# Lessons Learned Reviews of Mrs S – Responses from family

The family of Mrs S were invited to comment on both independent reports. This was to allow them to raise any factual inaccuracies they believed needed to be addressed. One family member did provide feedback and comments, some of which were wider than the scope of these reviews. As a result any comments that are not relevant to the scope of these reports have been redacted.

# Response to lessons learned report from Daughter 1:

My initial finding is that the rationale given in identifying the lessons are factually incorrect and whilst I apportion no criticism to the reviewer for basing their conclusions on information dictated to them, the conclusions reached through relying on this unevidenced information are unsafe.

Insight into this resides in the report, for example paragraph 28 makes claims that are potentially libellous, and includes allegations already disproven, presented as facts. Not only was it the home that ignored the GP advice, there was no conversation re attending during cares with the GP and it was the GP who first ‘escalated’ the concerns. It would appear incautious to make published claims of ‘unrealistic expectations’, ‘nuisance element’ etc. whilst withholding the ‘evidence’ on which the claims are based to avoid challenge. For example, is NYSAB agreeing it is unrealistic expectation that care plans are carried out – or does this refer to something else?

The report confirms the CQC did not detect poor care until after the film footage was revealed, but does not apply this equally to NYCC - then asserts that the CCTV does not evidence allegations of neglect. What CCTV does this refer to? That installed via court order?

The facts are that my mother was abused. Either due to lack of expertise or will, the safeguarding agencies did not recognise this until it was evidenced with video footage and up to January 2017 encouraged me to move mum to ‘solve’ the problem. The plans put in place to address the abuse were not actioned by the home – the agencies advised they had no power to enforce them. The same issues were raised as the same issues continued – that is that the care plans were not followed. It then appeared identifying the ‘whistleblowers, rather than the abuse, as the problem to be solved and removed - along with any means of continuing to evidence abuse, allowing the status quo of taking the word of the home, unchallenged to resume.

This arguably is reflected in the report.

As discussed at our meeting, NYCC withheld the information it provided to the reviewers and has now withheld that provided by other agencies including the home.

I would be grateful if you would forward me the information requested on 17.4.19 in addition to the withheld information in order to identify and challenge factual inaccuracies relied on in the report and to clarify if issues that appear to have been excluded have in fact been considered. (E.g. incident September 2016/involvement of NMC/court orders re cctv/police and GP safeguarding alerts/mum’s expression of her wishes ignored)

The briefing document, for example states ‘*SS contacted a number of agencies with footage from the camera(s), including CQC, NYCC and North Yorkshire Police. ‘*when in fact I shared the footage only with the police.

The police shared it with other agencies who then asked me for additional footage which my brother copied and took to NYCC– a small difference perhaps but suggests some degree of bias in the way the it is presented. Nor does it clarify that I shared the footage with the police only after NYCC dismissed my concerns.

Similarly, it was NYCC, not me, who raised the concern that the cleaner had put something in her pocket. (In the scheme of things this was the least of my concerns and it appeared the culture to take my mother’s sweets – there were several examples of several staff doing so). Again, a comparatively minor discrepancy, but misleading in its intention.

I also note the NYCC contact who viewed the footage, arranged for others to view it, drew up the Protection Plan and escalated concerns was not identified by NYCC to be interviewed.

I am disappointed there is no response to my questions, such as why NYCC has withheld the information NYCC, the home and CCG supplied to the reviewer, not only from me but from the NYSAB, why the key NYCC team manager was not listed for interview and why the serious choking episode (Sept 2017) prompting the LLR was not included in the report.

As per my responses below, I have informed there are several factual inaccuracies, some to the point of being libellous, however in not disclosing the information relied on to present these inaccuracies, you are denying the opportunity to present evidence to challenge them.

Prior to my camera the safeguarding agencies did not take my concerns seriously, accepting the word of the home not only to their treatment of my mother but their misdirecting that I, not their abuse, was the problem. The camera evidenced that my mother was being seriously abused and far from being the problem I was speaking the truth. I had understood the review was to learn from this, not perpetuate it.

I was told that the home would provide other ways to prove my other was well cared for if I removed the camera, however, as evidenced by the footage, my mother was reassured by its presence, so to protect their reputations against further camera

evidence, the agencies met with the home and agreed to use the court of protection to remove me rather than the poor standards and lack of safeguarding. Curiously, neither the police nor CGC were invited.

However, having being made aware of the footage content, the Court instead ordered that;

* a camera must remain in my mother’s room for her protection
* I must be allowed to visit every day, independently supervised to protect me from intimidation and further untrue allegations
* my mother must be allowed to reside at the home without threat of eviction and until such time as a suitable replacement home found, that her care plans be adhered to
* CCG find a suitable alternative home for my mother

All of this is evidenced in court documents. As is the fact my mother’s care plans remained ignored and evidence of it ignored by the agencies.

To this, as you are aware, my mother died 20 days before she was due to move to another home on 19 July 2018 and we await the outcome of the investigation to the contributory factors.

The purpose of review was to improve safeguarding so that reliance on the home’s word and victimisation of the complainant was eliminated and abuse recognised without the need to install cameras. I feel no lessons can be learned whilst this practice, as echoed by the Report, continues unchallenged.

I refute the apparently accepted conclusion that I was ‘tenacious at the expense of my mother’, p.6 and invite you to view the evidence of the abusive treatment my mother was subjected to and explain the basis on which my having to continually challenge this abuse, routinely ignored by safeguarding, was considered to be at the expense of my mother rather than having been necessary to protect her.

# Response to health report from Daughter 1:

**Daughter 1 has responded that in her view, the following statements and conclusions are factually inaccurate:**

**5.15** - It is untrue that the home provided aromatherapy – the 2 aromatherapists were privately engaged partly to provide human contact and to provide the massage directed by the physiotherapist and GP which the home failed to provide as agreed.

**5.19** ‘In the end the meeting was cancelled due to the deterioration of Mrs S’s health’

**5.25** ‘The care home demonstrated a strong commitment to supporting Mrs S family relationships including with daughter 1’

**5.30** – The requirements referred to were conditions of NYCC authorising a DoLs so cannot be seen to indicate compliance with court requirements.

* 1. – Following a serious choking incident in September 2016 and safeguarding review resulting in suspensions, a support plan was put in place including keeping a suction pump in Mrs S room. Additionally, to ensure all staff were aware of how to keep Mrs S safe, instructions were displayed in her room. (Photo submitted to NYCC)

I am unaware of any evaluation process that considered this protection was no longer required or on what basis or improvement to Mrs S condition it was decided no longer considered necessary. Thus these protections were still in place and relevant to meet her needs.

* 1. ‘Mrs S ....suffered a stroke resulting in contractures of her left leg and right hand’
	2. ‘Care home staff reported all cares were normal between 1 and 14 June and did not notice any changes in Mrs S appearance or behaviour’

**5.44** ‘There is no evidence of degrading care’, ‘the care home demonstrated that steps had been taken to ensure bed rest did not result in social isolation through her activities and mental health and wellbeing plans’

**5.57** – The requirement to keep a suction pump in her room was a safeguarding response to a previous choking incident episode and instruction confirmed by a notice on the wall in her room. It is unclear why it was not referred to in the Care plan, presumably as emergency instructions needed to be more visible to all staff so posted separately.