South Gloucestershire Safeguarding Adults Board

Winterbourne View Hospital

A Serious Case Review

By Margaret Flynn

Summary

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Preface and Executive Summary

After the transmission of the BBC Panorama *Undercover Care: the Abuse Exposed* in May 2011, which showed unmanaged Winterbourne View Hospital staff mistreating and assaulting adults with learning disabilities and autism, South Gloucestershire's Adult Safeguarding Board commissioned a Serious Case Review. The Review is based on information provided by Castlebeck Care (Teeside) Ltd, the NHS South of England, NHS South Gloucestershire PCT (Commissioning), South Gloucestershire Council Adult Safeguarding, Avon and Somerset Constabulary and the Care Quality Commission; correspondence with agency managers; contact with some former patients and their relatives; and discussions with a Serious Case Review Panel - which was made up of representatives from the NHS, South Gloucestershire Council, Avon and Somerset Constabulary and the Care Quality Commission.

Serious Case Reviews identify lessons to be learned across all organisations. Peter Murphy, the Director of Community Care and Housing and Chair of the Adult Safeguarding Board, drafted the Terms of Reference. These cover the period from January 2008-May 2011.

a) *The effectiveness of the multi-agency response to safeguarding referrals in respect of patients in Winterbourne View Hospital, measured against the expectations set down in the Safeguarding Adults Board detailed policy and procedures for the management of safeguarding alerts.*

b) *The volume and characteristics of the safeguarding referrals and whether and how these may have been treated as a body of significant concerns rather than as individual safeguarding episodes.*

c) *The circumstances and management of the whistle blowing notification and the operational effectiveness of the inter-organisational responses to the concerns raised. This aspect will also test the adequacy of existing whistle blowing policies and procedures and their relationship to safeguarding.*

d) *The existence and treatment of other forms of alert that might cause concern such as might emerge from, inter alia, General Practice services to the hospital, interventions from secondary services e.g. CPNs and NHS Continuing Healthcare reviews, reported injuries to patients and general hospital attendances, police and ambulance notifications of attendance at the hospital site.*

e) *The role of the Care Quality Commission as the regulator of in-patient care at Winterbourne View Hospital and the effectiveness of regulatory activity, including the operation of the inspection regime.*

f) *The role of commissioning organisations in initiating patient admissions to Winterbourne View Hospital and the contractual arrangements and patient review mechanisms by which the duty of care to patients was discharged. The relevance of, and compliance with, legislative duties and guidance, including the Mental Capacity Act 2005. Additional areas of examination are likely to include: the presence of pro-active measures related to the vulnerability of patients such as the involvement of relatives and carers and access to and provision of advocacy, in particular, Independent Mental Capacity Advocates.*

g) *The policy, procedures, operational practices and clinical governance of Castlebeck Ltd. in respect of operating Winterbourne View as a private hospital; in particular, those that are most pertinent to securing the safety, health and wellbeing of patients.*

There are Eight Sections

1. Introduction to the Serious Case Review
2. The Place and the Personnel
3. Chronology
4. The Experiences and Perspectives of Patients and their Families
5. The Agencies
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Section 1: Introduction

The introduction lists the other reviews commissioned following the broadcast of *Undercover Care: the Abuse Exposed* and details some of the challenges to gathering relevant facts and identifying lessons - including the inconsistent dispersal of information about individual patients and events at Winterbourne View Hospital. Section 1 includes a description of the content of the BBC Panorama footage:

- the harms to which adults with learning disabilities and autism were subject e.g. the use of water-based punishment; wrestling patients to the floor to be restrained; and unequal games of strength which patients could not possibly win
- the video diaries and commentaries of the undercover journalist
- the serious short-comings of Castlebeck Ltd, the owner of Winterbourne View Hospital, and the Care Quality Commission, to respond to the disclosures of a whistleblower
- the disdain of some staff, including those with supervisory responsibilities, for legal, moral and humanitarian constraints on their behaviour. They ignored the unjustified behaviour of their peers and hospital employees which resulted in the foreseeable distress of patients e.g. a woman patient was heard to call out "Why are you fighting at us all?" and a staff member observed of a woman patient, "The only language she understands is force."
- interviews with the Chief Executive of Castlebeck Ltd and the Regional Director of the Care Quality Commission. The programme was interspersed with the observations of professionals and the relatives of two patients, Simon and Simone

Main points

- Winterbourne View Hospital was a private hospital for adults with learning disabilities and autism, mostly accommodating patients who were detained under the provisions of the Mental Health Act 1983
- An undercover reporter secured employment as a support worker at Winterbourne View Hospital. During his five weeks as a Castlebeck Ltd employee he filmed colleagues tormenting, bullying and assaulting patients
- Fundamental principles of healthcare ethics such as respect for autonomy, beneficence and justice were absent at Winterbourne View Hospital
- *Undercover Care: The Abuse Exposed* recalled the long-stay NHS hospitals for adults with learning disabilities. Unlike such institutions however, Castlebeck Ltd, was not starved of

funds. In 2010, Winterbourne View Hospital had a turnover of £3.7m. Information from Castlebeck Ltd was not transparent enough to know how much was transferred to Winterbourne View Hospital's expenditure budget

Section 2: The Place and the Personnel

During 2002-2003, Castlebeck Ltd commissioned market research into business opportunities in services for adults with learning disabilities. This established that the development of a Bristol area Assessment and Treatment service, in a Castlebeck Ltd hospital, was commercially viable. This view was confirmed by local NHS commissioners. Winterbourne View Hospital opened during December 2006.

The hospital was designed for 24 patients occupying two, 12-bedded wards. Although initially patients' relatives could access rooms on the wards, over time this was not allowed and meetings took place only in the visitors' lounge.

Learning disability nursing and psychiatry were the two disciplines deployed at Winterbourne View Hospital. Irrespective of references in job descriptions to *multi-disciplinary team working*, there appeared to be no operational provision for this or for a multi-agency approach. Winterbourne View Hospital looked to learning disability nursing and psychiatry for its professional authority and knowledge base. However, the majority of staff at the hospital were unregulated support workers who are not subject to any code of conduct or minimum training standard. It appears that over time Winterbourne View Hospital became a support worker led hospital.

Hospitals are associated with healing and expertise under the supervision of doctors. The performance of hospital personnel is shaped by a form of corporate accountability – clinical governance. The stated purpose of Winterbourne View Hospital was to provide *assessment and treatment* and *rehabilitation.* Little can be gathered from the job descriptions of the nurses and support workers about how their responsibilities related to the stated purpose or how they were expected to spend their time. The adequacy of the hospital's staff training plan and e-learning is not known. However, there was a focus on the use of restraint. It is not clear how the hospital's structures and processes were preparing patients to return to their homes or localities of origin.

Main Points

- The planning and design of Winterbourne View Hospital made no reference to government policy in terms of developing local services for local citizens and closing long stay hospitals
- The baseline staffing establishment for the hospital was 1 Registered Manager, 1 Deputy Manager, 2 Charge Nurses, 3 Senior Staff Nurses, 6 Staff Nurses and 31 Support Workers
- Winterbourne View Hospital was geographically distant from Castlebeck Ltd's headquarters in Darlington
- Castlebeck Ltd was able to build a hospital for adults with learning disabilities and autism in South Gloucestershire without any negotiation with South Gloucestershire Council's

Department of Community Care and Housing, local agencies, or the regulator at that time, the Healthcare Commission

Section 3: Chronology

The recorded events between 2008-2011, concerning Winterbourne View Hospital are fragmentary and provide only a glimpse of the contacts between patients, hospital staff and external agencies i.e. the Healthcare Commission and the Mental Health Act Commission (until April 2009), the Care Quality Commission (from April 2009), Avon and Somerset Police, South Gloucestershire Council Adult Safeguarding, NHS South Gloucestershire Primary Care Trust (in a coordinating role), the First Tier Tribunal-Mental Health and the Health and Safety Executive.

During 2008, events at Winterbourne View Hospital anticipated some of the incidents which featured in *Undercover Care: the Abuse Exposed,* namely: the use of restraint by untrained personnel, the limited ways in which staff worked with patients, the under-occupation of patients and the discontinuity or absence of internal and external support, professional challenge or patient advocacy. There were two occasions when Winterbourne View Hospital operated without a Registered Manager, for seven months during 2008, when there was an acting manager and during the hospital's final 18 months. Although there was an acting manager throughout this period, he was not registered. This acting manager's predecessor, who was no longer at the hospital, was inadvertently still the Registered Manager. Patients were assaulted by staff and other patients, and staff were assaulted by patients. Castlebeck Ltd did not respond to evidence of the harmful restraints of patients when requested to do so by a Mental Health Act Commissioner.

The poor oversight of patients and staff continued throughout 2009. Castlebeck Ltd did not act on the actions required by the Healthcare Commission and records attested to the continued and harmful use of restraints. There is no evidence that the written complaints of patients were addressed. Castlebeck Ltd's Human Resources Officers were aware of the breaches of patients' supervision requirements, concerns about under-staffing and the misgivings of some staff concerning the use of restraint.

During 2010, "on the job" training and inadequate staffing levels persisted with poor recruitment practices and further instances of unprofessional behaviour in an increasingly non-therapeutic hospital. Patients lived in circumstances which raised the continuous possibility of harm and degradation. Castlebeck Ltd's managers did not deal with unprofessional practices at Winterbourne View Hospital. Absconding patients, the concerns of their relatives, requests to be removed and escalating self-injurious behaviour were not perceived as evidence of a failing service. The documented concerns of a whistleblower made no difference in an unnoticing environment.

There was nothing fair, compassionate or harmonious during Winterbourne View Hospital's final months of operation. Neither the hospital's discontinuous management, nor their sporadic approach to recruiting sufficient numbers of skilled professional and experienced staff, were prompts to Castlebeck Ltd to assume responsibility. These "input" matters were not given the weight they

merited in the ahistorical and "outcome" oriented reports produced by the Healthcare Commission and latterly the Care Quality Commission.

Before Castlebeck Ltd received a letter from the BBC alerting them to the "systematic mistreatment of patients by staff," it was business as usual at Winterbourne View Hospital. Patients' distress, anger, violence and efforts to get out may be perceived as eloquent replies to the violence of others – including that of staff – rather than solely as behaviour which challenged others and confirmed the necessity of their detention. Winterbourne View Hospital patients were chronically under-protected.

Main Points

- Hospitals for adults with learning disabilities and autism should not exist but they do. While they exist, they should be regarded as high risk services i.e. services where patients are at risk of receiving abusive and restrictive practices within indefinite timeframes. Such services require more than the standard approach to inspection and regulation. They require frequent, more thorough, unannounced inspections, more probing criminal investigations and exacting safeguarding investigations
- The average weekly fee of £3500.00 per patient was no guarantee of patient safety or service quality. As the relative of an ex-patient asked "Surely we can do better than this? Why aren't services helping and negotiating with families, ways of supporting our children so they don't have to be taken away and abused?"
- Winterbourne View Hospital strayed far from its stated purpose of *assessment and treatment* and *rehabilitation.* There were high levels of staff sickness and staff turnover at the hospital
- Winterbourne View Hospital patients were uniquely disadvantaged. Their concerns and allegations were dismissed as unreliable, the consequence of mental incapacity or their mental health status, or their desire to leave
- There is an urgent need to draw to a halt the practice of commissioning hospital places for adults with learning disability and autism and to begin the complex task of commissioning something better

Section 4: The Experiences and Perspectives of Patients and their Families

Conversations with five ex-Winterbourne View Hospital patients and contact with 12 families of ex-patients confirmed how hard it was for them to get professional help when they needed it. In the absence of such help, families were faced with two options: carry on dealing with the problems largely without professional assistance, or hand over complete responsibility to out of home/out of area services. These extreme options were experienced as bewildering. Family involvement in decision-making diminished as young people reached 18, were sectioned under the provisions of the Mental Health Act 1983, or entered mental health services.

There were many routes into Winterbourne View Hospital as two parents noted:
"Nobody was helping…the last resort was calling out the police. I'd had enough. I just gave up."
"Everything had built up and built up and I phoned the social worker and said 'I can't do this anymore. I am at my wits end. He is going to hurt somebody or he's going to get hurt and it's not fair on any of us and it's not fair on him.'"

One parent attempted suicide.

The backgrounds of the five patients and 12 families suggested that at different stages the ex-patients were clients of residential special schools, children's hospitals, child protection, foster care, care homes, challenging behaviour services, adult social care, day services, colleges, residential respite services, Bed and Breakfast accommodation, assessment and treatment services, forensic services and community learning disability teams. One man had been in employment and several had managed their own tenancies with support. Some had experienced such distressing life events and disrespectful encounters in their aspiration to be like everyone else that they sought the solitary temptations of self harm or attempted suicide.

Families mostly expressed concerns about the circumstances surrounding their relatives' admission to Winterbourne View Hospital, the use of psychotropic medication, evidence of aggressive behaviour, inattention to patients' appearance, the injuries they sustained and the incidents they disclosed.

Families acknowledged that their relatives had been traumatised by their experiences at Winterbourne View Hospital. For example, Tom was admitted to the hospital directly from his family home. Although he had been distressed by bullying at college, he had secured employment where he did well until he was promoted. The stress of this became too great and following a "big bust" he was permanently excluded from his workplace. When Tom took an overdose his family acknowledged that he required more help than they could offer or could be provided by local services and he was admitted to Winterbourne View Hospital for assessment. He was transported by two uniformed men in a security van with darkened windows. His family were informed that they should not visit for a month. Since Tom attempted to abscond – to return to his family – he was detained for treatment.

The family became attuned to Tom's distress during his placement at Winterbourne View Hospital. He told them about abuses that he experienced and witnessed. They reported these to the manager who dismissed their concerns with the suggestion that Tom would say "anything" to return home. Since the transmission of *Undercover Care: the Abuse Exposed*, Tom's behaviour has deteriorated. He has burned the clothes he wore at the hospital and because he recalled the cruelties and fear associated with entering toilets and bathrooms, he began to urinate in cups and his hygiene deteriorated. Since the home he was placed in after Winterbourne View Hospital could not manage Tom's distress and suicidal gestures, he has been transferred to a secure unit.

Main Points

- There was no evidence of prevention, support during crises or the provision of tenacious, long term support to families and care services in advance of adults with learning disabilities and autism being placed in Winterbourne View Hospital
- The families of patients at Winterbourne View Hospital had no experience of being regarded as partners, deserving of trust and respect, or even of collaborating with Winterbourne View Hospital staff. Their expertise, borne of the lengths to which they had gone to keep their relatives at home and in care services, was not acknowledged by Winterbourne View Hospital. They were excluded from having a full picture of events at the hospital
- The histories of some ex-patients revealed scant acknowledgement of lives interrupted by sexual assaults, the distress, bereavements and losses they had endured or of the significance of restoring a sense of living valued lives as men and women with support needs
- Occasions when two families recalled clear progress in the lives of their relatives were characterised by hospital staff seeking to understand and getting to know patients as individuals and offering valued continuity. More typically, however, families recalled the high turnover of young, untrained and inexperienced staff and inattentive managers
- Efforts by skilled professionals to prevent mental health problems developing in people with learning disabilities and autism were not evidenced in the histories of the patients and families who were able to contribute to this Serious Case Review
- There were examples of individual patients in Winterbourne View Hospital and their families being threatened with the improper use of mental health legislation

Section 5: The Agencies

Undercover Care: the Abuse Exposed focused on Castlebeck Ltd and the Care Quality Commission. There were other significant players, not least the NHS (which was principally responsible for commissioning placements at Winterbourne View Hospital), South Gloucestershire Council Adult Safeguarding and Avon and Somerset Constabulary. Section 5 provides summaries of what was expected of each agency, summaries of the information shared with the Serious Case Review and commentaries on these.

Beginning with **Castlebeck Ltd**, the company acknowledges that there was insufficient senior management oversight of Winterbourne View Hospital and that their staff's use of physical restraint did not reflect the training delivered. Castlebeck Ltd's review did not consider clinical governance, the staffing rotas or use of agency staff; the response to the whistleblowing email; police attendances at the hospital; or the operational relevance of the hospital's Statement of Purpose. Although Castlebeck Ltd took the financial rewards without any apparent accountability, its review does not address corporate responsibility at the highest level.

The **NHS South of England** (a cluster of three Strategic Health Authorities, NHS South West, NHS South Central and NHS South East Coast) examined the commissioning arrangements for most of the

patients placed at Winterbourne View. Individually and separately, NHS organisations were making 'spot' purchases. Mostly, NHS Commissioners used Castlebeck Ltd's own contract. The NHS South of England highlights concerns about the adequacy of the Care Programme Approach. It questions the independence of psychiatrists employed by independent hospitals and highlighted the absence of processes for NHS Commissioners to be informed of safeguarding alerts as well as a failure on the part of commissioners to follow up on concerns. The Strategic Health Authorities' oversight of Primary Care Trust commissioning did not work for Winterbourne View Hospital patients.

NHS South Gloucestershire Primary Care Trust (Commissioning) co-ordinated information concerning the contacts between the local NHS and Winterbourne View Hospital. Their review reveals that the patients' 78 Accident and Emergency attendances were mostly the result of epileptic seizures, injuries/ accidents and self-harm and that the majority were treated and discharged. It confirmed that clinical staff would not have been aware of patients' previous attendances as there is no alerting system in place. Although some NHS commissioners were aware of safeguarding concerns about Winterbourne View Hospital patients, there is no inclusive notification system across all services.

The Primary Care Trust scrutinised the case files of 20 Winterbourne View Hospital patients. Some patients had a multiplicity of physical health problems and it is not known whether or not these were treated or monitored. Patients' dental problems were extensive. There appeared to be a consistent lack of clarity in prescribing rationale with many patients taking anti-psychotic and anti-depressant medication. The cost of patients' medication was borne by NHS South Gloucestershire Primary Care Trust. Most patients were plagued by constipation. On occasions when referrals were made, the rationale for these was not consistently cited in either the hospital's nursing or medical records. The same records confirmed the extensive misuse of physical restraint. The records of patients whose physical restraints were accompanied by the use of tranquilisers inconsistently noted their type and dosage. It does not appear that the frequency with which some patients were physically and chemically restrained was shared during review meetings, with South Gloucestershire Council Adult Safeguarding or with NHS commissioning organisations.

In terms of **clinical leadership and professional responsibility,** there appeared to be a low threshold for detaining patients under section 3 of the Mental Health Act and the safeguards of a second, independent doctor supporting the application and the independent decision by an Approved Mental Health Professional seem to have been overridden.

Typically, treatment in Winterbourne View Hospital hinged on a misunderstanding of behavioural methods. The behaviour of patients was rarely interpreted as a response to physical pain; neurological and developmental problems; mental illness; psychological trauma; communication difficulties; or even a response to the routines and practices of nursing and support staff.

The only relationship that **South Gloucestershire Council Adult Safeguarding** had with the Winterbourne View Hospital was as its local safeguarding authority. It commissioned no places there and supported none of the patients financially. It received 40 safeguarding alerts concerning the hospital between January 2008 and May 2011. These were treated as discrete cases. South Gloucestershire Council Adult Safeguarding acknowledges that its safeguarding policy and

procedures were inconsistently applied and that their investigation and management of referrals were sometimes poor. It did not challenge the hospital's failure to produce reports nor some of the decisions of police colleagues. When Adult Safeguarding received the whistleblowing email it forwarded this to the Care Quality Commission. It was believed that the email's recipient, Winterbourne View Hospital's acting manager, was addressing the matters raised. While there must be an expectation that services supporting vulnerable adults will honestly report all allegations of abuse and crimes, this expectation was misplaced in this case.

There was no record of any **Avon and Somerset Constabulary** contact with Winterbourne View Hospital before January 2008. Between January 2008 and May 2011, there were 29 police contacts. All but one of nine, staff-on-patient reported incidents were associated with the use of physical restraint as practiced at the hospital. A single assault which was witnessed by another member of staff successfully resulted in a prosecution. Avon and Somerset Constabulary acknowledge their possible over-reliance on information provided by the hospital, not least concerning patient absconding; their limitations in recording and subsequent investigations of potential crimes; and insufficient recognition of what patients were disclosing, albeit in disguised ways.

The **Care Quality Commission** acknowledges that they did not respond to the Winterbourne View Hospital whistleblower and that neither they nor their predecessor organisations followed-up on the outcomes of statutory notifications. They did not contact the whistleblower because it was assumed that Castlebeck Ltd or South Gloucestershire Council Adult Safeguarding was doing so.

Main Points

- The corporate responsibility of Castlebeck Ltd remains to be addressed at the highest level
- NHS organisations, making "spot" purchases, were responsible for commissioning placements for the majority of Winterbourne View Hospital patients. They were mostly unaware of events at the hospital
- The nursing and medical files of 20 ex-Winterbourne View Hospital patients indicate that both their mental and physical health care were compromised
- South Gloucestershire Council adult safeguarding received 40 safeguarding alerts from Winterbourne View Hospital. These concerned patients who had been imported from other localities. Their expectation that the hospital would honestly report the circumstances concerning all allegations of abuses and crimes was misplaced
- Avon and Somerset Constabulary had 29 contacts with Winterbourne View Hospital. Before the transmission of *Undercover Care: the Abuse Exposed,* they secured the successful prosecution of a staff member
- The Care Quality Commission operates within the terms and requirements set out in the Health and Social Care Act 2008. The Department of Health requires the Care Quality Commission to ensure that services comply with regulations. Compliance with standards did not uncover the extent of abuses at the Winterbourne View Hospital

Section 6: The Findings and Recommendations

This section addresses the Terms of Reference and outlines the recommendations arising from these.

NHS commissioners believed that they were purchasing a bespoke service for adults with learning disabilities and autism. There was no overall leadership among commissioners. They did not press for, nor receive, detailed accounts of how Winterbourne View Hospital was spending the weekly fees on behalf of its patients. Even though the hospital was not meeting its contractual requirements in terms of the levels of supervision provided to individual patients, commissioners continued to place people there. Families could not influence the placement decisions. There was limited use of the Mental Capacity Act 2005, most particularly concerning adults who were not detained under the provisions of the Mental Health Act 1983. Although some commissioners funded advocacy services, Winterbourne View Hospital controlled patients' access to these.

The **whistleblowing** notification was not addressed by Winterbourne View Hospital nor Castlebeck Ltd, irrespective of the fact that it was shared with Castlebeck Ltd managers with responsibility for the hospital. Although connections were made in terms of safeguarding and patient safety, the inter-organisational response to the concerns raised by the whistleblowing email was ineffective.

The **volume and characteristics of safeguarding referrals** which were known to South Gloucestershire Council Adult Safeguarding were not treated as a body of significant concerns. South Gloucestershire Council Adult Safeguarding had only an edited version of events at Winterbourne View Hospital.

The **existence and treatment of other forms of alert** that might cause concern confirmed the complexity of safeguarding adults from both local authority and regulatory perspectives i.e. had both been aware of: patients' limited access to advocacy; notifications to the Health and Safety Executive; the hospital's inattention to the complaints of patients and the concerns of their relatives; the frequency with which patients were restrained and the duration and authorisation of these; the police attendances at the hospital; and the extent of absconding; then both may have responded appropriately in terms of urgency and recognition of the seriousness.

The **role of the Care Quality Commission** as the regulator of in-patient care at Winterbourne View Hospital was limited since light-touch regulation did not work.

On paper, the **policy, procedures, operational practices and clinical governance of Castlebeck Ltd** were impressive. However, Winterbourne View Hospital's failings in terms of self reporting, attending to the mental and physical health needs of patients, physically restraining patients, assessing and treating patients, dealing with their complaints, recruiting and retaining staff, leading, managing and disciplining its workforce, providing credible and competency based training and clinical governance, resulted in the arbitrary violence and abuses exposed by an undercover reporter.

The recommendations include investment in preventing crises; a commissioning challenge concerning ex-Winterbourne View Hospital patients; outcome based commissioning for hospitals detaining people with learning disabilities and autism; rationalising notifications of concern; establishing Registered Managers as a profession with a code of ethics and regulatory body to enforce standards; NHS commissioning organisations prioritising patients' physical health and safety; and discontinuing the practice of t-supine restraint i.e. restraint that results in people being placed on the ground with staff using their body weight to subdue them - in hospitals detaining people with learning disabilities and autism.

Section 7: Conclusions

The origins of Winterbourne View Hospital were not based on a local population needs assessment. Castlebeck Ltd spotted a business opportunity and were not discouraged by NHS commissioners. They had indicated their willingness to buy its services irrespective of national policy and guidance. The Review confirms that the apparatus of oversight across sectors was unequal to the task of uncovering the fact and extent of abuses and crimes at the hospital.

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