SOMERSET SAFEGUARDING ADULTS BOARD

Safeguarding Adults Review

MENDIP HOUSE

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Origins, aims and scope

1. This Safeguarding Adults Review (SAR) was commissioned by Somerset's Safeguarding Adults Board during March 2017. The Board's principal interest lay in drawing together the *critical learning* arising from practices which did not identify or act on evidence of bullying at Mendip House, a dwelling for six adults[1] with autism with a staff team of 26 (excluding those on zero hours contracts).[2] Mendip House was one of seven separately registered dwellings based at the National Autistic Society's[3] Somerset Court campus comprising 26 acres of land. There are also *outreach* and *day service facilities* at the campus. Mendip House was closed on 31 October 2016. It is the only dwelling which is owned by a housing association.[4]

2. This Review was undertaken as a desk exercise during April – June 2017. It is an atypical SAR since it was commissioned in the wake of extensive fact-finding and interventions initiated by Somerset County Council's Director of Adult Social Care. That is, it summarises and builds on enquiries undertaken by Somerset County Council (SCC), NHS Somerset Clinical Commissioning Group (Somerset CCG), the Care Quality Commission (CQC), the National Autistic Society (NAS), the National Development Team for Inclusion (NDTi)[5] and a Strategic Board established to oversee the local safeguarding enquiry process. The Review is partial since it concentrates on the key issues and general conclusions arising from their fact-finding between October 2012 – October 2016. The Safeguarding Adults Board sought consideration of the themes which have influenced safeguarding practice in Somerset and elsewhere. These include:

   a) the multi-agency response
   b) the characteristics of the safeguarding referrals
   c) the management of the whistle-blowing notification
   d) other sources of alerts
   e) the regulator
   f) the commissioning organisations and their reviews
   g) the operations and governance of Somerset Court
   h) the timely management of concerns arising from a service with multiple commissioners.[6]

3. To facilitate the involvement of practitioners across sectors who had been directly involved in the enquiries concerning Mendip House, all sectors were invited to outline their remit, powers, structure and enforcement resources during April 2017. It

[1] Of the six residents two were female and four male. All were White British. As at May 2016 two were aged 25-34, one 35-44, two 45-54 and one 55-64. Source: SCC AIS system (accessed 30/01/2018).
[2] https://www.theguardian.com/society/2016/jun/30/police-launch-investigation-at-somerset-centre-for-people-with-autism (accessed 5 May 2017); Notes of 11 May 2016 meeting: the police, the NAS and Somerset safeguarding; Whole Service Professional's meeting of 18 May states *25 staff*
[3] With potentially 30 placing authorities plus CCGs - Minutes of Strategic Board Meeting: 2 June 2016
[4] Whole Service Concern – NAS minutes of operational group: 1 June 2016
[5] The NDTi's work was commissioned by Somerset CCG
[6] The Terms of Reference drafted by the Acting Strategic Manager: 3 March 2017

was intended that these would exercise an important influence at a *learning event* at the end of the Review. A draft SAR was circulated during July 2017 and the *learning event* took place on 26 October 2017. Submissions and comments arising from the draft and from discussions during the event shaped the revision of this review.

An Overview Summary

4. The National Autistic Society *has publicly acknowledged that* [it] *failed badly in* [its] *approach at Mendip House* and this is repeated in comments[7] concerning the draft SAR. During the *learning event,* the NAS clarified that its apology included "all of the individuals concerned at Mendip House for our poor standards and practice which led to their abuse." Also, it noted that "we take responsibility for the failure of our managers and the failure in this case, of our systems to spot those failures."

5. During the 27 October 2017 learning event, the NAS explained its hierarchy, its safeguarding training, structures and procedures. There is a nominated individual and safeguarding lead with a direct line to the Chief Executive and the Chair of Trustees. Somerset Court was overseen by a Local Service Operations Manager reporting to an Area Manager. The continued operation of a service is determined by the Local Area Manager and the Registered Manager.[8] Since the failures at Mendip House were neither dealt with nor escalated, the resulting "uncaring environment" is "uncomfortable learning…People were not at the centre of what we were doing." CQC inspections did not identify these failings but once their reach became known, the NAS decided to close Mendip House. "Our responses were slow and lacked coordination…[and] quality monitoring visits weren't delivering [because] no trends were identified…Now, there is much greater emphasis on putting values into practice…our policies and procedures have been made clear and streamlined…we have a clear line of sight from the board to reality…[and] we are investing in our skills base…we have to create safe environments for our residents."

6. The NAS was commissioned to provide *flexible, specialised support* at Mendip House: *The aim of all services is to offer access to as full, enjoyable and meaningful a life as possible to each individual. Programmes are designed to offer additional help in communication and social skills and to compensate for difficulties in imagination.*[9]

7. Specialist support was remote from the experience of Mendip House residents. The closure of Mendip House may be traced to **May 2016** when incidents were revealed to Somerset's Safeguarding personnel by NAS whistle blowers, one of which was reported via the Care Quality Commission. The scattered knowledge arising from previous incidents was collated and an incubation of failures and harmful practices became apparent. One allegation concerned an employee who *used their*

[7] National Autistic Society – Comments and suggested amendments for clarification to *Safeguarding Adults Review – Mendip House'* (draft July 2017)
[8] NAS: *Remit, Powers, Structure and Enforcement Resources*
[9] The NAS' Statement of Purpose: August 2015

PlayStation (and phone[10]) *on shift…couldn't be bothered to take people out because of being on the PlayStation also didn't take a phone call.* In addition to the NAS' internal investigations, Somerset's Safeguarding Board identified *Whole Service Concerns* and established a multi-agency *Strategic Board*. An audit of case files requested by SCC during June 2016, found that Mendip House residents had been funding the meals of staff accompanying them during outings since 2014 (almost £10k was reimbursed to its six residents).

Table 1: The responses of the National Autistic Society to reported incidents

Dates	Reported incidents	Responses of the NAS	Residents
July 2015; April 2016	Employees were unaware that Rita had absconded from the site; the same happened in 2016.	She was found; her family and social worker were informed; risk assessments were amended; doors were alarmed; and her care plan was reviewed	Rita is in her 20s. Her placement was funded under S.117 of the Mental Health Act 1983 by a London borough[11]
May 2016 x2 June 2016	*Whole Service Concerns*[12] hinge on the bullying and disrespectful behaviour of employees towards six residents; it emerged during the Enquiry Team's file audit that residents had paid for staff meals during outings	Employees were suspended and an internal investigation began; the NAS appointed a Registered Manager from another service to investigate; the NAS met with the residents' families; placing authorities were informed; an acting manager from Somerset Court was introduced; as a result of the file audit, Rita was reimbursed (£1549.62)	

[10] From *Early chronology of Safeguarding Events,* SCC Safeguarding Team

[11] Rita's placement was made *as a place of safety following absconding from London* – Minutes of Whole Service safeguarding case conference: 18 May 2016; she has a history of absconding – Comments on draft SAR

[12] A Strategic Board was established by the Director of Adult Social Care. This included *inter alia* the Somerset Partnership NHS Foundation Trust, the CQC, Avon and Somerset Police and the Clinical Commissioning Group. Its purpose was *to facilitate communication with local partner agencies and with the large number of other local authorities commissioning residential services at Somerset Court* (Lessons Log June 2016). A *safeguarding Enquiry Team* was established *to investigate the concerns in Mendip House and other residential homes on the site*

May 2016	An employee contacted the CQC about the swearing and unprofessional response of a staff member to a resident who was masturbating and who later required assistance to go to the toilet	Employees were suspended and an internal investigation began	
May 2016 June 2016	Col is known to flinch in the presence of particular employees; Col paid for staff meals during outings	The NAS identified the employees, one of whom was suspended, disciplined and dismissed; Col was reimbursed (£1666.93)	Col is in his 30s. He lived in a *separate flat.* His placement was funded by North Somerset
July 2015	Des' anti-convulsant medication was missing	An internal investigation did not find the medication; revised and *tightened* procedures resulted in staff being *required to sign for Des' medication*	Des is in his 50s. His placement was funded by a Scottish authority
May 2016 June 2016	An employee made Des crawl around on all fours; Des paid for staff meals during outings	Staff were suspended and an internal investigation began; Des was reimbursed (£2030.54)	
May 2016 June 2016	The *Whole Service Concerns* included the actions of senior employees. Staff threw cake - which had been made by a resident - at Hal's head and crayons into his coffee; when he requested a biscuit, he was given an onion to eat and when he would not eat it he was sent to his room; Hal paid for staff meals during outings	Staff were suspended and an internal investigation began; Hal was reimbursed (£1620.84)	Hal is in his 50s. His placement was funded by a London Borough. He has lived at Somerset Court for over 40 years

May 2016 June 2016	The *Whole Service Concerns* included the actions of an employee who offered cake to Ruth and then took it away; Ruth paid for staff meals during outings.	Staff were suspended and an internal investigation began; Ruth was reimbursed (£715.40)	Ruth is in her 40s. Her placement was funded by a Midlands authority and Somerset CCG. She has lived at Somerset Court since her teens
May 2016 June 2016	The *Whole Service Concerns* included the actions of employees who threw cake at John. He was holding tea at the time which he spilled onto himself; John paid for staff meals during outings.	Staff were suspended and an internal investigation began; John was reimbursed (£1560.75)	John is in his 40s. His placement was funded by a Midlands authority and Somerset CCG
October 2015	John was a passenger in a car which belonged to a co-resident which was involved in an accident[13]	John was taken to hospital.[14] The incident was not reported to the CQC[15]	

8. During **May 2016**, Somerset's Safeguarding Adults personnel were faced with reports concerning the poor oversight of staff and a sustained failure to address the taunting, mistreatment and humiliation of residents. However, half of all safeguarding referrals from Somerset Court revealed that the most typical form of referral was (i) resident on resident assault and the risk of assault and (ii) the misuse of residents' finances (albeit without revealing the unauthorised expenditure identified by the Enquiry Team's file audit. See Appendix 1). Also, the distribution of the safeguarding referrals at Somerset Court suggested to the Enquiry Team that other dwellings at the site required scrutiny.

The Multi-Agency Response

9. The actions of the key agencies and the meaning of *partnerships* constitute central threads in this Review. The NAS identified the challenges of (i) having *a clear understanding* of the decision-making of statutory bodies, most particularly when the host authority is not purchasing services and (ii) inconsistent attendance at strategy meetings.[16] Statutory powers became muddled from the perspective of the NAS

[13] See Appendix 1
[14] http://www.hse.gov.uk/pubns/books/hsg220.htm (accessed 1 November 2017)
[15] Or to the Health and Safety Executive - under r.3 of the Management of Health and Safety at Work Regulations 1999, there is a duty to carry out risk assessments to non-employees which arise from or are connected with the employer's undertaking
[16] These share, discuss and consider known evidence and agree protection and enquiry actions

when, having commenced internal investigations (led by the Registered Manager of another service), it was advised that the outcomes for certain employees should be reconsidered, even though it is only an employer who may *take decisions to terminate individual staff contracts…close the service* [or] *hand the service over to a different provider.*

10. Avon and Somerset Constabulary confirmed[17]that it can (i) *prosecute under criminal law, subject to agreement from the Crown Prosecution Service* and (ii) *ensure records of interactions are recorded for disclosure and barring and share information to safeguard.*

11. Since 2014, the Care Quality Commission has inspected services against *five key questions: Are they safe? Are they effective? Are they caring? Are they responsive? Are they well-led?* The CQC rates *all providers and ratings are based on a combination of what inspectors find at inspection, what people tell CQC, Intelligent Monitoring data and information from the provider and other organisations. CQC award ratings on a four-point scale: outstanding, good, requires improvement or inadequate. Where a provider is rated as inadequate overall, they will be placed in special measures.* Since 2015, new legislation[18] introduced *Fundamental Standards.* The CQC is required to *monitor, inspect and regulate services…take enforcement action against…registered persons or managers who breach conditions of registration…*[and] *to monitor the operation of Deprivation of Liberty Safeguards.* The CQC's local inspection teams *are supported by enforcement leads and* the advice of the Legal, Prosecution and Inquests team. The latter *are an integral part of any enforcement action.* Its inspectors *communicate with local safeguarding and commissioning teams.* They *will always take into account information provided by…others.*

12. NHS Somerset Clinical Commissioning Group is required by the Care Act (2014) to retain oversight of the care it commissions, to specify the outcomes sought, and to monitor service *quality, access and patient experience.* Although there were no residents who were fully funded via Continuing Healthcare, Somerset CCG *provided joint funding with seven different local authorities…Each local authority was the lead commissioner and held the contract with NAS…Serious incidents are events in healthcare where the potential for learning is so great…so significant that they warrant using additional resources…the incident in relation to NAS was logged with NHS England as a serious incident when the safeguarding process was commenced…Somerset has recently implemented a new Care Home and Domiciliary Care Quality and commissioning board…jointly run between* Somerset CCG and SCC*. The board provides a formal route for decommissioning services where there are serious or sustained concerns.*

13. Somerset County Council local authority *has a duty to monitor the quality of services provided by all care and support organisations in Somerset, whether or not the care*

[17] Avon and Somerset Constabulary - *Remit, Powers, Structure and Enforcement Resources*
[18] The Health and Social Care Act (Regulated Activities) Regulations (2014)

and support is commissioned elsewhere. It is required[19] to have effective communications, relationships with providers and oversight of *the market* with a view to ensuring the sustainability of care. The local authority has the lead role in conducting enquiries or investigations regarding safeguarding. A joint policy with the Somerset Clinical Commissioning Group monitors Somerset providers. CQC inspection ratings below "Good" or a service subject to "Whole Service Concern" *automatically constitute a service provider default.* The local authority can suspend (i) new placements to a service and (ii) block contracting arrangements. It initially approaches *quality issues* informally. If this does not result in improvements, then a *Whole Service Concern investigation* results. This would include an *overarching strategy meeting…with the regulatory body and service commissioners…Where the police are the lead agency in a suspected criminal investigation, the implicated service shall be excluded…it is important to consider that other adults may also be at risk.*

14. A new safeguarding restructure is underway at the local authority which will transfer the Safeguarding and Quality Service from *Operations* to *Strategic Commissioning…A Commissioning and Quality Board has been established with the Clinical Commissioning Group…to support clearer evidence-based commissioning/ de-commissioning decision-making…The Safeguarding and Quality Service…has regular…meetings* with *commissioner, health and CQC colleagues.*

15. Tables 2-5 summarise the principal events as the NAS, SCC, the CQC and Avon and Somerset Constabulary sought to address the pressing circumstances of the six Mendip House residents and establish the adequacy of Somerset Court provision.

Table 2: The National Autistic Society

Dates	Events	Responses
1-5 May 2016	A member of staff at Mendip House[20] disclosed concerns to the Registered Manager (RM) of another NAS service; the concerns were not reflected in Mendip House's records	The RM informed senior managers and NAS' *internal review* resulted in four staff suspensions (by 5 May)
6 May	Somerset Court informed SCC and the CQC	A RM from the south of England was asked to *carry out an internal inquiry,* once agreement had been secured from SCC and the police

[19] Care Act 2014

[20] Mendip House had had a separate staff group since November 2015 - Minutes of Professionals meeting: 18 May 2016. However, *staff were able to hand in notice, have a two-week gap then* return on zero hours contracts…*able to work in other homes* – Minutes from 11 May 2016 meeting at Avon and Somerset Police, Bridgwater

9-10 May	Four members of staff were interviewed	Six Mendip House employees in total were suspended; a manager from Somerset Court was appointed for Mendip House
11 May	Meeting with the police and SCC's safeguarding personnel established that for c18 months Mendip House had been dominated by a "gang" of controlling male staff; investigations were inconclusive since concerned staff withdrew allegations; the interviews arising from the whistleblowing were *incredibly weak* in terms of the questions asked*;* the NAS SW Area Manager and HR managers did not know the names of the Mendip House residents and were unfamiliar with their support needs; *Whistle blowing staff are fearful of their identity being exposed*[21]	The police asked the NAS *to pause* its internal inquiry; the NAS undertook to provide a chronology of internal investigations; SCC considered *contingency planning;* staff at Somerset Court were briefed; additional bank staff were deployed; new staff received *additional training* and were *expected to read support plans*
18 May	At a *Whole Service case conference,* the NAS confirmed that Mendip House's manager was *likely to be suspended;*[22] it was acknowledged that *many* Somerset Court staff have *familial relationships*	Undertook to provide information concerning Deprivation of Liberty Safeguard applications; drafted a letter to residents' families; HR processes for suspended staff continued - liaising with the police and the Disclosure and Barring Service (DBS); and ensured that suspended staff could not enter the site

[21] Minutes from 11 May 2016 meeting at Avon and Somerset Police, Bridgwater

[22] The Registered Manager was responsible for two dwellings at Somerset Court. The Registered Manager had received a written warning during February 2015 for the *misuse of corporate card.* This expired 12 months later. The Registered Manager's supervision records highlighted *medication issues and errors…two major investigations…culture issues…behind with completing forms…*and a" laddish*" culture at Mendip*

May-June	An external consultant was commissioned to *hold investigatory meetings* with the suspended Mendip House staff and other staff members and make recommendations; the NAS was concerned about the administrative burden of the *Enquiry Team's* work;[23] its file audit identified *weaknesses* concerning residents' personal monies	Individual reports concerning staff were produced (see Appendix 2); residents' families received letters about the allegations and investigations and were offered an opportunity to meet the NAS Chief Executive; SCC expressed concern to the NAS and multi-agency colleagues about the external consultant's report since the terms of reference did not address the role of senior managers at Somerset Court; disciplinary hearings were held and four people were eventually dismissed; the DBS was informed
July	*Autism accreditation has been removed from Mendip House;* the NAS CE agreed to postpone disciplinary activity	The practice of the site manager was *looked at, at an organisational level*
August	The audit of Mendip House's finances concluded; five members of staff including the manager and the deputy were dismissed and two final warnings[24] were issued; the manager of the site was suspended;[25] the NAS disagreed with an advocacy service's statement concerning residents' mental capacity: in the NAS' view most Mendip House residents *did not have capacity;* the Whole Service Concern case conference did not have evidence that the NAS Action Plan was being delivered;[26] the NAS decided to close Mendip House	Reimbursements were confirmed and paid to residents; the Whole Service Concern case conference questioned the disciplinary outcomes. The NAS Press Release acknowledged that the charity had *failed badly*; advocacy returned to the service to address the NAS challenge; the Whole Service Concern case conference questioned NAS accountability; families contacted a councillor and MP concerning the prospective closure of Mendip House; formal termination letters were sent to the commissioners; the NAS was to review, update and provide additional safeguarding training at Somerset Court; and a new site manager and safeguarding and development manager were appointed

[23] *We are asked for a huge amount of information from the different parties, often the same, with short deadlines* - NAS: *Remit, Powers, Structure and Enforcement Resources*
[24] NAS' *staff investigations and disciplinaries only deal with the* [current] *allegations…* [it does not] *consider previous allegations or disciplinaries that are spent* (Whole Service Concern – NAS Professional Case Conference Minutes: 23 August 2016)
[25] The outcome of the disciplinary hearing is not known
[26] Whole Service Concern Case Conference 23 August 2016

September	The NAS updated its *Action Plan;* work at Mendip House focused on the transition of residents to other services; the NAS re-issued an updated *Safeguarding Adults and Whistle-blowing policy; safeguarding training* began; SCC advised the NAS of its grave concerns regarding the outcome of the disciplinaries (since not all staff were dismissed and the practice of managers was not scrutinised[27]) based on safeguarding investigations, shared CQC intelligence[28] and the NAS staff conducting investigations[29]	A member of staff who was due to return to work was dismissed; the DBS was informed; advocacy *actively involved…attending Best Interests' meetings;* the NAS began to address organisational values locally and nationally; SCC required assurance *and evidence* that the Action Plan was being addressed and monitored
November	All residents had left Mendip House and the dwelling was de-registered	Three former Mendip House residents remained *within the Somerset Court campus*

16. The National Autistic Society is primarily responsible and accountable for the practices revealed at Somerset Court. Its Registered Manager did not address (i) the unprofessional behaviour of a "gang" of male employees at Mendip House (ii) unprofessional practices elsewhere on the site, or (iii) increase its oversight in the light of poor recruitment practices, for example, the high turnover of employees on-site. It did not question the adequacy of its specialism. It did not question its single-site model of sourcing residents with diverse support needs. It did not adequately supervise or increase the oversight of those employees whose behaviour towards residents was devoid of merit or promise.

17. It does not appear that the placing authorities asked searching questions about the benefits of residents being placed at Mendip House or received detailed accounts of how fees were being spent on their behalf. Since the NAS was not accountable to Mendip House residents or to the placing authorities, it failed both.

[27] Strategic Board Meeting – 19 July 2016

[28] An anonymous letter to the CQC reported that staff repeatedly threw a resident into a public swimming pool and were reprimanded by the pool staff. The same resident was made to eat chillies and was regularly pushed, slapped and laughed at. The author described fear about speaking out

[29] Investigations concerning staff practices of 10 September 2013 and 21 January 2014, state*, this report is limited to drawing a conclusion about the validity of the allegations made and making disciplinary and/or training recommendations. This report will not determine what sanctions will be imposed if disciplinary action is recommended*

Table 3: Somerset County Council

Date	Events	Responses
6 May 2016	The NAS informed SCC of a whistle-blower's allegations concerning Mendip House	The NAS was initially asked to undertake an investigation. Subsequently a *Whole Service Safeguarding* Process was invoked by the CC
10 May	The CQC informed SCC of the allegations of a whistle-blower	
18 May	A *whole service's professionals meeting* agreed that communication with families and commissioners was required	SCC liaised with commissioners and LAs concerning all Somerset Court residents
June	SCC created a dedicated *Enquiry Team* and wrote to residents' families, their social workers and CCG contacts about the Somerset Court based Enquiry Team and provided contact details; an *early update* highlighting *risks* at each of the dwellings was circulated to the police, Somerset CCG and the CQC; the Director of Adult Social Services made contact with the NAS Chief Executive and requested that the disciplinaries were *postponed;* three Strategic Board Meetings took place;[30] and the Safeguarding Adults Board was briefed[31]	Social workers and CCGs shared information concerning the placements and reviews; Somerset CCG provided NHS England with fortnightly briefing; the NAS prepared an Action Plan; and the reviews of Somerset Court residents began

[30] See Appendix 3
[31] Safeguarding Adults Board Minutes: 2 June 2016

July	The Enquiry Team *reviewed the care…*attended the placing authorities reviews; *monitored* the NAS' *action plan and additional services; assessed the quality of care provided in the other six homes;* scrutinised the 2012-2015 investigations undertaken by the Bridgwater LD team which identified similar concerns, (that is, lack of respect for residents and concerns about finances, medication and whistle-blowing); a Strategic Board Meeting took place;[32] NAS was *asked not to act until they had received guidance from the Strategic Board…*in view of the fact that alerts were not raised. Also, the Strategic Board was concerned to ensure that suspended staff should not be returned to work without a full consideration of the wider issues	The roles of all agencies were questioned in the light of *a growing evidence base for the initial concerns…significant failure…regarding management, supervision, care and the impact;*[33]irrespective of request *not to act…*the NAS *were keen to remove staff and introduce new staff…were introducing a random call each month to a family to gain a view of their experience.* [In response, the Strategic Board questioned the adequacy of the NAS' action plan of 29 June 2016 for Mendip House in the light of staff suspensions[34]]; although the systemic problems highlighted during 2012-15 were raised with senior managers at SCC, the outcome is not known; the Enquiry Team's work was acknowledged to have been robust[35]

[32] See Appendix 3
[33] Whole Service Concern Professional Case Conference Minutes: 7 July 2016
[34] These had been discussed with the NAS Area Manager – Strategic Board Meeting minutes 19 July 2016
[35] Email briefing: 11 October 2016

August	The Enquiry Team was concerned about the quality of care provided by two other homes at Somerset Court; that referrals to health during early/ mid-July remained to be *actioned;* the LD service appeared to *over-look* the *safeguarding risks,* since care plans had not been followed; SCC noted that the NAS' disciplinary hearings did not take account of: previous and similar conduct concerns and allegations or even conflicts of interest, e.g. an investigation report (dated January 2014) concerning a Mendip House employee was undertaken by the partner of another Mendip House employee; a Strategic Board Meeting took place[36]	The Enquiry Team liaised with the CQC about the two homes; *Grave concerns* were expressed about the final written warning issued to a Mendip House employee to NAS – it was assessed as too lenient; the NAS reviewed the case and identified *other historical concerns* which were unknown to the hearing officer. The NAS subsequently dismissed the employee[37]
September	SCC expressed concern to the CQC about the NAS' Action Plan; a Strategic Board Meeting took place;[38] the Enquiry Team provided support to the *placing authorities to identify* potential placements; with reference to residents remaining at Somerset Court it was noted that *there would be some concern;*[39] the Safeguarding Adults Board received an update and account of the lessons emerging from the work of the Enquiry Team;[40] the Strategic Board suggested that SCC had *not been sufficiently rigorous and too accepting of NAS' word, especially around their action plan*[41]	Funding remained to be agreed and confirmed for the six residents; the NAS was challenged to demonstrate that Somerset Court could address and manage the support needs of three former Mendip House residents who were to remain

[36] See Appendix 3
[37] NAS – *Comments and suggested amendments*
[38] See Appendix 3
[39] Report for the Strategic Board meeting – 16 September 2016

October	The handover of safeguarding from the Enquiry Team to SCC was negotiated	
November	The Strategic Board stood down; SCC the CQC, the NAS CE, Chair of Trustees and Director of the Centre for Autism met *to discuss concerns;* a Whole Service Concern meeting[42] about the resident of another dwelling at Somerset Court questioned the effectiveness of *working together*, that is, *no one has agreed…why over the last five years he has spent so much time on the floor in a distressed state;* broadly, it was acknowledged that *perhaps we accept too easily what providers tell us*[43]	The Strategic Board recommended commissioning a Safeguarding Adults Review; SCC determined that future safeguarding alerts from Somerset Court would be subject to *a higher level of scrutiny*
December	A final briefing from the Enquiry Team was provided to the Safeguarding Adults Board.[44]	

18. The NAS had more evidence of the degradation of Somerset Court residents by its employees than it shared with SCC, the CQC or the placing authorities.

    Somerset County Council is responsible for addressing safeguarding adult concerns within the County. The NAS's own records revealed that critical information about Somerset Court, including *poor staff conduct, alleged assaults* and *drug use or sale,*[45] was not shared beyond senior managers at Somerset Court who took no action. During May 2016, the task arising from Somerset Court was considerable:

    > *The biggest challenge is how we engage with 30 different placement authorities* [from three UK countries]*, 26 being local authorities and four CCGs.*[46]
    >
    > *…if there had been fewer commissioners then the number of issues might have raised more concern…a double complication is that some residents have health and social care funding…some people had been reviewed recently and had not raised concerns.*[47]

[40] Safeguarding Adults Board Minutes: 8 September 2016
[41] Strategic Safeguarding Board – 16 September 2016
[42] Professional Case Conference Minutes: 24 November 2016
[43] Whole Service Concern Professional Case Conference: 24 November 2016
[44] Safeguarding Adults Board Minutes:1 December 2016
[45] Whole Service Safeguarding Enquiry – November 2016
[46] Whole Service Concern – NAS Minutes of Professional Strategy Meeting: 14 June 2016
[47] Whole Service Concern Professional Case Conference Minutes:7 July 2016

19. The Somerset Court referrals/alert information[48] conveyed little of the full extent of management and practice failures at Mendip House. SCC demonstrated a proactive management role in ensuring the safety of Somerset Court residents, challenging the NAS' professional activity and that of the commissioners responsible for funding placements. SCC involved itself in the NAS' responses to events at Mendip House by creating an operational team in a process of scrutiny and review. The Enquiry Team worked with families, it challenged the outcomes of the disciplinary processes and sought to impress on managers locally and nationally that the NAS' actions prior to and following the whistle-blowing incidents were wanting. The creation of the Team was a major undertaking and investment.

20. Somerset County Council has learned a great deal because of its Strategic Board and Enquiry Team's work. The Enquiry Team of three social workers and a learning disability nurse scrutinised practice at Somerset Court – reading records, contributing to reviews and initiating contacts with health care professionals. The Team abstracted from its own briefings a *learning log.* This is thoroughly compatible with SCC's wish to see *practice changes* through the provision of a supportive and interventionist approach – which it was equipped and competent to undertake.

Table 4: The Care Quality Commission

Date	Events	Responses
9 May 2016	The NAS informed the CQC of a whistle-blower's allegations concerning Mendip House; SCC reported that it had received *a number of concerns* the previous week	Since the whistle blower had contacted the CQC the previous month the CQC made a safeguarding referral on the same day
10-11 May	The NAS suspended five employees and the police *were now involved*;	The inspection team held a Management Review meeting
12 May	An unannounced *urgent, focused* inspection uncovered *issues reflecting lack of governance* and determined that *staffing arrangements were adequate to keep people safe and ensure continuity of the service*	The CQC liaised with NAS, the police, the Strategic Board and the Enquiry Team

[48] Appendix 1

18 & 24 May	An internal meeting was planned *to decide on what actions CQC might take including potential for a national, provider-wide investigation for NAS given seriousness…and similarity to Winterbourne View issues*[49]	The CQC attended a safeguarding meeting convened by the CC; the police were considering possible criminal investigations; the CQC decided to carry out *comprehensive inspections of all Somerset Court locations*
June	Unannounced inspection visits took place over three days	Liaison continued with the police and the local authority's safeguarding team; Mendip House was *rated inadequate overall*
July	The service was *inadequate;* a S.64 letter was served to NAS and the process of deregulating Mendip House began	The NAS elected to de-register Mendip House
August	A Press Release confirmed that the NAS proposed to cancel the registration of Mendip House; the CQC expressed concern about the final written warnings	A resident's parent contacted the CQC and gathered that *no enforcement action had been taken.* This was shared with other parents since not all families wanted Mendip House to close.[50]
November	*The earliest that CQC would re-visit would be in six months' time;*[51] at a meeting with the NAS CE, CQC *commented on the similarities found by CQC in NAS run homes outside Somerset Court…CQC colleagues continue to filter and share information around the country and will look at the national picture.*[52]	Assurance was required that an external agency was looking at the NAS Action Plan;[53] *the CQC have stated they would be extra vigilant in inspecting NAS services nationally*
December	Consideration of a prosecution continued[54]	

[49] Whole Service Safeguarding Minutes of Professionals' Meeting 18 May 2016 – during the learning event the CQC explained that this was a misunderstanding and that the process undertaken was to review inspection reports for all other NAS locations to identify if there were any common themes indicating widespread concern(s) that would be cause for a national, provider wide, investigation.
[50] CQC subsequently clarified that normal practice is for no comment to be made with regard to any enforcement action it is taking or considering taking unless the requirements of the legislation permit this sharing of information with certain statutory bodies. Currently enforcement action is published once all provider appeal processes are concluded and not upheld.
[51] Based on normal return inspection timescales from an Inadequate rating
[52] Strategic Safeguarding Board – 08 November 2016
[53] Whole Service Concern Professional Case Conference Minutes: 24 November 2016
[54] Safeguarding Adults Board: 1 December 2016

21. The NAS has registered 58 residential and community services across England, providing around 250 beds. Almost a third of NAS locations are within the South West. *During May 2016, 6% of NAS registered locations were outliers with high abuse notifications (higher than expected for the size and type of service…The concerns that preceded the closure of Mendip House were raised with the CQC in May 2016. There were no concerns regarding compliance nationally for the NAS at that time and the South West four of the 14 locations had been inspected and rated as Good…All registered adult social care providers are required to notify the CQC of certain significant events…Notifications are an important intelligence monitoring…The notifications from Somerset Court did not raise any particular concerns…during the course of the inspection of Mendip House in 2016, it was identified by the CQC inspection team and the SCC investigations team that there was significant under-reporting of incidents relating to Mendip House. People living in Mendip House had complex needs and all would have lacked capacity to make certain decisions and* [all] *require a DoLS[55]. CQC did not receive any notifications that DoLS had been authorised.[56]*

22. The CQC and a senior NAS manager had received allegations of abuse from whistle blowers during November 2014. The outcome of the NAS investigation was shared with the local authority but not the CQC. During August 2015, *allegations of abuse were raised with CQC…CQC recorded that the provider took appropriate action and the outcome was unsubstantiated.* During April 2016, a whistle-blower alleged the abuse of residents during the 2014 Christmas period. The CQC made a *safeguarding alert* to the local authority which asked the provider to investigate. It was not informed that a senior NAS employee at Somerset Court *was being performance managed*.

23. The NAS' *internal investigation into the November 2014 allegations raised concerns about the staff culture in the home.* During early 2015, employees *had raised concerns in supervision meetings,* yet *no action had been taken by NAS…these issues were not reported to CQC or SCC at the time. A provider audit in October 2015 had identified 43 areas for improvement…this was not reported to CQC at the time.[57]*

24. The history of CQC inspections at Mendip House does not reveal the bullying of employees and the failures of management oversight. The trigger for the CQC's August 2016 report concerning Mendip House was two whistle-blowing alerts, information from the local authority and scrutiny of NAS' internal investigations, supervision documentation and audit. It was noted that, *staff were asked to sign a declaration each time they had a formal supervision session to confirm they had not*

[55] The Deprivation of Liberty Safeguards (DoLS) are part of the Mental Capacity Act 2005. The safeguards aim to make sure that people in care homes and hospitals are looked after in a way that does not inappropriately restrict their freedom
[56] CQC Internal Review – 21 September 2017
[57] CQC Internal Review – 21 September 2017

witnessed any abuse. Staff had routinely signed to say they had not but had later reported alleged abuse to the provider as part of their investigation (p7).

25. **The regulator** identified *multiple breaches* of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 once it was alerted to the poor oversight of practice at Somerset Court. However, the documentation available to this review does not suggest clarity of purpose. *The inspection team have reported that there were a number of concerns identified during the inspection that were known to* SCC *and not CQC or vice versa but not both organisations prior to the inspection.*[58] SCC was led to believe that there would be a *national provider-wide investigation* and confirmation about whether or not there was to be a prosecution.[59] The CQC acknowledges that events to which it was alerted during November 2014 and August 2015 should have triggered a discussion concerning a potential inspection.

26. There were **other sources of alerts:** [60] [61]

    Care plans…very poor with no mental health or best interest's assessments recorded…DoLS [Deprivation of Liberty Safeguards]*…not being followed…recording poor…plans out of date.*

    NAS shared staff statements…which mention falsifying of records – leaving gaps to add things retrospectively…appeared to be no recorded plan of action within the home and no routines for the residents.

27. In addition, the review of a Mendip House resident whose physical health was compromised was abandoned during August 2015. This was *due to the poor and incomplete nature of the support plans and materials presented…a further review* [was] *set for November 2015 to allow the reports to be re-done and improved.*[62] The review was attended by the placing authority and Somerset CCG.

28. The evidence in Tables 1-3 and Appendix 1 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.

[58] CQC Internal Review – 21 September 2017
[59] CQC subsequently clarified that normal practice is for no comment to be made with regard to any enforcement action it is taking or considering taking. CQC have powers to prosecute registered persons for certain offences and continue to make relevant enquiries regarding the failings at Mendip House.
[60] Whole Service Concern – NAS Minutes of Professional Strategy Meeting: 16June 2016
[61] Feedback from the CQC noted that "The report that was published after the comprehensive inspection shows that even if the abuse had not happened at Mendip there were enough indicators of concern to still rate this location as inadequate overall. This was made very clear to the provider who initially felt that just suspending the staff was enough to mitigate the risk"
[62] Whole Service Concern Safeguarding Enquiry Team update for professionals: 7 July 2016

Table 5: Avon and Somerset Police

Date	Events	Responses
11 May 2016	Meeting with the NAS and SCC's safeguarding personnel and the police's Safeguarding Co-ordination Unit requested that the NAS *pause* its investigation	The management and planning of the investigation was discussed with Police Safeguarding Co-ordination Unit to determine how the investigation should be progressed.
18 May	At a *Whole Service's professionals meeting* it was noted that statements had been withdrawn; and there was no information to support a criminal investigation[63]	A listing of all employees at Somerset Court over 18 months was requested; the NAS proceeded with its HR investigation. The Investigation was allocated to the Avon & Somerset Constabulary Investigations team to progress and staff were appointed to undertake the alleged offences.
1 June	There was no clarity about whether or not there was to be a criminal investigation; the police have a statement from a member of staff…not at the point of making a decision if they will take action[64]	*The Police were comfortable with HR processes for suspended staff going ahead*[65]

[63] From 23 May 2016 there was a police investigation. This included *frequent conversations with* the CQC *to see what offences were possible from police powers or through CQC enforcement*
[64] Whole Service Concern – NAS Minutes of Professional Strategy Meeting: 16 June 2016.
[65] Whole Service Safeguarding - Minutes of Case Conference 18 May 2016. At the learning event in October 2017 the police stated this was not the ideal situation and had been a result of miscommunication.

7 July	*Taken no further action…unlikely that their investigation will be taken further…a significant amount of activity…it seems that CQC might have more appropriate powers than the police in relation to this matter; statements have been obtained…but are unable to force people to cooperate;* police protection was provided to one interviewee who was *deeply fearful* of colleagues	After reviewing the gathered evidence, the police met with the CQC to consider which was the appropriate prosecuting authority considering the range of powers and offences open to the CQC.
August	*The police are waiting for the HR proceedings to take place*[66]*.*	
September	*The police decided not to progress their investigation whilst the internal investigations were ongoing…the police investigation is now moving forward as quickly as possible…two statements have been obtained, the remaining issues will occur as soon as possible. Once all information has been gathered the threshold to go to the CPS will be considered*[67]	
November	*The police have confirmed that there was no likelihood of any criminal prosecution*[68]	

29. Avon and Somerset Constabulary *works in partnership, collaboratively to ensure the most appropriate action is taken by the most appropriate agency. Where we have intelligence but no formal allegations we can commence proactive, intelligence led investigations to develop into a criminal case…Depending on the nature of the criminal allegation made, these offences will more likely be investigated by our investigations teams which comprise detectives trained in vulnerability.*

30. The Avon and Somerset Police investigation was set aside at an unknown date. The decision determining that the police had investigative primacy did not appear to be communicated to all partners. This allowed some confusion and the commencement of NAS internal HR processes[69], as well as a perception that the police role had been limited to that of waiting for the outcomes of the safeguarding enquiry and the CQC inspections. At the time, it was not clear to partner agencies why it was

[66] Strategic Board Meeting: 3 August 2016
[67] Whole Service Concern Professional Case Conference Minutes: 15 September 2016
[68] Strategic Safeguarding Board – 08 November 2016
[69] The police subsequently clarified that, whilst a police investigation commenced immediately, it was phased to make use of the evidence collected in the NAS internal enquiry which could then be put to the suspects in interview.

challenging for the police to interview staff members who had been dismissed (see Appendix 3)[70]

The management of the whistle-blowing notification

31. Whistle-blowing is a dynamic process which hinges on allegations by an organisation's employees (past or present) of practices under the control of their employers which they believe to be wrong. An unknown number of allegations were made to individuals the whistle-blowers believed would take remedial action. The Responsible Individual[71] appeared to have no role. *The NAS had agreed a division of responsibilities between the Responsible Individual and the Director of Adult Services so that the former worked predominantly on site to improve practice and the latter attended meetings with* SCC *and other stakeholders.*

32. The circumstances of the whistle-blowing concerning Mendip House were that employee deviance was harming residents, compromising the services and working conditions at Somerset Court as well as the NAS. It is unusual to have a full understanding of:

    - the whistle-blower's intentions
    - the processes used by the whistle-blower and
    - the consequences for those who are involved.

    Most services would favour whistle blowers using internal rather than external channels to ensure that corrective actions might be taken. If, however, internal channels are perceived to be wanting, then no alerts will be perceived by the service. Arguably the NAS employees who were *not* subject to suspension benefitted from whistle blowers acting on their behalf.

33. On two occasions in early May 2016, members of Mendip House staff reported concerns to another home manager at Somerset Court and the CQC respectively (when the Mendip House manager was off sick). The former covered many of the incidents set out in Table 1, with the caveat that they constituted the *tip of the iceberg*. In addition, the whistle-blowers alleged that no action had resulted from previously expressed concerns and that staff found it difficult to speak out about concerns. Within days, the National Autistic Society announced an *internal investigation* to be conducted by an *independent registered manager.* Separately, the CQC liaised with SCC which played a vital role in leading an enquiry and liaising with commissioners.

The challenges for multiple commissioners

34. In parallel with SCC's lead with local authorities responsible for commissioning places at Somerset Court, Somerset CCG assumed the lead as the coordinating

[70] The police subsequently clarified that they had been given an incorrect address for one of the suspects and that another refused to answer calls

[71] An appropriate person, nominated by the organisation, who is responsible for supervising the management of the regulated activity provided

Commissioner, negotiating with the four health bodies (in addition to itself), responsible for jointly commissioned placements. An independent review of Somerset CCG's commissioning process[72] in relation to eight Somerset Court residents found that its *intervention…in the arrangements of these individuals…has been sporadic and predominantly reactive with no regular contact…proactive intervention has been almost non-existent* (p3-4)…*the nature of the commissioning role was unclear and appears to have been interpreted as predominantly financial…the role of the health professionals in* Somerset Partnership NHS Foundation Trust *in* [the care of two residents] *was also unclear* (p8-9).[73]

35. Social care and health care commissioners were broadly responsive to SCC's steps to ensure the safety of Mendip House residents when it was revealed that the NAS was not delivering what commissioners believed they were purchasing. However, within six months of the whistle-blowing notification, commissioners decided that three Mendip House residents could remain on the campus.

36. The **timely management of concerns arising from a service with multiple commissioners** was achieved but it would be incautious to state this without qualification. First, the campus model as exemplified by Somerset Court is dated yet favoured by some families. Second, commissioners continue to act as *place-hunters* rather than agents of individuals with autism or stewards of the public purse with the means to control fee levels. Third, the operational realities of certain Somerset Court dwellings bore no resemblance to the statement of purpose.

37. *A number of residents had already experienced abuse and assaults in other homes. Some families had fought to get a place for their son/daughter at Somerset Court believing that they offer a specialist service, renowned for their care of people with autism…..it is an issue for both commissioners and parents that they see the National Autistic Society and think they are getting proper care at last…..the residents have been "dumped" in Somerset because the commissioners are many miles away and then it's too far for them to come and review. [74]*

The operations and governance of Somerset Court

> *…the NAS Director of Adult Services and Area Manager…had not picked up on any of the issues over the last 18 months…why didn't they seek any outside help? …. didn't seem to realise the seriousness of the situation.*
>
> *When XYZ was in charge the place ran like clockwork but since…departure...things went downhill*

[72] Pitts, J. (2016) *Independent review of Somerset CCG commissioning arrangements for eight individuals residing at Somerset Court,* National Development Team for Inclusion
[73] Somerset Partnership NHS Foundation Trust was the single agency which had regularly provided services at Somerset Court over many years
[74] Whole Service Concern Safeguarding Enquiry Team up-date for Professionals Meeting: 7 July 2016

…a lack of staff available to provide the level of support…only one member of staff on duty…neglectful.[75]

Over the years internal staff have investigated other internal staff.[76]

38. There is an urgent need to consider how best to ensure better corporate safeguards in relation to the residential provision of adults with learning disabilities and autism, such as those at Somerset Court. The National Autistic Society did not benefit from credible reporting structures, the creation and composition of engaged board committees familiar to Somerset Court or the contribution of individual and collective non-executive directors attuned to Health and Safety for example. The National Autistic Society's oversight measures were ineffective since *they were not backed up with 'buy-in' ownership and oversight by management at a local level.*[77]

39. **Lessons and Conclusions**

The NAS Action Plan *contains a lot of actions for things which you would have thought an organisation like the NAS would have had in place years ago and adds a further question around leadership.*[78]

40. The staff at Mendip House engaged in behaviour that was cruel, *far below the standard expected and…contrary to the NAS' organisational purpose and values.*[79] The service at this dwelling, and others at Somerset Court 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. It appeared to be a permissive setting which rarely encouraged or discouraged approaches to activities e.g. preparing and offering residents' drinks and food. Too much discretion was left to the National Autistic Society employees. Decisions about continuing placements were not based on data such as what was being achieved with and on behalf of individual residents.

41. Assumptions about a service's reputation and expertise do not constitute evidence. Parallels have been drawn with Winterbourne View Hospital, albeit without the cameras. There were over 30 different placement authorities across Somerset Court and although concerns were raised with SCC's safeguarding team about other Somerset Court dwellings on at least four occasions between 2014-2016, not one identified concerns about Mendip House. Five years after the scandal of Winterbourne View Hospital this is remarkable.

42. Somerset County Council has no enthusiasm for placing adults with autism at Somerset Court. Yet it had to invest in an expensive and labour-intensive enquiry because of the lack of rigor and failures of judgement of commissioning professionals. It acknowledges that it was not sufficiently clear about what it

[75] Whole Service Concern – NAS Minutes of Professional Strategy Meeting: 14 June 2016
[76] Whole Service Concern – Professional Case Conference Minutes: 7 July 2016
[77] NAS – Comments and suggested amendments
[78] Whole Service Concern – Professional Case Conference Minutes: 7 July 2016
[79] NAS – Comments and suggested amendments

expected the NAS to do. It has arrived at the dispiriting conclusion that provider services must respond to such challenges as: *Since Somerset is a mass importer of people with complex health and support needs, prove to us that this service is not going to trigger a Section 42 inquiry; prove that this is a values-driven, evidence-driven and well led service.* Had the National Autistic Society addressed long standing concerns and the commissioners undertaken essential reviewing and monitoring, the workload of SCC and the Enquiry Team would not have been as extensive. Accountability is a topic of interest to taxpayers and politicians. SCC's council tax payers have funded an in-depth scrutiny of a failing service even though Somerset residents are not placed there. Since commissioners are responsible and accountable, arguably it is only a matter of time before they are prosecuted.[80]

43. It beggars belief that *staff were asked to sign a declaration each time they had a formal supervision session to confirm they had not witnessed any abuse.* Ditto evidence uncovered by the enquiry team in their reviews of previous safeguarding enquiries revealed that the NAS had routinely conducted internal investigations into the poor / abusive conduct of their own staff members in isolation and without reporting outcomes to either SCC or CQC. In these instances, and in those where they had reported them, there was recorded evidence that often a whistle-blower would themselves resign, while the alleged perpetrators were given warnings following disciplinaries and retained or recycled within the service. The former is an astonishing practice which arguably played a key part in the duration of abuses at Somerset Court, not least since the CQC and the Enquiry Team found that it was ineffective. The latter may constitute wilful neglect. The documentation does not evidence the NAS' understanding of the role of the Responsible Individual.

44. There is no sense that the Somerset Partnership NHS Foundation Trust's work at Somerset Court delivered health gains for residents or was even attentive to the possibility of residents being harmed by the NAS employees.

45. Individual care plans are neither optional nor static. They are part of required working methods. Employees at Mendip House did not prioritise areas for action irrespective of residents' support needs. It is possible that Somerset Court avoided setting goals in areas where they lacked the expertise to achieve them. A resident's review was abandoned during November 2015 because of the inadequacy of the documentation. It is astonishing that the commissioners concerned did not ask for money back or report the service to the CQC. Working methods and monitoring must relate to residents' care plans and a services purpose.

46. Inspection is perceived as a straightforward matter. The natural understanding of families would be that the National Autistic Society would employ experienced and competent staff and that if they do not, the CQC would step in to help, rescue or protect the residents. This review points to a different reality – the regulator acted

[80] www.theguardian.com/society/2017/jun/07/care-home-directors-convicted-over-devon-learning-disability-regime (accessed 11 June 2017)

once the harm was alleged to have occurred – without reference to the history of inspecting Somerset Court dwellings. The CQC's decision to act after the whistle-blowing is not good enough.

47. There can be no confidence that there is sufficient capacity in Speech and Language, psychology, behaviour support, learning disability nursing and psychiatry services to meet the needs of unknown numbers of adults who are placed outside their own localities. Thus far, there has been no conversation concerning the funding and capacity implications for local services.

48. It is possible that the delay in dismissing NAS employees impacted on the decisions of others to provide witness statements. Avon and Somerset Constabulary sought "pauses" in the NAS investigation and its approach was perceived as "wait and see."

Recommendations

49. Previous recommendations are cited in Appendix 4. The following recommendations were negotiated at the learning event on 5 September 2017. Only two out of the seven lead placing commissioners for Mendip House attended, and only two out of 30 responded to the request to submit information concerning its remit and powers.

50. Somerset Safeguarding Adults' Board[81] should recommend that:

i. the Department of Health, NHS England and the Local Government Association are requested to:

- prepare consultations to regulate commissioning;
- include in those consultations the role of 'lead commissioner' who will assume responsibility for coordination when there are multiple commissioning bodies of a single service and assume responsibility for ensuring that individual resident reviews start with principles and make the uniqueness of each person the focus for designing and delivering credible and valued support;
- include in those consultations the expectation that commissioners must notify the host authority of prospective placements;
- set out in guidance the remit, powers, structure and enforcement resources of all agencies immersed in the task of achieving better lives for adults with autism;
- assert a new requirement to discontinue commissioning and registering "campus" models of service provision
- assert a new requirement for (a) formal consultation with Local Authorities with Social Services responsibilities and Clinical Commissioning Groups regarding all planning applications for building residential services that would require registration with the Care Quality Commission to operate, and (b) to

[81] It was suggested at the Safeguarding Adults' Board meeting of 7 December 2017 that other Adults' Boards in the South West and Healthwatch England may wish to be associated with this request

decline planning permission for types of service provision for which there is no local demand and which fail to "think small" and "think community."[82]

ii. the Department of Health, NHS England and the Local Government Association be advised of the actions that Somerset County Council intends to take to address the detrimental persistence of "place hunting" by commissioners. That is, to require commissioners to:

- fund essential monitoring and reviewing processes;
- fund residents' access to local health services, most particularly community health services;
- identify a lead commissioner.

iii. Since it is unlikely that the Care Quality Commission would register this model of service now, Somerset Safeguarding Adults' Board should write to the Care Quality Commission requesting that it (a) makes this fact explicit in its inspection reports; (b) undertakes more searching inspections of such services; and (c) does not register "satellite" units which are functionally linked to "campus" models of service provision

iv. A Memorandum of Understanding is negotiated by Somerset County Council whereby the aggregate-level information concerning grievances, disciplinaries and complaints, for example, gathered by providers is shared with the Care Quality Commission and pooled with that of local authorities' safeguarding referrals, the "soft intelligence" of Clinical Commissioning Groups, the police and prospective commissioners. The "search costs" of information seeking, negotiating access, processing and storing are excessive – this is most particularly the case when Section 42 inquiries are invoked

v. The Care Provider Alliance, with the support of the Care Quality Commission and Skills for Care, issue its members with guidance on how the role of responsible or nominated individual in supervising the management of the regulated activity[83] should be performed in respect of quality assurance and safeguarding.

In addition to the recommendations made by the report author the Somerset Safeguarding Adults Board has also agreed:

vi. For the Somerset Safeguarding Adults Board to review assurance arrangements for all people currently placed outside of Somerset, and to monitor the implementation of any actions identified through this work

[82] This was suggested by the Safeguarding Adults' Board meeting on 7 December 2017

[83] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 6

Appendix 1: Summary of the variety of Somerset Court's Safeguarding Referrals 2015-16, from its seven dwellings

	Mendip	Great Wood	Porlock	Cotswold	Blackdown[84]	Knoll*	Lakeside[85]
Referral concerning							
Medication management	2				3	1	
Resident finances	7		2	1		1	5
Insensitive and unprofessional practices	6	3			1	2	
Assault by staff	1					1	
Assault/ risk of assault by residents		2	8	3	4	2	2
Car accident	1		1			1	
Resident bruising – unknown cause		1				1	
Inattention to residents' privacy		1		1			
Inattention to environmental hygiene			1				1
Failure to invoke the Mental Capacity Act 2005			1				
Unsafe deployment of staff					2		1
Resident fall				1			
Unknown				1			

*It is known that during **2013** a *substantial amount of medication* was missing from Lakeside.

During 2015, the day service at Somerset Court made a referral concerning resident on resident assault; and during 2016 a *medication issue* was referred by the *outreach* service and it was reported that a non-Somerset Court resident was assaulted by a staff member.

The Enquiry Team reviewed the NAS' investigations and noted the *high level* of *internal investigations undertaken by the NAS into their own staff without reporting these to either* SCC *or the CQC.*

[84] The Enquiry Team highlighted concerns about the quality of care at Blackdown
[85] The Enquiry Team highlighted concerns about the quality of care at Lakeside

Appendix 2: The National Autistic Society's commissioned *investigatory meetings*

During May-June 2016, the NAS commissioned an external consultant to conduct *investigatory meetings* concerning events which had led to the suspension of Mendip House employees. The consultant *reviewed all the written statements…visited Mendip House* twice…and met with *the suspended employees.*

Employees	Concerns and allegations	Explanations
1	Poor timekeeping; failing to *sign in… pull…weight* or fulfil *job role; throwing* items at residents*;* taunting residents	Although *regularly late from tattoo appointments* would *sometimes ring in…*employed to deliver 1:1; *people tended to throw pens…lads messing about…boisterous males*
2	Playing on PlayStation; throwing items at residents; using mobile phone; taunting residents; not fulfilling role; banter that *goes too far;* poor timekeeping	PlayStation was to engage residents – duties not neglected; did not recall cake throwing – had advised others not to throw pens; there is a culture of using mobiles at Somerset Court; *insufficient support* for hard to manage team; people do *not consistently sign in*
3	Playing on PlayStation; using mobile; inappropriate response to resident who was masturbating	PlayStation was to engage residents; used phone for work-related calls; not on duty at the time of alleged incident with resident
4	Playing on PlayStation; throwing items at residents; poor timekeeping; not *pulling weight; using mobile phone;* bringing children to *work;* making resident walk on all fours; taunting residents; *putting ribbon round resident's neck and riding him like a horse; paperwork* incomplete	PlayStation was to engage residents *– only happened at weekends;* recalled an occasion when fruit *might have* been thrown; there was a pen throwing incident…*quite laddish…throwing games took place most days; there is no monitored system for signing in; only one shift was a support one…the team divided into those who wanted to spend time cleaning…and those who preferred to go out; everyone* uses their mobile phone; on a single occasion the employee's child was present; the employee had not seen the resident walk on all fours; *bantering/ less serious atmosphere…had helped some* residents; no incident with ribbon *took place;* all *necessary paperwork* had been completed
5	*Management failings; paperwork failings; investigation* of resident's	The management is *challenging…*should have *shared struggles* against a backdrop of

	bruising; timekeeping; mobile phone use; bringing children into work; allowing a *culture of mobile phone use;* taunting residents	personal issues; addressing *capability* rather than *conduct issues…behind with supervision;* not aware *that some staff do not* sign in; *there was banter…aware of sexual discussions* which had been addressed; paperwork should have been delegated; no recall of bruising incident; shift hours are responsive; all late arrivals are matched with additional hours; children are present when items have to be collected for example
6	*Encouraging resident to eat raw onion; bringing* children *into workplace;* making racist and sexual comments to staff; taunting residents; poor timekeeping; throwing items; responding inappropriately to a resident masturbating	*Denied involvement* re: onion; has *never* brought children to Mendip House; have been the recipient of racist remarks, which were laughed at by the manager, *people should expect him* to remain silent; there is *banter* among support workers; always *signed in; not been party* to throwing things

The consultant concluded *that there is a factional culture at Mendip House* in which *individuals are scared to come forward and complain.* A *laddish culture* prevails with *differences of view* about its implications for residents. However, the *young male members of the team are often rostered to work together…allowing this behaviour…*it follows that *the majority of behaviours and incidents did happen…these were unsuitable and inappropriate…timekeeping is clearly a major issue…there is a general practice of ignoring the mobile phone policy…there is no…communicated policy concerning when it may be acceptable…to bring…children* to Somerset Court.

The consultant advised that disciplinary action should be taken in the light of *management failures; paperwork failings; poor timekeeping;* inattention to a resident's bruising; work allocation; playing on PlayStation and/ or using mobile phones instead of supporting residents; throwing items at residents; allowing a *taunting culture;* failing to undertake duties; and *failing to challenge racist and sexist behaviour.*

Appendix 3: Strategic Board Meetings[86]

These were chaired by the Director of Adult Social Services and included Somerset County Council, Somerset Partnership NHS Foundation Trust, Avon and Somerset Constabulary, the Somerset Clinical Commissioning Group, NHS England and the CQC. The purpose was to: reflect the spirit of the ADASS (2016) draft guidance and ensure effective communications, recommendations and lessons.

2 June 2016

The issues, allegations and actions taken since the alert were considered. None of the Somerset Court residents have been placed by local commissioners (it is *very expensive…not a model favoured)…in terms of commissioning arrangements, there is a clear pattern that when things get difficult the response is to ask for 1:1 care…there has been no* [NAS] *contact…to commission support with behavioural issues…they have wanted more funding for more staff.* In total, there are 26 placing authorities and four placing CCGs.

The draft terms of reference for the Enquiry Team and a discreet piece of work focusing on commissioning were discussed. It was agreed that *every commissioning authority should have a place on the Strategic Board, potentially 30 (including CCGs).* The purpose of meeting a NAS director was to *ensure that they understand that Somerset has serious concerns regarding the whole complex…the practice of care workers, the processes and the management.*

17 June 2016

The attendees represented Somerset County Council, Avon and Somerset Constabulary, Somerset Partnership NHS Foundation Trust, NHS England, Somerset Clinical Commissioning Group and the CQC.

Discussions hinged on the Strategic Board's Terms of Reference and feedback from discussion with the NAS. Broadly, reviews conducted by commissioning bodies had *not picked up key issues for the residents…the Mendip unit is chaotic…some horrible abuse…non-completion of Behaviour Support Plans…no epilepsy plans…little information in health records…there are no records of incidents…a lack of confidence with regard to incident reporting…skill levels.* The NAS did not appear to be mirroring the priority of SCC in terms of ensuring the safety of residents. *CQC are attempting to get NAS to realise how serious this enquiry is and that it is not just Mendip House that is being reviewed…*A *distance* from NAS was deemed *advisable* since *NAS have not recognised the seriousness of the Safeguarding Enquiry.*

The CQC confirmed *worse than expected* findings arising from its inspection with *weak* management and *poor* staff support. NAS *are not being proactive in keeping*

[86] *The decision was taken that the NAS should not attend all Strategic Board meetings. This means that…we were given no opportunity to respond if the comments were unfair or unfounded* – NAS Comments and suggested amendments for clarification

the CQC up to date…NAS seems to be trying to contain matters by moving staff around Somerset Court…*it is essential that CQC work with the police and decide who takes the lead.*

The police confirmed that *statements had been taken.* The learning arising from Winterbourne View Hospital was being considered.

Adult Social Care was to take the lead on initiating contact with residents' families.

30 June 2016

The attendees represented Somerset County Council, Avon and Somerset Constabulary, Somerset Partnership NHS Foundation Trust, Somerset Clinical Commissioning Group and the CQC.

The Enquiry Team provided an update. Having considered the Health Action Plans, social care records, incident reporting and internal investigations undertaken by the NAS, all were *wanting.* Two reviews remain to be conducted. There is *system weakness* concerning residents' finances. The Enquiry team had made referrals to speech and language therapy, Learning Disability nursing and physiotherapy even though the Somerset Partnership NHS Foundation Trust is contracted to offer three days a week of psychological support.

Feedback concerning contact with the NAS' Chief Executive and, separately, police and CQC updates were discussed. It was speculated that pre-May 2016 enquiries at Somerset Court were inadequate, arguably because of the reputation of Somerset Court as a *flagship scheme* to which families remained *highly committed.* There was a sense that the NAS was *playing down* the significance of events at Somerset Court. The NAS' *investigation report was insufficient.* A resident's review during 2015 was abandoned because *the records at Mendip House were in such a bad state.*

19 July 2016

The attendees represented Somerset County Council, Avon and Somerset Constabulary, Somerset Partnership NHS Foundation Trust, NHS England, Somerset Clinical Commissioning Group and the CQC.

The Enquiry's update suggested that at another Somerset Court dwelling there were concerns which echoed those at Mendip House.

The NAS' Chief Executive had agreed to postpone the staff disciplinary hearings. It was concerning that Somerset Court's manager was regarded as competent by the NAS.

The CQC intended to share its draft report concerning Mendip House on 20 July. It found inadequacies at three other dwellings on the campus.

Since the CQC had a *compelling case,* the police determined that the regulator *would be the best prosecuting agency*[87]*.*

The limitations of the NAS' Action Plan were itemised.

13 August 2016

The attendees represented Somerset County Council, Avon and Somerset Constabulary, Somerset Partnership NHS Foundation Trust, NHS England, Somerset Clinical Commissioning Group and the CQC.

The Enquiry Team's update highlighted challenges at other Somerset Court dwellings and the apparent failure of the NAS to promote and enforce its protocol concerning the funding of staff meals during outings. The Board was puzzled that one Mendip House employee was not going to be dismissed in the light of the employee's association with previous and similar safeguarding concerns.

The NAS are working with the CQC to close Mendip House. The police *were awaiting the HR hearing outcomes before deciding any further police action.*

One of the dwellings had a *high turnover of managers…themes/ concerns for the whole of Somerset Court seem to be systemic.*

An *interim report from the NDTi regarding commissioning arrangements* was considered.

16 September 2016

The attendees represented Somerset County Council, Avon and Somerset Constabulary, Somerset Partnership NHS Foundation Trust, NHS England, Somerset Clinical Commissioning Group and the CQC.

The Enquiry Team's update revealed that alternative provision was being sought for Mendip House residents; the staff member who had not been dismissed after the initial disciplinary meeting had since been dismissed; there were concerns about *the senior management coordinator;* and Somerset is *adopting the lead commissioner role.*

The CQC reported a *perceived reluctance to allow CQC to visit clients* [at a community service where safeguarding concerns had been raised. The service was subsequently assessed as *requires improvement*]; a single person was using the outreach service; there was a view that the NAS was *not being as open and honest with families about the causes and rationale for the decisions and actions.*

[87] This was a police view that CQC had a compelling case and CQC have since clarified that they had not undertaken specific enquires at that time to determine any possible prosecution

The Police reported that *it has proved challenging getting hold of those staff members who were dismissed…hoped that the investigation will be completed within the next few weeks.*

The *next steps* included reviewing NAS' Action Plan; and *drawing critical learning* from the whole enquiry.

10 October 2016

The attendees represented Somerset County Council, Avon and Somerset Constabulary, Somerset Partnership NHS Foundation Trust, NHS England, the Somerset Clinical Commissioning Group and the CQC.

NHS England reported its concern to ensure that *this work is picked up in the Transforming Care Programme.*

The Enquiry Team reported that since June, there have been c.20 safeguarding alerts – one concerned a former member of Mendip House who was moved after the allegations during May. *Questions are raised again about the decision-making at senior management level.*

Re-provision concerns prevailed. Four former residents were to remain on the campus.

The police investigation is complete. *There is not enough corroboration in statements to meet the CPS standard to pursue any prosecutions.* The CQC noted that it was *highly likely that warning notices will be served* because of concerns about *mental capacity/ best interests' compliance.*

The Enquiry Team is to step down at the end of October…*agreed that the SAR process be used to draw together the learning.*

8 November 2016

The Manager of the Enquiry Team prepared a report for the Strategic Board. This outlined the progress of:

- transition and review planning for the six former Mendip House residents
- a review of safeguarding referrals which pre-dated the May 2016 alerts
- the 20, post May 2016, referrals arising from Somerset Court which were managed by the Enquiry Team. One hinged on the intimidating behaviour of a member of staff who had been found guilty of gross misconduct by an internal NAS investigation during 2013. [The member of staff who blew the whistle resigned while this person was retained – despite already having a previous finding of gross misconduct.]

Appendix 4: Summary of the learning and recommendations arising from reviews concerning Mendip House and the Somerset Court campus during June, August and November 2016

The National Autistic Society's investigation noted that:

- *…there is a factional …laddish…culture at Mendip House*…[which] *has not been managed appropriately*
- *…the sheer number of consistent allegations…coupled with the acceptance expressed at the investigation meetings of a laddish/divisive culture*… [led the author to conclude that] …*the majority of the behaviours and incidents did happen* [with] *days organised around how certain members of the staff team wish to spend their time… NAS may wish to consider introducing some form of clocking on system*…[and] *consider tightening up guidance to managers*
- *Timekeeping is clearly a major issue…there is a general practice of ignoring the mobile phone policy across the whole of the Somerset Court site*…[and] *there is no…policy concerning when it may be acceptable for staff to bring their children onto the Somerset Court site*
- *…the office at Mendip House* [was] *messy and disorganised…* [and the Registered Manager] *must take the ultimate responsibility…consideration should be given to how audit and supervision processes might be tightened…so as to ensure that such obvious failures in compliance can be readily picked up through routine management as opposed to being allowed to continue unnoticed*
- *…Given the regulated environment…I would expect a Deputy Home Manager to be far more proactive in their supervision and oversight of the staff team…* [ditto the] *Senior Support Worker…should…be modelling the behaviours expected of the team* [whose] *timesheets do not…offer any accurate record of…timekeeping*
- The mobile phone *issue should be addressed across the whole of the Somerset Court site and the policy applied appropriately and consistently*

The National Development Team for Inclusion noted that:

- *Involvement of other professionals is sporadic…whilst there does appear to be a productive relationship with LD nursing staff from* Somerset Partnership NHS Foundation Trust *there appears to be no formal arrangement as to their involvement and expectations can be mixed…it is not clear whether informal complaint issues raised by…parents in May 2016 have been followed up with the Trust*
- *In December 2010 at a CHC panel meeting* Somerset CCG *accepted responsibility of funding 1:1 staff…pending a psychological assessment from the* Somerset Partnership NHS Foundation Trust*…the issue had been 'lost' for over a year*
- Somerset CCG *does not appear to have been kept informed of the wellbeing of individuals, either from the NAS or from clinical staff at the* Somerset

Partnership NHS Foundation Trust…*a serious incident occurred whilst* [a resident] *was on holiday in 2014 and yet it appears that the* [Somerset] *CCG was only made aware of this at the review the following year*

- *…there is no clear delineation of what constitutes healthcare need as opposed to a social care need*
- *In every arrangement* Somerset CCG's *involvement has been after the placement has been in existence, in some cases, for many years*
- *The review process was not robust and contact with the service in the majority of cases was reactive*
- *The nature of the commissioning role was unclear and appears to have been interpreted by others as predominantly financial…the role of health professionals in the* Somerset Partnership NHS Foundation Trust…*was also unclear in terms of the regularity of their involvement and the expectations of what they should communicate to* Somerset CCG *as commissioner*
- **It is recommended that**: *Following a decision of joint funding a letter is sent to the relevant local authority and the provider confirming the local authority's role as lead commissioner* [including reference to] *an expectation of joint reviews at least annually*
- *A system is put in place which monitors the frequency of reviews and reassessments…and alerts* Somerset CCG *if a review has not taken place*
- *Greater clarity over dates from which funding responsibility commenced*
- *Care providers are made aware of their role in passing information on to the* Somerset CCG *in a timely fashion, either directly or through the local authority*
- *Expectations on the part of* Somerset Partnership NHS Foundation Trust *are set out in writing*
- *The local Continuing Healthcare Operational Policy is updated…*[and] *strengthened to require a section on reviews and quality assurance…*[with] *explicit recommendations about lead commissioner for jointly funded packages of care*
- *A quality assurance tool and a care review tool are developed…for local and national use*
- *Any safeguarding concerns are fully considered on receipt of CHC applications, at CHC panels and review meetings…this should be part of the commissioner quality assurance and care review toolkit*
- *Continuing Healthcare teams review all applications for funding for individuals who are already placed in Somerset and consider whether specialist assessment is required to improve behaviour support planning, for example, before a full application is considered*

The Enquiry Team noted that:

- an *approach of individual reviews alone would not be effective and that there needed to be a process of risk assessment of the other homes based on the findings at Mendip House*
- asking the placing authorities *to conduct reviews for the individuals they were funding…required detailed coordination…which in most part maintained accountability*
- its *full-time presence* [at Somerset Court] was *critical to the effectiveness of the work with individuals and staff teams* [since it was] *able to respond more quickly and effectively to…subsequent safeguarding referrals*
- the circumstances of one person *should be referred to the SSAB for consideration for a SAR due to complex, long term unmet needs*
- *Every provider service has a safeguarding history of incidents and investigations* [which] *needs to be preserved* [and] *maintained*
- *…previous CQC inspection formats…prior to 2016 were no indicator of risk*
- *Real concern has to lie with the…placing authorities*
- *…the National Autistic Society is a large provider where the risks of them not investigating and managing safeguarding incidents effectively in their services remains high*
- *…the review…has highlighted concerns about the charity's staff recruitment, incident reporting, decision-making, disciplinary procedures and the attitude of the senior management*