Is Care Unsafe for People with a Learning Disability? The Case of Connor Sparrowhawk

by SARA RYAN AND HANNAH BRADBY Oct 10, 2014

Connor Sparrowhawk was 18 years old when he drowned in the bath in a NHS short term treatment and assessment facility (Slade House run by Southern Health NHS Foundation Trust) on 4th July 2013. He had learning disabilities and epilepsy and should never have been left alone to bathe unsupervised.

The consequences of Connor’s death are dreadful and ongoing for his family and supporters. Beyond the personal and familial loss, Connor’s death has highlighted the difficulties that our society has in offering people with learning disabilities dignified, considered care centred on their own interests. Connor’s family and supporters have been campaigning to highlight the organizational, legal and statutory barriers to representing learning disabled young people’s own interests in decisions about their so-called ‘care’.

The Trust that ran Slade House has sought to minimize the consequences of Connor’s death to their own organization. Southern Health initially sought to assert that the death was due to natural causes and that an internal investigation confirmed all due processes had been followed. Connor’s family had to fight for an independent investigation, although patient treatment and assessment facility (Slade House run by Southern Health NHS Foundation Trust) was 18 years old when he drowned in the bath in a NHS short term treatment and assessment facility (Slade House run by Southern Health NHS Foundation Trust) on 4th July 2013. He had learning disabilities and epilepsy and should never have been left alone to bathe unsupervised.

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death. Therefore, the family had to pay for legal representation at the inquest into Connor’s death, whereas the Trust was able to draw on significant resources, ultimately paid for by the tax-payer. In contrast to the initial investigation the independent report found that Connor’s death was preventable.

Unfortunately, cases such as Connor’s death are not nearly unusual enough, with a 2012 Mencap report documenting 74 deaths of young people with learning difficulties in NHS care over a 10 year period. Unacceptably high mortality rates were confirmed by the 2013 Confidential Inquiry into Deaths of People with Learning Difficulties (CIPOLD). Precious little progress has been made in reducing these terrible statistics. Connor died three years after the Winterbourne View scandal, demonstrating the failure of the Winterbourne Joint Improvement Programme.

A sustained and ongoing campaign is trying to unravel the circumstances of Connor’s death. The #JusticeforLB campaign continues to draw attention to his preventable death, while simultaneously fund-raising towards the costs of legal representation at the inquest. The 107 days that Connor spent in the Slade House facility before he drowned, informed a #107days campaign, over the 107 days leading up to the one-year anniversary of his death. A
draft bill to make it legally harder for the State to force disabled people into institutions against their own and/or their family's will is a work in progress.

NHS services for people with learning difficulties and chronic illness are all too often inadequate and indefensible deaths such as Connor's have not provoked enough improvement. Two months after Connor died, an unannounced Care Quality Commission inspection found the specialist facility to be inadequate in all 10 measures of assessment. Notably, no steps had been taken to improve things with the Trust's initial dismissal of Connor's death as due to natural causes. Enforcement notices were issued and it has since been closed to new admissions. Other units run by Southern Health have also received damning report from the Care Quality Commission such as Antelope House which has had enforcement notices served.

Legal safeguards exist for young people in the form of the Mental Capacity Act and the use of Deprivation of Liberty Safeguards (DOLs). With a judgement that a young person lacks the capacity to make a decision about staying in a treatment and assessment facility, a DOL offers some independent scrutiny of his time in a unit. However, such a judgement was not made in Connor's case.

Neither Connor's short-term nor his long-term needs were properly assessed during his time at Slade House. Connor's mother thinks this is symptomatic of more than just a lack of good practice in a poorly run facility. Rather, it is evidence of how learning disabled people are not seen as fully human. 'People like Connor', she writes 'are seen as commodities to be budgeted and, if possible, tucked away out of sight.'

The frequency with which people with learning difficulties die in 'care' and the lack of reform in the wake of these deaths makes her suggestion all too plausible.

About the Author: Sara Ryan's background is in Sociology and her research interests cover disability, difference, autism, disorder and qualitative methods. She completed a PhD at the University of Warwick in 2006 and began working in the Health Experience Research Group at Oxford University as a Qualitative Researcher. Her current work focusses on the use of qualitative data to inform the development of NICE Quality Standards and exploring ways of including more 'seldom heard' people in research.

1 COMMENT

HANNAH BRADBAY on Nov 26, 2014

An update on the slow and painful progress towards an inquest into Connor's death

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