Learning Together From Safeguarding Adults Reviews

Key findings and learning outcomes from the recent Safeguarding Adult Review concerning Adults Joanna, Jon and Ben - Norfolk SAB

Joanna, Jon and Ben:

Joanna was admitted to Cawston Park under S.3 of the Mental Health Act during Oct 2016, she died 17mths later at the age of 36.

Jon died 11 months after being admitted to Cawston Park at the age of 33

Ben was 32 when died 24 months after his admission to Cawston Park.

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 Clinical Commissioning Group (CCG) which had previously contacted 38 other services.

The Review:

During April 2019, Norfolk's Safeguarding Adults Board commissioned a Safeguarding Adults Review (SAR) concerning the deaths of two adults at a private hospital, Cawston Park, a private hospital.

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.

These all 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.

The review found there was a lack of information recorded for all 3 individuals in relation to the day-to-day care provided by the hospital. Significantly, there were 179 days where there were no daily records concerning Joanna. This represents one third of her time as an inpatient. For 450 days, there was no information concerning Ben (it should be noted that this represents the information made available by the hospital to the SAR – additional records were provided to the Coroner for inquest). There was a single day missing for Jon.

Key findings:

Surrey Safeguarding Adult Board are keen to ensure that the learning from this Safeguarding Adult Review is shared by all member organisations and that action is taken to prevent adults with care and support needs from experiencing abuse or neglect.

Accountability
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.

Professional curiosity and challenge
Limited oversight meant that the quality of reviews, advocacy, and professional factfinding was equally limited, making challenge difficult. This finding can be applied more widely across all providers – it is essential to recognise the opportunities practitioners have when visiting, to ask questions on behalf of those who cannot. Staff must not take things they are told at face value, should ask for evidence and make sure they are listening to the voice of the person, not just the provider of the service. The report highlights how 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 curious, ask the questions – they may be the only one who does.

The trauma of transition
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 – how may this influence behaviour or future decisions about their environment? 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.

Resist normalisation
The number of safeguarding concerns reported by or about providers can vary due to a range of variables, not always negative, for example a very open culture around reporting. 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.

Where the victim of abuse doesn't want to 'complain'
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. The confidence of staff to explore this is key – does the person feel at risk in their environment, do they feel it will make things worse for them, do they think there is no point because nothing changes? Explore with them the reasoning for this, do they have any impairment to their mental capacity which could impact this decision? 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. Information may still need to be shared, or action taken, especially where other adults may be at risk.

Key findings cont:

Prevention
One of the fundamental principles of safeguarding is prevention. The SAR noted a number of areas where this could have been improved. Providers need to be carrying out effective risk assessments, including environmental risk, and taking action to manage known risk. Again, visiting staff have a critical role here to ask questions and see the evidence they are doing this. Most importantly, involving and listening to family and friends, 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.

Questions to consider:

1. What lessons can your agency take from this case?

2. Which agencies should take key learnings from this case and how should they ensure these are actioned and embedded in their organisations?

3. How will the Safeguarding Adults Board gain assurance that a similar case doesn't happen Surrey and what evidence would SAB members like to see to assure this?

Link to full repot and resources: Joanna, Jon and Ben - published September 2021 | Norfolk Safeguarding Adults Board