

Winterbourne View Hospital - Serious Case Review published

Few will forget the shock of the May 2011 Panorama programme which exposed abuse at Winterbourne View Hospital of people with autism and learning disabilities. At the same time that this programme was aired, evidence was being heard at the Mid Staffordshire Public Inquiry about the care given at an NHS Trust.

The long-awaited report into Mid Staffs is due in October but, in the meantime, this Serious Case Review (*SCR*) has now been published.

In our briefing note we look at the recommendations made and how this sets the scene for the Mid Staffs report. If the recommendations from both reports are tackled head-on, we would hope that the vulnerable and elderly will see an improvement in both NHS and privately provided care.

Setting the scene

Speak to any NHS Commissioner and they will confirm that learning disability is an area where good, reliable and cost effective services are in short supply. Following research conducted by Castlebeck it was determined that Bristol was a commercially viable location and Winterbourne View opened in December 2006.

The hospital was newly built and had 24 rooms with two 12 bedded wards, meeting rooms and gardens. Families' first impressions were that it was "lovely", "absolutely perfect". At this stage it seemed that the facility was a positive step forward for caring for people with learning disabilities.

Fast forward just over four years. In May 2011 South Gloucestershire Council received a copy of a letter, addressed to Castlebeck, from BBC Panorama. The letter contained allegations of systematic mistreatment of patients.

Key concerns included:

- Abusive treatment of patients by staff
- Dangerous and illegal methods of restraint

- Needless suffering of patients
- Use of water-based punishment
- Transgression of professional boundaries in what was acceptable behaviour
- Documentation aimed to deceive senior managers and the CQC

The BBC's letter reminded South Gloucestershire Council of a letter from a Charge Nurse (Terry Bryan), copied to the Council in October 2010 which they had sent on to the CQC in November 2010. This letter had highlighted aggressive stance of staff, delays in securing treatment for patients and corralling patients in rooms. However, no significant action had been taken at this point.

On receipt of the BBC's letter, safeguarding meetings were convened and patients were moved to other placements. It was only after the Panorama programme was aired on 31 May 2011 that Winterbourne View Hospital was closed.

So what went wrong?

We will not go into the detail and examples of the abuse identified during the Panorama programme, or the SCR. The chronology in the SCR runs from pages 28 - 65 of the report and is a devastating and truly depressing read. The resounding fact is that there was horrific abuse of the most vulnerable people in our society.

Patients' and relatives' experiences

The SCR records that, following admission, relatives became increasingly secluded, not being allowed to visit during the week, only able to visit in public areas and not able to go to the second floor of the hospital, or visit patients in their rooms.

The reviewers did speak to two families where the relatives progressed very well, when initially admitted to Winterbourne View Hospital, but those improvements did not last.

The recollection of families was that there was a "high turnover of young, untrained and inexperienced staff and inattentive managers".

The agencies

The overriding question, of course, is how was the situation at Winterbourne View allowed to develop? The Panorama programme looked at the responsibility of Castlebeck and the CQC but the SCR looks more widely than that, to other agencies - those agencies that could and should have been able to stop or be alerted to the situation earlier.

The SCR considers reactions of the agencies involved to the exposure of abuse at Winterbourne View and assesses the reports that they published as a result.

Castlebeck Limited

Castlebeck completed their "Individual Management Review for Serious Case Review into Winterbourne View Hospital" in November 2011. This is six months after the Panorama programme. It highlights problems such as:

- A culture where service failings went unheeded

- Geographical distance from the corporate centre in Darlington
- Poor recruitment and selection processes, weak management and high staff turnover
- Patients at Winterbourne View with extreme levels of challenge
- Too high a number of physical interventions not reviewed by the Consultant Psychiatrist
- Commissioners should have challenged their care regime
- Castlebeck should have been able to rely on CQC to highlight failings

The SCR concludes that the Castlebeck review:

- Does not consider the company's response to the email from Terry Bryan
- Does not consider the lack of a registered manager for at least some of the time when the hospital was open.
- Does not conclude that corporate responsibility should be addressed (although 47 recommendations were made)
- The impression is that the company was seeking to deflect responsibility at least to some extent

The SCR concludes that Castlebeck, even in 2012, does not shape their practice by experiences of patients and ex-patients. The SCR is of the view that Castlebeck had limited appreciation of the events leading up to the Panorama programme, not least because they took the financial rewards (on average £3,500 per person per week) without any apparent accountability.

The SCR is certainly not an endorsement of Castlebeck's handling or self-reflection after the events at Winterbourne View were exposed.

The NHS (SHA and PCT).

The SHA's report "*The NHS Review of Commissioning of Care and Treatment at Winterbourne View*" records that NHS commissioners had secured 44 placements at the hospital in the time it was opened. For 25 placements, the commissioner had checked CQC registration and read the latest reports, for five there was also a recommendation from a clinician for the placement, for four patients, commissioners and families visited before the referral but for ten placements there was no evidence of any checks being made at Winterbourne View at all.

The SHA review concluded there was no formal process for commissioners in PCTs to be informed about safeguarding issues. There were ten examples of families raising concerns and a failure by commissioners to follow up issues, against a background of accepting the hospital's seemingly plausible explanations.

NHS commissioners were individually making spot purchases and did not benefit from sharing information.

It is accepted that SHAs have "been engaged in the development of commissioning and also exercise an oversight role in respect of performance of PCTs", but there was a failure in this case.

The role of SHAs was also examined in the Mid Staffordshire Inquiry. It was previously highlighted, in 2006, in the Healthcare Commission review of provision of learning disability services at Cornwall Partnership NHS Trust. The

conclusion in that report was that the “SHA did not ... manage adequately the performance of PCTs to commission good quality services”.

With the abolition of the SHAs fast approaching, only time will tell if the new structure will ensure that there is more effective supervision of NHS commissioning in the future. This is also expected as a theme within the Mid Staffs report.

South Gloucestershire Council

The Local Authority also conducted their own safeguarding review. The SCR is a little kinder to them and concludes that the report from the Local Authority was reflective and highlighted the difficulty in getting the balance right between overreaction and neglect in safeguarding cases.

The Local Authority accepted that there was consistent deferral to the police in cases involving Winterbourne View patients and a lack of follow up when Winterbourne View did not respond to requests for information. Many safeguarding cases concluded without any resolution. It also accepted that safeguarding investigations were conducted in isolation, which meant that the police were unable to see the bigger picture of what was happening at the hospital.

Avon and Somerset Constabulary

The police also conducted their own review.

This noted that there was no record of any police contact with Winterbourne View before January 2008, but that between January 2008 and May 2011 there were 29 police contacts. The report accepts there was evidence that police decision-making was affected by the lack of understanding of complex medical issues and an overreliance on information provided by professionals working at the hospital. There was also a failure of the police recording and investigating allegations of crime. Again, incidents were dealt with in isolation and families were not kept informed about criminal offences involving their relatives. In one case, the psychiatrist at Winterbourne View advised the police that it was better to deal with a patient-on-patient assault internally at the hospital and this was accepted by the police without dispute.

The Care Quality Commission

The CQC conducted both a compliance review of Winterbourne View and their own internal management view of the regulation of the hospital. The compliance review confirmed, unsurprisingly, that ten of the essential standards were not being met at the hospital.

The internal management review includes an acknowledgement by Cynthia Bower, outgoing Chief Executive of CQC, that CQC failed to respond to the whistleblower, Terry Bryan, and that both CQC and the Healthcare Commission failed to follow up safeguarding alerts in the past.

We will not go into detail into CQC’s report of their own performance at Winterbourne View Hospital but, in conclusion, the SCR considered that “CQC’s self-scrutiny is refreshingly honest”.

Recommendations

These are set out at pages 122 – 142,

There are 43 in total. The recommendations are wide-ranging and a selection are outlined below, grouped together under key headings:

Commissioning

- Commissioning should be with the aim to reduce the number of people using inpatient assessment and treatment services. This should be adopted and monitored by CCGs and the NHS Commissioning Board
- Commissioners funding placements should have up to date knowledge of services, including untoward incident reports, police attendances and DOLS
- Commissioners should make decisions about placements based on outcome data and have up to date knowledge of services
- CCGs to explore how A&E can highlight attendances per location as well as per individual
- Commissioners need to be proactive in ensuring patients are safe

Mental Health

- Adults with learning disabilities or autism should not, by law, be subject to the same restrictions as those subject to Mental Health Act legislation. They should have the full protection of the Mental Capacity Act
- T-supine restraint should be banned and should not be used as a “last resort” provision
- The CQC should focus on the way hospital managers discharge their responsibilities
- The use of anti psychotic medication should be reduced and the CQC should consider pharmacist-led medication reviews

CQC

- The CQC-registered Nominated Individual of the provider should provide an annual report on quality with the annual accounts
- CQC should provide advice and guidance on qualifications and the development of registered managers. A concern is expressed that registered managers should only be registered professionals (no indication is given of what type of professional they may be thinking of here).
- CQC should take enforcement action when registered managers are not in place
- CQC inspections should be carried out by sector specialists and inspectors must be qualified and competent to carry out inspections. Characteristics akin to HM Inspectorate of Prisons are suggested
- CQC should work with the Health Professions Council to describe in guidance what effective systems of clinical supervision look like

Deprivation of Liberty Safeguards (DOLS)

- The DH should ensure there is sufficient scrutiny regarding DOLS by the CQC.
- Patients who are subject to DOLS or detention should be able to access advice if they complain or if they are restrained.

Employment

- It should be a condition of employment of all health and social care staff to report all concerns to the Chief Executive of the organisation they are employed with and to the regulator
- Employment contracts should contain detailed whistleblowing clauses

Safeguarding

- When there is a failure to supply a safeguarding report, the Local Authority should consult with the regulator for a remedy
- Hospitals for adults with learning disabilities should be seen as high risk by Local Authorities and Safeguarding Boards. CQC should have more unannounced inspections with respect to these services
- The National Quality Board should devise a mechanism for aggregating safeguarding information and rationalise notifications

Conclusions

The report accepts that there was nothing new about the abuse at Winterbourne View Hospital. There has been abuse of learning disability patients in the past, depressing as that may be. It talks of the “wretched history” of Winterbourne View and how the hospital became a “case study in institutional abuse”.

What strongly comes out of the report is that patients and relatives were effectively silenced at Winterbourne View. A similar thing happened with patients and relatives at Mid Staffs, although this may have been for different reasons.

The management of Castlebeck lost sight of what they were there to do. The SCR concludes that they made decisions about profitability above decisions about effective and humane delivery of treatment.

The issues at Winterbourne View and Mid Staffs go to the heart of how we care for vulnerable people in this country.

Let's hope the recommendations (some very wide ranging, some requiring legislation and others re-stating guidance and legislation already available) in the SCR, together with the report from Robert Francis QC, go some way to making the changes needed in attitude and culture.

The opportunity for change must be grasped to ensure that we are not considering another report of another scandal in ten years' time.



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