Learning Together From Safeguarding Adults Reviews

Key findings and learning outcomes from the recent Safeguarding Adult Review concerning Mendip House

Mendip House:

The National Autistic Society (NAS) were the Registered Managers of Somerset Court Campus, a 26-acre plot with seven registered dwellings plus outreach and day services for adults with autism. Mendip House was one of the registered homes, providing accommodation and specialist support for six adults with autism.

In May 2016, personnel from Somerset Safeguarding team and the CQC became aware of incidents of bullying following anonymous reporting. Subsequently a review took place which identified;

- taunting, bullying, mistreatment and humiliation of residents;
- financial abuse;
- missing medication; and
- poor oversight of staff

"The service at this dwelling was characterised by absences: of goals for individual residents; of planning and providing people with credible support; of staff expertise; of management and commissioning attention."

The NAS accepts that is failed the residents at Mendip House due to the poor standards and practice which led to their abuse.

The SAR was commissioned following a number of reviews and investigations, to draw together the learning and understand why bullying and disrespectful behaviour from staff towards residents was not identified or acted on sooner, despite concerns being raised over a number of years.

The Review:

The SAR identified a number of **missed opportunities** to identify and react appropriately to these concerns over a number of years "the evidence suggests that the build-up to the whistle-blowing was known to the NAS service-level managers and yet timely and essential remedial action was not taken".

- Allegations were made to the NAS in November 2014 – an internal investigation took place which raised concerns about the staff culture.
- Allegations were made to the CQC in December 2014 and August 2015 – the CQC alerted the local authority who requested the provider to investigate.
- A further NAS internal investigation identified poor and abusive staff conduct, this was not referred on to the local authority or the CQC.
- Concerns were raised by staff in early 2015, no action was taken, and reports weren't made to the CQC. Staff who reported their concerns resigned while the perpetrators continued to work there.
- A resident's review conducted in 2015 was abandoned due to the inadequacy of documentation, including the lack of care plans. This was not reported to the CQC.
- A provider audit in 2015 identified 43 areas for improvement, these were not reported to the CQC.

Key findings:

The National Autistic Society:

The NAS were responsible for practices at Somerset Court, the Registered Manager did not address unprofessional behaviour or practices.

They did not escalate information to the CQC in relation to poor staff conduct, assaults or drug use, and they didn't increase oversight of staff.

The NAS were not delivering the services that the commissioners believed they were purchasing.

Somerset CCG:

Somerset CCG were not purchasing services but assumed the lead role of coordinating commissioning.

There was "no regular contact, pro-active intervention was almost non-existent".

Placing Authorities:

Commissioners were acting as place-hunters, rather than as agents on behalf of individuals with autism.

They did not ask questions or conduct reviews. "Residents were dumped in Somerset because the commissioners were too far away to come and review".

Somerset County Council:

The local authority had the duty to monitor the quality of care and support organisations.

Avon & Somerset Police:

There was confusion and poor communication between police investigations, NAS HR processes, safeguarding enquiries and CQC investigations. The police role seemed to be one of waiting for outcomes, it was unclear why the investigations had to wait.

Learnings:

There was a long history of abuse and neglect being reported at Mendip House indicating that staff behaviour was harming residents and compromising the services on offer. It was alleged that the reports made were the 'tip of the iceberg' yet no action was taken.

The staff culture at Mendip House was described as laddish and dominated by a gang of male employees. The Registered Manager did not address poor behaviour of staff spending shifts playing on computer games or using their mobile phones while ignoring the needs of residents.

- **How does the SSAB receive assurance of the quality of leadership and management training provided to Registered Managers?**

Although Somerset County Council had concerns raised about other premises at Somerset Court, they received no concerns in relation to Mendip House.

- **How does the SSAB gain assurance that behaviour of this type would be dealt with appropriately internally by leadership teams and escalated to the local authority to respond to?**

Somerset County Council did not place adults with autism at Somerset Court, however, they accept they should have set clearer expectations on the NAS to prove to them that their service would not trigger a s42 enquiry.

- **How does the SSAB receive assurance that the providers of services in Surrey are evidence driven, values driven and well-led?**

Had the NAS addressed these long-standing concerns and the commissioner's undertaken essential reviews and monitoring, Somerset County Council would not have had to fund an in-depth scrutiny of a failing service. "Since commissioners are responsible and accountable, arguably it is only a matter of time before they are prosecuted."

- **How does the SSAB gain assurance that reviews of out-of-county placements are conducted in a timely and effective manner, both to ensure the safety of Surrey residents placed in other areas and to avoid placing cost with other local authorities who complete the s42 enquiries which risks possible legal action at a later date?**