



Norfolk Safeguarding Adults Board

Safeguarding Adults Review: Joanna, Jon & Ben

EXECUTIVE SUMMARY

FINAL – PUBLISHED

DATE 09 September 2021

Issue Number	FINAL – PUBLISHED
Document Owner	Norfolk Safeguarding Adults Board
Date Approved	02 June 2021
Date Published on NSAB website	09 September 2021

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Contents

Summary	3
The Background.....	3
The Safeguarding Adults Review	3
The Challenges.....	4
The Lessons and Findings	4
Conclusions and Recommendations	5
Acknowledgements	9

Summary

Safeguarding Adults Review concerning the deaths of three Cawston Park Hospital Patients

“...with the closure of long stay hospitals and the campus closure programme, a new form of institutional care developed: what we now know as assessment and treatment units. Not part of current policy, and certainly not recommended practice, these centres have sprung up over the past thirty years. Containment rather than personalized care and support has too easily become the pattern in these institutions.” (Burstow, P. (2012) Foreword to the DH Review. “Winterbourne View Hospital – Interim Report”)

The Background

1. During April 2019, Norfolk’s Safeguarding Adults Board (“NSAB”) commissioned a Safeguarding Adults Review (SAR) concerning the deaths of two adults at a private hospital, Cawston Park (“Hospital”).¹ During December 2020, the death of a third patient was added to the review’s remit. The deceased, Joanna, “Jon” and Ben were in their 30s. They had learning disabilities and had been patients at the Hospital for 11, 24 and 17 months respectively. They died between April 2018 and July 2020.
2. The Hospital is registered with the Care Quality Commission (CQC) for the assessment or medical treatment for persons detained under the Mental Health Act 1983 and the treatment of disease, disorder, or injury. CQC’s website states that it has 57 registered beds across six wards, two of which are locked wards, The Grange and The Lodge. The deceased were placed at The Grange and The Lodge.

The Safeguarding Adults Review

3. The purpose of the SAR was to set out the experiences of the three adults in terms of their care management and the care and support services commissioned on their behalf. In particular, the Review considered the impact of the Hospital’s registration, inspections by the CQC, the Hospital’s governance framework, safeguarding referrals, other alerts and the voice of former patients, their relatives, friends, and the relatives of current patients.

¹ The care provider at Cawston Park Hospital is Jeasal Akman Care Corporation Limited, a Private Limited Company providing “other human health activities.” Sally-Anne Subramanian and Tugay Akman are directors and Tugay Akman is the Responsible Individual

The Challenges

4. The Covid-19 pandemic resulted in six virtual meetings of the SAR Panel. Only the initial meeting was physically co-located. The Panel is made up of representatives from the Hospital, the Care Quality Commission, Norfolk's Adult Social Services Department including its safeguarding team, the Clinical Commissioning Groups (CCGs) responsible for placing the three adults, the ambulance service, the local acute hospital and community care NHS Trusts and the police.
5. As the Review's accounts of Joanna and Jon's circumstances was "coming together" there was another tragedy at the Hospital. It was envisaged that adding Ben's circumstances to the Review would enhance the legitimacy of its findings. A balance prevailed between ensuring that Ben was not shortchanged by being added to a SAR that was reaching its conclusion and ensuring that the SAR should not compromise his inquest.
6. The Review relied principally on the Hospital to provide information concerning the care and treatment of the three adults. It provided partial and incomplete information about their day to day lives.

The Lessons and Findings

7. Joanna, Jon and Ben were admitted to the Hospital under sections of the Mental Health Act (1983). Joanna and Jon originated from London boroughs. 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. It was the only placement which could be identified by Joanna's CCG which had previously made contact with 38 other services.
8. 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. People's families could not value the unsafe grouping of certain patients, the excessive use of restraint and seclusion by unqualified staff, their relatives' "overmedication," or the Hospital's high tolerance of inactivity – all of which presented risks of further harm. In addition, these patients did not benefit from attention to the complex causes of their behaviour, to their mental distress or physical health care.
9. There was no information for (i) 179 days of Joanna's stay (ii) a single day for Jon, and (iii) 450 days for Ben.
10. Families questioned the Hospital's undocumented assumptions concerning patients' mental capacity which appeared to transfer responsibility to patients. For example, Joanna and Ben used Continuous Positive Airway Pressure (CPAP) machines as a result of sleep apnoea. Joanna's inquest heard that in the last 209 nights of her life the CPAP had been used on only 29 occasions and that she did not want to use it. Her parents and all previous placements had prioritised its consistent use and

maintenance. Neither her parents, nor her Consultant Neurologist, were advised that Joanna had ceased to use her CPAP. Similarly, there were 115 documented occasions when Ben declined to cooperate with its use. It does not appear that attempts were made to desensitise either Joanna or Ben to using their CPAPs.

11. Joanna and Ben were obese. Although Ben's weight reduced to 13.3 stones within two months of his admission to the Hospital, two years later, his postmortem revealed that he weighed 18.10 stones. Their CPAP machines would have required adjustments as a result of weight gain. Their protracted physical inactivity increased their risk of obesity, high blood pressure, high blood cholesterol, diabetes and heart disease. They did not benefit from being accompanied to outpatient appointments by support workers who (i) were competent in managing their anxieties and (ii) possessed up to date information concerning their health status.
12. The Hospital did not seek vital information about people's pre-Hospital lives. All that may be reliably gathered from Jon's records is that setting a discharge date is a meaningless activity if no attention is given to planning for this; specialist hospitals which are remote from people's families have unchallenged scope to retain patients; and there are no consequences if Clinical Commissioning Groups responsible for placements are not represented at critical review meetings.
13. There did not appear to be any timetabling discipline at the Hospital in terms of people's daily and weekly activities. Activities in which adults had particular expertise and interests, such as swimming, painting and drawing, for example, were not prioritised.
14. The Hospital is disadvantaged by the absence of accurate and timely information flowing up to managers and directors and down to staff and patients. Although first-person accounts from patients and their relatives are powerful means of establishing the impact of a service and would provide a holistic view of performance, they are absent. Little may be discerned of the Hospital's corporate and financial governance or the extent to which this is intertwined with clinical governance.
15. A CQC report during 2019 stated "The hospital was not working to the model of an assessment and treatment unit and therefore its operation was not in line with the expectations of the Transforming Care Programme." Its subsequent reports indicate that the Hospital was mired in familiar stalemate.

Conclusions and Recommendations

- a) **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.** Given the clear public interest in ensuring the well-being and safety of patients, and the public sponsorship involved, the Law Commission may wish to consider whether corporate responsibility should be based on corporate conduct, in addition to that of individuals, for example.

- b) **Norfolk and Waveney CCG and Norfolk ASSD should review their commissioning arrangements to embrace “ethical commissioning.”**² This should attend to:

“Ethical employment: Commissioners must be able to distinguish between the workforce practices of different providers and prioritise those acting as ethical employers.³ This might include prioritising those companies that are accredited by the Living Wage Foundation; have effective training, development and supervision; sign up to an ethical care charter; outlaw false self-employment and zero-hours contracts; and encourage staff to participate in collective bargaining.

Tax compliance: The ownership of all companies contracted to deliver public services should be available on public record. At the same time, a taxation test could require contracted private companies to demonstrate that they are based in the UK and subject to UK taxation law.

Transparency: A transparency test could stipulate that where a public body has a legal contract with a private provider, that contract must ensure full openness and transparency with no recourse to the cover of “commercial confidentiality...”

Localism: A focus on smaller and more local commissioning is needed – a challenge for public services commissioners who generally favour dealing with a small number of large organisations with established contracting infrastructures. Smaller organisations hold vast expertise about the precise issues affecting people in their area and can serve very small or isolated communities or specific communities of interest.

Ethical vision: To create change in adult social care, we need a guiding vision, rooted in ethical considerations of promoting good lives well lived, and protecting the wider economic, social and environmental wellbeing of a local area. Procurement legislation in Scotland seeks to promote just such a vision but has no real equivalent in England.”⁴

In addition, a **Community Benefit** test to nurture connectedness to communities would ask potential providers what they will gift to a locality. For example, apprenticeships for local school leavers; opportunities for local businesses and farms to provide goods; the provision of studio spaces for artists; and growing plots for gardeners. This would allow local credit for initiatives to be dispersed and to take root. The test should require the provider to exemplify the community benefit every year, in believable human terms, using people’s own words, for example.

- c) **Evidence of changing commissioning arrangements should be shared with Norfolk’s SAB.**

² <https://socialcarefuture.blog/2019/09/19/adult-social-care-and-ethics-time-for-a-new-relationship/> (accessed 13 April 2021)

³ This should embrace reliable identity and other pre-employment checks. See for example, https://www.cipd.co.uk/Images/pre-employment-checks-guide-dec-2020_tcm18-51572.pdf (accessed 1 April 2021)

⁴ See article by Bob Hudson: <https://www.theguardian.com/society/2018/aug/20/ethics-new-approach-outsourcing-social-care> (accessed 20 March 2021)

- d) NHS – England should ensure that (i) all placing CCGs are proactive in ensuring that they have up-to-date knowledge about the services they commission and how these are experienced.** The “four eyes principle” may be useful, most particularly if the additional “eyes” are those of a parent whose relative has current or recent experience of the assessment and treatment services being commissioned;⁵ and (ii) that when transfers take place between in-patient settings, these cease to be recorded as “continuous inpatient stay ...treatment for the purposes of the one year CTR” [Care and Treatment Review].
- e) Norfolk and Waveney CCG and Norfolk County Council should transfer all its remaining patients from this Hospital.**
- f) Norfolk’s SAB should make representation to the Department of Health and Social Care 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 (2005).⁶**
- g) Norfolk’s SAB should share this review with NHS – England since it was responsible for Jon’s placement. NHS – England and the CCGs responsible for placing people at Cawston Park Hospital should visit services, host reviews and ask questions** such as:
- how many patients have returned to Cawston Park Hospital for further assessment and treatment?
 - does Cawston Park Hospital have admission criteria concerning patients who have had previous episodes of assessment and treatment?
 - are there periods when the patient we fund is super-busy or are their days characterised by naps, snacking and sitting for hours?
 - are routines such as cleaning teeth, bathing, showering, changing clothes, hair washing and nail cutting, for example, expected and actively supported?
 - does the patient we fund sleep deeply during the night because they are physically tired?
 - how is the patient we fund, who is malnourished and/ or obese, encouraged and supported to make dietary and lifestyle changes?
 - what happens if the physical health of the patient we fund deteriorates because they are resisting essential, prescribed treatment such as CPAP?
 - what happens if the patient we fund refuses to participate in activities?
 - what examples are there of Cawston Park Hospital maintaining and developing the ability of patients to perform daily tasks and promoting their participation in purposeful and valued occupations?

⁵ The requirement that a business transaction should be approved by at least two individuals <https://www.collinsdictionary.com/dictionary/english/four-eyes-principle> (accessed 8 November 2019)

⁶ *The unintended consequences of taking people with learning disabilities and/ or autism out of scope of the Mental Health Act 1983* <https://thesmallplaces.wordpress.com/author/lucyseries/> (accessed 24 March 2021)

- on how many occasions have acute hospital security staff assisted Cawston Park Hospital's support workers to subdue an inpatient during acute hospital admission or attending clinic appointments?
 - where are the service destinations of all former Cawston Park Hospital inpatients?
- h) NHS-England should be invited to provide evidence to Norfolk SAB that these questions have been circulated and incorporated into its own processes.**
- i) Placing/funding Clinical Commissioning Groups are keepers of the public purse. NHS-England is invited to bring forward evidence of strengthened mechanisms for: discharge dates; the stability of accommodation within a service; close attention to an inpatient's physical health needs and experiences, their mental health needs and experiences, and the service's track record in addressing these.**
- j) 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.**
- k) Norfolk's SAB should set out for CQC's Chief Executive the consequences of Cawston Park Hospital's failure to enable family-centred approaches and engage with the expertise of patients' relatives. This is paralleled in CQC inspections. The inspectors would benefit from including parent "experts by experience" with recent experience of seeking to work with assessment and treatment services and units (see, for example, families' contributions to this Review). To maintain public confidence, CQC may wish to confirm (i) that it has no remit to determine whether patients should remain in such services, not least since this conflicts with national policy; and (ii) what specific actions it proposes to take in relation to locked wards in specialist hospitals and units.**
- l) Norfolk and Waveney CCG and the County Council should rebalance responsibility for Norfolk citizens away from "medical led admissions and social care discharges." The reform of the Mental Health Act (1983) should anchor discussions and agreements between these public authorities concerning ethical commissioning.**
- m) The taboo of addressing the racism of people with cognitive impairments remains to be explicit and made visible in all services. Norfolk's SAB should begin a process of (i) gathering the efforts and experiences of the county's service providers in challenging racism and racist stereotyping and (ii) convening "world café" conversations⁷ with providers and other interested people, including those at the sharp end of injustice.**

⁷ A process for fostering collaborative dialogue, sharing information and discovering opportunities for action. See Brown, J. with Isaacs, D. (2005) *The World Café – Shaping Our Futures Through Conversations That Matter* San Francisco: Berrett-Koehler Publishers, Inc.

16. The roots of private, specialist hospitals reside in business opportunism and profit-driven priorities. These are hospitals in which patients receive neither specialist assessment nor credible “observations” and treatment. The deaths of three young adults must plausibly question the “system response” - CQC’s continued registration of such hospitals and their continued use by CCGs and NHS-England.
17. There is a crucial difference between the health advocacy of patients’ parents and that of staff, regardless of pay scales. Cawston Park Hospital failed to recognise that its interventions were unequal to aiding patients in their physical and mental distress. It neither built nor sustained trust. It did not serve the larger aims of three people’s lives. Joanna was supported by staff who were untrained in the use of her CPAP. They did not begin CPR and a learning disability nurse and two support workers believed that her epilepsy was due to her “playing up and shouldn’t be minded.” The response to Jon’s breathing difficulties was unduly slow even though he had pleaded “I cannot breathe. I am dying.” Ben had ceased to use his already underused CPAP and his low SATS symptoms were ignored. His mother’s insistence that an ambulance should be called had no impact. Unless this Hospital and similar units cease to receive public money, such lethal outcomes will persist.

Acknowledgements

I am indebted to the families of people with learning disabilities and autism who became patients at Cawston Park Hospital, and to former patients. Their experiences have a compelling call on our attention.

Particular thanks are due to the Review Panel members who shared their understanding about events at Cawston Park Hospital. Their aspiration to identify people’s support needs and credibly intervene before they are labelled as challenging will be a fitting, post SAR legacy.

The GP member of the SAR Panel undertook a significant medication review and brought valuable understanding to the Panel’s discussions concerning drugs and other therapies. In addition, Norfolk’s Safeguarding Practice Consultants, who collated summaries of risks and risk concentrations from the Hospital’s many referrals, and the Social Work practitioner who continues to work with the families of Norfolk patients merit sincere thanks for their contributions.

I have been able to count on Walter Lloyd-Smith and James Butler for their assistance and commentary in reading and proof-reading drafts of the Review. They have provided much more than administrative support in seeking out information and exploring its relevance in stimulating discussion.

I hope that this Review, which is dedicated to Joanna, Jon and Ben, provides a further impetus to challenging an obsolescent model of specialist provision.

END.