Teeswide Safeguarding Adults Board

Learning from Regional and National SAR Cases:

Title of Review:	**SAR Joanna, "Jon" & Ben**
Theme of Review:	Private Hospital Setting
Local Authority:	Norfolk
Date Published:	September 2021
Link to Full Report:	SAR-Rpt-Joanna-JonBen_FINAL-PUBLICATION02-June2021.pdf (norfolksafeguardingadultsboard.info)

Case Details:

Joanna, "Jon" and Ben were all in their 30's with a learning disability and had been patients at Cawston Park Hospital for 17, 11 and 24 months.
They were all admitted to the hospital under sections of the Mental Health Act. Joanna and Jon originated from London boroughs and Ben was from Norfolk. Their behaviour was known to challenge services and sometimes their families. Joanna and Jon had experienced several out-of-family-home placements. Ben had lived with his mother for most of his life. Their placement at the hospital resulted from personal and family crises.
Joanne, Jon and Ben all died at Cawston Park Hospital within a 27 month period – April 2018 to July 2020.

The families of the three individuals' and other patients expressed concerns about:
• the unsafe grouping of certain patients
• the excessive use of restraint and seclusion by unqualified staff
• their relatives' "overmedication"
• the hospital's high tolerance of inactivity.

There was no information for 179 days of Joanna's stay, a single day for Jon, and 450 days for Ben.

Hospital practices were found to be indifferent and harmful with excessive use of restraint and seclusion by unqualified staff.
Upon Joanna's admission to the hospital, she had a reported history of Moderate Mental Retardation, Emotionally Unstable Personality Disorder and epilepsy as well as non-epileptic attacks. Joanna also had sleep apnoea and staff had not been encouraging or supervising the use of the CPAP machine, which was rarely used, unbeknown to Joanna's family or Respiratory Consultant. Joanna was found unconscious by staff and subsequently died, the inquest confirmed that a registered nurse and five care workers, all of whom were first aid trained, did not attempt resuscitation when Joanna was found unresponsive in her bed. When paramedics arrived, she had not been breathing for at least 18 minutes. The inquest concluded that she died from natural causes as a result of sudden unexpected death in epilepsy. The case had been referred to the CPS however they advised 'no further action'.

Ben who had downs syndrome died after a cardiac arrest. When Ben was admitted to the hospital the Consultant Psychiatrist noted that he had "no clear mental illness." However, the following month he was detained under S.3 and reference in the limited records available to being prescribed anti-psychotic medication, it is unknown for how long this was administered. Ben was also prescribed a sedating antihistamine which is licensed for short term use only, it does not appear that the prescriber set out the rationale for its continued use after the two-week trial or whether it was discussed with Ben's Respiratory Consultant. Ben had Obstructive Sleep Apnoea, NICE guidance states that patients should be given lifestyle advice including the reduction of sedative use. Ben contracted COVID-19 and in the weeks preceding his death had dangerously low blood oxygen levels.
CCTV footage during the hours preceding Ben's death was scrutinised by the police. Ben had been

cleaned and moved to his second bedroom, having defecated on and around his bed, a staff member approached Ben who was awake in his second bedroom and "rough handled" him by pushing him and dragging him down by his arms before hitting his head area with an open hand. The carer then looked up to make sure that there was no one looking and hit Ben again in the head area with the back of his hand.

Jon who had learning disabilities and autism died of hypoxic brain injury following a cardiac arrest after swallowing a piece of a plastic cup. Jon was known to self-harm and swallow foreign objects previously swallowing screws, parts of batteries and zips. The swallowing incidents did not result in changes to Care Plans or Risk Assessments. Jon's inquest reported that he had complained of breathing difficulties a few hours before his death. Although staff performed CPR it took some time before action was taken to assist him and a quicker response would have been expected, it also took some time before the defibrillator was used, some of the staff involved had not been up to date with their first aid training.

An inspection report published in January 2019 resulted from 'notification of an unexpected death of a patient, complaints and information shared from external agencies, the report did not provide an overall rating however did identify specific areas for improvement.
A further inspection report was published in September 2019 and determined that the service was inadequate and was placed in special measures. In April 2020 the hospital was issued with a Notice of Proposal to cancel the Hospital's registration as a provider.

The review makes 13 recommendations for critical system/strategic change. In addition, the review also highlights some key learning for practitioners.

NHS England and NHS Improvement response to Norfolk SAR:
https://www.norfolksafeguardingadultsboard.info/assets/documents/NHSE-NHSI-response-SAR-08.09.21-FINAL-SIG.pdf

Key Findings

1) The relatives of the three adults, and those of other patients, described indifferent and harmful hospital practices which ignored their questions and distress. They were not assisted by care management or coordination activities.
Family members and friends should be involved and listened to, welcoming them as equal partners wherever possible (and in line with the adult's wishes), using their perspectives to inform how a person's care and support is designed and provided.
2) The setting for this SAR was a private hospital where a very high number of the placements were commissioned by out of county CCGs, involving a variety of different funding authorities. This meant that face to face review was rare, **oversight was limited, and Norfolk agencies were often unaware of the individuals placed there. This in turn impacted accountability, communication, information sharing for both the day-to-day care and any safeguarding issues.**
3) Limited oversight meant that the quality of reviews, advocacy, and professional fact finding was equally limited, making challenge difficult. Evidence of risks were noted but not acted on. **Where there are evident risks, even if those are not seen as 'social care', staff must be 'professionally' curious and ask the questions.**
4) Too often the focus of interventions, especially physical interventions, is to simply manage the presenting behaviours, without consideration of the root cause and potential triggers to prevent them occurring in the first place. Some of the language used to describe behaviours – "kicking off", "pushing boundaries", "histrionic", "tricky" – puts blame on the person without recognising the context. **Where necessary, assumptions about behaviour must be challenged to promote more individualised service responses.**

5) There was a significant lack of meaningful activity for patients which in itself impacted negatively on their physical, emotional and psychological health. **With unstructured days, patients or service users will be bored, under-stimulated, frustrated; without exercise they may gain weight, lose muscle tone and motivation.**
6) The number of safeguarding concerns reported by or about providers can vary and it is not unusual that, in settings which support people who have a range of complex needs, there may be a higher number of concerns involving 'minor' incidents, often requiring no further safeguarding intervention. **It is important however to ensure that every incident is considered both as a unique event and also in the context of others in the same setting.**
7) **Another issue identified through the SAR was the normalisation of racist abuse towards staff by the patients.** The provider did little to address this, and staff did not routinely report incidents – it became something that just had to be accepted. **Such approaches can lead to toxic work environments and impacts on the care provided.** (Norfolk SAB have since published a 7-minute briefing on 'Managing racial abuse towards staff from people who lack capacity').
8) Sometimes people who have been abused by others will say they don't want to make a fuss / don't want to make a complaint. **Helping them to understand more about safeguarding and the processes which can support them is central to responsibilities to protect those who are supported by services.** The confidence of staff to explore this is key, information may still need to be shared, or action taken, especially where other adults may be at risk.
9) **Providers need to be carrying out effective risk assessments, including environmental risk, and taking action to manage known risk**, visiting staff have a critical role here to ask questions and see the evidence they are doing this.
10) The SAR found that some of the individuals had experienced a high number of moves in their lifetimes, sometimes at very short notice. **Services must consider the impact on the individual of moves from one setting to another, especially when poorly planned or rapid.** Place hunting in crisis situations may be unavoidable; but much more attention needs to be given to these points of transition to minimise the impact.

Other/National Recommendations including:

Norfolk's SAB should write to the Law Commission proposing a review of the current legal position of private companies, their corporate governance and conduct in relation to services for adults with learning disabilities and autism.

NHS England should ensure that all placing CCGs are proactive in ensuring that they have up-to-date knowledge about the services they commission and how these are experienced.

Norfolk CCG and ASSD should review their commissioning arrangements to embrace "ethical commissioning.

Norfolk CCG and County Council should transfer all of the remaining patients from this hospital.

Norfolk's SAB should make representation to the DHSC to ask what additional rights and protections will be afforded to adults with learning disabilities and autism who become vulnerable to detention in the same clinical settings under the Mental Capacity Act.

Norfolk's SAB should propose to the CQC that the legal process of registration cancellation should proceed irrespective of a service's improvements if these are attributable to the ongoing efforts of the NHS, local authority social care employees and Inspectors.

All of the recommendations arising from the report can be viewed on the NSAB Action Plan: Safeguarding Adults Review: Joanna, Jon and Ben Multi Agency Action Plan (norfolksafeguardingadultsboard.info)