Detention (MHA or DoLS) of people with learning disabilities
Best interests? Necessary and proportionate? Appropriate treatment?

Joanna Bailey: was from Romford, her family described her as being a loving, funny and fabulous daughter, who enjoyed listening to music, singing in karaoke competitions. Joanna loved animals, especially her dog Milo. She had learning disabilities.

On 28 April 2018, **Joanna died aged 36** whilst a patient at **Jeesal Cawston Park,** a private learning disability hospital where she was detained (MHA). Of the 556 days that Joanna was in the hospital there were **no care records** for 179 days.

INQUEST TRUTH, JUSTICE & ACCOUNTABILITY https://www.inquest.org.uk/joanna-bailey-close

Joanna's inquest was not held until November 2020 (family fought for a jury)

Joanna was found unresponsive in her bedroom with blood around her mouth in the early hours of 28 April 2018: *'Despite a registered nurse and five care workers on duty all being trained first aiders, **none of them attempted CPR**. The registered nurse, who is still employed by Jeesal Group, fetched a bowl containing a pulse oximeter, a blood pressure cuff and a thermometer, but not the defibrillator that was on the ward.'*

Paramedics arrived 18 minutes after being called but by then Joanna had died.

Detention and death at Jessal Cawston Park
This is Ben King, he is 30 years old and has Down's Syndrome and a severe learning disability. He was admitted and detained (MHA) at Jeesal Cawston Park on 8th July 2018 (just over two months after Joanna died). He will be dead in 2 years....

Care Quality Commission
Jeesal Cawston Park
Quality Report

CQC inspection in November 2018

Ben was admitted four months ago

Jeesal Cawston Park (Norwich, Norfolk) a private hospital for adults with learning disabilities and autistic spectrum disorder. On the day of the inspection there were 51 patients: **7 were under DoLS and 44 were under the Mental Health Act**.

- *'The provider did not deploy **sufficient numbers of staff to safely maintain patient observation** levels.'*
- *'Managers did not accurately identify **incidents and learning from incidents** was not routinely shared and discussed with staff.'*
- ***'Medication** was not stored safely or securely.'*
- *'We were concerned that the **physical healthcare needs of patients** were not being met or physical health concerns shared with staff and other care providers.'*

Why did the CQC carry out the inspection? 1. Notification of an unexpected death of a patient 2. Complaints 3. Information from other external agencies

Seven months later the situation has deteriorated further

Inspection June and July 2019

Overall rating: Inadequate (special measures)

43 patients: One voluntary, **8 under DoLS** and 34 under the Mental Health Act:

- **Transforming care:** *'The service was not proactive in enabling patients to leave hospital and return to life in the community. Some patients who had been resident at the hospital for some years had no discharge plan.'*
- **Staffing:** *'The provider had not ensured there were sufficient staff with the appropriate skills and training to deliver safe care and treatment to patients.'*
- **Mental Capacity Act:** *'We found no individualised assessments of capacity for specific decisions within patient records with the exception of the use of medication.'*
- **Restraint:** *'Staff did not consistently complete physical observations of patients following restraint.'*
- **Long term segregation:** *'Staff did not always ensure patients nursed within long term segregation were nursed in accordance with the Mental Health Act Code of Practice guidelines.'*

Inspection November 2019

*'..we found **significant concerns that required urgent action.** We have taken further enforcement action against the provider to require that, with immediate effect, the **Registered Provider must not admit any patients to any ward** at Jeesal Cawston Park hospital without prior written agreement of the Care Quality Commission.'*

Ben will be dead in 8 months...

Inspection February 2020

*'..we found **further significant concerns.** The provider had also not made all the improvements it was required to make following our previous inspections. We began enforcement proceedings against the provider and **issued a Notice of Proposal to cancel the hospital's registration** as a provider.'*

Ben will be dead in 5 months...

Inspection May 2020

*'We spoke to one independent advocate for patients at the hospital who highlighted concerns that the hospital **did not report all safeguarding incidents** and staff did not take responsibility for doing this. They were concerned that patient observations were not being completed safely as **incidents were occurring whilst patients were on enhanced observations**. They reported that **staffing levels were low**, and that staff were slow to respond to patients' needs.'*

Ben will be dead in 2 months...

Inspection August 2020
Ben died last month....

'*At this inspection, the inspection team found **further incidents where patients were placed at risk of harm** due to observations not being completed correctly.'*

*'We reviewed seven pieces of randomly selected CCTV footage and found that **on five of the occasions a member of staff was asleep** when they were meant to be carrying out their duties.'*

*'Staff did not sufficiently encourage patients to **maintain a healthy lifestyle**, for example to manage their weight by eating a healthy diet and do sufficient exercise.'* (Ben gained 3 stone (20.8 kg) in weight at the hospital in the year prior to his death and his obesity was listed as a cause of death by the coroner).

Inspection March 2021 (two years and four months since the first poor inspection)

Are services safe?	Inadequate
Are services effective?	Inadequate
Are services caring?	Inadequate
Are services responsive to people's needs?	Inadequate
Are services well-led?	Inadequate

*'Following our inspection and enforcement action, the provider **decided to close the hospital**. The provider reported that it expected that all people would be discharged, and the service would close by 12 May 2021.'*

Ben King suffered from sleep apnoea and used a CPAP machine at night. If someone with sleep apnoea is also overweight, they can develop a breathing disorder called obesity hypoventilation syndrome. Without weight loss, this can increase blood pressure, breathlessness and lead to death. In the year prior to his death Ben put on 3 stone (20.8kg) and he was clinically obese (13 stone, 106kg). Staff at the hospital did not identify weight loss as a goal and the number of physical activities offered Ben reduced. In addition, the sedative promethazine was used to control behaviour. He was found unresponsive by staff at 7am, 29 July 2020 and died later that day in hospital.

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

20 July 2021, Senior Coroner for Norfolk – report to prevent future deaths

- Ben King died aged 32. The coroner's report states:
- *'CCTV was shown at the inquest which revealed Ben King **had been assaulted in the hours prior to his death** and also that **1 to 1 observation was not carried out** in accordance with the Observations Policy.'*
- *'Basic dietary advice and guidance provided **was not followed by staff**.'*
- *'..(MDT) Meetings were **not held every 4 to 6 weeks as required**.'*
- *'Evidence was heard that **no substantive changes** have been made at the **residential homes owned by JHL and JRCSL** following the death of Ben King and the closure of JCP to deal with these concerns.'*

Coroner's report:
'..Jeesal Holdings Ltd (JHL) and Jeesal Residential Care Services Ltd (JRCSL) and possibly ***other linked companies with the same Directors****, continue to provide residential care to persons with mental health illness, learning disabilities, complex needs and physical disability. The concerns raised at the inquest* ***could apply to residential care offered by these companies and unless such concerns are addressed there is a risk that future deaths may occur****.'*

The hospital was owned by **Jeesal Akman Care Corporation Limited.** Its accounts for the year ending 31st March 2019 show the hospital's turnover was **£12.4 million** and it made a **profit of £1.8 million** (after tax). The hospital has 56 beds so each patient/bed costs £221,428 per year paid mainly by CCGs/NHS England.

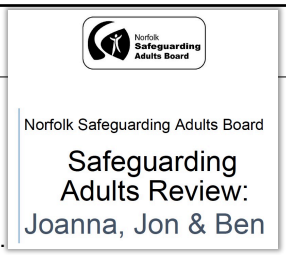
- Why are CCGs/NHS England paying over £200,000 per year for inadequate care?

The directors paid themselves a £2 million dividend for the year ending March 2019 and £1 million dividend the next year.

The two owners and directors of Jeesal Cawston Park, are also owners and directors of Jeesal Akman Care Corporation Ltd + Go Smart Care Ltd + Jeesal Holdings Ltd + Jeesal Residential Care Services Ltd + Jeesal Support Services Ltd.

CQC records indicate these companies operate **at least 12 residential care homes** for people with learning disabilities. (West Brook House, Vicarage Road, Treehaven Rants, Treehaven Bungalows, Shulas, Salcasa, Middleton's Lane, Lilas House, Creswick House, Casarita, Ashwood House, Chase House).

Norfolk SAB - Joanna, Jon & Ben - SAR
BBC News article



Published 9 September 2021

Between April 2018 and July 2020, three people died at Jeesal Cawston Park – **Joanna, Ben and Jon**.

- All three were in their 30s
- All of them were detained under the Mental Health Act...
- Of the 752 days Ben was in the hospital, there are NO care records for 450 days.

The CCG: were paying **£26,000 a month** for Ben's placement. The CCG Chief Executive: '*It's very difficult with a private provider to know how the funds are being spent and that's one of the reasons we're using NHS facilities more and more.*' (comment: No, it isn't difficult, you just need to visit the hospital, speak to Ben, speak to his Mum or read the CQC reports)

Ben: *'Ben wanted to return home to his mother. He became tearful when speaking to her on the phone and at the end of her visits. A month after his admission, the Hospital acknowledged that "a lot of Ben's distress is driven by his want to be with mum and people he knows…However, it formulated this as "attachment problems…issues" and planned "…to reduce the amount of time mum and Mencap [support workers] see Ben," and to limit the calls he made to his mother.'*

Ben's mother: *'The funeral car drove through Cawston Park Hospital because I wanted Ben to know that he was being taken out of there…Some days it's too hard to carry on. The thought of never hearing Ben laugh again.'*

'The concerns raised at the inquest could apply to residential care offered by these companies and unless such concerns are addressed there is a risk that future deaths may occur.' Was the Coroner exaggerating? Over the top?

CareQuality Commission

Jeesal Residential Care Services Limited

Westbrook House

Published 23 August 2021
Part of the 'Jeesal' group
A care home for seven people with learning disability and autism
https://www.cqc.org.uk/location/1-119626873

Inadequate

*'People living in the service had been **exposed to risk of harm.** Risks relating to **numerous areas** including the environment had been poorly assessed and responded to. **Safeguarding systems were ineffective** ....'*

*'People were **not being supported by staff who had the correct skills** and training....**People were living in dirty bedrooms with mould and damp**. Staff were not supporting people in the service to **eat healthily** ... Staff were not proactive in managing or responding to people's **healthcare needs.'***

*'We observed some staff behaviour that was **not respectful** and did not promote people's dignity. This included **staff talking about people in front of them** or referring to them in a disrespectful manner.'*

Several residents are under DoLS - this report should trigger a DoLS Part 8 review by the relevant Supervisory Bodies.

CareQuality Commission

Inadequate

Jeesal Residential Care Services Limited

Treehaven Rants

30th September 2021

Care home for 18 people with a learning disability / autism / mental health issue

*'This inspection was **prompted by a high number of safeguarding concerns** received by the local authority.'*

*'The **attitudes and behaviours of staff** did not ensure people received safe care. There was a culture of underreporting which meant **people were not protected from possible abuse.** People were exposed to unnecessary risk and were living in **an environment which did not promote their wellbeing or keep them safe.'***

*'There was a **poor staff culture and staff were either unable or unwilling to escalate concerns around the poor practice of colleagues**....We observed staff discussing information which was not appropriate in front of people with no regard to its possible impact.'*

***'The environment was no longer fit for purpose**, neither was it hygienically clean. We found multiple issues with the environment which posed **some immediate risks** and had resulted in one person being temporarily removed from their flat without consultation with family or other health care agencies to ensure it was in their best interest.'*

Inadequate

Jeesal Residential Care Services Limited

Treehaven Rants

Chemical restraint: *'Stopping the over medication of people with a learning disability, autism or both (STOMP). Staff were not aware of this guidance and had not received adequate training in managing people's behaviour without the use of medicines.'*

Best Interests: *'The provider and registered manager **were not acting lawfully** in terms of best interest decisions and we found evidence of one person being removed from the service when it was unlawful to do so. **No best interest meeting had taken place and the local authority and family had not been advised**.'*

DoLS: *'People had DoLS in place, and restrictions on their movements, but **not all of these were in date and not all had been authorised.** Staff were unaware who had a DoLS and the implications of the associated conditions in place.'*

Several residents are under DoLS - this report should trigger a DoLS Part 8 review by the relevant Supervisory Bodies.

https://api.cqc.org.uk/public/v1/reports/0f194931-0d6c-411c-925c-542382a71bcb?20211030120000

Inadequate

Jeesal Residential Care Services Limited

Lilas House

18th November 2021

Care home for six people with a learning disability and autism

*'**People were at risk of harm due** to the lack of effective systems in place to identify when people were at risk. Staff lacked knowledge and did not follow key care plans and risk assessments,..'*

*'**People were not supported to have maximum choice and control of their lives** and staff did **not support them in the least restrictive way possible** and in their best interests; the policies and systems in the service did not support this practice.'*

*'During the inspection we found **widespread concerns with the environment people were living in. The living conditions were not acceptable** which posed a risk to people's safety and their right to being supported that promoted their dignity and respect.'*

*'A **toilet door had a stable door design** where the top of the door could be opened from the outside whilst someone was in the toilet.'*

Several residents are under DoLS - this report should trigger a DoLS Part 8 review by the relevant Supervisory Bodies.

https://api.cqc.org.uk/public/v1/reports/79777bb0-82b7-4a34-ae62-87840da77160?20211118130000