

MEDIA STATEMENT

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Restraint Reduction Network responds to Cawston Park Hospital scandal

Norfolk Adult Safeguarding Board yesterday (10th September) published its [report](#), authored by Margaret Flynn, into the deaths of Joanna, Nicholas (known as Jon) and Ben - three adults with learning disabilities who unnecessarily died in their 30's whilst being looked after at Cawston Park Hospital.

Cawston Park Hospital is part of the Jeasal Akman Care Corporation Limited and was closed earlier this year (May 2021). Norfolk Safeguarding Adults Board (NSAB) conducted its review using "partial and incomplete information" provided by Jeasal. The review findings are shocking with Ben's mother, Mrs Egmore, [describing the deaths as a 'scandal'](#).

Jeesal has said they are "deeply sorry" and the report concluded that such hospitals should "cease to receive public money".

Joanna died with staff looking over her, unresponsive in her bed. The staff were all first aid trained, yet they did not attempt resuscitation. Joanna was supposed to be checked every 30 minutes as part of her care plan, however staff failed to observe her for two hours on the night that she died.

Ben was "gasping and couldn't talk" when his mother last saw him. He had previously been hit, dragged and whacked by staff. The offender has not been tracked or prosecuted. Ben's mother found him being held in "a hideous restraint" by staff at the failed hospital.

She said: "*They had him outright with his arms, holding him really tight and his head was flopped down. I think the restraint is called a Crucifix restraint... he pleaded with me to take him home. I wish I had put him in the car then. I drove off*".

Responding to Cawston Park scandal

Parent activist, Isabelle Garnett tweeted, "*'Mummy home' and 'he didn't need to be there'. A decade++ of human rights abuses & canary in the mines signalling from families. Hardest thing for lived experience peeps is seeing year after year of same predictable & preventable trauma happening.*"

Nicholas died after swallowing a piece of plastic cup. CCTV captured his final moments where he had told staff: "I cannot breathe. I am dying". Staff did nothing. Relatives described "indifferent and harmful hospital practices" and said their questions and "distress" were ignored.

Joan Maughan, who commissioned the report as chair of the Norfolk Safeguarding Adults Board said: "*This is not the first tragedy of its kind and, unless things change dramatically, it will not be the last*". *The report read as a long list of 'indifferent and harmful' practices. Predictably the organisational culture of such hospitals are closed and management fail to establish any kind of culture that shows care.*

At Cawston Park, and in contravention of [the Restraint Reduction Networks Training Standards](#), unqualified staff used excessive restraint and seclusion to manage people who were simply communicating their utter distress at their appalling living conditions. These people were overmedicated and suffering “abject boredom”.

Alexis Quinn, Manager of the Restraint Reduction Network, activist and Autism campaigner, responded stating: *“People’s ‘behaviour’ is communication. We know this. In circumstances such as the ones these poor people were detained in, it is little wonder they were expressing distress. Reading in the report that ‘patients did not benefit from attention to the complex causes of their behaviour, to their mental distress or physical health care’ is completely unacceptable.”*

The report author, Margaret Flynn drew parallels to other well-known scandals such as Winterbourne View, Whorlton Hall and Cygnets Yew Trees and Woodside. However, RRN shares deep concern that hospital scandals extend way beyond these horrific, publicised examples.

Where people equal profit there are perverse incentives. The review acknowledges this fact stating “the roots of private, specialist hospitals reside in business opportunism and profit-driven priorities. These are hospitals in which patients receive neither specialist assessment nor credible “observations” and treatment”.

The report rightly highlights that “the deaths of three young adults must plausibly question the systems response. The CQC has recently tightened up their inspection processes. This has meant that we are seeing more and more hospitals being rated inadequate. However abusive hospitals continue to be commissioned by CCG’s and NHS England. This means that remote hospitals, far from people's families have unchallenged scope to retain patients with no consequences for the abuse they enact. This must be addressed.”

Alexis continued: *“What we really don’t need now is more reports. Instead, the recommendations from the reports written over the past few years, such as [the CQC’s ‘Out of Sight’ report](#), need to be urgently and meaningfully actioned. A step forward would be to regulate commissioners, invest in community-based crisis housing and for the CQC to improve its feedback policies.”*

Meanwhile, academic Professor Chris Hatton tweeted that the NHSE must start making public how many people have died in these services. He says, *“the way information is presented at the moment makes this impossible to work out”*.

Watch the [BBC news report](#) exploring Maria Forwood’s emotional story about her son Adam’s experience at Cawston Park. Maria removed her son from the hospital.

Cawston Park is now closed. The report concludes with a warning, “unless this hospital and similar units cease to receive public money, such lethal outcomes will persist”.

The RRN is a coalition of committed organisations and individuals who provide education, health and social care services, alongside experts by experience and families, all aiming to eliminate the use of unnecessary restrictive practices.

To find out more about RRN’s work, visit: <https://restraintreductionnetwork.org/>

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Further Information

For further information, or to interview Alexis Quinn, please contact Laura Smith at Consilium Communications via lsmith@consiliumcommunications.co.uk / 07467945848.

Notes to Editors

- The Restraint Reduction Network has an ambitious vision to eliminate the use of unnecessary restrictive practices and make a real difference in the lives of people. The Network brings together committed organisations providing education, health and social care services.
- The Network was originally co-founded by the Crisis Prevention Institute. The facilitation and stewardship of the network was taken over by the Bild Group – a charity that exists to champion the rights of autistic people and individuals with learning disabilities – working alongside the Restraint Reduction Steering Group.
- The Steering Group includes representation from all relevant government departments, professional bodies, regulators, leading academics and wider practitioners in the sector. The group’s responsibilities include overseeing the development of new training quality standards and developing organisational and individual self-assessment tools to facilitate reduction in restrictive practices.
- Find out more about our work by visiting restraintreductionnetwork.org
- Join the Restraint Reduction Network for free by submitting your pledge to support the elimination of unnecessary restrictive practices by visiting www.restraintreductionnetwork.org/become-a-member
- Follow RRN on social media on Twitter @theRRNetwork, Facebook @RestraintReductionNetwork or LinkedIn [@Restraint-Reduction-Network](https://www.linkedin.com/company/restraint-reduction-network)