SAFEGUARDING ADULTS REVIEW: JOANNA, JON AND BEN, CAWSTON PARK

Safeguarding Briefing Joanna, Jon and Ben

What happened:

In April 2019 Norfolk Safeguarding Adults Board (NSAB) commissioned a Safeguarding Adults Review (SAR) into the deaths of two adults at a private hospital, Cawston Park. In December 2020 the death of a third patient was included in the SARs remit.

The deceased, Joanna, Jon and Ben were in their 30s, had learning disabilities and were all admitted under section of the Mental Health Act (1983) and had been at Cawston Park for 11, 24 and 17 months respectively. They died between April 2018 and July 2020.

Background and profiles:

Joanna and Jon originated from London. Ben was from Norfolk. They all at times had difficulty in their placements and living with family. The placement at Cawston hospital was a result of personal and family crisis. Joanna's clinical commissioning group had contacted 38 service providers, and this was the only provider that agreed to support her.

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. The families were worried 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. In addition, these patients did not benefit from attention to the complex causes of their behaviour, to their mental distress or physical health care.

Summary of Findings:

- A lack of information recorded
- Professional's made undocumented assumptions concerning mental capacity and appeared to transfer responsibility to the patient
- Lack of physical activity which increased the risk of obesity, high blood pressure, diabetes and heart disease.
- Not accompanied to outpatient appointments by support workers who had up to date information on health status
- Activities not pursued or prioritised
- Did not seek vital information of their prehospital lives
- The hospital did not have accurate and timely information flowing to managers and directors
- The hospital was not in line with the transforming care programme.

Action:

Immediate action – regular commissioner visits to be included in safe and wellbeing review, Improved reporting of visits, improved due diligence when making placements

Strengthened mechanisms for discharge dates, suitability of accommodation, attention to the persons experiences

The taboo of addressing the racism of people with cognitive impairments remains to be explicit and made visible in all services

13 Recommendations including:

- CCG's need to be proactive in ensuring they have up to date knowledge about service they commission and how these are experienced
- Ethical commissioning should not rely on high cost, out of area, independent hospitals
- Review people's placements to ensure they promote personal hygiene, meaningful activities, healthy lifestyles
- Address the racism of people with cognitive impairments

The full report can be found here:
SAR-Rpt-Joanna-JonBen_FINAL-PUBLICATION02-June2021.pdf (norfolksafeguardingadultsboard.info)