



Briefing paper for Practitioners

Safeguarding Adults Review for Joanna, Jon and Ben

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Background and context

The Norfolk Safeguarding Adults Board (NSAB) carried out a Safeguarding Adults Review (SAR) in 2020/21 into the deaths of three young adults with learning disabilities and complex needs, placed in a Norfolk private hospital. Joanna, Jon and Ben had learning disabilities and had been patients at the Hospital for 11, 24 and 17 months respectively. They all died in a 27-month period between April 2018 and July 2020.

The Care Act 2014 states that Safeguarding Adult Boards (SABs) *must* arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult. This is a statutory responsibility.

The overall purpose of a Safeguarding Adult Review (SAR) is to promote learning and improve practice, not to re-investigate or to apportion blame. The objectives include establishing:

- lessons that can be learnt from how professionals and their agencies work together
- how effective the safeguarding procedures are
- learning and good practice issues
- how to improve local inter-agency practice

The SAR Panels included relevant agencies involved the care and treatment of Joanna, Jon and Ben.

Summary of the cases

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 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.

Findings and areas for learning and improvement

This report is a very challenging read and reflects extremely poorly on the Norfolk system. There are learning points for professionals in health and social care including commissioning.

Accountability

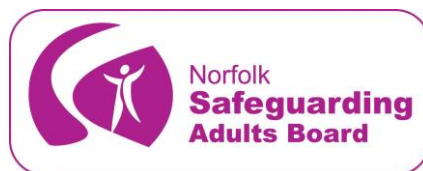
The setting for this SAR was a private hospital where a very high number of the placements were commissioned by out of county CCGs, involving a variety of different funding authorities. This meant that face to face review was rare, oversight was limited, and Norfolk agencies were often unaware of the 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 fact-finding 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.

Meaningful support for individuals with behaviours that challenge others

Too often the focus of interventions, especially physical interventions, is to simply manage the presenting behaviours, without consideration of the root cause and potential triggers to prevent them occurring in the first place.

All behaviours are communication, and the onus is on practitioners to try and understand what it might be. Where necessary, assumptions about behaviour must be challenged to promote more individualised service responses.

The SAR noted that staff often did not recognise self-soothing or employ appropriate diversion techniques. Some of the language used to describe behaviours – “kicking off”, “pushing boundaries”, “histrionic”, “tricky” – puts blame on the person without recognising the context.

The SAR also identified the significant lack of [meaningful activity](#) for patients which in itself impacted negatively on their physical, emotional and psychological health. With unstructured days, patients or service users will be bored, under-stimulated, frustrated; without exercise they may gain weight, lose muscle tone and motivation.

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.

As a county we encourage reporting and openness, and it is not unusual that, in settings which support people who have a range of complex needs, there may be a higher number of concerns involving ‘minor’ incidents, often requiring no further safeguarding intervention. It is important however to ensure that every incident is considered both as a unique event and also in the context of others in the same setting.



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. [Norfolk Safeguarding Adults Board have published a 7 Minute Briefing on this in August 2021.](#)

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.

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.

Recommendations

A total of 13 recommendations were made as a result of these findings. [Please refer to the SAR report for details and further information.](#)

NSAB Response

The NSAB will ensure that this learning is followed up through its Composite Action Plan (CAP) and test how well agencies have applied the learning from SARs through the Safeguarding Adults Review Group (SARG) and board meetings.

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