liddell, who was assaulted last year, died in hospital four weeks ago. Her family don't attribute her death to her mistreatment, but they maintain she never got over the bullying. Sheila's place at Cornelia Lodge was funded by Portsmouth Social Services. Her daughter, Nicke Bentley, a former lady Mayoress and city councillor, wants to know why the authority continued to fund places at a home where serious questions had been raised by the regulator, the Commission for Social Care Inspection, or C-SKY.

BENTLEY: It came out in court that the home was so badly run that C-SKY was one step away from closing it down. Surely social services must have been aware of this and they were still instigating people to go to this home. They actually had to go to a finance committee where the funding was actually appealed for, so you know, why wasn't social services more aware of the state of how this home was run?

URRY: Enquiries by File on 4 show Portsmouth Social Services were aware of problems at Cornelia Lodge, and suspended placements there in February 2005. But that suspension was lifted four months later, despite continuing concern noted in the inspection reports from the regulator. The authority's Strategic Director of Social Care, Margaret Geary, says her department was trying to work with the home to effect improvements.

GEARY: In terms of reports coming from the home, it seemed that they had reached adequate standards at that stage …

URRY: See, I can find nothing in the inspectorate report that suggests that this home was on an upward improvement curve.

GEARY: I'm not denying that this is a home about which there were concerns and we were working with the relevant authorities to try to manage those concerns.

URRY: How did you come to your judgement that things were getting better then?

GEARY: There had been an action plan put in place with health colleagues to help raise the standards in the home and we believed that those were being improved.

URRY: On what basis did you believe that though?

GEARY: That will have been on the basis of agreement between health colleagues, ourselves and the Commission for Social Care Inspection at the time.

URRY: And yet they produced this damning report just a few weeks later really. What it said, improvement was needed in all areas of service and that the home was in breach of care home regulations, breaking the law.

GEARY: And for that reason we worked with our health colleagues and the Commission for Social Care Inspection to undertake improvement work with the home.

URRY: Do you accept that during these months you lost your grip?

GEARY: The Government does not charge us as a local authority with overseeing the standards of private sector care homes.

URRY: No, but you have a duty of care to the individuals with whom you have a contract ….

GEARY: We have a duty of care to our individuals and we take that duty of care very seriously ….

URRY: Did you lose your grip on the individual cases then?

GEARY: No, we monitor those cases as closely as we can and the knowledge that was given to us at that time suggested that their care was adequate.

URRY: But it wasn't. Despite the interventions of healthcare staff, social services and the Inspectorate, the transformation the owners now say they've brought about didn't happen until after police became involved - too late for those who'd been slapped, punched and bullied. In another case we've looked at, both social services and the regulator took too long to act, with fatal consequences.

FINN: He never complained once. He must have been in so much pain, but he never said anything. Not a thing. I blame myself now because if I'd have seen how bad his foot was and how thin his body was and all these sores, I could have took him to hospital, but I didn't know. I have to live with this every day.

URRY: Pamela Finn has little reason for self reproach. Her father, 92 year old William Stone, needed full time nursing care, primarily because of his dementia. But he went into rapid decline at the residential home to which he'd been transferred, and which was supposed to be looking after him. In Southfield Manor at Styal in Cheshire, he lost 23% of his body weight in just three months. Mrs Finn is suing the owners of the home because of the neglect suffered by her father. Her lawyer, Rosamund Rhodes Kemp, argues mistakes were made right from the start.

KEMP: When he was first admitted, he was assessed, and it was then, I feel, that the problems first arose, because the assessment that was carried out didn't identify some of the potential risks to him, including his pressure areas. He was a high risk resident – in other words, he was at high risk of developing pressure sores. The initial assessment was not very accurate, so that set the ball rolling, because once the assessment had been carried out and the care plan developed, it didn't really concentrate on some of the areas of vulnerability that he had. He then unfortunately developed an infection. He became far less mobile, he wasn't eating and he wasn't drinking, so his care plan should have been redone, taking into account this deterioration.

URRY: Malnourished and dehydrated, Mr Stone's pressure sores, which had started on his foot, spread and got much worse. His daughter, Pamela Finn, was a regular visitor, but says she wasn't told how poorly he'd become, and that it wasn't easy for her to see what the problem was until the day he was taken into hospital.

FINN: Because when I went he was always fully dressed, he'd lost weight in his face but the rest of his body I didn't know how much weight he had lost.

URRY: What about the pressure sores? You were aware that there was a problem on his foot. What else did you know about those?

FINN: I had no idea that he had any other sores. The one on his foot was bandaged up when I went. I didn't even know it had gone to the size that it had gone to until we got taken aside at the hospital by one of the doctors and nurses to say that, because of how bad his foot was, they would probably have to amputate and also ….

URRY: He had to have his foot amputated?

FINN: That's what they told me, probably below the knee in the end, but because he was very poorly from the poisoning in his system, through this foot, they wasn't sure whether they'd be able to do that and they were just going to try and clean it up as best as they could. His body was covered in bed sores. The one on the bottom of his spine was apparently about 8" by 8". The doctor and the nurse took us aside to say it's the worst case that they'd ever seen. After a week my dad died ….

URRY: You're all right, don't worry ….
At Mr Stone's inquest in June of this year, the coroner detailed a catalogue of failings by staff, and by some outside professionals who visited the home. He found there'd been gross deficiencies in the care of a man who was wholly dependent upon others for all his physical and medical needs.

ACTUALITY IN CHESTER

URRY: But Mr Stone wasn't alone in being badly cared for at Southfield Manor. He was a client of Cheshire Social Services, based here at County Hall in Chester. They'd been aware of problems the previous year and, just like their counterparts in Portsmouth, they tried to work with the home to effect improvements.

URRY cont: They thought they'd succeeded and so, at the turn of the year, lifted a temporary suspension of placements, opening the doors for William Stone and others to be admitted.
Sheelagh Connelly, the county manager for Older People's Services denied they were lulled into a false sense of security.

CONNELLY: There was nothing that alerted us in those months between the January when the ban on placements was lifted and Mr Stone's death that indicated to us that anything untoward was happening at Southfield Manor.

URRY: How hard did you look?

CONNELLY: Well, what we will have been doing is we will have been visiting the home when we were talking about making any new placements of people, we will have been doing reviews in relation to new placements of people.

URRY: But given that social services themselves have had concerns the previous year and suspended placements there, shouldn't you have been much more alert to some of the problems that clearly then subsequently arose?

CONNELLY: I think we did what we could in relation to Southfield Manor. We did maintain further observation of Southfield Manor after the lifting of the suspension on placements, and I believe that we, as did other agencies, genuinely did believe that standards had improved at Southfield Manor. Had we become aware that there were any concerns in relation to Mr Stone or any of the other residents, then we would have taken action.

URRY: When hospital medics raised the alarm after his death, Cheshire Social Services reviewed the cases of all the 93 residents at that time. It unearthed much wider concerns about the abilities of care staff to cope with those who lived there. Finally, on June 19th 2006, Cheshire Social Services terminated their contract with Southfield Manor. In what they describe as an unprecedented step, they withdrew all 31 of their clients from the home. The home's owners, Craegmoor Healthcare, wouldn't be interviewed for this programme. They issued a statement from their chief executive

URRY cont: saying they again expressed their sincere sympathies to the family of Mr Stone but wouldn't comment further on the case because of pending litigation. The statement also pointed out that:

READER IN STUDIO: There is a new management team at Southfield Manor, and they have worked closely with our clinical governance experts to further improve our procedures. Additionally there has been significant investment in refurbishment. We are confident that Southfield Manor offers the high standard of care that service users and their families rightly expect. The delivery of high quality care is always our top priority.

URRY: The Coroner's office in Cheshire has told this programme that they have concerns about four deaths at Southfield Manor, including William Stone's, going back to when their records began in 2004. Only last month, a Lithuanian care assistant who'd been working at the home was convicted of ill treatment for twisting a plastic bag over the head of an 88 year old dementia sufferer, trying to suffocate him. Another carer intervened and the man survived. So where was the Commission for Social Care Inspection? It had conducted a series of inspections in 2004 and throughout 2005 because of continuing concerns about the wellbeing of residents at Southfield Manor. The number of deaths there had inspectors worried, as did the number of broken bones and the time it took to transfer those with injuries to hospital. They noted poor risk assessments, the lack of skilled and trained staff and the failure to maintain proper care plans, also filthy conditions. But incredibly, as William Stone's condition was worsening and his care plan was failing to take account of his needs, an inspection report less than five weeks before his death recorded there was:

READER IN STUDIO: A noticeable improvement in the plans of care devised for the residents. These addressed healthcare and personal needs in a more meaningful and individual manner.

URRY: The Commission's Mike Rourke concedes his organisation has been found wanting over Southfield Manor.

ROURKE: With hindsight, I think today we would have acted more promptly. We would not have allowed the provider such a long lead-in time to improve services. In fact, what we saw in response to our inspections was improvement, but it wasn't sustained.

URRY: Do you regret that judgement now?

ROURKE: Well, I think this is part of the organisation developing the way that it works, getting better at what we do and learning from lessons.

URRY: It's just that they've had plenty of alarm bells, and very serious ones as well.

ROURKE: There were alarm bells and we certainly were out there doing unannounced inspections, checking what was going on, making recommendations, requirements, issuing statutory notices. We feel that we have dealt effectively with this home. Standards today, we think, are much better and certainly …

URRY: But you thought that before, didn't you, so what confidence can people have in that?

ROURKE: Certainly today there would be no grounds to go to a care standards tribunal to seek the closure of this home.

URRY: How can it reach the stage where a man who's taken in fairly fit and active and three months later he dies of infections associated with the worst bed sores that nurses have ever seen?

ROURKE: This is clearly unacceptable. We will try very hard to make sure that when these issues are brought to our attention, that we will act appropriately. I think we ….

URRY: But do you accept you didn't appropriately at that time? I just want to be clear about that.

ROURKE: I think what I'm accepting is that, if we look with hindsight, we gave the provider a little bit too long to effect the changes that were necessary.

URRY: For the Relatives and Residents Association, the charity which campaigns for the wellbeing of older people in care, the Commission is failing to get to grips with its own functions. Chief Executive Dr Gillian Dalley argues the regulator is in a muddle.

DALLEY: CSCI has undergone huge budget cuts. The number of inspectors has been reduced pretty substantially over the last eighteen months, so I think inspectors are working under a lot of pressure. Perhaps there isn't enough commitment at the highest level to ensure enforcement action is taken when it ought to be taken, partly because there aren't alternative places to remove people to and the very idea of having to remove people because a home is being closed under an enforcement action is quite a traumatic thing for residents. There are a lot of …

URRY: It is a difficult decision, isn't it, to take that?

DALLEY: It is, but then I think if the decision to close a home isn't going to be made, then there ought to be much closer scrutiny of performance in the months after a very critical inspection.

URRY: Do they have enough tools at their disposal to ensure that standards are met and that standards are kept high?

DALLEY: If they used the enforcement that they could, I mean, they lay down requirements after inspection but they need the inspectors to be able to go back to a home and to ensure that those requirements are being put in place. I'm very well aware of homes where lists of requirements are laid down, and yet in succeeding inspection reports there's no indication that they've been actually put in place.

URRY: But the Minister for Care Services, Ivan Lewis, insists that overall the Commission is functioning well.

LEWIS: I believe the regulator is doing an incredibly effective job. I think there's a lot of evidence that the regulatory regime that was put in in 2000 has made a tremendous difference.

URRY: But the concern is that operators are given too much slack, too many opportunities to put things right that they're not doing.

LEWIS: It's disingenuous to suggest that you will ever have a system where there aren't individual circumstances that go wrong.

URRY: Some people do though think that you are effectively in retreat from this as a light regulatory touch, the inspectorate has been subject to budget cuts and that what they see as a pattern of the organisation effectively pulling back from the business of enforcing the regulations.

LEWIS: We've got stronger laws than we've ever had. We've got national minimum standards, which we didn't have previously. We're introducing star ratings.

URRY: Budget cuts? Unwillingness to enforce?

LEWIS: Local authorities are being told that they must use their commissioning powers and responsibility far more seriously to improve standards and improve quality. Regulation is a very very important part of that, but it's only one part of it, and to present that out of kilter gives a misleading impression.

URRY: In another case examined by File on 4, there was a failure to correct serious shortcomings, which a coroner decided had contributed to the death of an elderly resident at a care home in Cambridgeshire, and there were plenty of warning signs.

THOMPSON: It was nothing to have to walk round deposits on the floor in corridors. Unless somebody told them and pointed them out, staff had seen but they had walked round them.

URRY: Tim Thompson was a regular visitor to his grandmother, who was then in a home called Edendale in the Fenland market town of Wisbech. Elsie Thompson was 96 and had dementia, and Tim became increasingly concerned about the state in which he found her.

THOMPSON: Week after week we'd find my gran soiled and my aunty had to clean her up and change her. It was obvious she hadn't just had an accident, she'd been in this state for some time.

URRY: You complained about this to the home, did you?

THOMPSON: Yes, yes.

URRY: What was the response?

THOMPSON: When we complained about that, then they would actually come and clean her up, but that doesn't alter the fact that she was left to get in that state. My grandmother, she couldn't walk without a frame, and we'd find her in her room, sitting in a chair with no frame. She couldn't get to the toilet, she couldn't manage on her own, she was 96 years old. We turned up one week to find her there, she was crying and said, 'Thank God you're here, they wouldn't help me.' She was in a hell of a state.

URRY: Tim Thompson says he continued to raise his concerns with staff at Edendale, and with the owners at that time, Ashbourne Health Care, but that it wasn't making much difference to Elsie's quality of life in the home. To complicate matters for both sides, there was disagreement in the family about what should be done for the best. But as the weeks went by, Tim lost confidence in Edendale and was desperate to get his grandmother out of there.

THOMPSON: When we couldn't get anywhere, I told the home that if they didn't find her a place I would remove her from that home and I would bring her home to my home.

URRY: When you were suggesting to the home that that's what you might consider doing, what did they tell you?

THOMPSON: They told me that I hadn't got power of attorney, and if I removed my gran from there against the wishes of the home, they would call the police, because I was actually taking her out of there and effectively kidnapping her.

URRY: Having got no satisfaction from the home and its owners, Tim Thompson turned to the Commission for Social Care Inspection for help. After all, they said they were there to improve care and stamp out bad practice.

THOMPSON: I wrote a letter of complaint and I sent a copy to the Inspector of Homes, which I was led to believe was an independent body that kept an eye on care homes and their standards.

URRY: And what response did you get?

THOMPSON: I got a letter saying that on this occasion they had handed my complaint back to Ashbourne Healthcare for them to carry out an internal investigation. I couldn't believe it. Ashbourne Healthcare actually handed it back to the manager of the home we had complained about, and our complaints concerned the manager herself. I actually had a letter signed by the manager saying that our complaint had been looked into and action had been taken to correct it.

URRY: She'd been asked to investigate herself, effectively?

THOMPSON: Yes, that's right. It's unbelievable, isn't it?

URRY: It seemed to Tim Thompson that the regulator had spurned the opportunity not just to examine the concerns about his grandmother, but about poor standards in the home which he believed were affecting other residents. We've discovered the Commission won't now investigate anyone's individual complaints. Mike Rourke, business director for Inspection, Regulation and Review says the decision was reached after taking legal advice.

ROURKE: We don't believe that we've got the statutory authority to investigate complaints and we've taken views about that and we've talked to

ROURKE cont: the local Government ombudsman, for example, and our view is that we are not a complaints investigation agency so therefore we need to make sure what we do when we receive concerns, complaints or allegations and we think we've got that pretty much right now.

URRY: I don't think I'm yet clear about whether you actually have or are forbidden from using your powers to investigate individual complaints.

ROURKE: We don't investigate complaints ….

URRY: I know you don't, but it's a question of whether you've chosen not to or whether you are prevented by law from doing so.

ROURKE: We don't think we've actually got the statutory authority to do that.

URRY: So the difficulty is that when people start to complain to staff in the homes and use complaints procedure and they get no satisfaction from that, then they go to you, you just refer them right back to the home and staff they're complaining about in the first place.

ROURKE: Not necessarily so.

URRY: Well that's happened in a case we've looked at.

ROURKE: We would certainly look at someone who said, 'We don't think this has been dealt with properly.' We try to spot whether there are patterns. If we were alerted to a number of very similar concerns, that would trigger an inspection.

URRY: But how can you spot patterns if you don't investigate individual complaints?

ROURKE: Well we do log what people tell us and we do act, but we go out with a focus, we go out to look at a particular issue to see what's going on.

URRY: Twelve days after Mr Rourke's staff in Cambridgeshire had written to Tim Thompson saying they'd passed his complaints back to Edendale, matters became far more serious. One of Mr Thompson's many concerns which he says he raised with the home, was about an elderly male resident with dementia who'd been aggressive towards his gran - so much so he'd asked for them to be kept apart. He was right to be worried, as another family found out to their cost.

WOODS: A nurse led me to a screen and said, 'Before you go round, you must prepare yourself for a serious shock,' and when I did step round the screen I couldn't believe the mess that my father's face and head was in. I did have to go outside and just collect my thoughts and settle myself for a few moments before I could come back in and stay with him.

URRY: Andrew Woods had been woken by a telephone call in the early hours to be told his 86 year old father, Arthur, had been seriously injured in Edendale and was in hospital.

WOODS: He was just a mass of blood and bruising and swelling. It was nearly hard to recognise him at the time, he was in such a state.

URRY: What did the doctors tell you about what they thought had happened?

WOODS: At the night, at the hospital, the doctors didn't tell me anything that they thought had happened. It was the sister who said, 'Have you reported it to the police?' and I said no, and she said, 'Well you really ought to, given the state your father's in.' And I did go outside and I made the call to the police, but at that point, I have to say, it hadn't occurred to me to do that, because I didn't know really what had happened to my father.

URRY: It took an inquest earlier this year to establish that. Evidence given to the coroner showed that on the night, Arthur Woods had been attacked, and that there weren't enough staff on duty to prevent it. One had phoned in sick and not been replaced. It left just two to cover more than 25 residents at a home in which it was

URRY cont: difficult to monitor every part of the building. And those suffering dementia are often up and about during the night because the condition affects their body clock.

WOODS: I only found out from one of the carers, who the coroner called in to give evidence, apparently she had been on duty on the night with just herself and another carer, and they had been at the far end of the home dealing with one of the residents, and they had duly come back down to the carer's station after they had finished what they were doing, and saw two residents at the end of the corridor from the carer's station down where the sitting room was. And she started to walk towards them because they were standing together at the end and asked them, 'Is there anything the matter?' and one of them said, 'Don't worry about me, you want to worry about him in there,' and pointed through the open door to the sitting room, and my father was sat in an upright, winged sitting chair, saturated in his own blood with a pool of blood on the floor.

URRY: Five days later, Arthur Woods died in hospital. Although nobody seems to have seen what happened, on the evidence before him the coroner concluded he'd been assaulted. The violent resident whom Tim Thompson was so concerned about was implicated. The Woods family say they have no issues with the man or his family because his actions arose from his illness. In fact, staffing levels and other matters central to the care and protection of vulnerable adults at Edendale were in disarray. But once again, that only came to light after the untimely death of an elderly resident. Only then did the Commission discover the root of some of the problems which Tim Thompson was seeing in the failure to care for his grandmother. They included:

READER IN STUDIO: Inadequate staffing levels at night time and in general.

READER 2 IN STUDIO: Extremely high levels of sickness and absenteeism at an average of 155 hours a week.

READER IN STUDIO: No monitoring of sickness levels.

READER 2 IN STUDIO: A lack of supervision.

READER IN STUDIO: No training for care staff in adult protection.

URRY: Findings which came too late to save Arthur Woods. After his inquest, the coroner wrote to the minister and to the Commission, pointing out the need for regulations about minimum staffing levels, and for a timely replacement of a care home manager, something which in this case he found was part of a systems failure which contributed to Mr Woods' death. Those we've spoken with during research for this programme have also underlined the importance of the post of manager to the success of running a care home. It's something the Commission itself acknowledges, so we asked senior director Mike Rourke why that was allowed to drift at Edendale.
The coroner was concerned that there wasn't a timely appointment of a new manager and that you should have done more to ensure that.

ROURKE: We certainly expect providers to let us know, they have a duty to advise us if they have a manager leaving and we would expect them to respond very quickly. We know, of course, that you can't necessarily appoint someone overnight, they will be a gap. Our issue is how long's that gap going to be, is it reasonable and, more importantly, what interim arrangements are being put in place to provide adequate management.

URRY: What's a reasonable gap then, in your view?

ROURKE: We would expect no longer than six months, but that's in exceptional circumstances.

URRY: No longer than six months? It's just that in your inspection report, when the manager left this particular care home, your inspector gave them fourteen months – fourteen months before a new manager needed to be appointed.

ROURKE: I don't think that we gave fourteen months.

URRY: I've got the inspection report right here in front of me and that's exactly what it says.

ROURKE: Well, I think we would certainly be looking at a much shorter period of time now.

URRY: I'm just wondering why it took an inquest and an investigation by a coroner to highlight these concerns that your organisation should have picked up in the first place.

ROURKE: Well, I'd certainly think we were aware of concerns in this home. We were making recommendations, we were making requirements, we were also making statutory requirements as well. Certainly our view now is that the home has addressed the issues that the coroner has raised, and we've been out there recently and we think they have put a great deal right.

URRY: The owners of the home at the time, Ashbourne Healthcare, were taken over by another company, Southern Cross. They wouldn't be interviewed, but in a statement they said they had bought the business after the death of Arthur Woods and pointed out:

READER IN STUDIO: We have made many changes and worked in partnership with our Regulators to ensure that standards of care have continued to improve. Many of the changes related to a review of management, staff and the culture within the workplace which has taken time to address. A visit by the Commission for Social Care Inspection in July of this year identified that improvements have been made and sustained under our management.

URRY: But the coroner has written to the Woods family, telling them that the Minister for Care Services, Ivan Lewis, hasn't adequately addressed the issues he highlighted, and that he can take matters no further. Mr Lewis told File on 4 the coroner's concerns were a matter for the regulator to put right.

LEWIS: He felt that the regulatory system had let Mr Woods down, I think with very good reason. What happened was appallingly tragic consequences. But you can't set up a regulatory system at arms' length from Government and then every time you're asked to intervene, undermine that system. So of course we'll

LEWIS cont: consider the implications and the lessons from the case of Mr Woods. But I think what we found in that case was that there were lessons for CSCI in terms of the way that they have gone about fulfilling their responsibilities.

URRY: I think the coroner felt that you'd ducked it a bit as well. He wasn't too happy with the fact that you hadn't properly addressed his concerns.

LEWIS: Well, he has a right to feel that way. As I say, the inspectorate needs to learn lessons from what happened to Mr Woods and the fact that the coroner clearly feels there was systemic failure in that case. What I will do, as we look to new legislation, bringing together the regulatory framework for the NHS and for social care, is reflect on the lessons from these kind of cases and see whether it's the law that needs tightening and toughening and changing rather than the implementation of the law on a day to day basis.

URRY: And now, following our investigation, the minister has agreed to look again at the need for an independent complaints body for families worried about the care of their loved ones, as he prepares to put in place a new regulatory regime due in 2009.

LEWIS: It's really a question about whether there needs to be, in a new system going forward, some level of appeal if you're not satisfied with the way a home has looked at your particular complaint, or some element of independence in the way that complaints are considered. Registration and inspection is not the same as dealing with complaints. It's a very very different service, a very different role that we're asking the regulator to fulfil. But I accept that looking at whether there ought to be a right of appeal if you're not satisfied with the way an individual provider has dealt with your complaint or some sort of independent element in the system of considering complaints, I accept that that is something that we will have to consider going forward.

SIGNATURE TUNE