23 March 2018

Andrea Sutcliffe
Chief Inspector for Adult Social Care
Care Quality Commission
151 Buckingham Palace Road
London
SW1W 9SZ

By email

Dear Ms Sutcliffe,

**Mendip House Safeguarding Adults Review**

On 08 February 2018, the Somerset Safeguarding Adults Board published a Safeguarding Adults Review into the mistreatment and abuse of residents by staff at a care home for people with autism in Somerset run by the National Autistic Society. The Review was written by Dr Margaret Flynn, who also undertook the Serious Case Review of Winterbourne View Hospital in South Gloucestershire.

All the residents at the care home, Mendip House, and the wider Somerset Court campus on which it was situated, were placed by over 30 different Local Authorities and Clinical Commissioning Groups as far away as Aberdeen. None of the people placed at Mendip House were Somerset residents and parallels have been drawn with Winterbourne View by Dr Flynn, albeit without the cameras.

In summary, the findings of the Review are that:

- Somerset Court is a dated, single-site “campus” model of service provision which sources residents with diverse support needs from around the UK.
- The unprofessional and cruel behaviour of a “gang” of male employees at Mendip House home did not suddenly occur, and action could and should have been taken by the National Autistic Society earlier.
- Neither the history of safeguarding referrals nor Care Quality Commission inspections revealed the cruelty of employees or the failures of management oversight.
- People were placed at Mendip House as a result of the detrimental practice “place hunting” by Commissioners. It does not appear that the agencies that commissioned the placements asked searching questions about the benefits of residents being placed there, or received detailed accounts of how fees were being spent on their behalf.
- Care planning was poor. Decisions about continuing placements by the agencies commissioning the placements at Mendip House were not based on data such as what was being achieved with, and on behalf of, individual residents.
- 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 by Commissioners outside their own localities.

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Seven years after Winterbourne View it is highly concerning that campus based service models, that it is likely would be refused registration by the Care Quality Commission today, continue to operate unchanged, seemingly in perpetuity. The continued registration and inspection of services without reference to the outdated campus model gives the provider little incentive to make changes, or cease ‘importing’ people from across the UK when there is no local demand for the service being offered. Without a clear national position being taken by CQC on the continued registration of campus models (and those that, though described differently by the provider, are essentially a campus), I see little prospect of organisations moving away from business plans that are predicated on ‘importing’ people.

The Review makes important recommendations in relation to the Care Quality Commission that I am writing to you to today to request that you take forward urgently. These are that, since it is unlikely that the Care Quality Commission would register this campus model of service now, that it:

1. Makes this fact explicit in its inspection reports
2. Undertakes more searching inspections of such services
3. Does not register ‘satellite’ units which are functionally linked to “campus” models of service provision.

The Review has been discussed by the Independent Chairs of Adult Safeguarding Boards within the South West, who have written an accompanying letter in support of the recommendations of this Review. I am also aware that there are other Reviews in progress within the South West that relate to similar circumstances, which are likely to reach similar conclusions and make similar recommendations in the coming months. It is my view that without change it is highly likely that similar mistreatment and abuse will be uncovered elsewhere in the future, and I look forward to working with you on the implementation of these important recommendations.

Yours sincerely,

Richard Crompton
Independent Chair
Somerset Safeguarding Adults Board

Encl.

1. Supporting letter from Siân Walker, Chair, Devon Safeguarding Adults Board on behalf of the South-West Region Independent SAB Chairs Network
2. Mendip House Safeguarding Adults Review