



Norfolk  
**Safeguarding  
Adults Board**

## Safeguarding Adults Review about Joanna, Jon and Ben



In April 2019 **Norfolk's Safeguarding Adults Board (NSAB)** ordered a **Safeguarding Adults Review** about how 2 people with learning disabilities died at Cawston Park Hospital in Norfolk.



In December 2020 another person's case who also died at Cawston Park Hospital was added to the Review.

The 3 people died between April 2018 and July 2020.



This is an easy read summary of the report from the Safeguarding Adults Review.

**This Review Report has some difficult and upsetting information about peoples' lives and deaths.**

Hard words in this report are in **bold**



**Safeguarding** is about working to make sure people are safe from injury or harm.



**Norfolk Adult Safeguarding Board (NSAB)** is a group who work together to try and make sure people are safe from harm



A **Safeguarding Adults Review (SAR)** is done when someone is harmed or dies. The review checks what happened and looks to see if anything could have been done differently to keep people safe.



The **Care Quality Commission** check health and social care services in England to see how well they are being run. They do inspections and rate services.



**Commissioning** is about planning and providing health and social care services.

**Commissioners** are professional workers who plan and buy services from providers.



A **Clinical Commissioning Group (CCG)** is an NHS organisation which plans and delivers local health services.



**Adult Social Services Department (ASSD)** is the part of the County Council responsible for providing services and support for adults with additional needs.

This includes adults with learning disabilities and autism.



The **Law Commission** is an independent group who review laws and rules in England and Wales.

It was set up by Parliament.



**NHS England** is in charge of planning and commissioning National Health Service (NHS) services in England and Wales.



The **Department of Health and Social Care** is the part of the government in charge of health and social care services in England.



A **CPAP machine** helps people with breathing problems.

Some people have a condition where they need help with breathing at night.



An **Acute hospital** is a place you go to see a doctor quickly.

It is the type of hospital you go to in an emergency.



**Seclusion** is when someone is moved to a separate room or space away from other people.



**Restraint** is when someone is held to stop them from moving.



**Obese** is when someone is very overweight.

# Why we did this Safeguarding Adults Review



The aim of this review was to find out about the care and support that Joanna, Jon and Ben received before they died.



Reviewers looked at how Cawston Park Hospital was registered and inspected by the **Care Quality Commission (CQC)**.

It was registered as Jeesal Cawston Park.



The Review also looked at how the hospital was run and how they dealt with referrals about safeguarding and safety.



Reviewers also talked to people who had been patients at the hospital before and their friends and relatives.

The Review also heard from relatives and friends of people who are patients now.



# What we found out



Joanna, Jon and Ben all went into Cawston Park Hospital under sections of the Mental Health Act (1983).



Joanna and Jon came from London.

They had both lived in placements away from their families several times before.

Ben was from Norfolk and he had lived with his mum for most of his life.



Joanna, Jon and Ben were all listed as people whose behaviour could challenge services and sometimes their families too.



Joanna, Jon and Ben each went into the hospital because of a crisis in their lives.

Joanna's **Clinical Commissioning Group** tried 38 different places but they could not find anywhere else for her to go.



Family and friends of patients said the Hospital had worked in a harmful way. They said Cawston Park Hospital did not answer questions and ignored peoples' upset and distress.

### 4 big worries



Families said planning and activities were not co-ordinated to help people. They explained 4 key things the Hospital was doing which worried them:



Putting patients in groups which were not safe



Staff using **restraint** and **seclusion** too much and without the right training



Giving patients too much medication



The Hospital often leaving patients with nothing to do



Families said the Hospital did not spend time trying to find out why people were unwell or distressed.

**Days with no records kept**

Joanna **179**

Jon **1**

Ben **450**



Families said records were not kept properly about patients.

For more than a year lots of information about Ben was not written down.



Families said the Hospital assumed what patients could manage and decide about when they were unwell.

Sometimes the Hospital left responsibility with patients when they needed support with decisions.



Joanna and Ben both had **CPAP machines** to help them breathe at night. They often did not want to use them. The Hospital did not write this down, tell their families or consultants about this or do anything to help Ben and Joanna cope with their machines.



Joanna and Ben were both **obese**. Whenever their weight changed their **CPAP machine** would need adjusting.

The Hospital did not do check this.

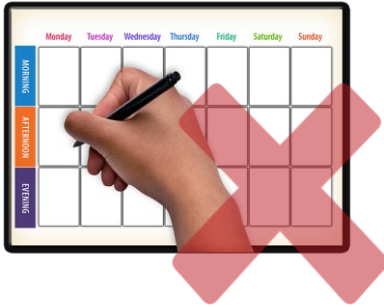


The Hospital support workers did not have the information or skills they needed to support patients properly at outpatient health appointments.





The Hospital did not make efforts to find out what people's lives were like before they became patients there.



There did not seem to be any timetables of activities and things to do.

Activities people enjoyed or were good at were not arranged for them.



The Hospital did not do good work to make sure people moved on.

Jon's records show that setting dates for him to leave the Hospital did not work because none of the planning was done.



When people are put into a specialist hospital far away from their home and their family there is a risk that they end up stuck there.

Hospitals may not do the work to support people to move on.



If **CCG** workers do not go to meetings then patients can be left in hospitals without anyone official asking why things are not changing for them.

# What needs to happen now



These pages show what **Norfolk Safeguarding Adults Board (NSAB)** needs to do now.



Write to the **Law Commission** and ask them to review the law about how private companies providing services for adults with learning disabilities and autism are managed and run.



Ask the **Department of Health and Social Care** how people with learning disabilities and autism will be protected when they are put into hospital under the Mental Capacity Act.



Share this review with **NHS England** as they were responsible for Jon being placed at Cawston Park Hospital.

Questions  
to ask



Ask **NHS England** to explain how they will check people are treated well and supported to move on.

Ask **NHS England** to answer questions about how people are placed in hospitals and what checks are done.



Tell **NHS England** and any **CCG** who place people in settings like Cawston Park Hospital they must visit and check the care.

They should ask questions like these about patients who they are funding to be there.

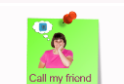


How many patients have come back here for more treatment?  
Where do patients move on to?

Morning



Afternoon



Evening



How does this patient spend their days? Are there activities and things for them to do?



How do you support this patient with their weight and help them to make healthy choices?



How do you support them if they are refusing things they need like their **CPAP machine**?



Can you give us examples of how you are supporting people to learn things and take part?



When patients have to go to an **acute hospital** how many times are security staff involved?



Ask **NHS England** to share their answers about improving commissioning and how they will make sure people are not left stuck in specialist hospitals in future.



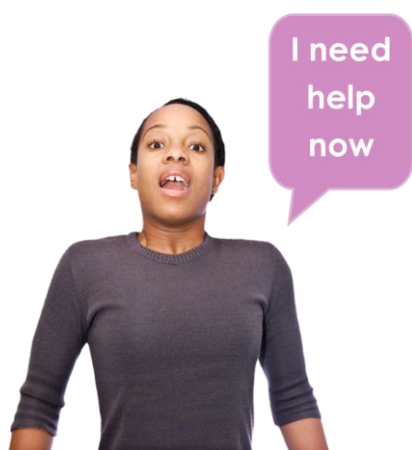
Propose to the **Care Quality Commission** that when services are not doing the work themselves to make improvements then their registration should be cancelled.



Explain to the **Care Quality Commission** what happened as a result of Cawston Park Hospital not working with families.



Bring organisations and providers together to talk about possible ways forward when racist views of people with learning disabilities affect how they react to the people supporting them.



Raise the issue of services not listening to families' health advocacy for patients.

Cawston Park Hospital staff failed to help Jon when he said he could not breathe. They did not believe Joanna's seizures were real and did not give treatment. They did not react to Ben's symptoms from not using his **CPAP machine**.



# What needs to happen now



This is what **Norfolk Adults Safeguarding Board** say **Norfolk and Waveney CCG** and **Norfolk County Council** should do now.

These are called recommendations.



Review how they **commission** services and begin ethical commissioning which means only buying services from providers who work fairly, safely and well.



Report back to **Norfolk Safeguarding Adults Board** about how changes to **commissioning** processes are being made.



**Norfolk County Council** and **Norfolk and Waveney CCG** to work together to transfer all Norfolk patients out of Cawston Park Hospital to new placements.



Work together to reach a better balance so their responsibilities are not split into putting people into hospital for medical reasons but then moving them on being about social care issues.

## Who helped with this report



**Norfolk Safeguarding Adults Board** want to say thank you to the families of people with learning disabilities and autism who were patients at Cawston Park Hospital. The experiences they shared with us were important and deserved our attention.