1 Background

Operation Jasmine was a wide-ranging investigation carried out by Gwent police between 2005–2013, into the deaths of 63 people living in care homes in South East Wales.

In 2002, Dr Das, ran 21 care home services but by 2006 there was just one remaining home. Five were closed by CSIW by 2006.There was a shortage of EMI nursing beds and Dr Das owned the only two EMI nursing homes in Caerphilly.

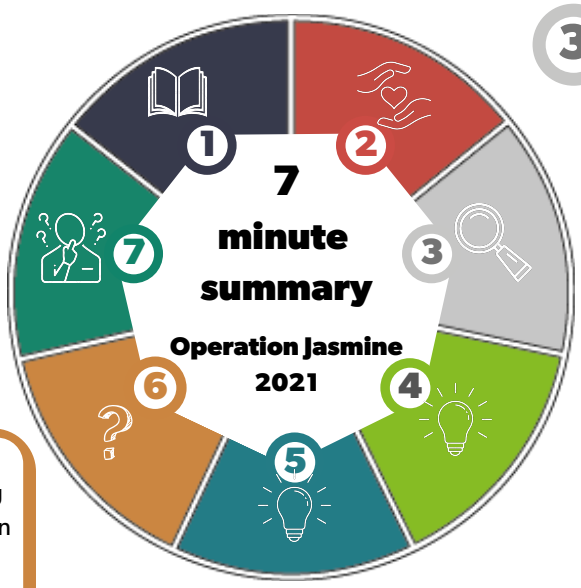
The Flynn Review was commissioned in December 2013 and the report 'In Search of Accountability' was published in May 2015. It made 12 recommendations, including that inquests should be held. As a result, inquests into the death of 7 people who lived in Brithdir Care Home, owned by Dr Das, were held between January and March 2021.

2 Why it matters

As part of these inquests, the coroner was exploring the role of state agencies in these deaths, what they knew, who they told, and what action they took to protect people. Agencies involved were the then Caerphilly Local Health Board, Caerphilly County Borough Council and the regulator, Care Standards Inspectorate Wales (now CIW).

The coroner concluded the deaths of five people were contributed to by neglect. People were being 'warehoused', and 'de-humanised', there was poor staffing levels and severe lack of monitoring, observation and care planning.

We know that much has changed in how local authorities, health boards and the regulator operate now, and in social care legislation. However, we need to reflect on the findings of the Operation Jasmine inquests and learn from these terrible events.



3 Key findings

Four key themes contributed to the resultant neglect:

Legislation: new legislation and frameworks were in their infancy and very unfamiliar to those having to operate them.

Provision: At the time alternative EMI nursing provision was limited, which led to Dr Das being given too many chances.

Agency actions: Health, local authority and inspectorate staff worked in good faith, but agencies were too focused on systems and process and as a result lost sight of the individual resident. Actions taken by the health board and local authority to provide support to the home to improve care, while necessary to protect people, made it difficult for action to be taken to close the home. Local authority reviews were not undertaken in a timely way.

Missed opportunities: agencies should have acted more promptly and robustly to deal with failings. There was a recognisable pattern that should have been noted.

4 Learning

Focus on outcomes for people – what matters to them. Avoid getting lost in the process or distracted, and focus on what needs to happen to improve outcomes for people.

Services which fluctuate between poor and adequate should be a cause for concern and should be responded to consistently.

Be curious: test the accuracy of records to provide the complete picture of care and outcomes.

Training and competence: training needs to be effective in improving staff competence, not just delivered.

Negative cultures leading to abuse: be mindful of the signs of negative cultures in services and take action if witnessed.

5 Learning (continued)

Share information and intelligence: enables the clearest picture and best evidence about the quality of services.

Work together: the best outcomes for people are achieved when working together to improve quality and safety of services.

Audit trail of decisions: keep an audit trail of the decisions we do/don't take and the rationale for them.

Meeting minutes: ensure minutes of meetings are clear, complete and accurate with agreed actions clearly set out.

Action Plans: Own or delegate actions and respond when the actions are not met.

Escalation and oversight: ensure there are well defined systems to escalate issues and report to the executive team.

6 Key questions to consider

Watch the Operation Jasmine: learning and reflection event webinar we held in December 2021, here.
Here are some questions to encourage group discussion and reflection:

- is practice, recording and organisational culture outcome focused?
- how effective are we at communicating with other agencies?
- do we ensure actions are explained, noted and acted on?
- how well do we currently respond to fluctuating performance?

7 What to do if you're concerned

If you're worried about someone you care for or who may be at risk, or want to raise a concern about care services please contact Care Inspectorate Wales via an online form here or telephone on 0300 7900 126 option 2.

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Social Care Wales

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