



**South Gloucestershire Safeguarding Adults Board**  
**Winterbourne View Hospital**

**A Serious Case Review**

By Margaret Flynn



# 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
6. The Findings and Recommendations
7. Conclusions
8. References

## 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.

Margaret Flynn and Vic Citarella, July 2012



South Gloucestershire Adult Safeguarding Board

# Winterbourne View Hospital

## A Serious Case Review

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2012

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# 1. Introduction

- 1.1 Winterbourne View Hospital in South Gloucestershire was a private facility *providing healthcare and support for adults with learning disabilities, complex needs and challenging behaviour, including those liable to be detained under the Mental Health Act 1983* (Care Quality Commission 2011). It was registered with the Care Quality Commission (CQC), to provide *assessment and treatment and rehabilitation* under the Health and Social Care Act 2008. The hospital's parent company was Castlebeck Care (Teesdale) Ltd (referred to in this Review as "Castlebeck Ltd"). On 12 May 2011, South Gloucestershire Council received a copy of a forwarded letter, addressed to Castlebeck Ltd, which had originally been delivered by hand to a Wiltshire County Councillor. The five page undated letter was from the producer of a BBC Panorama programme. It alleged that a number of patients at Winterbourne View Hospital were being abused, including patients who had been placed there from Wiltshire. Wiltshire County Council forwarded the letter to South Gloucestershire Council on the grounds that Winterbourne was located within its area.
- 1.2 The purpose of the letter to Castlebeck Ltd was to provide the company with examples of the "systematic mistreatment of patients by staff". Its "key concerns" included the abusive treatment of patients by staff; the motivation of staff in using dangerous and illegal methods of restraint; the needless suffering of patients; the philosophy of care espoused by some staff members; the ways in which staff boredom were expressed; the use of water-based punishment; the transgression of professional boundaries in terms of (i) individual practice (ii) inter-professional practice, (iii) what was acceptable and unacceptable behaviour; and (iv) documentation which was aimed to deceive, for example, senior managers and the Care Quality Commission.
- 1.3 As a private hospital, Winterbourne View was registered to provide the following activities:
- *Accommodation for persons who require nursing or personal care*
  - *Treatment of disease, disorder or injury*
  - *Assessment or medical treatment for persons detained under the Mental Health Act 1983*
  - *Diagnostic and screening procedures*<sup>1</sup>
- 1.4 The aim and objectives of Winterbourne View Hospital were set out in the *Statement of Purpose: Winterbourne View Independent Hospital* (June 2009):
- The aim of Winterbourne View is to provide a high quality specialist healthcare service for adults with learning disabilities and challenging behaviour. The treatment and support provided to each patient is based upon individual need and is aimed at assisting each person to achieve their full potential. Winterbourne View aims to promote the development of each individual through the application of the key principles of Valuing People: rights, independence, choice and inclusion. Winterbourne View's objectives are...to: provide its service through the recruitment, development and retention of dedicated, well trained and appropriately registered staff...ensure that each patient benefits from a multi-disciplinary team approach that includes substantial input and ongoing support from Registered Learning Disability Nurses, Consultant Psychiatrist, Occupational Therapist, Speech and Language*

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<sup>1</sup> In this and other sections, all text in italics indicates direct quotations from material provided by individual agencies



*Therapist and Psychologist...ensure that patients, their relatives/carers, social workers, professional advocacy workers and significant others are all, as far as is appropriate and practicable, encouraged to participate in the development of care and treatment plans...deliver treatment, care and rehabilitation services to patients that are developed through the principles of evidence/research based practice and the ongoing cycle of assessment, planning implementation and evaluation...develop behavioural strategies through the thorough assessment of the individual patients' behaviours. All interventions based on current best practice that embraces the ethics and principles of non-aversion, non-punitive, multi-elemental approaches...ensure that each patient has an individual risk assessment...a Health Action Plan...a Person Centred Plan...Provide a range of therapeutic, educational and recreational activities that address individual needs and choices...Provide expertise in: severe learning disabilities, including sensory impairment, epilepsy, autistic spectrum disorder and associated pervasive developmental disorders, challenging behaviours, dual diagnosis (mental health and learning disabilities).*

- 1.5** The BBC's letter summarised the main points of an email received from a former Charge Nurse of Winterbourne View Hospital. The email had been addressed to the hospital's acting manager on 11 October 2010. This alerted the acting manager<sup>2</sup> to the disrespectful, *confrontational and aggressive* stance of named staff; delays in securing emergency treatment for a patient with arm lacerations; the harmful consequences of *corralling* under-occupied patients in a sitting room; and *bad staff attitudes*. The Charge Nurse's letter was emailed to South Gloucestershire Council on 28 October 2010, and it was forwarded by the Council to the Care Quality Commission on 29 November 2010.
- 1.6** The BBC's letter offered Castlebeck Ltd *the opportunity to respond to the points we intend to make in an interview* and noted, *We should be grateful for your confirmation that you will inform all the above named staff of the allegations...please confirm that you will inform the relevant regulatory and patient placement authorities of these matters so that the relatives of those named in this letter may be informed of our intention to feature them in our forthcoming programme.*
- 1.7** On 13 May, South Gloucestershire Council convened an urgent safeguarding meeting to consider the BBC's letter, take immediate steps to ensure the safety of patients and begin to find alternative services for each. As the programme revealed, Castlebeck Ltd had suspended the Winterbourne View Hospital staff associated with the abuse and a police investigation had started. As a result of the programme's transmission, staff members were arrested and bailed in advance of court proceedings.
- 1.8** The covertly filmed Panorama, "Undercover Care: The Abuse Exposed" was broadcast on 31 May. Subsequent to the broadcast, other safeguarding alerts were received by South Gloucestershire Council.
- 1.9** On 24 June 2011, Winterbourne View Hospital closed.

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<sup>2</sup> The manager was not registered with the CQC.

## **2. About this serious case review**

**2.1** This SCR was commissioned by South Gloucestershire Adult Safeguarding Board. It builds on management reviews<sup>3</sup> from:

- Castlebeck Ltd
- Care Quality Commission
- NHS South Gloucestershire Primary Care Trust (Commissioning)
- Community Care and Housing Department, South Gloucestershire Council
- Avon and Somerset Police

**2.2** Additional evidence for the findings included information from the BBC Panorama programme, “Undercover Care: the Abuse Exposed,” the BBC’s letter to Castlebeck Ltd about the film’s content and conversations with a sample of ex-patients and their relatives, and an examination of the commissioning of Winterbourne View Hospital places by NHS South of England.

**2.3** The purpose of this SCR is to produce a report which draws together, analyses and comments on the sum of the above. A SCR is neither an alternative to a police investigation nor a substitute for a complaints process. A SCR is a way of holding agencies to account but not individuals to blame. SCRs identify lessons to be learned across all organisations concerning service failures, errors in practice and in the exercise of professional judgement. It was agreed that the Terms of Reference of this SCR should address:

- 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 response 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.*

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<sup>3</sup> Individual Management Reviews (IMRs) are agency self-appraisals. They generally collate relevant information and are written by individuals without line management responsibility for the personnel involved in a case. Such reviews should critically examine individual and organisational practice, underlying causes, management oversight and culture within a team, for example, by interviewing staff and scrutinising policies and records. If an IMR identifies inadequate practice or decision-making, it should identify the changes to be made.

- 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.*

2.4 The Terms of Reference were drafted by Peter Murphy, the Chair of the Safeguarding Adults Board and the Director of Community Care and Housing, South Gloucestershire Council and agreed by Margaret Flynn, the Independent Chair of the Serious Case Review.

2.5 The Serious Case Review covers the period January 2008 – May 2011, i.e. from the date that South Gloucestershire Council received the first safeguarding referral to the transmission of “Undercover Care: the Abuse Exposed.” The Care Quality Commission and the police were invited to submit information from the original date of registration in 2006, and subsequent registration under the Health and Social Care Act 2008.

### 3. Other reviews

3.1 In parallel with the Serious Case Review there was an on-going police investigation and the **Avon and Somerset Police** in liaison with the Crown Prosecution Service sought to ensure criminal justice was not compromised by the Serious Case Review or any of the organisation-specific reviews. In addition, there were five separate, organisation-specific reviews, i.e. **Castlebeck Ltd** commissioned an independent review of the company’s *culture, medical protocols and communications systems* from PwC<sup>4</sup> (the redacted version of which was published online on 16 November 2011), and a clinical review of *all patient records* (excluding those of Winterbourne View Hospital patients) from Debra Moore Associates. The **Care Quality Commission** produced a compliance review (July 2011), concerning Winterbourne View Hospital and embarked on a *responsive review* of the 23 services owned by Castlebeck Ltd in England. This occasioned the closure of two further Castlebeck Ltd units: Rose Villa in Bristol and Arden Vale, near Coventry. The Care Quality Commission also commenced a *learning disability inspection programme* of 150 hospitals and care homes in England. The Care Quality Commission published a guide for whistle-blowers during January 2012, and a summary of a targeted inspection programme of 150 hospitals and care homes for adults with learning disabilities during June 2012. The **NHS South of England**, on behalf of NHS England and with the agreement of the Department of Health, coordinated an investigation of the NHS’ role in commissioning services for 48 former Winterbourne View Hospital patients (involving nine Primary Care Trusts). **NHS South Gloucestershire PCT (Commissioning)** – assumed a coordinating role on behalf of NHS commissioners, as agreed by NHS South West - and reviewed collaboration in the NHS in South Gloucestershire and

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<sup>4</sup> PwC is PricewaterhouseCoopers LLP a professional services firm

Bristol. Finally, the **Department of Health** undertook to abstract the general themes and learn from the sum of the reviews, taking into account, *the current policy framework and support and services for individuals with learning disabilities and/or autistic spectrum conditions who may have mental health conditions and/or behaviours that challenge*. The Department of Health published an interim report during June 2012.

**3.2** The **Equality and Human Rights Commission**, in its regulatory capacity, contacted the Primary Care Trusts which had placed residents at Winterbourne View Hospital to inquire about their commissioning function and strategy and the steps they took to discharge their duties under the Human Rights Act 1998.

#### **4. Some limiting considerations**

**4.1** During the course of the SCR the twin tasks of gathering relevant facts and identifying lessons were inhibited by:

**a)** The absence of a lead body specifying what was required of all agencies e.g. the preparation of a complete list of the 51 former Winterbourne View Hospital patients; and agreement about how their identities were to be protected, with all agencies employing the same means of identifying individual patients; a listing of the patients' contact details whose circumstances were to become the focus of the police investigation and, where feasible, their relatives; an agreement about the police interviewing patients and former patients with the support of social care personnel (perhaps drawing on practice developed elsewhere (e.g. the Investigations Support Unit of Liverpool City Council, Silverman, 2005; Fareed, 2006, "Michael" with Pathak, 2007, for example); an account of what was known of the circumstances leading to the departure of the (almost 400) former employees of Winterbourne View Hospital; and information concerning the outcomes of complaints originating from Winterbourne View Hospital patients as well as their relatives;

**b)** Substantial information gaps in four domains:

**i.** Although Castlebeck Ltd's Management Review describes Winterbourne View Hospital as *one of the best performers within the group - from a financial perspective*, it does not appear that the weekly charges were directly tied to the cost of the various components of assessment and/or treatment. Correspondence with Castlebeck Ltd in November 2011, confirmed Winterbourne View Hospital's turnover as £3.7m in 2010. Given that *no amounts were returned to shareholders or management (apart from salaries) in that or any other year*, Castlebeck Ltd was asked, *on average, how much of the £3.5k charged per week, per patient, was spent on (a) patient activities (b) physical health care (c) psychiatric input (d) nursing staff (e) support workers (f) assessment and treatment (g) food and catering (h) heating and lighting (i) laundry and cleaning (j) maintenance and repair and (k) administration*. The company declined to answer because of the "commercial sensitivity" of such information. However, it noted that *not every admission was charged at £3.5k per week. (This was) an average and the cost of each placement was determined by the individual assessed needs of the patient...Castlebeck believes that the weekly average charge is comparable to other providers offering similar services and this is best evidenced by the fact that Commissioners continued to make*

*placements within the service. If the fee had been out of line with the market then Commissioners would have placed admissions elsewhere.*

- ii. Castlebeck Ltd declined to share the un-redacted report *culture, medical protocols and communications systems* they had commissioned from PwC after the transmission of the BBC Panorama. Similarly, their Individual Management Review was redacted.
  - iii. The GP contracted by Castlebeck Ltd to provide services to Winterbourne View Hospital patients was advised by the Medical Defence Union and the General Medical Council not to share any information<sup>5</sup> concerning the care of Winterbourne View Hospital patients. The advice was that permission had to be secured from the ex-patients to access their primary care records.<sup>6</sup> This was not feasible because contact with the relatives of these individuals and other ex-Winterbourne View patients confirmed that ex-patients had been significantly traumatised by events at the hospital and further contact was likely to be unduly distressing. Also, the police and the Crown Prosecution Service were keen to ensure that criminal justice outcomes were not compromised by approaching ex-patients who were assisting with their investigation. Accordingly, the Review had to rely on the nursing and other records within Winterbourne View Hospital to establish whether or not a “baseline view” of patients’ health status was secured at the time of admission for example.
  - iv. The information concerning patients detained under the Mental Health Act is not sufficiently specific, e.g. whether or not the terms were under S.2 (for assessment) or S.3, (for treatment) and whether or not they had been detained elsewhere. With reference to the voluntary patients, it is not clear that they benefitted from capacity, best interests or Deprivation of Liberty Safeguards assessments.
- c) User and carer empowerment, participation and partnership have had major impacts on service delivery in the NHS and accordingly, the initial meeting of the Serious Case Review Panel endorsed the importance of gathering the perspectives of ex-patients and their relatives. However, the process of establishing the whereabouts of ex-patients and relatives and checking with the police who could, and could not, be contacted - given their prospective roles as witnesses in the criminal trial - was critical.<sup>7</sup> It follows that not all ex-patients and relatives who had indicated their willingness to contribute to the Serious Case Review were able to do so within the timeframe;
- d) NHS South Gloucestershire PCT (Commissioning), in a coordinating role, undertook to read the files of a sample of hospital patients at the time of its closure. This was a major

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<sup>5</sup> Public Interest is considered in the NHS Code of Confidentiality (Department of Health 2003): *Under common law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service* (p.34)

<sup>6</sup> During early 2012, NHS South Gloucestershire PCT (Commissioning) did secure permission from 11 former patients. Their records confirmed the findings of this Review concerning their treatment and physical healthcare

<sup>7</sup> Ultimately the prosecution of Winterbourne View Hospital staff did not rely on the evidence of former patients. However, during the preparation of the Serious Case Review, they were potential witnesses

- undertaking. Access had to be negotiated; the files had to be copied, then sifted and organised. This painstaking process was so protracted it reduced the time required to canvass information about matters which the files revealed e.g. the basis on which patients were detained; and the volume and duration of restraints within the hospital. As a result of the recording practices within Winterbourne View Hospital, only general observations may be made about the histories of some of the former patients. It was not until mid-February 2012, that the examination of 20 case files (i.e. just over a third of the hospital's former patients) was completed;
- e) Media revelations which had not been shared with the Serious Case Review e.g. on 5 June 2011, the Sunday Mirror newspaper reported that a former employee of Winterbourne View Hospital was *repeatedly ignored when she raised concerns about systematic abuse* with the hospital's manager and deputy manager. *She telephoned regulators at the Care Quality Commission in October (2010)...said it would ring back but never did.* (The CQC have no record of this contact and have had no response to correspondence asking about the contact.) *She met the BBC team in January and gave them information about which patients were being abused and by which members of staff.* On 30 July 2011, *The Independent* newspaper reported that an ex-patient of Winterbourne View Hospital *had previously been mistreated at an NHS institution in Cornwall;*
  - f) The process of scrutinising records held within Winterbourne View Hospital took a long time and revealed the inconsistent dispersal of information about individual patients across patient records, nursing notes, medical notes, care plans and multi-disciplinary team notes for example. Ultimately, the histories of 20 patients were shared with the Serious Case Review Panel. The histories of the majority of the 51 Winterbourne View Hospital patients are not known;
  - g) A small quantity of documentary evidence located by the police (during their post broadcast investigation) concerning complaints, disciplinary proceedings and the *concerns* of patients and employees of Winterbourne View Hospital was not shared by Castlebeck Ltd. It had been expected that such information, redacted where necessary, would have been shared. The company's decision not to do so highlights a crucial feature of adult Serious Case Reviews – they are a non-statutory, voluntary process and neither individuals nor agencies can be compelled to contribute;
  - h) the appropriateness of Serious Case Review methodology to making sense of the institutional abuse within Winterbourne View Hospital when compared with the *Independent Longcare Inquiry*<sup>8</sup> (Buckinghamshire County Council, 1998) for example. There is no predesigned, tried and tested methodology for adult Serious Case Reviews concerning institutional abuse. However, an investigative review of this nature requires ordering and accordingly, this Review draws from South Gloucestershire Council Adult Safeguarding policy and procedure. The Serious Case Review Panel meetings sought to

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<sup>8</sup> An independent inquiry into the ill-treatment and wilful neglect of residents with learning disabilities in a private home which concluded...*that the protection of vulnerable adults depends on openness by proprietors and managers; vigilance by all who have responsibilities towards, or contact with residents; encouragement for the communication of suspicions; and prompt, co-ordinated action when information about possible harm to the welfare of residents is received or discovered* (p.3).

make sense of information from dispersed sources, tease out learning and themes and begin conclusion drawing. This prompted some further questions of authors and agencies to check for their plausibility;

- i) The potential for counter-briefing as the Care Quality Commission and NHS South West undertook to share and/or publish their reports independently of the Serious Case Review. Although there is no expectation that Individual Management Reviews are published, the Care Quality Commission drafted their IMR with the intention of publication. Their IMR was shared with the Department of Health because the latter sought to abstract information arising from the sum of reviews, including the CQC's inspection programme (2012).

**4.2** Although some agencies were forthcoming in acknowledging their failings, irrespective of the public interest in the risk of such abuse recurring, concerns about individual and agency reputations and concerns of business viability prevailed. Such considerations do not sit easily with the distress and disbelief of Winterbourne View Hospital patients and their families. They know that if it had not been for the undercover-mediated revelations of the BBC Panorama, then needless human suffering in an unnoticed hospital would have continued.

## **5. Process**

**5.1** Although the various reviews were diverse in terms of focus and methods, there was neither precedent nor guidelines upon which they could draw. The Terms of Reference stated:

*In the light of the substantial gathering of information that will accrue from these single organisation enquiries, it will be particularly important that careful coordination of enquiry activity occurs that can be a useful source of information to the SCR Panel in terms of the production of organisation-specific management reports to aid the work of the SCR Panel.*

*It is recognised that the evolution of the separate enquiries requires a willingness to share information across organisations as part of the overall process. It is expected that information will not be unreasonably withheld if relevant to the completion of any of the enquiries.*

**5.2** Correspondence accompanying the Terms of Reference made additional requests of agencies e.g. Castlebeck Ltd and the Care Quality Commission were asked about Winterbourne View Hospital's management oversight and clinical governance respectively.

**5.3** The Terms of Reference acknowledged *some inter-dependency across the reviews*. This took the form of discussing what information might usefully be shared with those responsible for other reviews; discussing the content of the IMRs with some authors; meetings with Lee Reed, the Chief Executive, and senior managers of Castlebeck Ltd (19 September 2011 and 16 April 2012), with South Gloucestershire's Safeguarding Adults Board (17 October 2011 and 20 June 2012), Welsh Assembly Government civil servants - since the Serious Case Review was not considering the three ex-patients placed by Health Boards in Wales (8 November 2011 and 23 July 2012), representatives of the NHS South West (22 November 2011), the Department of Health (19 December 2011, 13 March 2012 and 26 June 2012) and with senior managers of the Care Quality Commission (6 February 2012 and 26 June 2012).

**5.4** The Panel met on two occasions in advance of any IMRs being available for discussion: 25 July and 15 September. The majority of IMRs were submitted in the first week of December,

in time for the third meeting of the Panel on 5-6 December 2011. Three further meetings of 20 February, 15 March and 19 June 2012, discussed draft sections of the Review.

**5.5** Contact with ex-patients and their relatives were mostly person to person. Such meetings involved, either in combination or individually, Margaret Flynn, Lorraine Spring and Jane Hubert. After each meeting, letters were drafted summarising the main points of discussion. Subsequent telephone contact ensured that the information in the letters was factually correct. The relatives of ex-patients consistently indicated their willingness for the police and NHS organisations to read their letters.

## **6. The BBC Panorama programme *Undercover Care: the Abuse Exposed***

**6.1** The programme which occasioned this Serious Case Review had a compelling “breaking news” element, that is, the announcement that 13 members of staff had been suspended and the patients moved to safety. The attention-grabbing elements were fivefold:

- a)** the range of harm to which patients were subjected and the emotions, including elation, of those exercising merciless power,
- b)** the video diaries and commentaries of the undercover journalist, Joe Casey, who secured employment for five weeks as a support worker at Winterbourne View Hospital, complemented with the commentaries and concerns of experts, the relatives of two patients, Simon and Simone, and reporter Paul Kenyon,
- c)** the serious shortcomings of Castlebeck Ltd, the hospital’s owners and the Care Quality Commission, the regulator, to respond to the disclosures of Terry Bryan, a former senior nurse at Winterbourne View Hospital,
- d)** the staff, including those with supervisory responsibilities, who ignored the arbitrary violence, degradation and great distress of patients, and
- e)** interviews with the new Chief Executive of Castlebeck Ltd and the Regional Director of the Care Quality Commission regarding the failures of their organisations to act on the disclosures of Terry Bryan, which may have halted the hands-on cruelties observed.

**6.2** The programme consisted of a disjointed sequence of scenes on the “locked ward”/top floor of Winterbourne View Hospital, which appeared more authentic for not being professionally composed of focused, rock-steady shots. Two of this ward’s ten patients, Simon and Simone, whose families had consented to film footage which included them being shown, featured most prominently in the programme. Only the staff who were filmed mistreating patients were identified. The faces of the non-abusing staff and other residents were obscured.

**6.3** The ten men and women appeared to spend much of their days in a lounge with peripheral seating, and a wall mounted TV, where members of staff sat among them. The under-occupation and boredom of patients and staff was striking. A woman support worker with six years’ experience was filmed “casually poking” the eyes of Simone (who featured in subsequent coverage wearing glasses which she should have been wearing during the period of undercover filming). When Simone was wrestled to her knees by another member of staff, her back became exposed and she was slapped hard on her bare flesh by Alli, the same support worker.

**6.4** Three support workers were associated with a woman patient’s distress as they wrestled her to the floor. Her distress was exacerbated by a care worker lying across her chest with her arm across her throat. Charlotte, having confiscated the woman’s pillow case, stated, “When



you apologise you can have it back...you don't get to chuck stuff at me and get away with it...you should know that alright?" Later, Charlotte advised Joe Casey, the undercover journalist, of the treatment of patients, "If you have to smash her, you smash her...I just whack 'em all down."

- 6.5** Alli bounced forcefully on the lap of a male patient, Simon, in the lounge and yelled as she did so. Later, she shouted at him, "Don't you push it or I'll put your head down the toilet. Get your hands away from me..." Alli and her colleagues knew that Simon was fearful of toilets. She took Simon's favourite drinking bottle and told him, "It's going out the window." She played "catch" using his bottle as a ball with Graham (who had applied to work in Winterbourne View Hospital as a kitchen porter), and Simon moved to shut the nearest window. Graham noted that "It's like his dummy" as they played.
- 6.6** Jason, a support worker, engaged in another unequal game - this time, of boxing with Simon. As Simon cowered in a chair, Jason towered over him, boxing his head and asking repeatedly, "How do you end the fight?" Simon was heard to respond, "Ding, ding." Jason then quizzed Simon about what happened in a quiet lounge. It appeared that he had accused Simon of something. Jason told Simon, "He gets your balls and he hangs you by them." He imitated Simon's voice as Simon denied the accusation.
- 6.7** Excessively harsh hand-slapping prompted a woman resident to call Wayne, a senior support worker, a "Slapper". Simon was one victim of this unequal game of strength. Unexpectedly, Wayne slapped Simon across his face when the game appeared to be over.
- 6.8** Wayne exploited Simon's fear of toilets by crushing him against the wall of a toilet. Simon cried out in distress. This was rationalised by Wayne as a method of teaching Simon a lesson for his bear-hug greetings. "This is how everyone else feels when you grab hold of them." Later in the lounge, and without provocation, the back of his knees were kicked by Wayne. Simon fell backwards to the floor where he was heard to cry out as he was pinned down by Wayne. A woman patient was heard to ask, "Why are you fighting at us all?"
- 6.9** Viewers were informed that the programme would prove to be life saving for Simon. He returned to the care home he had once lived in, which was close to his family home. When asked about Winterbourne View Hospital by reporter Paul Kenyon, he gave Winterbourne View Hospital an emphatic thumbs down, describing it as "rubbish...horrible...not staying at Winterbourne ever again."
- 6.10** Simone, a patient at Winterbourne View Hospital for four months, was pinned on her back under a chair by Wayne. She managed to turn onto her front and Wayne jerked back her head by her hair while simultaneously pulling her arm up. He said, "Don't hit me again." Graham wrapped a blanket around Simone's head saying "Night, night." Thirty minutes later, he had Simone in a head lock as another member of staff distributed sweets. Wayne was heard slapping Simone. Simone's threats to "Get the police on you", were ignored. Four days later, Simone was again pinned under a chair, this time on her side, with her right wrist pinned under Wayne's foot as he watched TV. She was crying out with pain. He slapped her hard.
- 6.11** On another occasion, when Simone was once again being pinned down on her back by Wayne, Michael dropped his knees heavily onto Simone's legs. Wayne slapped her hard and told her to "shut up." Wayne explained to Joe Casey that on a previous occasion he had

- inadvertently placed a leg of the chair on Simone's arm which had resulted in extensive bruising.
- 6.12** In another scene Wayne taunted Simone with the questions, "Do you want me to get a cheese grater and grate your face off? Do you want me to turn you into a giant pepperoni? Get a razor and cut you up?" In other scenes Graham instructed Simone to "suffocate in your own fat" and he called her a "gimp".
- 6.13** A woman with a personality disorder and a mild learning disability, about whom there were rumours "that she had been abused", was targeted by Wayne one morning. He explained to Joe Casey how to get this woman up. Wayne stated that "She refuses to get up so what we do is, we should just be as annoying as possible...if she doesn't get up I'll give you the nod...we'll launch her out". After announcing "Time to get up Princess", Wayne told the woman that he was "going to grab hold of" her and "drag" her from her bed. He did this with Joe Casey's cooperation. The latter observed that within minutes, the woman was in the corridor "naked and hysterical". Wayne's written account of the incident was untrue, "She was reluctant to rise this morning and refused to attend to her personal hygiene...Despite staffs' efforts to direct her and offer of female support... myself and Joe attended...she became aggressive..." The woman's acute distress persisted into the afternoon when she sought to jump out of a window. Wayne and a male support worker laughed and goaded her to do so. Next, Wayne attacked another patient in the same room, asking "What's that you say about my mum? My mum's a saint". Finally, he targeted Simon, who had his back to him. Wayne pulled down his shorts and slapped his exposed buttocks hard. He adopted a fighting posture over Simon claiming, "I'm warmed up – let's go. Why don't you want it? I'm gonna bite your face off then".
- 6.14** The restraint of a woman patient was filmed in which Danny covered her head and placed his knee on her neck.
- 6.15** In one scene, Graham read to patients from a book about underwater volcanoes.
- 6.16** Charlotte observed of a male patient to Joe Casey, "He's pushing it and pushing it...so we're gonna floor him...he'll be kissing the carpet". She expressed satisfaction that there were so many staff on duty they were going to "abuse" their presence to overwhelm this patient.
- 6.17** Michael bent Simone's fingers and wrists and bent her arm up her back as he sat with her on a settee in the lounge. Subsequently, he explained to Joe Casey that, "...when she's in a bad mood the only language she understands is force".
- 6.18** On a single day, Simone was assaulted on no less than five occasions. Having been attacked by Graham, Simone, fully clothed, was given a cold shower by Graham and Alli. The latter squirted shampoo onto Simone and instructed her to "Wash it off...wash it off". Then Alli asked, "You gonna listen next time?" Kelvin, a nurse who observed part of the proceedings, did not intervene. Simone called out for her mother.
- 6.19** Later, Simone was doused in cold water in the hospital's grounds by Wayne. This was witnessed by Graham and Joe. Among Wayne's instructions to Simone were, "Fight properly and then we'll have a row...Let me know when you have some balls and we'll have a fight". This was in a temperature of "just above zero". Graham noted that "We need to shut the curtains" as Wayne taunted Simone with such questions and instructions as "Getting cold now? Shut up! Stop threatening me...don't just stand there threatening me...Talk nicely to me and I'll talk nicely to you". After about 15 minutes, when Simone was prostrate and

shivering, Wayne said, “We’re gonna bring her in ‘cos she’s shaking...I knew she’d get cold quickly but I thought I’d last her out”.

**6.20** Wayne admitted to Kelvin, the nurse, that he had thrown water on Simone because she had been spitting. Kelvin took no action. Later, Simone was filmed sitting on the floor of a corridor as Graham and Alli threw cold water at her. Simone had refused to go to bed. A Charge Nurse, Sookalingum, (a nurse for 35 years) appeared amused as he was told that Simone became soaked doing a handstand while wetting herself. He did not intervene when Holly, a support worker, with Graham’s assistance, set up a cooling fan beside Simone.

**6.21** The final footage of nursing practice at Winterbourne View Hospital occurred when Alli, Graham, Holly and Sookalingum, the Charge Nurse, were on the same shift. Joe Casey observed as Simone was restrained on her back on her bedroom floor, Graham held her nose and the others appeared to force her to swallow a Paracetamol tablet. Then, Graham hit Simone with his gloves, shouting, “Nein, nein, Nein” and tipped the water from a vase of flowers, a gift from her parents, over her face. Later, during her “second shower of the day” in which Simone was fully clothed, she had had a bottle of mouth wash poured over her head, which stung her eyes. Joe Casey recalled that, “She was devastated. She was in tears. I was the only person who wasn’t doing anything. She kept looking at me and everyone else was just attacking her...”

**6.22** Simone was transferred to another hospital before the programme was broadcast.

**6.23** Interspersed within the programme were the observations and reactions of Terry Bryan, the whistleblower; Professor Jim Mansell, who had written extensively about the support of adults with challenging behaviour; Andrew McDonnell, a clinical psychologist; Simone’s mother and brother; Simone’s parents; and Paul Kenyon, the reporter. Their observations included the following:

- The operating costs of Winterbourne View Hospital, which could accommodate up to 24 people, were £4m a year. Castlebeck Ltd has an annual turnover of £90m a year and provides services to 580 adults;
- Relatives of patients in Winterbourne View Hospital had no idea of the abusive practices within the hospital, not least because they could only access the “Visitors’ Area”. Although “several staff reported abuse, assaults even, nothing changed”;
- Simone’s parents were distressed that although Simone had disclosed that she had been hit, kicked and had her hair pulled, they had not believed her because they did not believe that staff could be so cruel;
- Notions of a hospital, nursing, assessment, treatment, rehabilitation and support were emptied of meaning and credibility;
- The “worst abuse” occurred in the locked ward where patients were under-occupied and bored;
- Wayne, a physically powerful, unqualified senior support worker, who had worked in Winterbourne View Hospital for over three years, appeared gratuitously violent towards patients and set the tone for the behaviour of other support workers.
- The salary of support workers is around £16k a year;
- Joe Casey described witnessing Simone’s assaults during a “very, very long shift”;
- The restraint practices in operation were illegal, illegitimate, dangerous and painful as the patients’ cries and screams testified. A woman patient had suffered a broken

arm while being restrained in 2010. In a single week 24 restraints were recorded. Joe Casey noted that this number was an under-estimate because, typically, they went unrecorded. Some incidents of restraints were planned and others occurred because patients were provoked by staff. The latter appeared to believe they were justified in punishing patients, not least so that they could “get” the patients before the patients got them;

- Before the transmission of the Panorama programme, a support worker, Melanie, who had been convicted of assault, had slapped a woman patient who used a wheelchair and had forced wet wipes into her mouth. Another member of staff had “head-butted” and broken the nose of a male patient in October 2010 – and yet these facts did not affect the management of staff practices at Winterbourne View Hospital;
- Described in the introduction as “a huge failure at the heart of our system of care”, the programme recalled the endemic abuses which are known to have existed in long-stay, NHS hospitals in the past. As a model of service delivery i.e. in terms of the physical structure of a service; the people for whom a service is designed; the practices of a service’s employees and managers; and the service’s ideological underpinnings, Winterbourne View Hospital was described as providing “the worst kind of institutional care”.

**6.23** In addition to the evidence set out above, the programme included interviews by Paul Kenyon with Lee Reed, the Chief Executive Officer of Castlebeck Ltd and Ian Biggs, the Regional Director of the Care Quality Commission. The former expressed shame and offered unreserved apologies for events in Winterbourne View Hospital. He acknowledged the fact that Castlebeck Ltd’s managers could and should have suspended the four members of staff identified by Terry Bryan and said that he would have expected even a support worker with two days experience to intervene. Ian Biggs acknowledged that the CQC made a misjudgement in failing to respond to the evidence submitted by Terry Bryan on three occasions<sup>9</sup> and apologised for this. He acknowledged that inspectors had undertaken three inspections in the preceding two years and that these had not identified evidence of abuse. He disagreed that the regulatory system had failed. He asserted that the Care Quality Commission is one part of the “system” of adult protection.

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<sup>9</sup> The CQC have records of two contacts initiated by Terry Bryan

## Section 2: The Place and the Personnel

This Section is based on information supplied by Castlebeck Ltd, NHS Commissioners and the families of ex-patients.

### 1. The Origins of Winterbourne View Hospital

- 1.1. The origins of Winterbourne View Hospital reside in a market survey/feasibility exercise which Castlebeck Ltd commissioned from Social Information Systems during 2002-03. The survey's terms of reference were threefold:
  - *Current and future demand for Learning Disability services*
  - *The current supply configuration and future market opportunities*
  - *Reporting requirements.*<sup>1</sup>
- 1.2. The Social Information Systems' report was structured to address the policy context, organisational context, commissioner feedback and competitor analysis. This fact-finding determined that Bristol and the surrounding area had insufficient capacity within both the NHS and independent sectors and therefore provided a market opportunity to develop an Assessment and Treatment service...In addition to the externally produced research by Social Information Systems, more local market intelligence was obtained through direct discussion with local NHS Commissioners and via local knowledge gained via a senior member of staff with local healthcare sector knowledge.<sup>2</sup> In the light of a previously aborted project (which was to have been developed in the Midlands), Castlebeck Ltd's Board took the view that developing their own hospital would be more commercially viable.
- 1.3. *The intention was to work with Matrix R Ltd to develop a purpose built, turnkey 24 bed assessment and treatment hospital...for 24 patients with severe learning difficulties/challenging behaviour. The hospital was to comprise 2 x 12 bed ward areas across two floors with each floor having their own dining area. This would allow for gender separation if necessary. (This separation did not occur. However, during July 2009, in the wake of a Healthcare Commission inspection, the floors were split with the top floor designated an acute admissions ward. The upper ground floor became a progression ward for people who did not require the level of security of patients allocated to the top floor.)*
- 1.4. *The project brief was to provide a high quality service that met the perceived needs of the intended patient group in 2006.*
- 1.5. *The Head of Property and Estates, together with the Managing Director for Castlebeck. Adult Services provided senior level input into the building design. Both had extensive experience in the healthcare sector in terms of building design, estates management and operations.*
- 1.6. *Aurora Partnership Ltd project managed the design and building of the hospital on behalf of Castlebeck...with Matrix R Ltd who developed the scheme to Castlebeck's requirements. The design was heavily influenced by the exhaustive design deliberations for an earlier service, Arden Vale, which was located in the West Midlands. The design of Arden Vale had involved considerable operational, nursing and clinical input led by a former Chief Executive of*

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<sup>1</sup> The italicised text in this part of the report is abstracted from material provided by Castlebeck Ltd

<sup>2</sup> The NHS South of England confirmed that "there were early discussions between Castlebeck and NHS commissioners about the needs of the population and the need for specialist provision" (p26).

Castlebeck with the benefit of support from eminent practitioners in the learning disability field.

- 1.7. *Due to problems with the contractors, the original completion date for the project was delayed and this was further exacerbated when Matrix R went into receivership. Therefore, instead of opening as intended in June 2006, the hospital was not handed over until November 2006, and after gaining registration from the Healthcare Commission, it did not open until just before Christmas 2006. (The Healthcare Commission's Inspection Report 2008/2009, incorrectly stated that the hospital was built in 1996. This error was repeated in the Care Quality Commission's Inspection Report 2009/2010.)*
- 1.8. *Those Commissioners who were shown the building plans were positive about the design and layout of the building.*
- 1.9. Three NHS commissioners<sup>3</sup> of Winterbourne View Hospital placements observed:
  - *One of the problems we had faced prior to the opening of Winterbourne View was the distance of hospitals that could or would admit people with learning disabilities detained under the MHA, with people having to go as far afield as Hampshire, Norfolk, Wales, etc. In 2006, we were happy that a local facility was opening that would offer people a much closer alternative...placements were often made at relatively short notice and obviously geography has a part to play, so in many cases it was a 'sellers' market.*
  - *It was often felt to be inappropriate to admit to local mental health inpatient facilities so a placement out of area became the preferred choice for these patients.*
  - *There is a clear recognition that managing crises is best done locally and the re-design of local services is focused on preventing out of area placements and where appropriate, treating people in local inpatient facilities.*
- 1.10. *Winterbourne View Hospital was located in a business park at Winterbourne, South Gloucestershire. Castlebeck Ltd's Statement of Purpose (2009) noted that it is within walking distance of local amenities and a main bus route. Its proximity to Bristol enables easy access to a range of community and leisure facilities.*

## **2. The Layout of Winterbourne View Hospital**

- 2.1. *The topography of the (sloping) site eventually dictated the internal design of the hospital which accounted for the constrained layout. In terms of overall space utilisation, Winterbourne View was one of Castlebeck's best examples at 76 sqm per patient overall. While the constrained site was acknowledged not to be an optimum size, the "split-level" design was felt to afford some advantages in terms of safer separation of deliveries, visitors, laundry etc. from direct resident activities. However, with the benefit of operational use, the end result was that the design of the hospital was not particularly conducive to ensuring that patients could utilise the space available whilst being supervised without it being intrusive... the primary factor was ensuring patient safety was paramount at all times.*
- 2.2. *Once the final site was identified and agreed it became apparent that the design would need to be changed to three storeys rather than two, resulting in the offices, staff areas, kitchen*

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<sup>3</sup> In January 2012, the NHS South of England asked NHS Commissioners about placements at Winterbourne View Hospital whether or not they had a full cost breakdown of the average weekly charge of £3.5k. The replies of three respondents contained reflections on their rationale for placing people at this hospital

*and public areas together with the main reception being located on the ground floor with two ward areas consisting of twelve beds each above. Unfortunately the final design layout allowed little flexibility for providing for gender segregation and with hindsight it was acknowledged that it would have been, economically, more viable to provide 14 beds on each ward to maximise resources.*

- 2.3.** *As the Statement of Purpose noted, each patient has their own room with en-suite bathroom facilities. There are also 2 assisted bathrooms for patients who require assistance. Privacy screening is installed to all windows overlooking other buildings and garden areas. All bedrooms, communal bathrooms and toilets can be locked from inside.*
- 2.4.** The design layout features in Annex 1. The ground floor consisted of: an entrance lobby; two meeting rooms (which were subsequently merged); offices for administrative staff, the Psychiatrist, the Manager and Deputy Manager; staff changing rooms and staff rest room/training; kitchen and store rooms; laundry; and an archive store. A lift and stairwell were close to the foyer. The upper ground floor had three lounges and a *sitting area*. A non-smoking lounge opened into the garden and one lounge was designated a *quiet lounge*. In addition to the 12 bedrooms, there was a sluice room, an Office/Nurse Station and a staff toilet. There was a dining area, a laundry for patients and three toilets for patients. There was an *Education and Computer Room* and an *Activity Room (Dry)*. The first floor resembled the upper ground floor. In place of an Education and Computer Room, however, there was a *Rehabilitation Kitchen* and a *Snoezelen Room*.<sup>4</sup> There was also a Drugs Store and Treatment Room. The first floor's Activity Room was designated *Wet*.
- 2.5.** Castlebeck Ltd stated of the ward which featured on BBC Panorama that it *contains en-suite bedrooms...there are two lounges, an activities lounge with a table tennis table, a dining room and other smaller spaces to allow patients the ability to take advantage of spending time by themselves in addition to small and large groups. There is a nurse's office located in the centre of the living space area but this does not give good visibility to all areas of the ward, relying on professionals being on the ward interacting therapeutically with patients. There is access to the garden via the back staircase.*

### **3. Initial impressions**

- 3.1.** Four families<sup>5</sup> shared their first impressions of Winterbourne View Hospital as a building. They described it as "lovely" // "absolutely perfect" // "the place was new and clean"// "You go in and there's a lovely room that they take you into to talk." One family especially liked the fact that the windows opened onto the garden because their relative liked to get out and wander. They were pleased too that "it had got computer rooms, activity rooms, a lovely lounge with a telly in it. The staff didn't have to cook, there was a chef and they had a laundry room. It had got everything".
- 3.2.** However, two concerns were expressed (i) the location was regarded as less than ideal in terms of its accessibility by public transport, and (ii) the garden, which was "full of cigarette ends". Having seen staff smoking in the garden, one family expressed concern about the risk of fire.

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<sup>4</sup> A Snoezelen is a controlled, multi-sensory environment, typically including lighting effects, different textures, colours, sounds and scents

<sup>5</sup> Twelve families whose relatives were patients at Winterbourne View Hospital contributed to the Serious Case Review during 2011 (see Section 4)

#### **4. Later impressions**

- 4.1.** Families struggled to locate in calendar time the point at which their experience of visiting their relatives at Winterbourne View Hospital changed their perceptions of the place. The families of patients who were in-patients for both extended and brief periods recalled that access to their relatives' bedrooms was not permitted. Without exception, this was worrying for the families who had previously been able to spend time with their relatives in the privacy of their own rooms.
- 4.2.** Eight families shared their later impressions of Winterbourne View Hospital. One family knew that their son moved from "floor to floor" and did not know which floor he was on towards the end of his stay because they "were not allowed upstairs by then". At one stage he was on the top floor which, they had learned from their son, was sometimes referred to as the "punishment floor." When their son was admitted, they were not allowed to see his room because "no one under 18 was allowed on the wards" and a young relative was with them. One parent was allowed to go up, alone, to the son's room. These were problem-free visits. However, the family also recalled that "at a certain point, things changed. They did up the reception room so that it was more comfortable and from that point onwards" they were refused access to their son's room. This troubled them. "I think they had something to hide. Things weren't right. To stop you all of a sudden...they didn't give me any reason...you couldn't see what was going on at the end."
- 4.3.** Even when staff from their son's new home visited Winterbourne View Hospital to assess him, the acting manager advised that they could not go to his ward "because it upsets the other patients."
- 4.4.** Being required to wait in the reception area rather than visiting the wards became a familiar experience as three families recalled. When the first family visited they were "kept in the reception area." They were not allowed further in the building. Their son was on the top floor. They were told that he would start off there because he was "at risk" but that ultimately he would be "moved down and then out." They visited and took him out during the weekends, but they were "not allowed" access to Winterbourne View Hospital during the week because of the activity programme.
- 4.5.** The second family had no experience of visiting their son since he was at Winterbourne View Hospital for a very brief period. However, they visited before his admission. They shared the concern of his care manager and staff working with their son, that although he was to be placed on the top floor, the acting manager would not show them this floor. He explained that it was because "there was a client on that floor who targeted him". Later, the family decided to challenge the decision to place their son on the top floor because they were concerned that he would not be able to get out. However, the Manager said that he had "changed his mind and that he was now going on the other floor." The third family did not visit Winterbourne View Hospital until the day that their daughter moved in. They were allowed into her bedroom on the top floor. The family believed that "the difficult ones" were accommodated on the top floor for the security of their peers.
- 4.6.** Three of the families were consistently taken to the visitors' lounge. One believed that no one was allowed to go upstairs and although another wondered why they were not allowed



“upstairs,” they felt reassured because “It was a nice place downstairs where...we had a meeting, but we were never invited up.”

- 4.7. One family had supervised contact with their relative during visits. They were distressed that they had no privacy and had to become accustomed to sharing the visiting room with other visitors.

## 5. The Personnel

- 5.1. Winterbourne View Hospital’s relationship with Castlebeck Ltd is illustrated in Annex 2. This indicates that within a top-heavy, vertical and multi-layered hierarchy, learning disability nursing and psychiatry were the two disciplines deployed at the hospital, i.e. it was not employing multi-disciplinary personnel. Given the nursing backgrounds of the Managers and Deputy Managers, according to the Organogram (organisational hierarchy), this was intended to be a learning disability nurse-led service. The Charge Nurses were accountable to the Manager and the Deputy Manager.

- 5.2. The Job Descriptions of the Support Workers (“Healthcare Assistants”) stated that they were:

*Responsible to the Nurse in Charge...duties as required...to include...support patients in developing living skills as part of a multi-disciplinary team. To follow individual patient care regimes. To act as associated Key-Worker as required. Complete and maintain all relevant documentation. Act as escort for patients in respect of appointments and activities...participate when directed, in activities of a non-direct care nature.*

- 5.3. In addition, the Support Workers were required to be attentive to Health and Safety legislation and the policies and procedures concerning the safeguarding of vulnerable adults. They were required to bring to the attention of the Nurse in Charge *all unusual incidents and occurrences* and to comply with Castlebeck Ltd’s policies concerning in-service training programmes, dress, appearance and conduct.

- 5.4. The major responsibilities of the Senior Care Assistant (qualifications NVQ level 3 in Health and Social Care or equivalent), who was responsible to the Nurse in Charge, resembled those of the Support Workers. In addition, they were to:

*Assist the Nurse in Charge in the supervision of support staff; function as a focal point for advice, guidance and assistance...Responsible for identified sections of the initial and ongoing assessment package of patients; act as NVQ Assessor; to act as Key-Worker; demonstrate and apply knowledge and skills gained through training.*

- 5.5. The Charge Nurses’ Job Description included most of the responsibilities of the Support Workers. These and all Winterbourne View Hospital nurses were expected to have RNLD/RNMH<sup>6</sup> qualifications. Specifically, the Charge Nurses were:

*Responsible and accountable for the provision of nursing care...responsible for the personal performance in the assessment of care needs, development, implementation and evaluation of care plans...to be an effective role model to all staff...maintain a learning environment and assist with the induction of new staff...communicate and liaise with (hospital staff and the staff of other establishments)...bring to the attention of the Senior Support Team any persistent absenteeism, unpunctuality, sickness and inappropriate behaviour, attitude and or conduct displayed by staff...ensuring that all emergency protocols are followed...participate*

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<sup>6</sup> Registered Nurse Learning Disability/Registered Nurse Mental Health (formerly Mental Handicap)

*in discussions as required, including patient reviews, tribunals and handovers...carry out assessment visits as part of a multi-disciplinary team assessing potential patients...act as line manager...particularly in relation to registered nurses for the deficits, excesses and best practice in clinical matters. To foster good working relationships and promote the Company to external agencies, families of patients...responsible for all clinical practices...to liaise with management in the promotion and development of policies, procedures, practices. Systems and resources management so that the Company's aims and objectives can be developed and achieved...be available for contact via on-call...responsible for the co-ordination, including distribution of manpower and other identified resources...manage situations requiring prompt action in accordance with the Company's disciplinary and grievance procedures. Act as the focal point for professional nursing advice, clinical support, research application, training and standards of care...Bring to the attention of the management team instances where they believe the attitude of management is unjust...Responsible for all legal documentation and correspondence raised in relation to patient...matters...overall responsibility for supervision of all staff within the establishment...Maintain registration with Nursing and Midwifery Council...ensure practice is up to date...The post holder is responsible for their own nursing practice.*

- 5.6. The Senior Staff Nurses were responsible to the Charge Nurse and their job description resembled that of the Charge Nurses. Similarly, elements of the job description of the Staff Nurse, (accountable to the Charge Nurse), were abstracted from that of the Charge Nurse.
- 5.7. The job descriptions of the Deputy Manager and the Manager of Winterbourne View Hospital required RNLD/RNMH (or equivalent), a Registered Managers' Award (or equivalent) and an A1 Assessor's Award (or equivalent). The Deputy was responsible to the Manager and the Manager was responsible to both the Director of Operations (South West) and a Senior Manager. Their job descriptions are almost identical. Both were expected to be conversant with *external requirements relevant to their establishment...Care Quality Commission...Health and Safety Executive*. Each were responsible for *the provision of nursing care...all clinical practices within the establishment...the coordination...distribution of staffing and other identified resources...and deal with any deficiencies and/or ineffective uses*. Finally, each was expected to *act as part of the multi-disciplinary team and ensure that provision is made for all of the functioning of that team*.
- 5.8. The expectation of team-working featured in all job descriptions. All but the Support Workers (the Healthcare Assistants) were expected to engage in multi-disciplinary team work. Another feature spanning all job descriptions was the importance of considering, *the effect of your presentation*.
- 5.9. Above the manager, and outwith Winterbourne View Hospital, was the Director of Operations South West (the Nominated Individual for registration purposes) and a Senior Manager (who, at the time of the BBC Panorama transmission, was the former Registered Manager of Winterbourne View Hospital). They reported to the Managing Director (part of the Castlebeck Ltd Board). All three of these managers were geographically distant from Winterbourne View Hospital.
- 5.10. Between December 2006 and June 2011, Winterbourne View Hospital had both a high staff turnover (*with over 380 staff employed during a five year period*) and high sickness rates. (Mackenzie-Davies and Mansell, 2007, confirmed that difficulties in recruiting and retaining direct care and professional specialist staff are familiar to assessment and treatment

centres.) In addition to the Registered Manager and Deputy, the staffing establishment comprised eleven nurses, (two Charge Nurses, three Senior Nurses and six Staff Nurses) and 31 Support Workers.

- 5.11. The psychiatrist had a short line of accountability with no management responsibility for any of the staff working directly with patients. The psychiatrist's reporting structure was to a Clinical Director who was not based at Winterbourne View Hospital.

## **6. Some observations about the Winterbourne View Hospital personnel**

- 6.1. Six families reflected on their contacts with the hospital staff. One family was disappointed that hospital staff did not engage with their experiential knowledge concerning the importance of daily routines and interpersonal boundaries for their relative. Three families expressed concerns about the appearance of staff and one noted that, "The whole feel of the place didn't add up. It had a bad feel about it and (relative) wasn't happy. It wasn't just the attitudes of care staff – they looked as if they'd been dragged off the street. Not the type of person you'd expect to be in charge of vulnerable people."
- 6.2. One family believed that initially, Winterbourne View Hospital did a lot for their daughter. "They brought her on leaps and bounds. They managed to control the violent behaviour...her talking got better, she would talk more sensibly, she made friends, she loved it there. She had physiotherapy". In addition, the hospital was instrumental in helping their daughter to lose weight with the result that she could walk a few steps. However, these early gains were short-lived. "The physiotherapy discontinued and she put weight back on."
- 6.3. Another family was attuned to the "fast turnover of staff." On one occasion, a member of staff who had known their relative for two weeks wrote a report about him. To the consternation of this family, a senior manager asked them for information and advice about a potential career move.
- 6.4. A family recalled that when their son first went to Winterbourne View Hospital, the staff said that they could visit at "any time." However, after a while, they had to give notice. At the beginning, the staff were welcoming and always had time to talk, but this changed. They want to know what training the staff were given, to what standard, and whether or not they were specifically trained to work in an assessment and treatment unit because, "They didn't seem to have a clue." They were concerned that on some occasions when they rang they could not always understand the people they were talking to because the quality of their spoken English was poor.
- 6.5. On an occasion when a family saw the psychiatrist and wanted to speak to him, they heard him tell a member of staff, "Tell him to go away. I haven't got time." In contrast, another family's faith in psychiatry was renewed at Winterbourne View Hospital. Another psychiatrist took the time to understand their daughter and her history. It was where her diagnosis of autism was made.

## **7. Staff training and professional development**

- 7.1. Castlebeck's *Statement of Purpose* stated:  
*Castlebeck use a thorough recruitment process to select staff, ensuring that they are motivated, enthusiastic and committed to professional development and to providing a high quality service to patients with a learning disability and autism...All staff are recruited in accordance with national POVA (Protection of Vulnerable Adults) guidelines and*

recommendations...All staff receive regular supervision and participate in regular team meetings. Supervision focus is on both staff management issues and Clinical Practice. All staff receive annual appraisals which include the identification of training needs. The training and development of staff is the cornerstone of a high quality service...Winterbourne View aims to maximise the quality and expertise of its staff through comprehensive mandatory training for all staff including:

- Learning Disability Qualification; NVQ II/III in Mental Health Care (Support Workers only); Fire training; First Aid, CPR, Food Hygiene; Health and Safety; Moving and Handling; Manual handling instructors training; Mental Health Act (1983), Mental Capacity Act and Deprivation of Liberties; Safe handling of medicines; Managing Challenging Behaviour/ Personal safety and conflict management/non-aversive, BILD accredited, physical intervention training (MAYBO<sup>7</sup>); the SHARED Approach<sup>8</sup>; Mental health and learning disability training; autistic spectrum disorder training; epilepsy awareness; employment law; record keeping; vocational assessors Award; Registered Manager Award; teaching and assessing in clinical practice.

The professional development of staff is fully supported by Castlebeck and Winterbourne View...staff at all levels...The Consultant Psychiatrist and Clinical Psychologist<sup>9</sup> both provide ongoing training, academic sessions and support to the staff team (p7-9).

Other specialist input is brought in on a sessional basis and in accordance with the needs of patients...might include Speech and Language Therapy, Physiotherapy and Occupational Therapy (p10).

- 7.2.** Castlebeck Ltd (2011) noted that a culture developed at Winterbourne View Hospital in which key performance indicators highlighting service failings went largely unheeded. These included...attendance at staff training.
- 7.3.** Castlebeck Ltd provided information concerning the training offered to 25 staff members. All but one had received the three-yearly, MAYBO full 3 day training and 10 people had received this on two occasions (between March 2007 and February 2011). Fourteen people had received the MAYBO refresher with five people receiving this on two occasions and one person on three occasions (between August 2007 and December 2010). All but one member of staff had received Safeguarding Adults and POVA training (offered between October 2007 and April 2011). All but four people had received the three-yearly First aid at work training (between September 2006 and November 2010); and all but three people received the yearly Fire training (between September 2006 and March 2011). In addition, four staff members attended an array of events between November 2009 and May 2011: unspecified events concerning Dysphagia awareness and Epilepsy and an Autism Conference.

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<sup>7</sup> A provider of conflict management training across various sectors [www.maybo.co.uk](http://www.maybo.co.uk) (accessed on 29 February 2012)

<sup>8</sup> The SHARED Approach is described by Castlebeck Ltd. in their *Statement of Purpose* as a unique model, proprietary to Castlebeck Care (Teesdale) Ltd and Castlebeck Group Ltd. The shared approach provides a process and framework for utilising the best in contemporary practice. It is aimed at addressing individual needs relating to challenging behaviours using socially valid techniques that are least restrictive and non-aversive. The SHARED approach incorporates the following elements: assessment...general aims...strategy...plan...resources...implementation...evaluation

<sup>9</sup> The *Statement of Purpose* stated that Winterbourne View Hospital was served by a P/T Consultant Clinical Psychologist who was not based at the hospital

## **8. The activities of staff**

- 8.1.** Castlebeck Ltd's *Statement of Purpose* concerning Winterbourne View Hospital stated that it offered:

*...a full, structured programme of purposeful activities to each of its patients. There are 3 activity rooms, a training kitchen and a training laundry. Wherever possible activities will take place in a community setting using education and leisure resources available in the local area...each patient's daily programme will be designed to meet their individual needs and choices. The available range of activities...will include: basic literacy and numeracy skills, self care and domestic skills, community and social skills, health promotion, sports, information technology, individual and group fitness programmes, arts and crafts, news and current affairs, educational visits, creative arts therapy, individual and group therapy sessions such as Coping and Tolerance Sessions, drama, rambling/walking group, horticulture, access to adult education where possible, access to employment training and supported employment, outings to places of interest, shopping, cinema, theatre etc., exploration of leisure pursuits, hobbies and pastime. Exploring social and cultural diversity (p15).*

- 8.2.** Although staff have a key role in mediating such opportunities, how they undertake work with patients is dependent on the design of the service i.e. making sure that the overarching aim and management practices are closely linked to staff performance and the desired patient outcomes. It should be noted that Winterbourne View Hospital's Nurses and Support Workers worked 12 hour shifts: either from 8.00 a.m. to 8.00 p.m. or from 8.00 p.m. to 8.00 a.m. While it is not known how these hours connected to the care plans and activities of patients, it does not appear that such hours were designed to nurture either staff or patient well-being. However, such long hours are associated with blocks of time off during week days as well as occasional weekends.

- 8.3.** Two families recalled what they knew about their relatives' activities:

One said that on admission, their son was promised a "highly structured timetable" that they would be expected to continue in the family home. "After about six weeks we saw no evidence of any timetable so we talked to a manager...on my next visit I was shown a timetable chart with Velcro stickers in his room. After two weeks we noticed the chart was unfinished...when I asked the psychiatric nurse assigned to him, she told us that she was unable to finish the chart or commence any useful programme because of the high number of restraints that took place in the hospital and that she believed that he would be better off elsewhere."

- 8.4.** Another family were aware that the staff did not talk about what their son had been doing on the occasion of their visits. They asked if his activities could be written down but this did not happen. They were informed that Winterbourne View Hospital operated "a programme called "24/7" - but they had no idea what 24/7 actually meant for their son. "We had no idea how he actually participated in it." When they asked the staff what he had actually done they were told that he "may have been to a farm, or may have gone for a drive" and they said, "No, what *did* he do, not what he might have done. What did he specifically do?" And there was nothing.' They know that their son spent a lot of time sitting in the TV lounge. The staff were "always asking for money" for him to do things – but it was never clear to them what he was doing. A written report suggested that his trips out had been

incorporated more frequently in his “24/7” timetable. But as the family asked: “What timetable?” Also, the report was muddled about who had done what with him, taken him shopping, for example.

- 8.5.** Although the staff from their son’s new service asked about “24/7” – they couldn’t find anything. “There was always something missing.” In fact there were many gaps in his records – including the omission of such crucial information as the names of staff signing off accounts of incidents. The family believe that their son was under-occupied in Winterbourne View Hospital because there was nothing documented that suggested he had taken part in any training. Neither were there any photographs of him taken during trips.

## **9. The Status and Place of Winterbourne View Hospital within Castlebeck Ltd**

- 9.1.** Winterbourne View Hospital was described in their *Statement of Purpose* as *Castlebeck Ltd’s first service to be established in the South West.*

- 9.2.** As Castlebeck Ltd noted, *there was limited executive oversight...A proportion of the team were promoted through the ranks, irrespective of their experience or ability...This resulted in a culture where...indicators highlighting service failings went largely unheeded, e.g. staff turnover, sickness absence and attendance at staff training. Given this failure of senior management, it had the effect of sanitising any unfavourable information. Information was not passed to senior staff and so the external perspective and Board perspective remained positive...Because Winterbourne View Hospital was geographically distant from Darlington, calls for assistance were largely unheeded by regional management. They in turn failed to respond in a proactive way to concerns raised. Information that made it beyond this level was frequently down played and therefore the Executive Team were not able to give it the attention it required.*

- 9.3.** Castlebeck Ltd observed of Winterbourne View Hospital that *from a financial perspective, Winterbourne View Hospital was one of the best performers within the group. Yet the high levels of sickness with a number of disciplinary actions...5.3% in 2009 and 6.8% in 2010, did not invoke Board level/ Executive Team concern. Admissions to Winterbourne View Hospital were steady. In December 2006, 4 patients were admitted. Thereafter patient admissions are as shown in the table below.*

### **Winterbourne View – Admissions (2007 – 2011)**

	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
<b>January</b>	2	-	1	2	-
<b>February</b>	-	-	-	-	1
<b>March</b>	1	2	1	1	1
<b>April</b>	1	2	-	1	1
<b>May</b>	1	-	-	-	1
<b>June</b>	2	1	-	1	-
<b>July</b>	2	3	3	2	-
<b>August</b>	1	-	2	1	-
<b>September</b>	2	-	-	-	-
<b>October</b>	1	2	-	1	-
<b>November</b>	-	1	1	-	-
<b>December</b>	1	-	1	-	-

## 10. Reflections

- 10.1. Irrespective of World Class Commissioning,<sup>10</sup> it does not appear that there were any pressures on NHS commissioners to perform differently in terms of preventing mental health problems among people with learning disabilities and autism, or to perform to a higher standard, i.e. what might have prompted commissioners to ask: why don't we try something different here and now with this family and why don't we develop some pre-crisis support? Winterbourne View Hospital was dependent for its supply of patients on the lack, or absence, of family support and prevention services, or the lack of success of these services.
- 10.2. Irrespective of the references to *multi-disciplinary team working* in the job descriptions of all but the Support Workers, the Organogram does not reference the context in which it was to develop, including working with, for example, a GP, a lead pharmacist, a dentist, a Care Programme Approach coordinator, Community Psychiatric Nurses and social workers. While these professionals were not directly employed by Castlebeck Ltd, there appeared to be no operational provision for multi-disciplinary working. Crucially, no job descriptions cite experience of, or qualification in, physical healthcare, autism, working with people who challenge services or working with people with mental health problems as being required individual skills. Furthermore, the reporting structure from the Support Workers to the Senior Support Workers, to the Staff Nurses, to the Senior Staff Nurse, to the Charge Nurses, to the Deputy Manager and Manager is remarkably long. It is not clear how the boundaries between the nurses and support workers were developed or maintained, or how the division between their responsibilities was determined. The same observation holds with regards to agency workers. What appears to have happened is that, despite the presence of a team of 13 professional nurses including managers, over time, Winterbourne View Hospital became a Support Worker-led hospital.
- 10.3. It should be noted that all job descriptions were silent about the processes of *assessment and treatment* and *rehabilitation* i.e. the stated purpose of this independent hospital.
- 10.4. The job descriptions of the Deputy Manager and the Manager made no specific reference to their being physically present and routinely available to colleagues and patients in Winterbourne View Hospital. The hospital's Registered Manager was not based at Winterbourne View Hospital during the months prior to the BBC's undercover filming. No evidence was forthcoming of a culture of professional or clinical supervision.
- 10.5. Castlebeck Ltd promoted an unworkable management structure. It should have organised personnel and resources with a view to attaining the intended results i.e. *assessment and treatment* and *rehabilitation*. The key worker system was present in name only.
- 10.6. The adequacy of the hospital's staff training plan and e-learning packages are not known. What is clear is that professional standards and codes of practice had no bearing on patient care. Although different workgroups are subject to differing standards and regulators, the largest group of staff – the Support Workers – were, and remain, outwith any professional regulation and are not subject to any of code of conduct or minimum training standard.

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<sup>10</sup> World Class Commissioning was launched by the Department of Health in 2007. Described as *the key vehicle for delivering a world-leading NHS*, it promoted increased clinical and patient input, combined with a more accurate assessment of local requirements to ensure that services are more closely designed to meet patient needs over time. There were four elements: a vision for world class commissioning, a set of world class commissioning competencies, an assessment system and a support and development framework.

- 10.7.** Further, it seems unlikely that the registered nurses were competent in delegating and supervising the unregistered healthcare assistants. Research<sup>11</sup> evidence suggests nurse education does not prepare students for the practicalities of this role.
- 10.8.** The training information shared by Castlebeck Ltd suggests that there was no training for service development (e.g. Towell and Beardshaw, 1991) at Winterbourne View Hospital. The training programme was skewed towards restraint practices with nothing about working with patients. Such a narrow focus, unconnected to either the purpose of the hospital or to a career ladder, had little promise in developing a capable workforce. There was no evidence of a training strategy or an associated training programme specifying the core competences of staff providing *assessment and treatment* and *rehabilitation*. Similarly, there was no evidence of efforts to assess the impact of training, or more broadly, to elements of the lives of patients at Winterbourne View Hospital.
- 10.9.** Neither Winterbourne View Hospital nor Castlebeck Ltd were required to specify to Commissioners how:
- they were deploying resources for their patients
  - their structures and processes were preparing patients with learning disabilities, some of whom had autism, and mental health problems to live fulfilling and valued lives
  - they were making use of the changing policy context to ensure that their provision was properly responsive.

## **11. Summary Points**

- 11.1.** Business opportunism, which was not discouraged by NHS Commissioners, was associated with the development of Winterbourne View Hospital as an *assessment and treatment* and *rehabilitation* hospital for adults with learning disabilities in 2006.
- 11.2.** The hospital was geographically distant from Castlebeck Ltd's base in North East England and there was little evidence of senior executive oversight. The hospital employed Support Workers, Nurses and Psychiatrists. It was not a multi-disciplinary establishment and there was no operational provision for multi-agency working.
- 11.3.** The initially favourable impressions of some families gave way to worries concerning their access within the building and the unsafe grouping of patients. A minority of families expressed satisfaction with the gains made by their relatives in Winterbourne View Hospital.
- 11.4.** The training and professional development of staff were limited at Winterbourne View Hospital. The skills which were most conspicuously promoted, and arguably the core competences sought by the hospital, were those associated with restraining patients.
- 11.5.** Little can be gleaned from information from Castlebeck Ltd about how staff were expected to spend their time at Winterbourne View Hospital, how their tasks were identified and allocated and whether job variety, for example, was encouraged.
- 11.6.** The Registered Manager at Winterbourne View Hospital did not fulfil the role of lead professional or establish a patient environment synonymous with the Care Quality Commission's Essential Standards of Quality and Safety in respect of an effective system of

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<sup>11</sup> Hasson, F., McKenna, H.P. and Keeney, S (2012) Delegating and supervising unregistered professionals: The student nurse experience *Nurse Education Today* (In press)



clinical governance<sup>12</sup>. This appears to be the case with several of the Outcomes but particularly those appertaining to supporting workers (Outcomes 12 and 14). Nor did the Nominated Individual appear to have any role in terms of exercising responsibility for supervising the management of legally regulated activities at the hospital.

- 11.7.** From the Commissioners' perspective, Castlebeck Ltd had a good reputation. This was not justified. While the notion of a *return on investment* is familiar to shareholders, it is remote from commissioning services. Commissioners did not specify the performance targets required of Winterbourne View Hospital or even the key milestones – the critical points that assure everyone that the hospital is achieving all that it has promised concerning a patient; and they did not seek information about the accomplishments and achievements of the hospital with regards to its patients i.e. in terms of money invested and the results achieved in the short and medium term. In turn, Castlebeck Ltd benefitted financially to a substantial degree.

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<sup>12</sup> The 14 Outcomes of *particular importance* to effective clinical governance, together with prompts, are documented in the CQC (2010) *Guidance about Compliance Essential standards of quality and safety* i.e. *respecting and involving people who use services; consent to care and treatment; care and welfare of people who use services; cooperating with other providers; safeguarding people who use services from abuse; cleanliness and infection control; management of medicines; safety and suitability of premises; safety, availability and suitability of equipment; requirements relating to workers; supporting workers; assessing and monitoring the quality of service provision; complaints; records.*

## Section 3: Chronology

### A chronology of recorded and disclosed events concerning Winterbourne View Hospital

Some of the challenges in producing a chronology of events at Winterbourne View Hospital arise from the partial information available to the SCR and the intermittent contacts between external agencies, patients and hospital personnel. As a result, the following chronology is incomplete. It provides glimpses only of some of the events which occurred at Winterbourne View Hospital during the final three years of its existence. The sources are:

- Castlebeck Ltd, *Serious Untoward Incident (SUI) - Root Cause Analysis*<sup>1</sup>(RCA) closed at National Clinical Governance 2011
- Castlebeck Ltd, *SUI/Safeguarding Logs 2011*
- Castlebeck Ltd (2010) *Quality Accounts (Part 3) and Clinical Governance: Annual Report January 2009-March 2010*
- Castlebeck Ltd, *Clinical Governance April 2010*
- Correspondence from Castlebeck Ltd's Chief Executive, 23 December 2011
- Terry Bryan's 11 October 2010, whistleblowing email to the hospital manager
- Regulation 28<sup>2</sup> notifications
- RIDDOR<sup>3</sup> reported accidents involving patients and staff
- The patient records scrutinised by NHS South Gloucestershire PCT
- The documented account of South Gloucestershire Council Adult Safeguarding concerning discrepancies in information provided by Avon and Somerset Constabulary
- Miscellaneous papers secured by Avon and Somerset Constabulary during their post 31 May 2011 investigation
- Articles and papers forwarded by the relatives of a Winterbourne View Hospital patient.

1. Quotations from records are *in italic* in order to make clear that they are verbatim extracts. Information is included from:
  - a) Castlebeck Ltd
  - b) Avon and Somerset Constabulary
  - c) Healthcare Commission, Mental Health Act Commission and Care Quality Commission
  - d) South Gloucestershire Council Adult Safeguarding
  - e) NHS South Gloucestershire Primary Care Trust (Commissioning)
2. Given the fragmentary nature of the information, this section of the Review is interspersed with summaries in text boxes.

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<sup>1</sup> A methodology promoted by the National Patient Safety Agency aimed at identifying the primary source of problems or events

<sup>2</sup> Regulation 28 of the Private and Voluntary Health Care (England) 2001 requires the notification of such events as death, serious injury and misconduct by a Registered Manager or employee, within 24 hours of their occurrence

<sup>3</sup> RIDDOR, the Reporting of Injuries, Disease and Dangerous Occurrences - to the Health and Safety Executive

3. Four patients were admitted to Winterbourne View Hospital<sup>4</sup> when it first opened in **December 2006**. During **2007**, 14 patients were admitted and one patient was discharged.
4. During **2007**, two out of four RIDDOR incidents were reported to the Health and Safety Executive (HSE). These concerned injuries sustained by staff restraining patients. No other agency had any incident referred during this period.

## 2008

On **13 January** 2008, a senior support worker *was part of a 4-man team restraining a violent man. During the restraint the patient hit the staff member with his knee*<sup>5</sup>.

On **21 (or 22) January**, a patient *attacked and bit* another patient. *Commissioning teams for both patients involved*. The victim was interviewed by the hospital manager who subsequently told the duty social worker that the victim did not want to involve the police.

On **11 February** 2008, a patient *alleged physical abuse by staff members. Staff member suspended...internal investigation completed...Protocol to be put in place re allegations...agreed by police Public Protection Unit (PPU), South Gloucestershire Council Adult safeguarding, commissioners and Winterbourne View*. This incident was subject to a Strategy meeting on **19 April**.

Police intelligence report (of **20 February**) noted the assault of a patient at Winterbourne View Hospital, from *where she had allegedly been trying to escape...Uniformed officers attended and noted carpet burn injuries...It was decided...the assault was as a result of having been lawfully detained*.

On **26 February**, *during the course of the working day a patient became agitated and was self-harming...staff intervened...(a staff member) was hit accidentally in the chest*<sup>6</sup>

During **February**, Winterbourne View Hospital notified the Mental Health Act Commission of *an incident concerning a detained patient...and the outcome from the investigation*.

On **2 March** 2008, a patient *described as being of low mood stated that "he doesn't like it here and he wants to die"*.<sup>7</sup>

On **10 March**, a nursing record stated in relation to a new patient that *a record of all conversations to be kept by nursing staff, including recording of telephone conversations*. There was no reason given for this.

On **16 March**, a patient *attacked and bit* another patient. *Commissioning teams for both patients involved – treatment plans assessed alongside risk assessments – staffing and observation levels addressed*.

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<sup>4</sup> Winterbourne View Hospital was registered by the Commission for Healthcare Audit and Inspection (the regulatory agency at the relevant time) as an independent hospital. The Registration Certificate clearly stated that it was a hospital. At the time, the Registration Certificate had to be displayed in public. This is no longer a requirement

<sup>5</sup> From HSE records

<sup>6</sup> From HSE records

<sup>7</sup> From nursing records

Also on 16 March, a patient alleged *that staff member assaulted her. Staff member suspended – investigation completed...Police interviewed but no further action – passed back to Winterbourne View.*

A nursing record described a patient as having *manic behaviour for most of the day...at one point pushed support worker, which resulted in restraint...restrained on the floor by support worker...without using MAYBO<sup>8</sup> technique.*

On **27 March**, the day after a patient was admitted; because of *severe challenging behaviour* (which was not specified in the medical notes) the patient was restrained by three staff members.

During **March**, a Mental Health Act Commissioner visited Winterbourne View Hospital.

On **12 April**, a nursing record stated of a new patient that she was *woken by staff whilst sleeping in the day room then tried to lock herself in the bathroom. Became abusive towards staff when they tried to escort her from the bathroom - Restraint used for 10 minutes, then calm.*

On **15 April**, the Police recorded a professionals' meeting at Winterbourne View Hospital following the alleged sexual assault of a patient by a member of staff. A strategy meeting took place on **18 April**.

A Police incident report (of **29 April**) recorded a patient to patient assault. *There is a record of multi-agency involvement...The investigation was concluded with no formal police investigation...due to (mental) capacity issues...The decision was made by a Public Protection Unit investigator in consultation with a doctor from Winterbourne View Hospital, i.e. a psychiatrist.*

On **7 May** 2008, a worker was *kicked in the breastbone by volatile patient. Review of procedures in MAYBO techniques with this particular patient to minimise injuries from kicks...Risk assessment reviewed and circulated to all staff.*<sup>9</sup>

On **31 May**, the Registered Manager left the hospital. He had been in post since January 2006.

During **May**, the Mental Health Act Commission (MHAC) published *its second Annual Report*. This noted that the Mental Health Act Commissioner *was able to speak to three of fifteen detained patients, the Deputy Manager, nurses on duty and reception staff.* The Report noted that their previous visit of October 2007 resulted in an *"action plan"* which set out the hospital's response to the main recommendations. *Whilst it is pleasing to report that some of these recommendations have received a full response, unfortunately the majority remain unresolved...no (patient) record contained any evidence that the detention documents had received any medical scrutiny...the last Annual Report (a) recommended that all records...describe the circumstances of a patient's admission. At the time of the inspection only one of nine records contained this document, (b) described complaints from some patients about limited access to their bedrooms. Again...there were descriptions of arrangements where access to rooms was restricted. The MHAC has been informed that this practice*

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<sup>8</sup> [www.maybo.com/physicalintervention](http://www.maybo.com/physicalintervention) - describes the skills associated with the safe management of behaviour which challenges e.g. by avoidance and disengagement. Such non-aggressive skills help to calm a situation "since they do not use pain to seek compliance." MAYBO training enables staff to identify the least aversive options (accessed on 29 February 2012).

<sup>9</sup> From HSE records

*is commonplace throughout all hospitals in the group as there is company-wide policy to prevent theft from rooms during day activity periods (c) recommended that the restraint policy should be audited and updated. During the visit no evidence for the new arrangements for the audit of this intervention, or any new policy could be found. This was a disappointment and the hospital is urged to undertake a review of practice and procedure at the earliest opportunity. The report added that on previous visits patients were concerned about (Advocacy) services. While some service commissioners fund advocacy services, most do not and these patients continue to pay for such support...at the level of individual patient experience there appeared to be little progress on this issue. The report also recommended that the Managers should actively plan to provide a smoking shelter.*

A Police incident report (of **19 June** 2008) recorded the assault of a staff member by a patient during restraint...*The crime was not fully investigated as the carer had apparently reported it for recording purposes only.*

On **20 June**, there was a reference in nursing notes to a comment made by a patient *regarding an attack on a staff member...the member of staff deserved to be attacked as "she shouldn't have treated me that way".*

During **June/July** 2008, an *Acting Manager* was appointed who became the Registered Manager during December 2008 i.e. for seven months during 2008, the hospital was without a Registered Manager.

On **8 July**, a woman patient alleged *physical abuse by staff members. Staff member suspended...internal investigation completed...Protocol to be put in place re allegations...agreed by police PPU, South Gloucestershire Council Adult safeguarding, commissioners and Winterbourne View* (see **11 February** re Protocol). The Police incident report (of **9 July**) recorded the assault of a patient by a member of staff. *The victim later retracts her allegation and the investigation is subsequently concluded.*

Castlebeck Ltd undertook a Root Cause Analysis (RCA) of the allegation. This set out the allegation in full, i.e. that a staff member had *held, hurt and bruised her wrist by pushing his thumbs into it, bent her hand back until it hurt, knelt on her chest, hurting it, twisted the top of her ear and caused bruising to her legs.* Fourteen days later the woman patient *"retracted" her allegation.* Four months later, the woman patient *withdrew the retraction and then changed her mind again...a number of times and became distressed so further discussion on the allegation was not felt appropriate.* The RCA determined that the member of staff responsible for the restraint, *was not MAYBO trained...yet at charge nurse level deemed himself competent to be actively on the floor and able to restrain...Circumstantial evidence includes the burn marking on the patient's right hand...and misgivings of some staff about the staff member's motives for delaying statements and data completion post incident...there was also a systematic lack of understanding amongst the staff group of the observational policy and appropriate recording/ monitoring in a wider sense...at the time of the incident there had been a serious disruption of management structure and an experience for staff on the floor of confused, disharmonious and unclear leadership...In relation to the retraction issue, it is felt most likely that this was mishandled with good intention (without awareness of legal*

*implications and managed with a view to reducing distress and optimising care.)* These findings were published in **October 2009**, i.e. 15 months after the patient's allegation of assault.

On **18 July**, a strategy meeting was held at Winterbourne View Hospital. It concerned a patient who was believed to be making *false allegations*.

On **6 August** 2008, a nursing record stated of a patient, *unsettled behaviour, throwing bottles out of the window, crying, verbally abusive and making allegations about staff threatening to re-instate Section 3*.<sup>10</sup>

During **August**, activities appear to have been curtailed or cancelled e.g. *patient has reported boredom lately as some sessions cancelled – explanation – staff shortages at the moment*.

During **September** 2008, the Healthcare Commission carried out *a desk top review of Winterbourne View. Concerns identified include the lack of a substantive Registered Manager for the hospital. An acting manager is in place...and the hospital's failure to provide comprehensive details and records concerning serious untoward incident investigations*.

On **26 October** 2008, *Patient agitated today as unable to go out on afternoon trip? Escalating behaviour stating 'it's like a prison in here'*.<sup>11</sup>

On **31 October**, *patient asked for his 'cell' to be unlocked (night) – refused by staff until he called it a room*.<sup>12</sup>

On **17 November** 2008, *a patient was unable to go to farm today due to staffing and other issues*.<sup>13</sup>

On **20 November**, South Gloucestershire Council Adult Safeguarding challenged the adequacy of the internal investigation arising from a patient's allegation of **8 July**. Their report noted, *inter alia*, that there were *too many systems in place for recording care, not easily accessible* and that the frequency of archiving documents rendered *cross referencing difficult*. Further, concerns noted included discrepancies in evidence; the use of correction fluid; the failure to interview staff who had made statements; inattention to the circumstances regarding the retraction; the uncertain connections between risk assessments and care plans; and the failure to "sign off" and date records.

On **1 December** 2008, *a patient was awake during the night as unable to sleep became agitated and finally was restrained on bed for 15 minutes*.<sup>14</sup>

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<sup>10</sup> An application for admission under section 3 of the Mental Health Act 1983 may be made in respect of a patient on the grounds that he is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital, and it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section and appropriate medical treatment is available for him. A "mental disorder" is defined in section 1(2) of the Mental Health Act 1983 as meaning any disorder or disability of the mind. Pursuant to section 1(2A) a person with a learning disability shall not be considered by reason of that disability to be suffering from a mental disorder or requiring treatment in hospital for mental disorder unless that disability is associated with abnormally aggressive or seriously irresponsible conduct on his part.

<sup>11</sup> From nursing records

<sup>12</sup> From nursing records

<sup>13</sup> From nursing records

<sup>14</sup> From nursing records

On **1 December**, the Healthcare Commission carried out *an unannounced inspection*, arising from the receipt and review of the hospital's annual self-assessment. It focused on *staff training and development, record keeping and information for patients*. However...*the assessors observed areas of damage to the environment that posed an immediate risk to the electrical safety and fire safety for patients, staff and visitors...The Healthcare Commission issued two statutory notices under Regulation 51.*<sup>15</sup> Significantly, the Inspection Report noted that *There is currently no registered manager at the hospital although an application has been received and is been (sic) processed...The assessors are concerned that not all patients needs are being met in that some patients may be having a negative effect on the therapeutic outcomes for others accommodated*. Of the 14 standards inspected (out of a potential 73), 2 were *met*, 10 were *not met* and 2 were *almost met*. Those which were not met included *controlled drugs, suicide prevention, information for patients about complaints, resuscitation procedures, quality of life for patients, human resources, policies and procedures, patient records, Section 17*<sup>16</sup> *leave, health care premises and health and safety measures*.

**At the end of 2008**, a support worker who was also known as a *Day Service Co-ordinator* left Winterbourne View Hospital. This worker was given the post on the basis of her enthusiasm...she worked 9-5 Monday to Friday. However, when the hospital was short staffed she would cover shifts. After her departure, an *alternative approach...involved a team of 6 support workers, led by a Senior Support Worker, who were required to provide the activities programme over the course of the week...these staff were also required to work as part of the overall support worker staff numbers and to provide cover if the wards were short of staff for any reason.*<sup>17</sup>

During **2008**, 11 patients were admitted to Winterbourne View Hospital and five patients were discharged.

**Just over 12 months after Winterbourne View Hospital first opened, events in 2008 brought into view some of the “off guard” incidents which featured in the BBC’s Panorama programme i.e. the use of restraint by untrained personnel, the limited means with which staff worked with patients and the discontinuity or absence of internal and external support, management, challenge and advocacy.**

**For seven months during 2008, Winterbourne View Hospital operated without a hospital/registered manager – a person with statutory as well as executive responsibilities for (i) regulated activities and (ii) compliance with regulations - as well as making sideways relationships with individuals at Castlebeck Ltd and other agencies over whom they had no supervisory responsibility. Further, Castlebeck Ltd failed to respond to evidence of the harmful restraints of patients when requested to do so by a Mental Health Act Commissioner. Recording practice at the Winterbourne View Hospital was poor. Patients were assaulted by staff and other patients; and staff were assaulted by patients.**

<sup>15</sup> Regulation 51 of the Private and Voluntary Health Care (England) Regulations 2001 (SI 2001/3968), required a hospital to take immediate remedial action where the Healthcare Commission issued a notice (the 2001 Regulations were revoked with effect from 1 October 2010).

<sup>16</sup> Section 17 of the Mental Health Act 1983, allows a responsible medical officer to grant a detained patient under their care permission to leave the hospital where they are detained.

<sup>17</sup> From correspondence with the Chief Executive

## 2009

During **January** 2009, the *financial abuse* of a patient by their *family* was referred to the *Court of Protection*.

On **1 January**, a staff nurse sustained *bruising to the lower rib area* following the restraint of a patient *using MAYBO techniques...A review of training requirements will be carried out to ensure all staff are fully competent with MAYBO.*<sup>18</sup>

On **19 January**, a *detailed action plan* was submitted to the *Healthcare Commission* as a result of the unannounced inspection of December 2008.

A Police incident report (of **26 January**) recorded the assault of a staff member by a patient...*via a phone call from Winterbourne View Hospital...Police officers...speak with the member of staff and the manager but not the patient. The victim had been bitten on the head, been scratched and had some hair pulled out. No further investigation of the circumstances is carried out.*

On **4 February** 2009, a patient about whom it was documented, *recurrent dislocation of knee – need to be mindful when using restraint*, was restrained after an attempt to abscond. After this it was noted that the *knee dislocated and then went back into place. Patient crying with pain, leg raised.*

On **23 February**, a patient disclosed that the hospital manager had hurt her neck during a restraint. A Castlebeck Ltd manager noted on the South Gloucestershire Council Adult Safeguarding 'alerter form' that *no injuries were noted and physical evidence would not be present due to the lapse of time, therefore the police were not called at this point.*

On **5 March**, a patient disclosed that a staff member had kicked her, hit her and stuffed her knickers in her mouth during a night shift incident. This was reported to South Gloucestershire Council Adult Safeguarding.

On **6 March**, an incident form notes that a patient *sustained scratches to neck during a restraint...member of staff inappropriately held the patient during a restraint as they had keys in their hand.*

On **10 March**, Castlebeck Ltd carried out a Regulation 26<sup>19</sup> visit and submitted their report to the Healthcare Commission on **24 March**. This reflected the concerns of Winterbourne View Hospital staff about *their vulnerability to allegations and investigations by the police and South Gloucestershire Council Adult safeguarding*. The CQC subsequently noted that *the limitations of the report* arising from the minimal contribution of patients and the *limited input from external sources were not identified as a cause for concern.*

On **24 March**, the Healthcare Commission carried out *an unannounced inspection to follow up on action against the Improvement Notice*. It was an evening visit *and not all standards were inspected*

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<sup>18</sup> From HSE records

<sup>19</sup> Regulation 26 of the Private and Voluntary Health Care (England) Regulations 2001 required unannounced, six monthly visits by the responsible individual, another of the directors or an employee who was not directly concerned with the conduct of the establishment. The visiting person was required to interview patients, their representatives and employees, inspect records of complaints and prepare a written report (the 2001 Regulations were repealed with effect from 1 October 2010).



because *two service users...had unplanned hospital visits that day*. The assessors noted that *Winterbourne View was again found to be failing to comply with regulations in a number of areas, i.e. standards concerning controlled drugs, suicide prevention, patients' records, information for patients about complaints, resuscitation procedures and quality of life for patients were not met*.

On **1 April** 2009, the Care Quality Commission was established. The transitional arrangements required Winterbourne View Hospital to re-register under the Health and Social Care Act by October 2010, i.e. for the first 18 months of its operations, *the Care Quality Commission had to regulate...against the National Minimum Standards of the Care Standards Act and to continue to utilise the existing Healthcare Commission methodology*.

On **16 April**, a patient's *aggressive behaviour towards staff...resulted in two restraints*. Nursing notes stated that the patient later complained of *sore fingers on right hand which is swollen and bruised*. The patient attended A&E for an x-ray the following day and a fracture clinic the day after where *fingers taped together for support*. The patient returned to A&E for an x-ray on 20 April, for *x-ray of painful right wrist following a fall during a seizure*. The patient had *wrist pinned and plated* the following day.

On **20 April**, Winterbourne View Hospital notified the Care Quality Commission and the HSE that during an epileptic seizure, a patient fell and sustained a wrist fracture. The patient was taken to hospital and admitted the following day for an operation.

During **April**, a support worker noted in their appraisal *I am struggling to follow senior support worker directions due to shortage of staff, no time to link with senior support worker. Many things I don't understand about when and where company policies apply*. The CQC (2011)<sup>20</sup> noted that *there was no further appraisal...and no indication of any response to these observations*.

A Police log (of **24 May** 2009) recorded a patient missing from Winterbourne View Hospital. The patient was described as *a danger to other members of the public and a danger to herself*. The patient was found by the police and was returned to the hospital.

The CQC (2011) noted that *the person-specific care plan of one patient was incomplete or contained information of variable quality with no evidence that the planning and delivery of care met her needs*.

On **18 June**, the Mental Health Act Commissioners visited Winterbourne View Hospital.

During **June**, *Concerns were raised by European Lifestyles<sup>21</sup> into the practices at Winterbourne View. Full investigations commenced...disciplinary procedures followed...all action fed to CQC, commissioners and South Gloucestershire Council Adult safeguarding...Several safeguarding meetings held July, August, September and November 2009 - CQC involvement in meetings*. A Public

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<sup>20</sup> The Compliance Review of July 2011

<sup>21</sup> European Lifestyles is a specialist service provider working with people with learning disabilities, mental illnesses and people with traumatic brain injuries (see [www.european.lifestyles.co.uk](http://www.european.lifestyles.co.uk), accessed on 29 February 2012). European Lifestyles employees were present because they were supporting a patient prior to the patient's transfer to a supported living service

Protection Unit investigator was *involved in the responses to allegations around the use of restraint...he was satisfied that it was not appropriate to treat the incidents as assaults* and believed that *the quality of recording of incidents could be improved. He offered to give advice...about this.*

During **June 2009**, Castlebeck Ltd's Manager at Winterbourne View Hospital was registered with the CQC. She was an experienced nurse: RNLD, RMN, SEN<sup>22</sup> with a Diploma in Management, who had worked in *a number of Independent Hospitals and Care Homes*. The Registered Manager had worked for Castlebeck Ltd since 1988 and at Winterbourne View Hospital since mid-2008.

On **21 July 2009**, nursing records indicated that a patient who had been admitted just five days earlier, having been described as *tearful on arrival...unsettled* was subject to *restraint for 4 ½ hours*, Lorazepam was administered and then she was *restrained twice for approximately 5 minutes*. Eight days after admission she was described as *physically aggressive towards staff, kicking, spitting, racially abusive, using sexually inappropriate language and stripping...(and making) allegations of rape*. She was *restrained intermittently from 08.00 to 17.00*.

During **July**, an *Action Plan* arising from a Healthcare Commission Inspection was reviewed by Castlebeck Ltd: *two Regulation 51s were issued regarding the poor state of the overall environment of Winterbourne View. The team are working hard on making improvements, not only to conform with regulation but to bring the environment up to the Castlebeck standard of a 'homely' environment that is safe via robust risk management and prompt maintenance routines. We are going to split the floors – top floor acute/ admission with a structured routine and dedicated staff. The upper ground will be the 'progression' floor to maximise independence focusing on deficits of daily living skills and community participation, with a dedicated staff team. We are starting the process with redecoration of all patient areas and refurbishment of lounges. This will then progress to personalisation of all bedrooms.*

On **20 August 2009**, it was alleged that *a patient had given a woman patient a pot of sperm...to become pregnant...Risks...explained...consented to receive the morning after pill. Psychology input for both...Educational sessions conducted...plus a men's group...Capacity assessments completed...not a matter requiring the attention of South Gloucestershire Council Adult Safeguarding.*

*After an aggressive incident, patient required emergency dental work having bitten a member of staff. Staff member suspended...internal investigation completed. Police investigated but decided self-defence.*

A Police incident report (of **20 August**) recorded the above assault: *A service user was assaulted by a carer. The allegation was that the carer punched the service user to the face having been bitten. It was decided by the investigator...that the carer had acted instinctively in self-defence and no formal action was taken.*

HSE records stated *During observation of a disturbed patient, the patient lunged at the staff member without any warning signs and bit him with force and refused to let go...Increase in observation consisting of 2 staff to patient and review of risk assessments for patient.*

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<sup>22</sup> Registered Nurse, Learning Disability; Registered Mental Nurse; State Enrolled Nurse

On **22 August**, a patient who had been admitted just four weeks earlier was described in nursing records as *tearful as night staff arrived; requesting attention but staff were busy dealing with other unsettled patients. Became physically and verbally aggressive and expressed suicidal thoughts. Restrained*. The duration of the restraint was not specified.

On **25 August**, there was a strategy meeting concerning a male patient which involved the police. Concerns were expressed regarding staff recording at Winterbourne View Hospital.

On **26 August**, the patient who was assaulted on **20 August** was assaulted again by a staff member. Although the police were involved, it was observed that *it does not appear to have been investigated by the Public Protection Unit*.

The CQC (2011) noted inconsistency in the *identified risks care plan regarding knee dislocation during restraint* which required the Nurse in Charge to decide whether or not the patient should attend hospital in the event of knee dislocation. However, records noted that *hospital staff had advised not to bring the person to hospital as there is limited assistance they can provide due to ongoing knee problems*.

During **August**, the manager and deputy manager received a joint letter amounting to a complaint from a patient: *Dear X and Y, I am writing to you about me, on the 8/08/09 I did not go out because Z was the only nurse on and I had to stay indoors and this is always when he is on. I like to go out please. During the week there is 3 nurse on the weekend where I am, from (me) I can go out there is only 1 nurse [sic]*.

During **August**, a step down unit, Rose Villa (also operated by Castlebeck Ltd) became operational and nine of the patients from Winterbourne View were transferred over. This service also allows for some people who were detained under the Mental Health Act to be treated in the community on a Community Treatment Order.<sup>23</sup>

On **11 September** 2009, a letter amounting to a complaint was signed by seven patients: it stated that nurse *B is always promising things that we can go out shopping on Friday but then he is not actually on shift today, D is, signed...[sic]*

On **14 September**, a worker from European Lifestyles witnessed an *inappropriate restraint*.

On **17 September**, a Detective Constable interviewed the member of staff with a social worker and decided that *the incident did not constitute a crime*.

On **25 September**, a worker from European Lifestyles witnessed a staff member respond to being *grabbed* by a patient by *pulling* the patient's hair. The police did not attend the resulting safeguarding strategy meeting.

During **September**, disciplinary proceeding concerning a member of staff commenced. The staff member had been suspended because on the night shift, **12-13 September** 2009, she had left the

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<sup>23</sup> Community Treatment Orders became available under the Mental Health Act 1983 pursuant to the Mental Health Act 2007 with effect from November 2008. They were designed to help "revolving door" patients with histories of hospital treatment followed by relapse and readmission.

hospital at 22.10, and did not return until 12.15, without notifying the nurse. She had had a tattoo done in the car park. In a letter (undated) to the manager she stated, *I had no fixed address to return to when my shift finished. I have been experience severe family problems [sic].*

**Throughout January to September 2009, the poor oversight of both patients and staff is apparent. Castlebeck Ltd did not act on the actions required by the Healthcare Commission. Although patients attached importance to activities, including going out, these did not happen.**

**Records attested to the continued and harmful use of restraints and unchallenged perceptions of patient behaviour.**

**There is no evidence that the patients' written complaints received any response from either Winterbourne View Hospital or Castlebeck Ltd.**

On **7 October** 2009, the *front tooth on bottom jaw* (of a patient) *broken off during a biting attack on a member of staff and an assault on a female (staff)...Internal investigation completed. Police investigation...patient cautioned.* In the light of the two biting incidents (see **August** above) a Public Protection Unit investigator *strongly urged Winterbourne View to invest in CCTV.* This recommendation was *discussed with the senior management team, CQC and the commissioning teams of patients – large privacy and dignity issues raised and all against...therefore not put in place.* The letter was not copied to South Gloucestershire Council Adult safeguarding. There was a strategy meeting arising from the patient's broken tooth and the incident was reported to the HSE.

Winterbourne View Hospital informed the Care Quality Commission about the above incident: *A patient was being restrained with approved physical intervention techniques to prevent them throwing a chair at staff...the patient was alleged to have bitten the staff member. In the attempt to remove their hand from the mouth of the patient the patient's tooth came out. The staff member also had a broken skin injury. The patient had no history of biting...it was not clear if the staff member had a disciplinary record of other incidents.*

A Police intelligence report (of **13 October**) detailed the events of **7 October**, when a patient touched the breast of a woman staff member *then became very aggressive and suffered a broken tooth which came out onto the floor...The assault against the patient was described as self-defence.*

A Police log (of **14 October**) records two calls from a patient stating *"things kicking off at the hospital."* The patient *explained that he was upset and stressed.* Because a communications operator spoke to a member of staff who confirmed that *all was in order at the hospital, no police officers attended.*

A letter from the Public Protection Unit (of **21 October**) requested that Winterbourne View Hospital managers invest in a CCTV system, in view of the *2 separate incidents at Winterbourne View in which 2 service users had their teeth knocked out by carers during a restraint situation. Both patients appear to have been punched in the face.* Given that *any restraint is usually carried out by 2 or more*

*people so any allegation of improper or criminal conduct is countered by two people's word against the victim – the victim always unlikely to make a good witness in a criminal prosecution (given your clients' vulnerabilities), no doubt something your staff are aware of...If CCTV is not implemented I will have to seriously reconsider our approach to investigating incidents at Winterbourne View.*

On **30 October**, a patient alleged that a relative had been sexually abusing her...Winterbourne View followed Crown Prosecution Service guidelines in relation to contact with relative and input from other professionals...criminal proceedings undertaken.

On **31 October**, a staff member left her shift prematurely. Having been employed for a matter of weeks, the resulting Human Resources investigation conveyed something of the experience of a new member of staff.

*She stated she had not received any MAYBO training before she was put on the floor and on several occasions was left to work completely on her own...she had spoken to the manager regarding a restraint which she had observed and was not happy with as it appeared the staff member was winding up the resident...she had not wanted to disclose the employee's name initially...was aware that all staff knew about the complaint she had made...staff member K...began bullying her...said he was only joking when he realised he had upset her...another member of staff harassed her...touched her bottom. Met with HR Officer, stated that she had mentioned her concern over a restraint...claims she saw other things but is too scared to say following the breach in confidentiality of her 'whistle-blowing'...has a loss of trust in her line manager...gave HR Officer a copy of her induction programme...all highlighted items she had not been trained on. An investigation interview established that the staff member had no training plan. In a meeting with the manager, he explained that he needed more information to chase up her complaint...said that he told the staff member that he would approach the whole team about the issue...the staff member told him she didn't want to come across as a grass...he reminded everyone that if they observed an incorrect procedure happening they should let someone know. On 6/11/09, the staff member wrote: ...I went on the floor without having MAYBO training and without my CRB check having come back...Throughout the period of employment I received no training at all...During my final 3 days at Castlebeck we were very short staffed...**29 October**...a patient was restrained by 5 members of staff leaving me alone with other patients...**30 October** there were 4 support workers and a nurse on duty...there was an incident...leaving me on my own with the remaining 10 patients, 2 of which are level 4<sup>24</sup>...on **31 October** in the handover meeting there was only a nurse and two support workers. I asked the nurse what would happen (re inadequate staffing) said she would call the manager...phone was turned off... (re breach of confidentiality) the Manager said to all staff that the support workers needed to be aware of the way in which they spoke to and treated the patients as some Rose Villa staff had been noticing inappropriate behaviour from staff and had complained. The HR Officer concluded that the staff member had not been bullied or sexually harassed and wrote, I found no evidence to suggest that you received a lack of or insufficient training.*

During **October**, Winterbourne View Hospital submitted an annual self-assessment to the Care Quality Commission which led to the decision to undertake an inspection.

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<sup>24</sup> Castlebeck Ltd has an Observation Levels Policy. Level 1 refers to general observation, Level 2, to intermittent observation, Level 3 to 'within eyesight' observation and Level 4 to 'within arm's length observation.'

The *Mental Health Annual Statement* concerning Winterbourne View Hospital was published. This noted that *relations between Mental Health Act Commissioners and senior managers of the hospital have remained constructive throughout the reporting period...the CQC was particularly pleased and reassured to note that the Board takes issues of concern raised by Mental Health Act Commissioners on visits very seriously and clear action plans are immediately put into place.* The CQC commended the *diligence of the Managers...and the Senior Management Team in ensuring that all detentions are lawful and clearly documented capacity assessments.* With reference to (i) the Care Programme Approach (S.117)<sup>25</sup> *the quality and detail of care plans is impressive, as is the linkage between care planning and risk management processes* (ii) Deprivation of Liberty Safeguards, *there were no identified patients liable to or treated under DoLS*<sup>26</sup> (iii) *Patient care and treatment staff on duty were visible and attentive to the patients cared for and the patients seen collectively and in private were complimentary of the nursing and medical care received. The MHA Commissioner was also pleased to note the good staffing ratio in place and the provision of regular healthcare monitoring by the local GP surgery.* The Recommendations for Action hinged on *ongoing compliance with Part 1V*<sup>27</sup> *of the Mental Health Act, efforts to ensure active user participation in the care planning process, service protocols/ procedures and staff training...in relation to Deprivation of Liberty safeguards and a review of the S.17 leave arrangement process.*

Also during **October**, Castlebeck Ltd concluded the Root Cause Analysis arising from the allegation of physical assault by a woman patient on 8 **July 2008**, i.e. 15 months after the allegation. The RCA stated *it appeared that the patient's allegations are often linked in some way to physical intervention. A theory that would sit alongside this would be that of the patient wanting to be held physically, this being linked to comfort. There is also an issue that being involved in physical intervention incorporates an element of truth to an allegation of assault as staff have actually held her at a time of distress.*

On **13 December** 2009, a patient met with two professionals. A handwritten note of the meeting states that, *D's spoken to his solicitor today about moving. He's aware that the situation is going to a tribunal next year...says he's still fed up with being here...not been sleeping too well...found his glasses but says he doesn't like wearing them...not been sleeping too well because* (another patient has) *been shouting.' D says he's on 'a new tablet' but he doesn't know what it's for.*

On **15 December**, the Care Quality Commission carried out an announced inspection at the hospital. The concerns regarding the state of the hospital had *been rectified*. Of the 23 standards assessed during the inspection, 18 were *met* and 5 were *almost met*. The latter included, *controlled drugs, ordering and storage of medicines, staff training, health and safety and information for patients.*

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<sup>25</sup> Section 117 of the Mental Health Act 1983 states that aftercare services must be provided to patients who have been detained in hospital for treatment under section 3. It includes patients on authorised leave from hospital and patients who were previously detained under section 3 but who stayed in hospital after discharge from section 3.

<sup>26</sup> See the Mental Capacity Act 2005(as amended by the Mental Health Act 2007), Deprivation of Liberty Safeguards ("DoLS") provide legal protection for people who may be deprived of their liberty within the meaning of Article 5 of the European Convention on Human Rights in a hospital (other than under the MHA 1983) or care home, whether placed there under public or private arrangements. The DoLS were introduced to ensure that deprivation of liberty can only take place when it is in the best interests of the person concerned and when it is authorised by a supervisory body.

<sup>27</sup> Part IV of the Mental Health Act 1983 deals with the treatment of detained patients. It prescribes the procedure that must be followed prior to specific types of treatment being carried out.

Accordingly, the registered person was required to *ensure that, the management of controlled drugs conform with the requirements of the Controlled Drugs (Supervision of Management of Use) Regulations 2006...warning notices are in place where medical gas cylinders are stored...there is a clear record of staff training in place...staff receive training...and on the prevention management of aggression, techniques to diffuse situations and physical intervention techniques.* Also, the registered person was to ensure the safety of patients, staff and visitors and provide patients with accessible and *accurate information* concerning the complaints policy.

During **December**, Winterbourne View Hospital appointed a new manager. CQC noted that *neither the provider nor the former Registered Manager informed the commission formally* of this change.

During **2009**, nine patients were admitted to Winterbourne View Hospital and 11 patients were discharged.

**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. Reference to staffing ratios and staff training during 2009, anticipated a persistent pattern of under-staffing, the persistent practice of restraining patients – absorbing the attention of many staff - and circumscribed staff training opportunities.**

**The disquiet of the Police about operations at Winterbourne View Hospital was evidenced by their suggestion that CCTV cameras should be installed.**

**The misgivings of some Hospital and Rose Villa staff concerning the use of restraints and their antecedents in Winterbourne View Hospital were known to Castlebeck Ltd's Human Resources Officers. Similarly, breaches of patients' supervision requirements were known to Human Resources Officers. Although Winterbourne View Hospital reported externally to the Police, NHS commissioners, the CQC, the HSE and South Gloucester Council Adult Safeguarding, their reporting meant that no single agency possessed a "whole picture". The reports were not matched by energetic efforts within the hospital or Castlebeck Ltd to remedy the build-up of failings.**

## **2010**

On **1 January** 2010, Castlebeck Ltd's new Manager began work at Winterbourne View Hospital. This manager was *never formally registered as manager*. Castlebeck Ltd stated that the previous Registered Manager *sent form to CQC regarding cancellation of her registration*. Between **January 2010–October 2010**, the new, acting Manager was supported by the *former* Registered Manager.

On **4 January**, a staff member received a reply to a grievance of **November 2009**. It stated: *I have found that the training you had completed during your employment was sufficient. A lot of training within Castlebeck is on the job and as incidents occur. Consideration had been taken that you had not*

*completed your MAYBO training and staffing levels were adjusted accordingly...training constantly happens on a daily basis on the floor.*

On **11 January**, a patient alleged a sexual assault by another patient. The patient alleging the assault was transferred to another Castlebeck Ltd service...*risk assessments of (the alleged perpetrator were) reviewed by Multi-Disciplinary Team (MDT)...maintained on level 4 observations. Liaised with commissioners for both patients... Treatment plan assessed...Police interviewed...no further action taken.*

On **10 January**, Winterbourne View Hospital informed the Care Quality Commission of the assault (recorded by the hospital as occurring on **11 January**). *Staff were reminded of the need for constant vigilance of those in their care.*

A Police log (of **12 January**) detailed the post 11 January events which concluded, *The suspect was arrested and interviewed but insufficient evidence was available to put the matter before a court.*

On **17 January**, accident forms noted that a patient *sustained a cut to left ear during a restraint.*

During **January**, the Care Quality Commission received the action plan prepared by Winterbourne View Hospital as a result of the announced inspection of **15 December**.

On **2 February** 2010, it was alleged that a patient was *punched in the back twice grabbed by the ears and pushed to the floor by a staff member...Staff member suspended...investigation completed and disciplinary action initiated.* South Gloucestershire Council Adult Safeguarding was informed on **7 February**.

A Police log and incident report (of **8 February**) recorded the assault of a patient by a member of staff. *The incident was reported to the police by a Winterbourne View Hospital nurse. The victim was subject to a video interview...The suspect was interviewed...and denied the offence. No further action...due to lack of evidence.* South Gloucestershire Council Adult Safeguarding met with the police to discuss the incident.

On **8 February**, Winterbourne View Hospital informed the Care Quality Commission of the assault of **2 February**, as disclosed on **7 February**. The assault occurred *because the patient did not want to have dinner with others in the dining room...the member of staff had been suspended pending the outcome of the investigation.*

On **22 February**, Winterbourne View Hospital informed the Care Quality Commission that a consultant psychiatrist and manager observed a staff member *"yank a patient forcefully...push the patient and then shout at them". The staff member was immediately suspended.* South Gloucestershire Council Adult Safeguarding was informed on **23 February**, and the Public Protection Unit was sent a copy of the alert. Although the police *agreed that it is appropriate for internal investigation by Castlebeck Ltd*, they have no record of this.

On **23 February**, the disciplinary hearing concerning a support worker began. The process explicitly dealt with the number of staff on duty: the Deputy Manager was asked, *if he would normally leave a support worker on their own if a resident was highly agitated. The Deputy Manager said that is what seems to happen at Winterbourne View...said that he would assess...as sometimes there can be*



*limited staff. The Support Worker explained that she was on her own with the residents and that the Charge Nurse knew this...said there were not many staff in that day. It was recommended that the Support Worker undergo a disciplinary hearing...also recommended that the Deputy and Charge Nurse receive supervision for knowingly allowing a support worker to be working alone on the first floor with the patient clientele being of a more challenging behaviour. Winterbourne View staffing levels should be reviewed.*

On **24 February**, Winterbourne View Hospital informed the Care Quality Commission that a patient had disclosed self harm to a psychiatrist, that is, the insertion of a biro into their abdominal wall. The patient was admitted to hospital for operative treatment.

South Gloucestershire Council Adult Safeguarding was informed of an *allegation that a staff member had squeezed a patient's neck while restraining him and he could not swallow. Also alleged second restraint around the neck whilst he was on bed. Alleged that when the staff member gets angry, he gets 'rough'. Threats to cancel home visit used as a sanction. Police saying unable to speak with patient 'and he would probably deny anyway'.*

During **February**, Winterbourne View Hospital notified the Care Quality Commission of the arrest of two staff members by the UK Border Agency. Castlebeck Ltd state that they *were not deemed to have done anything wrong and the Borders Agency came into Winterbourne to give training on how potentially fraudulent documentation could be identified in the future. The suggestion was that there was an 'illegal set up' in the Bristol area. It should be noted that such false documents are fairly sophisticated duplicates.*<sup>28</sup>

On **2 March** 2010, a *patient was bitten by fellow patient. Patients moved to different floors. Case conference held with South Gloucestershire Council Adult safeguarding. Liaised with commissioners for both patients. Full MDT and risk assessment review. Police informed but patient wanted no further action to be taken.// A patient became agitated, kicking, spitting and throwing objects at staff. Fellow patient bit patient. CQC and South Gloucestershire Council Adult safeguarding informed. Risk assessments reviewed. RCA requested and needed.*

A Police log (of **3 March**) noted of the assault of 2 March, (as reported by the Deputy Manager) *the incident was not recorded as a crime...no further police action took place.*

On **13 March**, a patient was described in nursing records as *attention seeking all morning. Became physically and verbally abusive towards staff – restraint (of unspecified duration).*

On **22 March**, a patient wrote to the acting manager: *I feel let down because there are never enough staff...and patients good behaviour is not being rewarded with outing and activities as far as I was aware there should be 6 staff to a floor so outings and activities can be arranged but constantly, only 4 staff so outings and activities get turning up other patients see the same too. Your sincerely...[sic]*

On **24 March**, a patient disclosed to an *advocate that a member of staff squeezed his neck whilst being restrained...internal investigation completed and disciplinary action initiated.*

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<sup>28</sup> Information provided by Castlebeck Ltd in April 2012

On **24 March**, Winterbourne View Hospital informed the Care Quality Commission of the above allegation. *Patient revealed...that they had been unable to swallow whilst being restrained by a support worker. The provider gave no other information.* The police were informed, carried out interviews and advised *Winterbourne View to carry out internal investigation.*

**Irrespective of Castlebeck Ltd's assertion that they use a thorough recruitment process to select staff, ensuring that they are motivated, enthusiastic and committed to professional development, the reality was far removed. Both "on the job" training and inadequate staffing levels kept company with the tolerance of unprofessional behaviour and poor recruitment practices. There can be no avoiding the dangerous and punitive use of restraint or the fiction of interventions supposedly based on current best practice that embraces the ethics and principles of non-aversive, non-punitive, multi-elemental approaches.**

On **10 April** 2010, a patient complained that a support worker *had bruised her chest, arm and shoulder and had pulled her hair and scratched her.* The outcome of this is not known.

On **20 April**, a patient wrote on a form entitled, *I want to say, On Saturday I 'played up' after being assisted by staff I had calmed myself down in the quiet lounge and (a staff member) had come to check on me and called me a fucking nasty cow and evil bitch.*

A Police log (of **29 April**) concerned the relative of a service user *behaving aggressively outside Winterbourne View Hospital...An area search was completed with no sign of the individual...No follow up action.*

During **April**, CQC sent the form back to the ex-Registered Manager stating *it was the wrong form.* Accordingly, at the time of the Panorama filming, the ex-Registered Manager was the Registered Manager.

On **7 May** 2010, a staff member was *bitten by patient on arm.*

On **19 May**, a staff member alleged that a patient had been *treated and spoken to inappropriately by fellow...staff...Staff members suspended...internal investigation completed...disciplinary action against member of staff.* In the resulting investigation, the following points were made:

The acting manager *said that there were some difficulties on the top floor involving a patient. The manager said that the floor may have been stretched for staff.*

A Senior support worker *said that ...he informed H of what was going on and H had replied that X and Y would not work for her and would not do as she had asked...//*

The support worker *said that (i) he had the rest of the group in the lounge and H was doing the meds, (ii) meds took a long time to do, an hour and half to two hours, (iii) he started breakfast for everyone on his own...(iv) after lunch X did the incentives<sup>29</sup>...a lot of the patients went to their own*

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<sup>29</sup> A means of encouraging patients to engage in activities

rooms after lunch...(v) at one point patient fell when a hair pull technique was implemented...(vi) he had told staff how bad upstairs had been and that no one had come to help them anyway...(vii) he was annoyed at the staffing levels as they were dangerous but he was glad that nothing happened...he wasn't able to leave the residents to get hold of anyone else to help//

The nurse said that she did not feel that X was using de-escalation techniques with patient. H said that she felt that X was being too assertive with patient. H said that she is not a Learning Disability nurse though and it might be that being a bit more stern is what is normal in Winterbourne View.

Castlebeck Ltd checked Winterbourne View Hospital's rotas<sup>30</sup> for May 2010 and noted, at no point was a single support worker on shift either during the day or on night shift...Winterbourne had an establishment of 31 support workers. In the early part of May there were 26 in post but approval was given for additional posts and towards the end of May there were 33 in post although one was on long term sick, one was on maternity leave and one was pregnant working in the office. At no point during this or any other period, did the company's management intend there to be only a single support worker on shift.

South Gloucestershire Council Adult Safeguarding was alerted on **20 May**. A patient had been agitated and volatile. Two staff members deliberately left the patient 'stranded' without support. There was a strategy meeting on **25 May**.

On **2 June** 2010, a support worker sustained a sprained elbow after falling as she was being lifted by a patient onto a trampoline.<sup>31</sup>

On **10 June**, a Capacity Assessment by a psychiatrist established that a patient has capacity to consent to medication and physical intervention.

On **12 June**, a staff member forced an armchair into the chest of a patient until he was crying out in pain and nearly crying - the chair was then removed.

It was during **June 2011** (i.e. a year later), a former staff member disclosed the above incident to police investigating the abuse highlighted by the transmission of *Undercover Care: The Abuse Exposed*. This was the first time that the police were notified of the event.

On **15 June**, a patient attended A&E for cut to arm – self injurious behaviour.<sup>32</sup>

On **17 June**, a meeting was held with a nurse to discuss an incident when a patient had injured themselves resulting in...hospital treatment. The nurse, who had been in charge, did not attend to the person's wounds as needed...they had not completed the required documentation...The nurse left the organisation before the investigation was completed. Castlebeck Ltd did not inform the CQC and the nurse was not reported to the Nursing and Midwifery Council or to the Independent Safeguarding Authority (CQC, 2011).

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<sup>30</sup> Information Castlebeck Ltd provided to the SCR during April 2012

<sup>31</sup> Reported to the HSE

<sup>32</sup> Reported to the HSE

A Police log (of **18 June**) recorded a missing patient, described *as a danger to herself in view of self harming was found within two hours by the police and returned to the hospital*. The CQC were not informed of this incident.

The CQC (2011) noted that the absconding patient was detained under S.37. The *mini root cause analysis* of the incident stated that the prescribed observation levels *appeared to be confusing for staff, consequently communication of observations required were unclear...staff may have played down the observation levels* for this patient.

During **June**, a support worker was suspended because they had *acted inappropriately and had locked a patient between two doors*. The incident was neither reported to South Gloucestershire Council Adult Safeguarding nor to the CQC. The support worker resigned three months later (CQC, 2011).

**The concerns expressed by a support worker regarding *dangerous staffing levels* and those of a nurse regarding levels of assertiveness in dealing with a distressed patient are indicative of the many guises of institutional abuse. Feedback from patients had no impact on practice at Winterbourne View Hospital.**

On **3 July** 2010, two staff members wrote about their experience of accompanying two Winterbourne View Hospital patients to a Service Users' Forum: *during the evening the two service users mentioned their keyworkers and nurses in charge. One mentioned that she did not like (her nurse)...I advised that if she had an issue she must speak to manager and not discuss in front of other staff and service users. (The other patient) said (support worker) told me to spit at her and kick off when she was on duty. The patient then said... she told me to get her //or attack her. Why didn't you say anything? The patient said she didn't want to get anyone into trouble...told them that enough had been said and to stop the conversation. The subject was changed and nothing else has been mentioned since.*

On **5 July**, nursing and medical notes described events during the day for one patient: *refused to attend GP appointment as a particular member of staff was unable to take her. Became physically and verbally aggressive towards the member of staff - biting, kicking and trying to self harm. Restrained using MAYBO off and on for an hour. Seen by (the psychiatrist) put on Section 5(2<sup>33</sup>)...later converted to Section 3 due to significant deterioration in behaviour.*

On **17 July**, a patient complained to the manager: *All the staff are being nasty to me they are leaving (my friend) out...on the 17/7/10 and they are leaving her out on the 18/7/10 (One support worker) is being really horrible to me.*

Also, another patient made a complaint: *I had my hair done at the hairdressers and when I got home (a staff member) made nasty comments about my hair he said I would look like Edward scoccorshand*

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<sup>33</sup> Section 5(2) of the Mental Health Act 1983, provides holding powers under which a non-detained patient may be detained by a doctor for up to 72 hours

*[sic] if I didn't take care of it he said to stop going on about my hair he's had enough of it for 3 days & said I will talk about it for next 3 days.*

On **17 July**, a Support Worker outlined her concerns in writing to the acting Manager: *I felt the residents were treated in an abusive way (in the community). Support Workers A, B and C kept wandering off without telling the other staff. I found it very difficult to work...residents are not getting the support they need and are being misunderstood by staff... (e.g.) the response of a patient to a question from Support Worker 2 invoked Support Worker 2's anger and he shouted that the patient was winding him up...(after which) the patient said he didn't want to go on the afternoon trip. Support Worker 2 told him he was going. Ultimately, the patient (did not go out because he punched another patient). On an occasion when another patient returned from the hairdressers she was very happy...wanted to show it off. Another Support Worker was rude...said she wasted her money, usually looks like Edward Scissorhands and that he can look good after spending £20 on clothes...also told her to stop going on...The patient was visibly upset...The Support Worker said 'Not long left' and patient J asked 'Till when?' The reply was, 'Till I don't have to see your ugly mug'...said he was joking. Whilst out with Support Worker 3, patient J was apparently dancing on tables and chatting 'birds' up...came back very rude, as did a woman patient who was also quite elated. Patient K was very over excited and not listening to staff. Patient L also did not talk his best and get his incentives for being rude to others. It seemed the group had no supervision... (and) no support to deal with the aftermath. Patient M was given bags of sweets...to 'keep her happy'...hence a sugar rush in the evening.*

On **18 July**, a staff member verbally and physically assaulted patient during personal care. Witnessed and reported by...staff member...Staff immediately suspended and subsequently dismissed...Police investigation...perpetrator charged.

South Gloucestershire Council Adult Safeguarding was informed on the same day. A support worker saw staff member assault a patient on four occasions to arm and shoulder over a ten minute period, and then attempted to wrap a dirty nightdress over her face to stop her from spitting.

A Police log (of **19 July**) recorded the assault of a patient by a member of staff as reported by a colleague. Although the member of staff denied the assault, she was charged and convicted. South Gloucestershire Council Adult Safeguarding was aware of the case but they were not informed of the trial outcome or the compensation paid to the patient's family. The patient's family were unaware of the incident until they received compensation.

On **19 July**, Winterbourne View Hospital notified the Care Quality Commission of the above incident. *The allegation was made that the care worker slapped the patient on two occasions on the arm and shoulder in the shower and in the patient's bedroom.*

On **19 July**, a patient, whilst being restrained on the floor, was allegedly still struggling and making attempts to attack the staff. Whilst struggling, the patient twisted and fractured their wrist. The patient was taken to A&E for emergency treatment (see **22 July** and **25 September 2010**).

A Police intelligence report (of **20 July**) concerned a patient holding a plastic knife to her own throat. Staff took the knife from her. A police officer attended...and decided there was no need for further action on the basis of advice from hospital staff.

On **22 July**, a patient wrote a letter, which amounts to a complaint, to the Manager and the Deputy: *I got restrained for trying to run away by Support Workers 1, 2, 3 and 4. Support Worker 3 had my head and Support Worker 4 had my right arm and slapped left side of my face I had a swollen lip and have got a bruise in my mouth. Support Worker 4 grabbed my left wrist which is my bad one and was bending around Support worker 2 let her do it she then slammed my right wrist into the floor I heard it click [sic].*

On **23 July**, a patient's hand was injured during physical intervention. A&E diagnosed a broken hand. The HSE records noted that a *patient was being restrained due to severe aggression against carers. During restraint she twisted her arm violently away from a member of staff holding her arm. The member of staff felt something was not right with the patient's forearm and consequently let go of it.*

On **29 July**, Winterbourne View Hospital notified the Care Quality Commission that a *patient, whilst being restrained on the floor, was allegedly still struggling and making attempts to attack the staff. Whilst struggling, the patient twisted and fractured their wrist...was taken to A&E. The Care Quality Commission Mental Health Act Commissioner noted concerns about process for external review of this type of notifiable incident.*

The CQC (2011) noted of this incident that the Mental Health Act Commissioner *was concerned to note that the 'patient' was not offered an opportunity to seek legal or advocacy advice.* Furthermore, the acting Manager and Deputy Manager's *mini root cause analysis* did not acknowledge the *inconsistent and conflicting* accounts of the incident, leading the CQC to conclude that there was neither an attempt to identify the cause nor take action to improve patient safety.

Terry Bryan's email (of **11 October**) noted that, *when I arrived, I asked one of the service users how she broke her forearm. She said she "moved the wrong way in a restraint". This was subsequently verified by staff members.*

On **31 July**, a patient was noted to be *upset when night staff came on duty, missing his mum. Talked to his mum on phone for 15 minutes. He told her he was upset because fingers were hurting and a (named) staff member had bent them back.* No follow up was recorded.<sup>34</sup>

On **1 August**, the patient's mother rang to express concerns about her son's disclosure that he had had his fingers bent back and that they were hurting. *Staff explained that he needed a lot of re-direction (and) had not mentioned the fingers.* No follow-up was recorded.

On **10 August**, the nursing notes concerning a new patient stated that the patient disclosed *that he did not feel safe because the staff 'swear a lot' at the patients.* The patient was *reassured by Staff Nurse and encouraged to speak to a nurse whenever the patient felt unable to manage thoughts or was anxious.*

On **15 August**, Terry Bryan began working at Winterbourne View Hospital.

On **19 August** 2010, Joe Casey (the undercover journalist) applied to work at Winterbourne View Hospital.

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<sup>34</sup> From nursing records

The acting manager of Winterbourne View Hospital received an email. This followed a previous email from a trainer in which *concerns* had been mentioned. The email stated that, in the light of sacking a staff member (who was subsequently convicted of assaulting a patient), *There is a cultural problem. I've seen various things like within the first week of working on the floor someone restrained...3-4 times in a day when not necessary and staff slapping someone's chest whilst they are being restrained. At the start of June two patients were encouraged to play fight and later staff used a wrist lock on a patient. A week later a staff member became annoyed with a patient and pinned him to the floor with a chair...I hope this is useful in the future for you.*

On **22 August**, a patient alleged that a staff member had verbally threatened him (He reported to his mother that a staff member had told him, "I will punch you in the face if you are not quiet.")...*investigation found member of staff not working on or around the day of the alleged incident. Risk assessments and care plans reviewed...No Further Action by Public Protection Unit.*

*During a period of unsettled behaviour a patient banged her head twice on the corner of a wall. Attended A&E, head glued- Increased observation - RCA required.*<sup>35</sup>

On **24 August**, Joe Casey was offered a job at Winterbourne View Hospital (which he did not take up until 14 February 2011).

During **September** 2010, Terry Bryan described *an incident with one established support worker who invited him to the dining room of the first floor where a patient was making a phone call. The support worker said that the patient was being inappropriate in his conversation...the patient was upset that his phone call was being monitored by 2 staff members...The support worker felt we were in a perfect position to challenge the patient about the phone call...saying that the patient's call should have been stopped and that we should have restrained him there and then.*

On **2 September**, a patient requiring dressing for a *query carpet burn* disclosed that *someone did it*. No follow up recorded.

On **3 September**, a *patient alleged that she was sexually assaulted by patient...investigation as to why observation levels were not adhered to at the time of the incident...disciplinary action taken...observation levels increased. Risk assessments and treatment plans assessed. Involvement from commissioners for both patients and multi-disciplinary team input...Criminal proceedings undertaken// Safeguarding procedure explained and local authority informed. Social Worker and Next of Kin informed. On hold pending investigation.*

A Police intelligence report (of **13 September**) recorded the above assault. A patient was subsequently prosecuted.

On **5 September**, a new patient was *asked to finish a telephone call with his mother as another patient needed the phone. He became verbally aggressive and then threw the phone at staff and became physically aggressive. Bit himself on his hand...restrained.*

On **7 September**, medical notes stated that a new patient disclosed to his mother that *a member of staff had grabbed him around the neck during a restraint and had disclosed to other residents that*

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<sup>35</sup> Reported to the HSE

he had been “naughty”. Also concerned that access to his bedroom was restricted and he was not allowed access to his room to calm down. It was reported to management for investigation.

On **17 September**, a patient disclosed to an advocate that *staff were winding him up and it was difficult because he had to tell staff everything he was doing e.g. going to the loo...very intrusive. Unable to spend his ‘free time’ in his room and no flexibility with timing of phone calls...staff to be informed.*

On **17 September**, the *Assessment and Review Document* of a woman patient detained under section 3 of the MHA was drafted. This described the patient’s challenging behaviour as *, aggression, violence or passive non-aggressive behaviour, severe disinhibition, intractable nosiness or restlessness, resistance to necessary care and treatment, severe fluctuations in mental state, extreme frustration associated with communication difficulties, inappropriate interference with others.* The document stated that reinforcement, *is based on a very simple principle that for (woman patient) to present with appropriate and acceptable behaviour, he must look his best, talk his best and do his best...it is hoped that the system will assist (woman patient) to acquire necessary skills for his day to day functioning and reduce the negative behaviours by replacing them with good behaviour (sic).*<sup>36</sup>

On **19 September**, Terry Bryan noted that *a patient self-harmed at 10pm...she was left all night without treatment to 4 lacerations to forearm.* The following day *she had 19 sutures inserted.* This was reported to the HSE on **20 September**.

The CQC (2011) noted that the incident report of 20 September *that recorded an event that evening...A person on a frequent level of observations sustained a serious self harm injury but medical treatment was not sought until the next day...there was no mention of the risk assessment being reviewed following the incident. The accident report seen was completed 10 days later and conflicting information was recorded with that on the incident report.*

In his email, Terry Bryan noted the use of threats by members of staff to manage patients. On **20 September**, he observed a staff member *issuing threats...if she didn’t stop shouting, she’d not be doing some unspecified thing on her upcoming birthday.*

The minutes of the unit-led clinical governance committee meetings for **23 September**, stated that a relative had contacted the hospital *in respect of lost money...no further information or action taken is recorded (CQC, 2011).*

On **25 September**, a Mental Health Act Commissioner visited the hospital and *identified concerns with the quality of an investigation of an incident and requested additional information to be submitted to the Care Quality Commission.*

A patient whose arm was in plaster, *said that during a restraint procedure on 23 July 2010, they suffered a fracture to their left wrist.*

On **25 September**, the nursing notes described a patient who had been *verbally aggressive to other patients being ‘escorted’ by staff away from the communal area.* The patient’s clothing was *ripped ‘accidentally’ during escort.*

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<sup>36</sup> The document contains further examples of “cut and paste” text.



On **26 September**, a patient had two incidents of self injurious behaviour including two cuts to her right arm. Steri strips were put in place. Attended A&E the following morning - Increased observations for 24 hours - RCA required.<sup>37</sup>

On **29 September**, an allegation of staff sleeping on duty was made to Winterbourne View Hospital's acting Manager and Deputy.

A Police intelligence report (of **2 December** 2010) concerned the decision of the Crown Prosecution Service that there was *insufficient evidence...to prosecute* the relative of a patient who was alleged to have been sexually assaulted *during a visit*.

The disrespectful ways in which some staff members engaged with patients anticipated the exchanges glimpsed in the BBC Panorama. Winterbourne View Hospital patients lived in circumstances which raised the continuous possibility of harm and degradation. Although a Mental Health Act Commissioner expressed the view that an injury sustained during restraint should be subject to *external review*, this had no impact on the scrutiny of patients' injuries. Two patients were silenced when they sought to disclose their dislike of a staff member. It is noteworthy that these disclosures were made during a Castlebeck Ltd-mediated event promoting self advocacy. A support worker's account of her experience of working with colleagues who were offensive to patients confirmed that disciplinary powers were used to punish and diminish patients. It also confirmed that Castlebeck Ltd's managers did not deal with unprofessional practices. Not only were injuries sustained by the patients subjected to restraint, but they were led to believe that it was their own fault e.g. because they *moved the wrong way in a restraint*. Relatives who challenged the practice were offered reassurance. Patients were subjected to interference with their privacy when they made phone calls and used their bathrooms. Such restrictions do not appear to have arisen from either patients' treatment plans or Castlebeck Ltd's policy.

Terry Bryan's email described an incident which occurred on **5 October** 2010. *A patient was angry, but only shouting. When 2 established staff members approached her she dropped to the ground and stayed still with her arms held out in a T supine position (as taught on MAYBO course). In spite of this, she was enthusiastically restrained by these 2 staff members. There was no resistance from the patient at all, yet it still happened.* On the same day, Terry Bryan talked to two patients about absconding from the hospital. *A staff member came up the corridor at high speed, shouting to both...to get back in the lounge.*

In his email, Terry Bryan noted the use of threats by members of staff to manage patients. On **5 October**, he observed the staff member *issuing threats...about a home visit* which she attributed to the *Castlebeck way*.

On **4 October**, staff accompanying a patient whose self injurious behaviour had resulted in A&E visits for wounds to be sutured and were advised that *A&E staff were not happy to see patient back again and with the same cuts. May refuse to give her treatment in the future.* It is not known whether or not A&E took any action concerning this possibility.

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<sup>37</sup> Reported to the HSE

*A patient placed herself in the bath...headbutted the bath resulting in an open wound. Taken to A&E via ambulance - Wound closed with 6 steel staples - RCA completed and the injury was reported to the HSE.*

On **10 October**, a body map was completed on behalf of another patient. This showed extensive bruising to her arms, bite marks as well as broken skin. The nursing record attributes these injuries to the patient *throwing herself on the floor numerous times*.

Terry Bryan described the aftermath of the assault of a staff member, which also occurred on **10 October**. *After the patient had hit out at a staff member, he was taken up to the First Floor as a threat of what would happen to him if he didn't behave himself.*

On **11 October**, Terry Bryan sent his *whistleblowing concern* email to the acting manager of Winterbourne View Hospital entitled, *I've had enough*.

On **14 October**, a patient took the opportunity of a court appearance to *repeatedly ask the judge to remove him from Winterbourne View Hospital*.

On **15 October**, a patient attended A&E for cuts to left arm – *self injurious behaviour*.<sup>38</sup>

On **16 October**, a patient *self injured during the night with an unknown object (later found to be a razor blade) causing injury to right arm, stomach and leg. Area dressed. Taken to A&E in the morning when more safe to do so. Stitching required....RCA required*.<sup>39</sup>

On **17 October**, a patient told his mother about the behaviour of staff members. The Public Protection Unit gave advice about social work interviews – two other patients were named as victims - and the three transcriptions were shared with the PPU. The police have no record of these events.

On **18 October**, clinical team notes stated that a patient *smashed TV set, 2 physical interventions, patient stomping around...struggles to understand why still at Winterbourne View Hospital. Requested to stay on 1<sup>st</sup> floor. New risk – physical aggression towards staff - Move back to upper ground floor, increase medication*.

On **21 October**, a patient *produced a letter of complaint...he was mishandled by a member of staff...Risk assessment and treatment plan review...referred to PPU – allegation found to be untrue*. (This incident is also recorded as occurring on **27 October**. *RCA needed. Need incident form*).

On **24 October**, a patient *noticed to be missing. Immediate search of vicinity was carried out. Patient was located and returned to unit - RCA required*. This patient was detained under S.3 and was found a mile away from the hospital. There was no incident report, no risk assessment and no mini root cause analysis.

On **25 October**, a patient sustained *carpet burns*.

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<sup>38</sup> Reported to the HSE

<sup>39</sup> Reported to the HSE

On **26 October**, the acting manager advised South Gloucestershire Council Adult *Safeguarding of receipt of Terry Bryan's email.*

On **28 October**, the acting manager forwarded Terry Bryan's email to South Gloucestershire Council Adult Safeguarding.

On **29 October**, South Gloucestershire Council Safeguarding Adults responded, *this isn't very encouraging and certainly can't be ignored.* The reply included a series of questions about the events detailed in the email.

On **30 October**, a relative was *observed inappropriately touching patient during a visit...After advice from South Gloucestershire Council Safeguarding Adults and the police, relative not to have any contact...All risk assessed and agreed by South Gloucestershire Council Safeguarding Adults.*

During **October**, Winterbourne View Hospital was registered under the Health and Social Care Act 2008. *No conditions were put on registration.*

During **October**, Ashleigh Fox, a newly qualified nurse who worked in Winterbourne View Hospital (from **September to December 2010**), telephoned the Care Quality Commission about abuses in the hospital. (The CQC have no record of this telephone call and have not been able to contact her.) In an article in the Sunday Mirror (**5 June 2011**), she described being *repeatedly ignored when she raised concerns about systematic abuse...complained about the appalling behaviour of staff...I should have been listened to when I came forward but no one took any notice. The abuse simply continued.* She said she saw residents routinely pushed about, belittled and humiliated. But when she raised her concerns...she was told that making a fuss was not the Castlebeck way...Encouraged by Terry (Bryan, her line manager), Ashleigh Fox met the BBC team in **January (2011)** and gave them information about which patients were being abused and by which members of staff. "It was always made clear to me that Castlebeck was a business...and certainly it seemed more about making money than helping people." Within days of starting her job she said she witnessed scenes which left her shaking with anger and in tears. "One male member of staff told a female patient to "Shut your f\*\*\*ing pie hole...another resident was also belittled and sworn at. After just two weeks she saw a support worker bend a patient's wrist so much she feared it might break. She also noticed patients were covered in bruises. She raised each incident with her manager but nothing was done..." I lost count of how many issues of verbal and physical abuse I reported, "She's had an unsettled day" was the euphemism we had to use for someone who'd been pinned to the floor."

Also during **October**, Winterbourne View Hospital's Registered Manager (who had been in this post for ten months) transferred to manage another Castlebeck service in North East England. She was initially appointed as manager after the original hospital manager left and worked alongside the existing hospital manager to support him into his new role...until **October 2010**, albeit...on an ad hoc basis as she had other responsibilities elsewhere in the region between **January 2010-October 2010**. The new acting manager had been the hospital's deputy manager. He had completed his RNLD nurse training in 1995. He began working in Winterbourne View Hospital in 2007 as a Senior Staff Nurse rising to Deputy Manager in 2009. The Deputy Manager had completed her RNLD nurse training in 2004.

On **1 November** 2010, during physical intervention with a patient, a staff member was kicked in the head by a fellow patient. Escorted to A&E.

On **2 November**, accident forms noted that a patient sustained carpet burns to left knee and marks on upper right arm and scratches to face during a restraint.

On **4 November**, the unit-led clinical governance meeting minutes stated that a relative had complained that they had not been kept informed of their relative's care...no further information nor action taken is recorded (CQC, 2011).

On **8 November**, whilst waiting for medication, a patient began aggressive (sic) towards staff attempting to hit out at staff. Patient bit support worker on the left upper arm breaking the skin. Attended A&E. RCA required. The nursing record and incident form suggest that the patient had become physically and verbally aggressive...when prevented from wandering down corridor. He was restrained for 20 minutes...spat out oral Lorazepam. Psychiatrist contacted for permission to (inject the drug). Request not granted over the phone.

On **12 November**, an email from South Gloucestershire Council Safeguarding Adults to the acting Manager of Winterbourne View Hospital highlighted their difficulty in making contact to arrange a meeting.

On **13 November**, an altercation between patients...Review of risk assessments and observation levels for both...staff training being addressed and staff levels increased by use of agency.

On **14 November**, staff heard a loud cry from patient's bedroom. Upon investigation staff noted blood to the back of her head. Ambulance called and patient attended A&E...stated had banged head off bathroom door frame. RCA completed. This was reported to the HSE.

On **15 November**, South Gloucestershire Council Safeguarding Adults emailed the acting Manager of Winterbourne View Hospital with comments concerning Terry Bryan's email, asking a number of questions. It proposed that they should meet and agree a way forward, including communication with commissioning bodies and CQC.

On **16 November**, a family reported during a visit, that their relative had a bruised eye. Investigation found bruising caused by extreme self injurious behaviours displayed leading up to the family visit. Review of treatment plan, care plans and risk assessments. Staff training addressed – more specific autism training being organised.

On **17 November**, four alerts were received by South Gloucestershire Council Safeguarding Adults.

On **18 November**, South Gloucestershire Council Safeguarding Adults was advised that Terry Bryan had left Winterbourne View Hospital.

On **25 November**, South Gloucestershire Council Safeguarding Adults emailed the Care Quality Commission's Compliance Inspector requesting a discussion.

An incident report of **28 November** stated that a patient had done a runner. They were found in the neighbouring NHS Deanery car park.

On **29 November**, South Gloucestershire Council Safeguarding Adults forwarded Terry Bryan's email to the Compliance Inspector.

On **29 November**, a nurse resigned from the hospital. The following notes, abstracted from the probationary review, notification of suspension and investigation into capability which prompted the resignation, spanned **May-November 2010**.

In terms of *performance* during the probationary period – *(the nurse) said that the ward was very short staffed...(another nurse) was in and he should have sorted out more staff...the hospital is always short staffed. The HR Officer and the Deputy Manager, on (16 August), said that she was aware of this and that steps were in place to resolve this issue and prevent it from happening again...The nurse said (the job) is different because it is Learning Disability and they are Mental Health trained...said that she felt people were surprised that she was instructing them to complete tasks...tried to explain that when she is Nurse In Charge she needs to know what is going on and where everyone is on the ward...one support worker was refusing to support because a patient was 'kicking off'...said that she felt there were too many restraints going on upstairs and patients are being restrained for the wrong reasons. The nurse said she felt that staff needed more training and skills in how to verbally de-escalate situations...she finds the staff more difficult than the patients.*

An investigation into the nurse's capability on **26 October** noted that she was: *rude to a patient's parents...negative and unhelpful towards staff...not been informing the management at Winterbourne View of serious incidents...you have not been engaging in the restraint process, even though you are fully trained to do so...not following clear instructions...not partaking in handover process...not adhering to observation levels...not meeting deadlines.*

Also during **November**, a staff member was suspended pending a disciplinary investigation. He was dismissed two months later. This was because *he picked up two female hitchhikers (who were in the vehicle for approximately two hours) while collecting a patient from home; on another occasion he was driving erratically (with) staff and patients in the vehicle; and also, he made an inappropriate comment to a patient regarding a member of staff self-harming in the past. In a witness statement, the member of staff stated that ...she told (her colleague) to shut up...said that his comment got to her a bit...said that self-harming was in her past and it had nothing to do with her work life.*

On **1 December** 2010, during a family visit, a staff member, observed a patient's relative *inappropriately touch patient in a sexual manner and attempting to kiss her. Social worker and South Gloucestershire Council Safeguarding Adults informed.*

A Police incident report (of **2 December**) concerned the *sexual assault of a patient by a relative during a hospital visit. Ultimately, the Crown Prosecution Service decided that there was insufficient evidence to prosecute the suspect.*

On **3 December**, nursing records described a patient as *unsettled all day, exposing herself. Restrained – became violent in restraint.*

On **5 December**, a patient had had an earlier incident...*requested to use toilet at 16.00hrs locked self in and banged head by corner of the door frame reopening wound. Attended A&E, required 6 stitches. Level 4 observations at all times. RCA completed and reported to the HSE.*

On **6 December**, Terry Bryan wrote to the Care Quality Commission regarding a *serious complaint* to which he attached his email of **11 October**.

On **8 December**, the Compliance Inspector received Terry Bryan's communication.

On **10 December**, a patient *reported a small lump on right testicle to staff*. There is no further mention of this in the nursing or medical records.<sup>40</sup>

On **11 December**, a staff member sustained a *bite to hand causing broken skin*.

A patient who *became argumentative and disruptive whilst out on a community visit, tried to bite a member of staff...as he attempted to restrain the patient. Unable to do a MAYBO restraint due to space restriction in the van...was held on his side along the back seat until he became calm*. The patient's relatives *rang the unit to discuss the incident*. They believed that their relative had been assaulted – *hit around the face* - even though *no physical injury was noted*. The patient *did not want to complain...the police noted no physical injuries... no further action taken by the police*.

A Police log report (of **12 December**) concerned the assault of a patient by a member of staff, as reported by the patient's parents...*the attending officer assessed that no crime had been committed and that the patient had been restrained lawfully*. Neither South Gloucestershire Council Adult Safeguarding nor the funding commissioner was notified of the incident.

A patient was taken to hospital for *MRI<sup>41</sup> scan*. The nursing notes do not record why this was requested or the body part to be scanned.

On **13 December**, medical notes concerning a psychiatric review stated that *patient is managing behaviours much better and there is no use of restraint on a regular basis*.

On **13 December**, the unit-led clinical governance meeting minutes stated that a patient's family complained about (i) management and (ii) visiting arrangements. There was no record of action taken.

On **14 December**, a *staff member was bitten by a patient during incident requiring treatment at A&E*.

On **18 December**, nursing records described a patient who, *when unable to get enough attention...became violent, kicking the glass panel in the dining room door. Attempted to cut self with glass. Restrained for 45 minutes. Intramuscular Lorazepam given following refusal of oral medication*.

On **30 December**, a *staff member used a head butt to release himself from hold of patient...against a wall...Staff member suspended...investigation completed...staff member handed in notice during disciplinary procedures. Police concluded self-defence// during an incident on the floor, patient attempted to lash out and grabbed staff member arms pushing him against the wall. Staff member responded by head-butting the patient*. South Gloucestershire Council Safeguarding Adults, social worker and CQC informed.

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<sup>40</sup> As a result of the Serious Case Review this was followed up and he received treatment

<sup>41</sup> Magnetic resonance imaging is a scan which is used to diagnose health conditions. It produces detailed pictures of organs, tissue and bones

A Police log and intelligence report (of **30 December**) recorded the head butting of a patient by a member of staff: *It was established that the patient had grabbed the staff member first around the wrists and the staff member was left with no other option to escape from the grip other than to head butt the service user...The patient sustained a broken nose...no criminal offence had occurred.*

On **31 December**, Terry Bryan rang the Care Quality Commission's National Customer Care Centre. He was told that his complaint of **6 December** had been received and forwarded to the Compliance Inspector.

A patient was taken out in the van *as reward for good behaviour. Opened side door of van (no child safety locks on.)* An incident form was completed.

One patient's section was altered from section 3 to section 37 during **December**, *due to an alleged assault on a staff member*, for which he was prosecuted and convicted. South Gloucestershire Council Adult Safeguarding and the commissioners were *unaware* of the patient's altered status and the circumstances which occasioned this until the First Tier Review-Mental Health of April 2011, *where Mental Health Act paperwork was found to be incorrect*. The patient explained to his social worker that the reason he bit the staff member was *because medication was forced against his will*. The investigator from the Public Protection Unit *felt it was poor practice but not criminal*.

During **2010**, nine patients were admitted to Winterbourne View Hospital and 13 were discharged.

**There is evidence – though limited - that a minority of Winterbourne View Hospital nurses and support staff made the connection between the behavioural disturbance of some patients and: physical healthcare problems; the demands placed on them; the limited environmental stimulation within the hospital; and the unsafe grouping of patients.**

**However, absconding patients, requests to be removed and escalating self injurious behaviour were not perceived as evidence of a failing service. A&E's concerns about continuing to treat a self-injuring patient were addressed only to Winterbourne View Hospital's staff.**

**The departure of the Registered Manager led to the Deputy, another learning disability nurse, becoming the manager (albeit not registered with the CQC).**

**Further injuries sustained by patients during restraint, further concerns expressed by relatives, unattended physical healthcare needs and the documented concerns of a Mental Health nurse employee and a whistle-blower made no difference in an unnoticing environment.**

**Winterbourne View Hospital's registration *without conditions* and without apparent reference to its unpromising track record gives the impression of the regulator's passive complicity.**

## **2011**

On **8 January** 2011, there was an *altercation between two patients over phone usage. Risk assessment and Multi-Disciplinary Team review of both...further phones for the ward*

*bought...Commissioning team informed of incident. Staff levels increased by agency...Passed to police PPU.*

On **9 January**, a patient self harmed...attended A&E...received 5 stitches to arm wound. RCA completed. The incident form states cut to left forearm 40cms long by 1cm wide, deep wound showing fatty tissue, re-opened old cut. Taken to A&E, nurse there not happy wound had been left. Sutured wound and course of antibiotics given for 5 days as infected. It does not appear that A&E took any action in terms of reporting the delay in securing treatment.

On **10 January**, the investigation interviews concerning staff sleeping on duty took place (see **29 September 2010**), and disciplinary interviews resulted.

On **13 January**, a patient hit another patient on the head...Review of risk assessments and observation levels for both...staff training addressed. Staffing levels increased by use of agency.

The patient who self-harmed on **9 January**, re-opened wound to forearm. Attended A&E - Referral to psychology - RCA completed.

On route from treatment room to lounge a patient hit another patient on the head and pulled her hair.

A Police log (of **17 January**) recorded a patient missing from the hospital. *This is the second report of the patient as a missing person within 7 months.* The incident was not reported to the CQC.

On **18 January**, a patient disclosed sexual assault by a relative...Section 117 home leave was not granted. Staff supervision on all visits...psychology input...Passed to PPU. The police have no record of this disclosure.

A patient attempted to hit another patient who quickly retaliated punching in the face...fell on the floor and was kicked as she got up. Next of Kin, South Gloucestershire Council Adult Safeguarding and CQC informed...RCA completed. The CQC (2011) scrutinised the resulting documentation. The deputy manager completed the root cause analysis three months later. This stated that *normal procedures may not have been followed in the lead up to this incident. It occurred during evening handover when fewer staff are deployed on the floor...it does not appear that the appropriate skills and diversion techniques were implemented by the staff...staff to receive specific training on diversion/diffusion techniques.*

On **24 January**, nursing records note of one patient, seeking staff attention, patient became physically violent towards objects then began to strip. Covered with a duvet by staff and removed to quiet room. Restrained in quiet room using MAYBO technique – became physically violent and verbally abusive. Tranquilising medication was administered, including intramuscular administration.

On **25 January**, an altercation between patients resulted in physical violence from both parties - RCA completed.

During **January**, the Mental Health Act Annual Statement was published. This noted that *the CQC is pleased to note that the unit continues to provide a good level of quality care to the patient group cared for and the staff are enthusiastic and caring.* The Statement outlined the changes to the admission and assessment pathway by moving patients who are progressing to a separate floor



*within the unit thus offering them more flexibility and those requiring a higher level of care are supported on another floor of the building, thus enabling patients to have a perspective on the progress they have achieved in their care pathway. The Recommendations and Actions Required were fourfold: Winterbourne View Hospital should consider (i) what steps it needs to take to ensure greater compliance with those aspects of the MHA and the Code of Practice which CQC visits are still highlighting for attention i.e. the presentation of S.132<sup>42</sup> rights, including information about Independent Mental Health Advocacy (IMHA) (ii) how patients can participate more meaningfully in the care planning process (iii) whether a training need is identified for staff concerning the MHA, DoLS and IMHA (iv) whether existing procedures are sufficient to ensure that the rights of patients wishing to leave the ward are not compromised.*

Also during **January**, investigation meetings which had begun in **October 2010**, concerning a support worker were concluded. It was alleged that he *shouted at a patient showing signs of anxiety; made no effort to use de-escalation...agreed with negative comments (patients) were making about other patients; antagonised a patient which resulted in a display of challenging behaviour.* A witness reported of one shift that, *it was hectic... (the support worker) had said to her that "it's the worst hour of the shift working with Patient X". Patient X was distressed during the time the support worker was providing 1:1 support for Patient X and he was telling her to do something and then telling her off and sending her to her room...totally inconsistent...caused Patient X distress.* The support worker said of another patient he was *a nutter...in front of other patients...He joked about the source of distress of another patient, and as a result...the patient required restraint very shortly afterwards.// The support worker said he could not remember...he was asked if anyone had asked him to take his piercings out...he said he did not remember.* The outcome of the meetings was the decision *that no further action will be taken in respect of this allegation.*

On **1 February** 2011, South Gloucestershire Council Safeguarding Adults met with the acting manager of Winterbourne View Hospital, the Operations Manager of Castlebeck Ltd and the Care Quality Commission to discuss the whistleblowing concerns. *As a result of this...Winterbourne View management were given a series of actions, including an internal review of the specific concerns.*

The CQC (2011) noted that on **3 February**, a patient's bruising was identified on a body-map. There was no recorded follow-up.

On **11 February**, *the relative of a staff member* at Winterbourne View Hospital called the Care Quality Commission's National Customer Services Centre asking *about the staffing levels and the restraint procedures being used at the hospital.* The caller's questions were passed onto the Compliance Inspector for the hospital.

On **14 February** 2011, Joe Casey began working at Winterbourne View Hospital.

On **16 February**, *two patients absconded while on outing with other patients, off duty police intervention.* Family social worker informed, plans and assessments reviewed. *RCA required.* The CQC were not notified of the incident.

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<sup>42</sup> Section 132 of the Mental Health Act 1983 places a duty on the managers of a hospital to provide information to detained patients, in particular information about the provision of the Act under which they are detained and about the right to apply to a tribunal.

*A patient lunged at a patient, biting her face and hitting her around the head area. Patient retaliated resulting in the (aggressor) patient's glasses being broken. RCA required.//The patient became aggressive...hitting with her hand resulting in MAYBO intervention. Patient reopened wound to arm. First Aid administered within unit. RCA completed.*

It was noted in nursing notes about this incident (or perhaps another incident on the same day?) that the *incident highlights need for extensive staff training in diversion and de-escalation techniques.*

On **20 February**, a patient wrote to the psychiatrist stating *I don't feel I'm being supported by some staff.*

A Police intelligence report (of **21 February**) recorded two missing patients from the hospital – including one who had been missing on two previous occasions. *Both stated that they did not wish to return to the hospital. One patient stated that she hated the unit.*

“Staff on shift” information suggests that undercover filming took place on **23-24 February**.

The CQC (2011) noted that on **24 February**, a patient was *restrained under a duvet for 15 minutes.* Both the acting Manager and Castlebeck Ltd's Regional Director confirmed that *this was not an approved form of restraint.*

On **26 February**, a patient rang the nurse call stating *she had self harmed using a screw from her bed, re-opening an old wound. Taken to A&E - RCA required.*<sup>43</sup>

During **February**, Castlebeck Ltd's new Chief Executive *commissioned a comprehensive review of the entire Castlebeck approach to activities (because of his) concerns...that patients and service users were not being offered access to employment, education or recreational activities in a consistent, structured and outcome focused way and that those tasked in many cases with the role of Activities Co-ordinator were often utilised to cover staff shortages elsewhere in the service.*

On **1 March** 2011, *during an aggressive period with patient, staff member received injury to wrist. Escorted to A&E, plaster slab applied. RCA completed.*

“Staff on shift” information suggests that undercover filming took place on **1 March**.

On **2 March**, an *alert was sent to South Gloucestershire Council Safeguarding Adults prior to a patient's admission.* It was alleged that a relative had hit him at home. This resulted in a strategy meeting. *Winterbourne View monitored signs of injury following leave, liaised with social worker.*

On **2 March**, a support worker sustained a *sprain to left wrist after being pushed over by patient.*<sup>44</sup>

On **2 March**, a patient disclosed to her family that two staff members had leaned on her chest during restraint causing chest pains. An incident form was completed. Neither the CQC nor South Gloucestershire Council Adult Safeguarding was informed.

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<sup>43</sup> Reported to the HSE

<sup>44</sup> Reported to the HSE

On **3 March**, nursing notes recorded that a patient disclosed to her family that *two members of staff were lying across her chest while restraining her and caused chest pain*. The CQC (2011) noted that no action was taken in response to these concerns.

The CQC (2011) noted that an Incident Form concerning one patient recorded their restraint using MAYBO techniques. However, the specific technique was not identified. Ultimately, seven staff members were involved in the restraint.

“Staff on shift” information suggests that undercover filming took place on **3, 6 and 7 March**.

On **14 March**, a staff member was *bitten by patient on left hand. No break to skin. Reported to Infection Control lead nurse*.

“Staff on shift” information suggests that undercover filming took place on **16, 17 and 22 March**.

On **23 March**, a *patient attended A&E following an incident of self injurious behaviour and attempting to climb out of windows...CQC informed, risk assessment and care plan reviewed. RCA required*.

On **23 March**, a support worker described events concerning the use of the residents’ phone: (Patient B) was *on the phone to her mother and was to come off it after 5 minutes as other service users required the phone...by the time I reached the ‘shop floor’ she had been on approx. 5 more minutes...I asked (Patient B) to “start saying goodbyes” and explained other service users were waiting to use the communal phone (House phone). Patient B made no effort to adhere to my instruction*. The support worker spoke to Patient B’s mother. *I found her to be very intimidating...threatened to make complaints* (The support worker explained about other patients whose) *families aren’t able to speak to relatives as regularly as Patient B does...there is a pay phone if she needed more phone time...Patient B will monopolise the phone as long as she has the opportunity...Patient B’s mother...decided to take umbridge (sic)...continued to present herself in a threatening, aggressive manner...asked if she wished to say goodnight to Patient B in order to diffuse the conversation. She said no and said for me to tell Patient B “she wouldn’t ring anymore” which obviously, I didn’t and Patient B’s mother hung up on me*.

During **March**, the review of patient activities was concluded (this had been instigated by Castlebeck Ltd’s Chief Executive during February). *One of the recommendations was that each hospital should have at least one dedicated Activities Co-ordinator who was not part of the overall support worker numbers and had a different reporting line to ensure the post remained separate from the day to day based ward operations*.

The CQC (2011) noted of one patient that she had *either injured or harmed herself on 10 occasions. For all of those injuries, no wound care plans were in place and there were no records of how wounds would be dressed, treated and monitored*. Separately, it was noted that a staff member was suspended following an *allegation that they had head butted a patient and had used an inappropriate MAYBO technique*. The CQC (2011) were not informed. They found no evidence of any supervision and the staff member was not reported to the Independent Safeguarding Authority.

**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 professional and experienced staff, were prompts to Castlebeck Ltd to take responsibility for their own failings.**

**Such "input" matters were not given the weight they merited in the ahistorical and "outcome" oriented reports produced by the Healthcare Commission, and latterly, the CQC.**

On **4 April** 2011, a *patient ran at another patient and started hitting her. Staff intervention was required. CQC and South Gloucestershire Council Safeguarding Adults informed - RCA required. The CQC's (2011) subsequent scrutiny of the statement form recorded that one of the people was held by staff using 'hooks and cradles.'* These techniques were not documented in their physical intervention risk assessment to guide and inform staff.

On **7 April**, a *patient remained unsettled after previous (and unspecified) incident. She spat at another patient who retaliated and slapped her on the face. CQC and South Gloucestershire Council Safeguarding Adults informed, risk assessments and care plans reviewed for both patients - RCA required. The resulting SUI documentation established that usual procedures not in place. Short of staff during day and inexperienced agency staff on duty - Action: further staff training to be undertaken and use of trained staff on the first floor.*

On **11 April**, *four patients became extremely aggressive and challenging on a night shift. Whilst staff were in restraint with a patient...situation quickly escalated and the patients began destroying the environment...smashing windows and using broken pieces of wood to threaten staff...became too unsafe for staff to manage or restrain so the police were called. Internal fact finding commenced// A patient spat on another patient who retaliated. A previously uninvolved patient tried to defend the (aggressor) patient. Another patient then began smashing property. Police attended and placed the patient who had been spat on, in cuffs. Review of care plan to take place. RCA required// Patient damaged property, attempted to abscond, placed cable around her neck, attacked staff. Intermittent restraint by staff and police officers. Review of care plan and risk assessment to take place. RCA required// the patient who had initiated the spitting was abusive to staff, damaging property. Police restrained her and placed in leg restraints for three hours. Upon release she again attacked staff, handcuffs used again. Review of care plan and risk assessment to take place - RCA required.*

An incident form states that once the police left, a patient who had been restrained with handcuffs and Velcro leg restraints was subsequently restrained by staff *using MAYBO techniques*. Tranquilisers were also administered. South Gloucestershire Council Adult Safeguarding received four separate alerts. The police treated it as a single incident.

A Police log (of **11 April**) concerned the above incident. Following damage to windows, fire doors and walls and the unsuccessful restraining attempts of staff, *a number of officers attended...resulting in the police restraining service users with handcuffs and leg restraints.*

Given the seriousness of this incident, it is striking that the request by South Gloucestershire Council Adult Safeguarding to undertake a review was not prioritised (CQC, 2011).

On **14 April**, the nursing notes state that a patient was *physically aggressive towards staff* which resulted in *a restraint and 'removal' to a quiet lounge using a 'full wrap' for 10 mins. PRN Lorazepam given. Bruises noted on upper L thigh, both sides of upper chest...bruising unexplained.*

On **25 April**, a patient was *restrained for 1 hour and 16 minutes...for swearing, hitting staff, throwing furniture.* She was given tranquilizing medication.

On **26 April**, a patient was taken to A&E for a head wound attributed to self-injurious behaviour.<sup>45</sup>

On **30 April**, a *staff member was assaulted by a (new) patient and was reported to the police. Police have cautioned patient. Risk assessments and care plans reviewed. RCA required.* The incident was described in clinical team notes as *Patient stormed out of main lounge, told not acceptable behaviour and then punched member of staff on left side of face and top of left arm. Restrained by staff on floor face up (2 staff on each arm and one on legs) for 20 mins and given Lorazepam.*

A Police log (of **30 April**) recorded the assault of a staff member by a patient. The attending officers *decide that the patient has no capacity due to his mental health issues and decide that no crime has been committed.* NB The police could not have cautioned the patient given the mental health status.

During **May** 2011, a patient disclosed that conditions of Section 17 leave were being breached. *Section 17 leave suspended immediately. Liaised with commissioning team and relative...Awaiting further South Gloucestershire Council Safeguarding Adults and local authority/ commissioners input.*

On **3 May**, a new patient was *finding it difficult to settle in, refusing medication and not wanting to leave his room. Reported that he didn't like staff and alleged that a staff member had pushed him and threatened to punch him...spoke with relative who stated that the patient often makes allegations against staff when unhappy.*

The CQC (2011) noted that the minutes of a staff meeting of **10 May**, stated *Staff appear to be confused as to when they should use restraint. Some nurses are practising different approaches rather than MAYBO, when possible MAYBO would be the right approach for certain situations.*

On **11 May**, *patient to patient assault* resulted in...*discussion during MDT...review risk assessments...care plans and observation levels. Patient had started transition to lower floor...Staff training issues being addressed. Staffing levels reviewed and reviews taking place of mix of patients on 1<sup>st</sup> floor.*

*Patient to patient assault – both retaliated... Discussion during MDT...review risk assessments...care plans and observation levels and treatment plans. Commissioning teams informed...Staffing levels reviewed and reviews taking place of mix of patients on 1<sup>st</sup> floor. Staff training issues being addressed...Does not need to go forward to South Gloucestershire Council Safeguarding Adults.*

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<sup>45</sup> Reported to the HSE.

When a patient was asked by a staff member about their bruised eye, the patient said *“staff member X did it on purpose”*. X suspended...passed to the Police via South Gloucestershire Council Safeguarding Adults.

On **12 May**, a notification was received from the Managing Director of Castlebeck (Teesdale) Ltd...enclosing a letter from the BBC outlining instances of abuse their reporter had witnessed whilst working undercover at the hospital.

The CQC was informed of the prospective Panorama transmission.

Also on **12 May**, when asked about how he was getting on with staff, a patient replied, *X keeps having a go at me, telling me to get up, I tell him to piss off. Y is horrible to me. Sent me to quiet room for kicking off.*<sup>46</sup>

On **13 May**, South Gloucestershire Council Safeguarding Adults held a multi-agency strategy meeting, an outcome of which was that the Care Quality Commission would carry out a responsive compliance review at the hospital. The meeting included the police, some of the ten NHS organisations and councils commissioning care from Winterbourne View Hospital. Castlebeck Ltd offered assurance that there would be no new admissions to the hospital during investigations.

On **14 May**, a patient being returned to the hospital after a trip out disclosed that she was too scared to go back upstairs as she would be beaten up.

During **17-18 May**, the Care Quality Commission undertook a responsive review.<sup>47</sup> This found that Winterbourne View was non-compliant in 10 of the 16 outcome areas.<sup>48</sup> As a result, Castlebeck agreed to the continued suspension of further admissions to the hospital.

On **18 May**, a patient disclosed that he was visiting a relative on home leave, in breach of the conditions in S.17...all leave cancelled.

Castlebeck Ltd had suspended 15 staff and arrangements were made to bring in temporary staff to provide additional cover.

On **23 May**, a patient's poor dietary intake and an increase in the severity of head banging was acknowledged to be associated with the need for an urgent dental appointment...still refusing to attend dentist and have general anaesthetic which is necessary to undertake the amount of dental work required. Ongoing oral pain...No medical problems identified by GP.

The CQC sought further assurances from Castlebeck Ltd to ensure that Winterbourne View Hospital would not admit any more patients.

On **23 May**, the Chief Executive of Castlebeck Ltd wrote to the relatives of Winterbourne View Hospital's patients to inform them of the allegations which have been brought to our attention relating to the physical and verbal treatment of a number of named patients...All staff alleged to have behaved inappropriately were immediately suspended and reported to the police...All

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<sup>46</sup> From nursing notes

<sup>47</sup> The resulting *Review of Compliance* was published in July 2011

<sup>48</sup> Health and Social Care Act 2008

*commissioners, care managers and families of those service users directly named...were telephoned immediately...The transfer of those service users, either within or out of Castlebeck has been discussed with their families or care managers...only two service users have been transferred...We would like to reassure you that there is no evidence currently to suggest any other service users have been affected...I want to reassure you personally that patient safety is the absolute priority for all Castlebeck services...We have always had a zero tolerance policy towards inappropriate behaviour directed against those use our services.*

On **25 May**, a patient alleged that she had been bitten by a patient. The woman making the allegation *had started the transition to move to lower floor – due to diagnosis and behaviours that challenged, this was a carefully planned process that could not be rushed...had started spending days on the lower floor and sleeping on the 1<sup>st</sup> floor. Risk assessment review...During South Gloucestershire Council Safeguarding Adults interview...said it was a different patient that had bitten her...discussed in strategy meeting...16 June.*

On **25 May**, a patient making what was her 13<sup>th</sup> attempt to abscond was taken to the quiet room using full wrap rapid escort and restrained in T supine (face up). Nursing notes stated that the restraint lasted approximately 5 hours. Two days later, she was subject to restraint which lasted approximately 6 hours.

On **27 May**, the Care Quality Commission issued a Notice of Proposal to Castlebeck Ltd to remove registration from Winterbourne View.

On **28 May**, a patient attended A&E for head and hand injuries – self injurious behaviour.<sup>49</sup>

A relative questioned how a patient sustained a black eye.

On **29 May**, a patient attended A&E for cut to left arm – self injurious behaviour. This was reported to the HSE.

On **31 May**, the BBC Panorama, “Undercover Care: The Abuse Exposed” was broadcast.

During **June**, there were four further occasions when patients were accompanied to A&E for treatment for their self injurious behaviour.<sup>50</sup>

During **2011**, four patients were admitted to Winterbourne View Hospital. Two patients were discharged in advance of the transmission of the BBC Panorama.

**Before Castlebeck Ltd received the BBC’s letter, it was business as usual at Winterbourne View Hospital. Patients who could describe their experiences were in the minority. After 12 May 2011, however, patients’ distress, anger, violence and efforts to get out of the place may be perceived as an eloquent reply to the violence of others - including that of staff - rather than behaviour which confirmed the necessity of their detention.**

**Winterbourne View Hospital patients were chronically under-protected. It should be noted, that even after the receipt of the BBC’s letter, a patient was subjected to the default response of excessive restraint - lasting approximately 11 hours during 25 and 27 May.**

<sup>49</sup> This was reported to the HSE.

<sup>50</sup> This was reported to the HSE.

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

*“Well, they’re looking after the most precious thing to us, aren’t they?”*

Mother of an ex-patient

### 1. Introduction

- 1.1. This section is largely based on notes arising from meetings with six families, complemented with brief telephone conversations with three families and letters drafted by a further three. The meetings and phone conversations took place between June and October 2011. They described their private trauma, self-blame and regret that they did not challenge Winterbourne View Hospital’s Manager and staff who dismissed or misrepresented their concerns and failed to respond to their complaints. This rendered their relatives isolated, disenfranchised and exposed to continuing violence in a non-therapeutic hospital. The experiences of their relatives were incongruent with their lives with their families.
- 1.2. These families were disbelieving that there was little evidence that their relatives were assessed or even studied exhaustively with a view to getting to know them, understanding their behaviour, addressing their treatment needs proficiently and helping them realise their aspirations. Both the conversations and correspondence confirmed that parental wellbeing is closely linked to that of their daughters and sons. While all of these families have strengths, these have been tested and overshadowed by the exposure of abuses in Winterbourne View Hospital. The families no longer regard professionals as the bearers of legitimate knowledge.
- 1.3. The conversations with five ex-patients and relatives were open-ended. Once they had confirmed that the information shared was accurate, a series of concerns emerged, beginning with the point of admission and insights from being at Winterbourne View Hospital. Some families recalled the impact of medication, the deteriorating behaviour of their relatives and the implications of them being under-occupied at the hospital (which are also considered in Section 6). The assaults and how families learned about these reinforced the distress they endured in the immediate aftermath of the programme’s transmission. Finally, some ex-patients and families considered future prospects for themselves and for other adults with learning disabilities, autism and mental health problems.
- 1.4. In the following sections, a little of the lives of 12 ex-patients is outlined. Their names have been changed. As with their families, diversity was the norm rather than the exception.

### 2. Daughters and sons

- 2.1. Tom is an engaging young man with enormous promise. He loves his young sibling with whom he has a close relationship, not least because he used to assist with his sibling’s bottle-feeding. Tom attended a special school from which he went to college. It was when he was at college that things began to go wrong. He was bullied. Although the bullying resulted in a major loss of self-confidence, Tom went on to secure employment and he acquired valued work skills. Tom loved his work and because he was so good, he was promoted to undertake more skilled work. This was detrimental. He could no longer do all



- that was expected of him and Tom had a “big bust,” the outcome of which was that his employers permanently excluded him. This resulted in his family accessing respite services.
- 2.2.** Carl is a very affectionate man. Although he is not big he is “extremely strong.” He has poorly controlled epilepsy. Carl’s learning disability and autism became evident when he was an infant. Carl is very helpful in the family home and can assist with emptying the dishwasher and bringing in washing for example. Although he was not aggressive as a child, when he reached puberty he became physically aggressive towards others. Irrespective of Carl’s aggression in the family home, he remained there until he was 16, when he went to a residential school. When Carl becomes angry his family have learned that it is possible to distract him with something that he is able to do, such as watering plants. They are able to manage him for periods of a few days at a time. Carl’s family described him affectionately as a man who, “when he is nice he is very, very nice and when he is horrid, he is horrid!”
  - 2.3.** Kate was once a lively and energetic 11 year old “rushing about all over the place and with lots of friends.” A stroke left her without a short term memory and with the use of only one arm. After several months in hospital, Kate became a weekly boarder at a special school. Now, she uses a wheel-chair and is doubly incontinent. Kate enjoys her keyboard and she enjoys having lots of people around since she is an avid people-watcher.
  - 2.4.** Jack is a gifted story teller. As a child he could create a rich story from a single picture. It was Jack’s epilepsy and learning disability that resulted initially in a placement in a children’s hospital and then in a residential school. On an occasion when petit mal recordings were made of Jack’s epilepsy, 1000 episodes were recorded in a single day. When Jack and his sibling were given money for sweets he would spend it on a bus ride instead. Jack was known to the bus drivers who ensured that he returned home. He is not given to complaining. Jack is a generous man who would willingly “give you his last penny.” Jack’s family do not understand why Jack’s behaviour appears to alternate between being “as good as gold” and then, threatening violence.
  - 2.5.** Ida lived with her family until she was 15. She perplexed her parents and teachers because although she could talk and read, her understanding appeared very limited. In retrospect, she was a child who “slipped through the net.” Over time, Ida resisted attending school and she sought to hide from other pupils. She even hid her face as she walked to and from her home. Ida’s behaviour impacted on her siblings who went to the same school. Ida was not diagnosed with autism until she was an adult. Over the years Ida’s behaviour has deteriorated and includes self-injury and head banging as well as damaging her family home. “She often just cries and cries.”
  - 2.6.** Lily lived with her family until her admission to Winterbourne View Hospital. She uses sign language and has a few words. Lily has medication for her epilepsy and asthma.
  - 2.7.** Bill likes a laugh and a joke and he loves ‘Only fools and horses.’ He loves to entertain people, singing karaoke, and dancing. He loves music, and at his party he acted as DJ. He is very keen on football, and has recently changed his allegiance from Manchester United to Chelsea. He also likes to watch American wrestling on the television, and James Bond. He doesn’t like stairs. Bill cares about people. The problems arise when he becomes anxious. It’s all to do with anxiety. He “kicks off” and when he does so it is not known what he’s going to do. Although Bill does not talk very well, those who know him can understand him. He is skilled at “acting anything out”. He has a really vivid imagination and his memory is amazing. Bill doesn’t forget anything. He is very strong.

### **3. Some memories**

- 3.1.** Sid and Ross were both injured by staff at Winterbourne View Hospital. Ross outlined his own experiences: he lived at home until he was 19, spending some time at a residential school. Then he went into one care home after the other, saying that 'it didn't work out for me. I just didn't like the homes'. He has lived in various Castlebeck Ltd homes. He was unhappy in the first one which had a high fence round it and he recalled crying on the phone to his family, to take him home.
- 3.2.** When Ross went to Winterbourne View Hospital, the staff seemed all right at first, but he discovered that the way the staff treated clients was 'horrible,' and he described some of the things they did to patients. He said that some staff there abused a lot of people, including him: 'They bounced my head off the walls. I had a lump on my head'. He told his family but they couldn't do anything about it. When the family visited they were not allowed upstairs, they had to wait downstairs. The staff used to check their bags to make sure they weren't bringing anything in, like sweets.
- 3.3.** Ross said that he was abused at Winterbourne View Hospital by a male member of staff, and he was worried that he was getting away with it 'I bet he's sitting in a cell, right, he's doing what he wants inside, isn't he? I just want something done about it. He's in prison, but that's not the point. I want to see his face, because he's not going to get away with it'. He was worried that he will not be punished, and that he is just 'sitting there laughing his head off', and 'he won't give us anything for it, he won't give us any compensation, will he?' Ross wants to go to the trial and 'sort it out'.
- 3.4.** Ross recalled that there were good things about Winterbourne View as well as bad. He used to play football, go swimming, bowling, and down to the seaside. There were parties at Christmas, with a catwalk, and all the girls would dress up. He used to push a friend round in her wheelchair, and help her get things she couldn't reach, although sometimes she would hit out. Ross said he missed her. Ross used to help the maintenance men and help in the kitchen. The chef would cook him a special meal. In many ways it was 'better than this place – but I didn't like it, didn't like what the staff were doing to us'. He recalled however that some staff were nice.
- 3.5.** Later Ross moved to Rose Villa where he was much more independent, living in a flat with one other man, and they did everything for themselves, including shopping in Tesco's. But he said that that the staff there were like the staff at Winterbourne View and treated him 'like dirt'. He liked two people there, one of whom he used to help with looking after the dogs. Ross really enjoyed having a job that helped others and he would like to have one again.
- 3.6.** Ross stated that in spite of his experiences in Winterbourne View and Rose Villa, these were not the worst places that he had lived in. He said he had been in 'loads of worse places than them, all over the country', and that he had been abused in lots of care homes.
- 3.7.** Ross was moved from Winterbourne View Hospital after he was arrested for breaking things up in Rose Villa. He was admitted as an emergency and he doesn't want to stay in his current placement. He was looking forward to his Mental Health Review Tribunal: 'because I can't stay here, in this place. I've had enough of it. It reminds me of Rose Villa, it reminds me of Castlebeck'. Although Ross said that he was not being abused, he just doesn't like it. Mostly, Ross wants to be nearer to his family. He stated that his current placement was

driving him crazy and making him ill: 'I want to settle down in my life, not keep going to hospitals. I want to live in my own place'.

- 3.8.** Ross has lived in his own place before but it didn't work out because it was in a rough area. He said that he started taking drugs.
- 3.9.** Ross wants to live alone with support staff coming in. He said that he can look after himself, cook and wash his own clothes. He has diabetes but he can inject himself, with a nurse to help. Ross wants to go back to college, and carry on with the arts and culture and cooking courses that he once did. He said that his mum wants him home: 'I'm lonely here. I'm alone all the way. I'm depressed. There's no point in me staying here, I get depressed sitting here. I just want to see my family'. Ross doesn't want his family to visit: 'I don't want them up here, because it's not a place for all my family to visit. I don't want my mum to see me here. She's getting old now. I don't want her to worry'. He doesn't want a young relative to come either: 'and see [me] in a lock down unit'.
- 3.10.** Ross said that if the tribunal doesn't let him move he would lose his rag, as he did previously. 'They sit round the table and they tell me can I go or not, and I tell you, I want to be free, be with my family. My mum's waiting for me...' There is no one that Ross felt he could talk to. He doesn't understand why he has to be locked up: 'I am not dangerous. I am not dangerous to the public. I haven't got mental health problems.' Ross wants to be able to go out, play football, have a smoke outside. He added that although he could do these things now, he didn't want to do anything because the placement is institutionalised, and in his experience, more so than Winterbourne View: 'This place is institutionalised. Everything's got to be plastic, like plastic plates, plastic forks, plastic spoons. I'm not used to that. I used to have my dinner on a proper plate. It makes me institutionalised. I told the doctor that I don't want to be institutionalised...I've just had enough'.
- 3.11.** Apart from his family home, the best places Ross has ever lived were Bed and Breakfasts. He was placed in these when services couldn't find him anywhere to live. Ross said that he gets bored where he is now. The daytime activities are not the sort that he likes. He doesn't like going into town with a group of people to have coffee in a café. He would rather do things on his own, or just with a friend: 'Why can't we go out on our own? I'm capable of going out on my own. I'm not going to run to the train station, am I? They keep our money and it's frustrating for me. Why can't I keep my own money in my pocket? I've really had enough of it here. I won't be happy wherever I go. My life is shit. I might as well kill myself. When I was in a home, right, I was going to do it. I tell you now, they've got to let me go. I want to settle down because I've been to homes and homes and homes and it making me ill, big time. I wake up in the morning and I look at all my pictures of my family. I've got to go back to [where I come from]. But if I stay here, looking at the walls all day, it's making me ill. I get depressed looking at these walls all day. I want to live somewhere where I'm appreciated. I've been everywhere. It's time for me to settle down. I'm depressed. I'm tired. I'm telling you now, I can't be in this place for much longer. I'm a kind bloke. I'd do anything for anyone, but I've been waiting and waiting. They have got to let me out of here because I'm going to be more and more and more depressed. I want a house...I want my own space, with my own cooker, and all my stuff in the house. I never want to go back to another hospital.'
- 3.12.** Sid had been injured by staff when he lived at Winterbourne View Hospital. He described himself as 'a film man' with a huge collection of DVDs. Sid was very concerned about what

was going to happen to Winterbourne View Hospital and where people had moved to. He spoke of 'ill treatment and dishonest care' but did not elaborate. He recalled that he did not like being restrained saying that it was: 'painful all over. Hurt my bones.' Sid didn't like being in Winterbourne View Hospital – even though he recalled that the food was good - and that people: 'worked their way down to the garden floor.' Sid watched the Panorama programme and said: 'it wasn't very nice.' Sid explained that he was an 'informal' patient and that 'people have been on section years and years and years'. He wanted to know about the staff who had been arrested and said it was: 'their own bloody fault.' His conversation was interspersed with the refrain, 'I love my mum.'

- 3.13.** Although Pat was spared the violence experienced by other patients, he recalled seeing patients having water thrown at them. Pat used to live at home with his mother, and then went to a number of different schools. When he became ill he was sectioned. Pat had moved from one school to another, all over the place, including to a Rudolph Steiner school. Pat said he had 'a lovely brother and sister' who looked after him. Also, he was visited by family friends. Pat was still adjusting to the death of his mother who was very young. He said: 'that was very bad, she was lovely'. Pat doesn't see his father at all, and his brother is his legal guardian.
- 3.14.** Pat moved to another Assessment and Treatment centre from Winterbourne View Hospital. His family didn't see Winterbourne View before he moved in but his brother phoned up the first day and visited him a couple of times.
- 3.15.** Pat was placed on the bottom floor which was supposed to be unlocked, but he recalled that a patient 'who was quite poorly' used to run down to reception, after which the bottom floor was locked as well. Paul said 'There was a lot going on there, not on the bottom floor, but it could have started. You probably saw the programme about what was going on upstairs. That nice chap, the undercover one, Joe, I used to know him quite well'.
- 3.16.** Pat said that Winterbourne View Hospital seemed all right at first. The staff on the ground floor were quite helpful and he became good friends with one of the staff members. There were a few 'incidents' there, but Pat said that they got him: 'on a good track', getting up early and doing things. There were 'incentives' to do things, he could get points and earn money for doing different things, and for good behaviour. He would sit down in a group and tick how many points he had earned. It was good, but he thought perhaps it shouldn't have been for money. He said that there were good things at Winterbourne View Hospital. He went out on trips and went to the beach at week-ends. Sometimes he went to pubs to watch the football and drove out to see places of interest. There were competitions, and he could win prizes, pens and things, if he had done a good picture or story. One thing Pat liked at Winterbourne View was the puddings, which he no longer has.
- 3.17.** Pat said that he didn't see much of what was going on at the hospital because he was downstairs, although he did see (a male staff member) pouring water on a woman patient and dragging her inside. The people upstairs were the ones who were doing it all. He talked about them using 'Maybo restraint'. Pat said that he had had to be restrained sometimes - one day he got upset about something and he threw a table and went for a member of staff. He was restrained and staff called in the police. When they came they talked to Pat but nothing else happened. Pat explained that when he gets upset he hits himself and bangs things: 'I really go berserk. It's quite sad really'.

- 3.18.** Pat saw the Panorama programme and was: 'quite surprised and quite shaken up'. He knew that the hospital had now been closed down and was boarded up. Pat was very distressed to discover that he was not going to return to a residential home he had lived in. He said: 'When I heard I wasn't going back...I cried'. He had had to leave because he was doing things they couldn't deal with. He knew that if he did go back he would only have to leave again. Pat explained that he is fine when he is settled but he gets: 'unsettled'. He would like to move back to where he was brought up and near to his nan who is in her 80s. Pat talks to his nan every day and sees her sometimes.
- 3.19.** Pat is interested in lots of different things. He is especially interested in water, gas and electricity, but because gas and electricity are dangerous to use, he tries not to think about them, and to focus on water. He knows the names of all the reservoirs around the country. He knows about many things. He likes history, for example, and he knows all the English kings and queens. He is interested in the natural world and different kinds of plants.
- 3.20.** Pat has a keyworker who has known him for a long time. In fact, he once lived with her family. She was working at the day centre Pat attended and they got on very well. She invited Pat to live with her and her family to give Pat's mum more time with his siblings, who were quite a bit younger than Pat. Pat's keyworker remains a very loyal friend.
- 3.21.** Helen did not want to talk about her experience of being placed at Winterbourne View Hospital. Although she likes where she is living now, she would really like to return to where she used to live. Also, she wants to see her family.
- 3.22.** Helen recalled that she liked having friends at Winterbourne View Hospital and that it was nice there. She had lots of pictures of her friend who was at Winterbourne View Hospital. She said that some of the staff at Winterbourne View were nasty people, and they had hurt her friend. Helen had tried to help her and they pushed her on to the floor and hurt her head. She said that they were holding her down, although she hadn't done anything wrong. She had to go to hospital because she had bruises on her knee. Helen recalled that they had hurt another friend as well, even though she hadn't done anything wrong either. Helen had some pictures of staff members. She said they were awful, and that they hurt her friends, including Sid who was: 'kicked on the back of the leg even though he hadn't done anything wrong.' Helen took the picture of Sid off her computer because she explained that it made her sad to look at it. Helen was very upset staff had hurt her 'best friend in the world'. She had not seen her best friend since the hospital closed, however, a meeting was being arranged.
- 3.23.** Finally, Laurie described his history of moving from one home to another. With the help of his keyworker whom he has known for many years, he recalled that there was 'nothing' that he liked about Winterbourne View Hospital. Laurie was concerned that because he had moved so far from his family it was difficult for them to visit him regularly. Both Laurie and his family want him to return to be closer to the family home. Laurie's family visited Winterbourne View Hospital twice before Laurie moved in. His mum had been positive about the move until the initial visit. She did not like either the staff she met or 'the feel of the place,' not least because she was not allowed to see what was to be Laurie's bedroom. It was explained that there was 'a patient off baseline.' Laurie explained what '24/7' was: 'they made us go down to the art room' where he liked to knit and do crochet – both of which he does well. He knitted a scarf for his keyworker and sent this to him. However, he

did not enjoy what he saw as 'baby games.' Laurie said of one staff member that he was: 'a shit. He was horrible to the patients. He used to wind a few (patients) up deliberately.'

- 3.24.** Laurie and his keyworker recalled an occasion when Laurie was placed under s.37 of the Mental Health Act 1983, having been restrained. He had bitten a staff member. Laurie's keyworker expressed disquiet about the incident and the use of the MHA because it was so unlike Laurie whose behaviour, while occasionally difficult, was consistent. Laurie said that it was 'medication time' and he was asked to queue for his medication. He told the staff that the waiting area was 'too packed for me down there' and he went to the lounge waiting for the area to 'unpack.' The staff challenged Laurie: 'they told me to get down to the clinic room and I said 'I don't want to'. I ran to hide in the toilet. They came and forced me out. They came in pushing me down the corridor. They pushed me into the clinic area then [three staff members] tried to strangle me.' This happened after Laurie had been restrained, having been dragged to the ground. When Laurie became calm, they released him and he refused to have his medication.
- 3.25.** Laurie said that when he was on duty one staff member would come into his bedroom and jump on him and tell him to get up. Also, during his placement at Winterbourne View Hospital, he phoned his family and keyworker every week. The hospital staff did not like Laurie doing so. In turn, they locked him out of his bedroom and insisted that he made personal phone calls in communal areas so that staff could monitor his conversations: 'They banned you making phone calls in your bedroom and made you do phone calls in the lounge.' Laurie's keyworker explained that Laurie had told him that he felt that he was not as bullied as some of his friends because he could, and would, tell his parents. He does not want what he saw happen to some of his friends to happen to anyone else.
- 3.26.** Laurie's keyworker was shocked by the Panorama programme and knew immediately that Laurie was targeted by a staff member. He felt so guilty about Laurie being placed at Winterbourne View Hospital that he went to collect Laurie himself and return him to his pre-hospital placement.
- 3.27.** Laurie was concerned about other ex-patients, including his friend Ross. They are both keen Manchester United fans. Laurie said that he and Ross might consider going to the trial and watching from the public gallery. He had been concerned that he might have had to give evidence at the trial. He was reassured by his keyworker that this would not be necessary.
- 3.28.** In the future Laurie would like to have his own place with the support of women staff. He does not want the support of any agency staff.

#### **4. Admission to Winterbourne View Hospital**

- 4.1.** For the ex-patients whose families described their circumstances, there was an acknowledgement that with the admission to Winterbourne View Hospital and/or previous secure settings, life would never be the same again.
- 4.2.** Tom became so anxious that he could not remain with his family and took an overdose. His admission to Winterbourne View Hospital was remote from anything he and his family had envisaged. Two uniformed security men arrived in a van with darkened windows. His parent remarked, "This is disgraceful! He's anxious enough as it is...I was left sobbing on the pavement. I wanted to go with him but (when he was there) I was told I wasn't allowed to visit him for a month. They said he needed settling in time, and I said, 'I'm sorry, I'm not leaving him for a month without seeing him. He'll wonder where I've gone. He'll think I've

abandoned him and I'm not doing that to him...It was so traumatic when he was taken away to Winterbourne and then it just got worse..."

- 4.3. Tom's family believed that since he was detained under s.2 of the MHA, he would only be in Winterbourne View Hospital for 28 days. However, Tom attempted to escape and he "ended up on a s.3 which meant that they could hold him for six months or longer." He wanted to be back with his family.
- 4.4. Carl's admission to Winterbourne View Hospital was evidence of the practice of moving adults with challenging behaviour in an unplanned fashion to one service after another throughout the country when they become "too difficult." This had led his parents to "paint the blackest possible picture" of Carl to bring these serial placements to a halt. It did not work. Carl has been in four different assessment and treatment units and four homes.
- 4.5. Similarly, Kate "was moved from place to place, moving nine times in 23 years." Although this included seven years in her own flat with full time support, Kate's deteriorating behaviour led to the succession of placements. One place "became a punishment regime...neglectful of her needs." Ultimately she was transferred to Winterbourne View Hospital which her family did not realise was a hospital: "we always understood it was a care establishment."
- 4.6. Don was a young adult when he was admitted to Winterbourne View Hospital. Having become increasingly aware of how his autism denied him the opportunities of his peers, he had attempted suicide. His family were told that since he could be "preyed on" by other patients in the local psychiatric facility, they were relieved and grateful that their crisis resulted in the authorities working hard "to find good quality amenities and expertise for Don's care, especially when we were told what it was going to cost."
- 4.7. When Jack left school he returned to the family home but the death of a parent resulted in a further placement. When his parent re-married, Jack went home once again, using a residential respite service at the weekends. After the death of Jack's step parent, Jack said that he wanted to live independently and a place was identified. However, this was short lived because of an outburst triggered by a misunderstanding which resulted in him being returned to the family home by the police. His family believe that he experienced a form of "breakdown" believing he was someone else and failing to recognise his relatives. On one occasion when he locked-up a home Manager, Jack was sectioned and he was placed in three hospitals before he was transferred to Winterbourne View Hospital.
- 4.8. As a young teenager, Ida was eventually placed in a special school but a pattern of moving her from one school to another commenced. In adulthood, this pattern transferred to Ida's accommodation. Distressing episodes in Ida's life included being raped; having her money stolen by a man she believed to be her boyfriend; taking an overdose; having an abortion; and being excluded from her family home because of her propensity to cause deliberate damage. On some occasions Ida pleaded with her family to be allowed into the family home saying "I won't do any harm...help me...what is the matter with me?" This prefaced her smashing windows and cutting herself. The promised service for dealing with such emergencies took six hours to arrive. Ida was placed in a succession of homes where typically, the staff were untrained in autism. Ida's self harming persisted and on an occasion she attacked a member of staff. Ida was admitted to a Castlebeck Ltd home as a "holding place" and from there she was admitted to Winterbourne View Hospital.

- 4.9.** Lily was placed in Winterbourne View Hospital without reference to her family. She was admitted directly from her day service.
- 4.10.** Having been excluded from school when he was 16, Bill remained in the family home with “no support.” “Different people came to do different things with Bill but because there was no routine, it was no good.” Bill’s family associate the absence of routine with deterioration in Bill’s behaviour. Under-occupied, Bill was “all over the place.” He would suddenly run out of the house and on occasion he damaged cars. Over the years, the various programmes introduced to manage Bill’s behaviour did not result in any improvement. “Bill has always had the same behaviour.” Services appeared to have little grasp of how difficult the management of Bill’s behaviour was for his family. “They came to do risk assessments for taking him out and said that he needed two to one” but the family had no option but have one to two because Bill has a young sibling. The final straw was when Bill went on a rampage around a supermarket and the police took him away. However, because Bill had not committed a crime, Bill was released and he returned to the supermarket. The family reflected, “...everything had built up and built up, and I phoned the social worker and I said ‘I can’t do this anymore. I am at my wits end. He is going to hurt somebody or he is going to get hurt and it’s not fair on any of us and it’s not fair on him,’ No one could do anything with him.”
- 4.11.** That evening, the family was visited by Winterbourne View Hospital staff who confirmed that Bill could be admitted the following morning. Bill was told that he was going somewhere that was going to help him with his behaviour.

## **5. The early days**

- 5.1.** Tom’s family recalled that the staff who featured in the Panorama programme were “so nice” to them. They used to greet them and report on Tom’s progress.
- 5.2.** Kate’s family believe that initially, Winterbourne View Hospital did a lot for Kate. “They brought her on leaps and bounds. They managed to control the violent behaviour...her talking got better, she would talk more sensibly, she made friends, she loved it there. She had physiotherapy, they now got [her hand] to open a little bit.” In addition, the Hospital was instrumental in helping Kate to lose weight with the result that she could walk a few steps. However, these early gains were short-lived. The physiotherapy discontinued and Kate put weight back on.” Initially, the family believed that the staff “were all lovely.”
- 5.3.** One family’s faith in psychiatry was renewed in Winterbourne View Hospital where a psychiatrist took the time to understand their daughter and her history. It is where their daughter’s diagnosis of autism was made.

## **6. Insights from contact with Winterbourne View Hospital**

- 6.1.** On the occasions that Tom’s family took him out, he was fine. It was returning him to the Hospital that invoked his distress. He would say, “Oh no! Have a cup of tea.” He would flap his hands and sweat – confirming to his family, who are very familiar with this behaviour, that he was desperately unhappy in Winterbourne View Hospital.
- 6.1.1.** On an occasion when Kate’s family visited on her birthday they were concerned that her presents were left in carrier bags in her room. Because of her hoist, there was little floor space. They asked a member of staff if Kate could be assisted to tidy her room and sort out her birthday presents. They were told to put their complaint in a letter for the management.



In the letter, the family took the opportunity to refer to Kate's want of cleanliness which troubled them because Kate required frequent personal care. Her family associate the refusal to allow them further access to Kate's room with their letter, even though "The staff said that no one was allowed up there anymore because other residents didn't like it because they don't have mums and dads visiting."

- 6.1.2.** On a single occasion when Kate's family made an unexpected visit to Winterbourne View Hospital, Kate was out. They were advised that weekday visits "interrupted their routines. They had different programmes and things going on."
- 6.1.3.** Don's family acknowledge that they were misled about other Winterbourne View Hospital patients. Having been told that Don would be with a "bunch of young guys" he was with mostly middle aged patients. His family were so concerned that Don's phone calls conveyed his enduring fear and wish to return home during his first week, that they arranged a weekend visit to take him out. However, on arrival they were informed that, "Don could not go out because there was no staff member to accompany us. I insisted I be let in to see him and stayed there from around 11.00 a.m. to 3.00 p.m. while phone calls were made and I argued that he was a voluntary patient and should be allowed out with me...While I spent time in the garden, lounge and dining room, a number of patients talked to me and I discovered that they did not have much to do other than eat sweets and smoke cigarettes. Finally, I got the hospital to agree [I could take Don out] but on the condition that he was back before 5.00 pm... [over the next few weeks] It was always dreadful taking Don back knowing about the power they had to section him."
- 6.1.4.** A psychiatric nurse disclosed her concerns to Don's family about patients' health care "in general...their diet and exercise and how there was a reward system of giving out sweets."
- 6.1.5.** One family's impression of Winterbourne View Hospital was that it was somewhat "slapdash."
- 6.1.6.** Lily's family were distressed that they were not allowed to visit Lily unsupervised. They visited every weekend and these visits were consistently stressful because they would "often hear Lily yelling and crying when we drove up and got into the building. They wouldn't tell us what they did to cause her to be upset." On an occasion when a family member requested a glass of water they were informed by staff "We're not allowed." They were troubled that Lily "always came down [to the visitors' lounge] in very second hand clothes."
- 6.1.7.** Bill's family were concerned that during some visits, Bill "didn't have any conversation" and occasionally would say, "Go now, Bye."
- 6.1.8.** When Bill first went to Winterbourne View Hospital, the staff said that the family could come any time to see him. Then after a bit, they had to give notice. At the beginning the staff were welcoming and always had time to talk, but this changed. The family recalled the staff from Rose Villa (a Castlebeck Ltd home in Bristol) were welcomed to Winterbourne View Hospital with a sign, 'Welcome to Winterbourne View Rose Villa staff' in the reception area. There was a suggestion box in Winterbourne View Hospital and although Bill's family made a suggestion, no-one ever got back to them.
- 6.1.9.** One family want to know what training the staff were given, to what standard, and whether or not they were specifically trained to work in an assessment and treatment unit because "They didn't seem to have a clue." This family were concerned that on some occasions when they rang they could not always understand the people they were addressing because their spoken English was poor.

## **6.2. Medication administration**

- 6.2.1.** Jack's family were troubled that his epilepsy appeared to escalate in Winterbourne View Hospital. Prescribed changes to his anti-convulsant medication meant that his fits returned, "just as they did when he was a boy."
- 6.2.2.** A visiting family witnessed another family (in the visitor's lounge) requesting something for their daughter's headache. "The staff took well over an hour before they gave her something for her head." They were troubled too that "they wouldn't allow us to bring in clothes for their daughter [and even] refused her medication. This family were distressed that they were not told about their daughter's epileptic fits, even though they learned that "she had collapsed and lost consciousness [taking] about 2-4 minutes to come round."
- 6.2.3.** Bill's family recalled that on occasions when they visited, Bill appeared "drugged up." When Bill left Winterbourne View Hospital there was a problem with his medication. "It had been written down or dispensed wrongly."

## **6.3. Behaviour changes**

- 6.3.1.** Jack's family believe that Jack's placement in Winterbourne View Hospital has resulted in significant and damaging change. They believe him to be more aggressive, he shouts and swears and makes threatening gestures. "He wasn't like that before."
- 6.3.2.** Bill's family had witnessed Bill saying "You're going down!" and also bending thumbs back in play fighting with his relatives. They knew that Bill had destroyed his room at the hospital as well as some of his possessions. They believe that Bill became more aggressive during his stay in Winterbourne View Hospital.

## **7. Abuses**

- 7.1.** Tom's family spoke to Tom on the phone every day and he whispered "about people being thrown down on the floor, tablets being chucked down their throats and water poured down as well, making them gag. He saw people bullying, hitting, pulling people's ears (including Tom's). Tom was threatened by the head nurse who said he would hit him "in the face if he didn't shut up." There were occasions when Tom was bruised and his clothes had been ripped. Tom's family believe that his desire to return home was fuelled by what he experienced and witnessed in Winterbourne View Hospital.
- 7.2.** Kate's family were concerned that Kate described a member of staff as "bossy." They shared this with the Manager and explained that, although Kate had been known to "make-up" stories, they feared that unattended to, it might "get out of control if he didn't listen to what she was saying and why." However, nothing was done and the family reflected that this mirrored their own experience, "They're not listening. I sometimes feel, 'Are you listening to what I am saying?' I'm not here. Obviously you can't see me."
- 7.3.** Don's family were very concerned about Don's unabated confusion, fear and desire to be back home. Although they were "desperate to get him out of there [they] were told that if we did not return him after a home visit he would be sectioned." The practice of restraining patients impacted on their telephone calls to Don. One evening when they could not speak to Don he subsequently explained that it was because "somebody was kicking off." Don became "fixated and talked continually about restraints" which staff confirmed characterised daily events. Further, it took almost a year for the family to persuade professionals to cease to prescribe the drugs prescribed for Don at Winterbourne View

Hospital. The rationale was that they “were causing hardship for us whilst having to deal with the repercussions of Winterbourne View.”

- 7.4. When the abuses came to light, Ida’s family asked Ida whether or not anything had happened to her. She said, “Yes, one day they got me to go into the bath and I didn’t want to go. She said she was on the floor and they couldn’t get her in so they went to get [a male support worker and [they] thought, that’s not right because he’s a man. She was probably in her nightwear and she said he shoved her in the bath and poured water on her. We only have Ida’s word for it but [we] think it probably did happen.”
- 7.5. Lily’s family were concerned about an occasion when Lily had “bruises on her arms and a black eye...[and] she was signing for food...she [had] lost weight. Although they were told that they could “bring food in for Lily” they discovered that “the staff had it instead.” They were concerned that they could not take Lily out, even though other relatives were allowed to do so.
- 7.6. Bill’s family recalled an occasion when they took a Mother’s Day present into Winterbourne View Hospital for Bill to give to his mother. Even though Bill’s mother visited on Mother’s Day there was no present and no one seemed to know anything about it.
- 7.7. Bill’s family recalled that “They actually stopped us from seeing him, as a punishment. They said he had been ‘off-balance’ or whatever, but that would just make him worse. But now I think it was because something had happened, and he had marks on him. He got marks on him even at home. Up there he often had carpet burns, which he signed were from being restrained.” Sometimes when Bill was restrained they would tell him that if he went on behaving badly he would never be able to go home. They would say if you’re good you’ll be able to go home. They also told him that he was going home for Christmas, and then at the last minute they said “no”. In the family’s view, Bill and other patients ‘lived in fear.’ How they were managed “was not discipline, it was abuse and torture.”
- 7.8. Bill’s family have documented evidence that Bill was restrained 45 times in five months and that on a single day, he was restrained “on and off” all day.
- 7.9. On the occasions when Bill’s family visited Bill at Winterbourne View Hospital he was often in a mess. They complained “many times” about the mess he was in. Once when they went to get him to take him out he was in a “disgusting state.” He had food all over him, and the staff had to get him changed. They used to say they didn’t know the family were coming even though the family visited every Sunday. When they brought him back the staff often took a long time to answer the door. On one occasion the family waited 15 minutes. Once, Bill had an accident (he wet himself) because no one came to the door. On another occasion, Bill’s parent got stuck in reception and no one answered the buzzer. They had to get the attention of someone working in the kitchen.

## **8. Disclosing and reporting abuses**

- 8.1. Tom disclosed abuses to his family about “what the staff had done” and they reported these to the Manager. When the family disclosed that Tom had been threatened by the head nurse, the Manager denied the allegation stating that “the head nurse would never have said anything like that.” The Manager suggested that Tom had made a mistake, claiming that the head nurse was not present on the occasion cited. The family were not convinced because, “Tom would not ever mix people up.” On another occasion Tom rang the police to say that he wanted to go home. “They didn’t believe what he told them. No one believed

him." Tom's family did believe Tom and were concerned that the staff shared the Manager's view: "...the staff just said that he said these things because he wanted to go home. They said, 'don't forget, he wants to go home, he'll say anything and make things worse than they actually are. This doesn't happen here.' They said he had probably seen people being restrained which can be quite traumatic [but that] he was exaggerating the situation."

- 8.2. Kate's family learned that there had been "an incident with Kate" from the Manager. In the year before the BBC's undercover filming they were told that Winterbourne View Hospital "had got the police in...it's all been dealt with, she's fine, don't worry about her." When they saw Kate the following weekend she reported that she was "fine." Some months later the Manager rang to tell them that there would be a compensation cheque in the post and that the member of staff concerned received a suspended prison sentence.
- 8.3. Don's family became familiar with the removal of Don's property. "I gave Don my mobile phone but was told that he could not have it because of the camera so I bought him a phone with no camera. Staff saw me give it to him but they took it away after I had left and locked it in a cupboard. Don didn't have anything to occupy him but when we took in CDs and DVDs...again they took them away after we had left. We were told it was hospital procedure because he might break the CDs and cut himself...We provided him with all sorts of arts and crafts equipment because the hospital did not seem to supply anything much to occupy the patients. Everything was subjected to the same silent vetting procedure even after we had told them to talk to us and let us know what to take."
- 8.4. Jack's family were concerned that when Jack was seriously injured, staff informed them that he had "tried to bite" somebody. They thought this explanation implausible because it conflicted with Jack's explanation that somebody had "beaten him up." However, the family regret that they did not wholly believe Jack and even told him that he was "imagining it." The family are relieved that they are not the only family to have made such an error, not least because "Jack never showed that he didn't like it there."
- 8.5. Although Ida's family had not suspected anything, occasionally Ida said things about a woman staff member. This was difficult for them to make sense of because this woman had been to the family home and had "seemed very nice." Ida observed that "she was nice to you, but not to me." Ida had disclosed that she was worried when particular members of staff were on duty at night.
- 8.6. Lily's family reported that Lily "always seemed miserable." There were occasions when, during visiting, Lily was "agitated and going out of the room all the time."
- 8.7. Bill's family were told that Bill "enjoyed" the experience of being restrained. Having been told on one occasion that Bill had "cracked someone's ribs" they now believe that this could have resulted from either the trauma of having been restrained or from the goading observed in the BBC programme.

## 9. **BBC Panorama Undercover Care: the Abuse Exposed**

- 9.1. One parent heard about the programme, from the NHS, a week before it was transmitted: "Before I watched the programme...I wrote a letter to Panorama stating all the things that [my son] had told me and all my concerns and everything to them, before I watched the programme...I said this is what my son had told me and that it was the truth of the matter."
- 9.2. Another family were phoned by Winterbourne View Hospital's Manager. The Manager told them that there had been some allegations and that these "might be in the press." He did

not say that it was to feature on TV. It was their son's care manager who provided further information.

- 9.3. A third family were visited by a BBC reporter who informed them that he was making a programme "about abusive care in the care industry." A letter from Castlebeck Ltd in advance of the Panorama transmission offered erroneous reassurance that the abuse did not concern their relative.
- 9.4. A fourth family received a phone call from the Manager of Winterbourne View Hospital.
- 9.5. A fifth family received a letter from Castlebeck Ltd informing them that they would see something in the media about Winterbourne View and that their relative was not involved. It was their relative who confirmed that they "were going to be on Panorama."

## 10. **The impacts of *Undercover Care: the Abuse Exposed***

- 10.1. One family described being "absolutely devastated" by the programme: "I recognised all the staff on there and I recognised everything they were doing to them, [my son] had mentioned or told me about it. It was like him on the phone to me...and they were trying to tell me that this wasn't going on and it was absolutely, oh soul destroying. For God's sake, how can people be so evil, vile? [The staff] were so nice to me. How could [the staff] do that to them? All these emotions were going through me."
- 10.2. Another family experienced "total shock...Within the first six minutes I was absolutely appalled...I couldn't believe what was going on. I was sat there in absolute disbelief... [the patients] were doing nothing at all [to have provoked such treatment]. It's beyond belief." They reflected that it had been a "harrowing time" for them.
- 10.3. A family recalled that the programme referring to one patient's "beating" i.e. a woman being beaten in the shower and having wet wipes stuffed in her mouth..." They were disbelieving that such vulnerable patients could be brutalised by employed nurses and professionals. They regretted the necessity of undercover filming.
- 10.4. This family are left wondering "what makes a good carer or a bad one" and reflected that they do not think that they will "ever trust anyone ever again." They remain shocked that "so many staff were involved in the abuse."
- 10.5. Jack's family report that even mentioning Winterbourne View Hospital or Bristol prompts Jack to say "You're not sending me back there. They beat me up."
- 10.6. Ida's family were shocked by the programme because they "recognised all the staff in it. It would have been even more shocking if Ida had been involved." They were shaken because they "never expected to see anything like that." They reflected that they could see how the abuse could happen because "bored staff" were on 12 hour shifts looking for excitement.
- 10.7. Another family reported that they were deeply distressed by the "bad treatment" and concerned that one of the staff members was one of the people with responsibility for their relative. The sibling of a patient, who also has support needs, "is scared that she'll end up in a place like Winterbourne View Hospital."
- 10.8. Bill's family reflected that "If Panorama hadn't gone in we'd have been none the wiser. It's the not knowing. Bill must have gone through hell and we don't know." Before the transmission of Panorama, Bill's family were determined to get him out of Winterbourne View Hospital. They were disbelieving that it took two years to assess Bill and the fact there were no noticeable changes in Bill's behaviour confirmed their belief that Bill's "treatment" was questionable. The only difference that the family could see was that when Bill had had

a regular member of staff they 'learnt to understand what he was trying to tell him'. They said he communicated more, but in fact it was just that they had "gradually come to understand him better."

- 10.9.** Bill's family "cannot understand" why the CQC and South Gloucestershire County Council did not act on alerts. The profound distress resulting from what may have happened to Bill has resulted in "time off work" and health problems for family members. They believe that other services may be worried that it is happening in their residential homes. "The families that let their children be shown must be going through hell. But at least they *know* what happened to their sons and daughters – we don't know what happened to Bill." Bill's family would like to know how many of the staff arrested had dealings with Bill.

## **11. Into the future**

- 11.1.** Tom's family are concerned that although Tom did not see the Panorama programme, he has been traumatised. His experience confirms that not all memories are created equal - trivial and traumatic experiences differ in terms of their durability (McGaugh 2003). "He can't read but he heard things on the radio and saw (a male staff member) on TV and saw pictures of Winterbourne View...His behaviour now has just deteriorated. He's hallucinating, he's seeing (the male staff member) all the time, he's gone up on the moors and burnt all the clothes that he had in Winterbourne, he's burnt them all, so he's got rid of the memories. It's like a release of something. His hygiene has gone down because he's got all anxious about going in the shower - he says that's where they used to do it, at shower time, it was where they were cruel to a lot of them. And he keeps going like this [pushing up and scrunching her jaw sideways with her hand], he says '(the male staff member) used to go like this to my face', these are all things that have come out now. He said 'he used to pull my ears, as well'. He says 'I told you mum, I told you, didn't I, I told you this was happening'. And I said 'yes, Tom, you did tell me what was going on.' And I did try to talk to the Manager, and I thought things were OK, you know, I genuinely thought that the Manager was nice. The Manager must have known. I absolutely hate the Manager. I'm so angry because I was in meeting after meeting with the Manager and I kept on saying, 'do you think, you know, at the end of all this, Tom might be able to come home?'
- 11.2.** Although Tom had left Winterbourne View Hospital prior to the undercover filming, and he was making progress in his new home, the coverage associated with Winterbourne View Hospital changed everything: "Since then it's just like a different Tom again." It has brought it all back to him. He had to be moved to a secure unit for a trial period, where he is now, because he was so distressed. Although the residential home can no longer manage his behaviour, Tom's family want him to return there as soon as he can. However, the home struggled to manage his unpredictable behaviour and distress. When Tom gets into a state of heightened anxiety it is difficult to reason with him: "I cannot knock them. They have been by him 100%. Tom [was] so distressed, he [was] walking about the streets in his dressing gown and the police [were] constantly bringing him back to his [family] house... he started barricading himself in his room and peeing in cups, which he had never done before. Tom told his family that (the male staff member) wouldn't let him go for a wee, so he had to do it in his room.
- 11.3.** Tom kept turning up at the family home and at his grandmother's home, sometimes drenched through. The family said that he was 'breaking his heart every five minutes' and

that he was destroying things again. The medication they put him on just made him worse. “He gets so anxious...crying and shouting out in the streets, you know, he wants to come home. He’s got himself in such a bad way that he’s been up to the top of the car-park a few times, saying he didn’t want to be here anymore. He doesn’t deserve to be here anymore, that he hates this (male staff member), and at least he’ll be safe in heaven.”

- 11.4.** The family believe that since Tom stated that he is dreaming about (the male staff member) “all the time” that he probably absconded to get away from him and that “His mind is not working as it should...the tension in him builds up and then explodes.” They have offered to drive Tom back to Winterbourne View Hospital so that he can be reassured that it is boarded up and closed.
- 11.5.** Tom is concerned about his friends, other ex-patients of Winterbourne View Hospital. “He is such a lovely and loving caring man. Now, his main concern is that all his friends are all right. Now they are no longer in Winterbourne he can’t place them anywhere...he wants to know where the people are who [were] horrible.” Tom is reassured that another ex-patient is also in the secure unit. The family are disbelieving that independent living has been suggested for Tom and ask “How the hell do they expect him to be independent? But it has all been taken out of my hands, and unfortunately it happened the way it did, and since then he’s deteriorated. For almost 21 years in my life, Tom was the most lovely lad. Yes, he was hard work, a little disobedient, didn’t want to do as he was told, but I never used to have any problems like this. It was so traumatic when he was taken away to Winterbourne, and then it just got worse, absolutely horrendous, and I can’t yet see the light at the end of the tunnel...Who knows what the future holds for him, you know, I’m just hoping we’ll get this out of the way. All I want is for him to have as much of a normal life as he possibly can. And just to be safe. The world’s cruel enough as it is. It’s hard enough for us ordinary or normal people with right minds to deal with things sometimes. I know he’s somewhere safe at the moment, and I tell him that when he gets better he can go back to his own home [with professional support]. I love him to pieces.”
- 11.6.** One family want to go court when the (male staff member’s) case comes up. They want to see the male staff member locked up, so that they can get on with their lives.
- 11.7.** Carl is currently in his fifth assessment centre where managing his behaviour has been a “huge problem.” His family believe that when Carl moves to new units the staff are intimidated by him and he knows this. In turn, he targets someone who is fragile. His post-Winterbourne View Hospital placement was especially distressing because, within days, the Manager was suspended for “goading” Carl. His family do not want Carl to be admitted to another private hospital.
- 11.8.** Carl’s family want compassionate and “trained staff” to support Carl. They want Carl to remain in public services – preferably in the NHS. They are also seeking reassurance that Carl actually receives what they are told he will receive. “We were told there were trained staff there [at Winterbourne View Hospital]. Carl was supposed to have 2 to 1 from 7.00 a.m. until 11.00 p.m. but he didn’t.” They noted “Our experience of [private] companies caring for vulnerable people has been absolutely abysmal. Our son is moved around as if he’s a piece of furniture...He needs a place where there is a strong routine and definite boundaries...homes tend to have inadequate routines.” In his family home Carl has had “routine, firmness and consistency and he responds to this.” The family have learned that

arguing with Carl is ineffective because it makes him angry and “his behaviour escalates.” However, “no-one seems to take any notice” of this valuable, experiential knowledge.

- 11.9. At a post-Winterbourne View Hospital review, a psychologist working with Don proposed that Don was suffering from post-traumatic stress disorder as a result of his Winterbourne View Hospital experience. Don’s social worker was present and she apologised to the family for not having engaged with their concerns.
- 11.10. Jack’s family are satisfied with Jack’s current living circumstances. He lives near his family in his own flat with 24 hour support. The family are made welcome whenever they visit and Jack has frequent contact with them. They very much want Jack’s flat to be a permanent home. They have negotiated “a system” with Jack’s carers for the occasions when Jack becomes angry and threatens violence – which is rarely enacted.
- 11.11. Ida’s family are satisfied with her current Assessment and Treatment service. The approach there is “different.” The staff are very experienced and they are committed to sorting out Ida’s medication. Ida has told her family that she cannot sleep and has panic attacks and cries. It matters to them that the staff are “kind to her and don’t tell her to shut up as they did at Winterbourne View.” Her family would very much like to “reclaim” their lives.
- 11.12. Bill’s family state that “All we want for Bill is for him to be safe, in the right environment with specialist help.”

## 12. Thinking about the implications for services for adults with learning disabilities, autism and/or mental health problems

- 12.1. One family articulated the pressing need to value professional caring which is relationship-centred, skilled and sensitive to people’s subjective experience, including where they are in the life course. “There is too much staff turnover. They employ youngsters who don’t know what’s involved and they don’t have the training and experience.” Staff require the experience and maturity to make sense of the “delayed adolescence” of young men with learning disabilities for example.
- 12.2. A second family reflected that because their son’s behaviour has worsened since being at Winterbourne View Hospital, it would have helped to have had a structured, empathic and consistent service, “...if he had gone into a structured environment and stayed there, he would be a different person now.” They make the connection with the experience of foster children. “I can’t imagine what it must be like for them to keep moving house. It must be dreadful...I don’t think anybody gives it a thought. When our son moves, they’re not thinking about how he’s feeling. He’s very anxious when he moves. He’s hyper-vigilant all the time. When he goes into a new house he goes in all guns blazing. He doesn’t go in quietly because he’s scared. He’s frightened. He doesn’t know what’s happening to him and they don’t know him. I just think it’s absolutely appalling.” To understand the ways in which individuals with learning disabilities and autism experience their identities and perceive their support needs, skills such as *empathic witnessing* (e.g. Barnard 1995) have to be in place.
- 12.3. The policy priorities of localism and partnerships with families are strongly favoured. These should make it possible for people to sustain their connections and for families to be able to contribute their knowledge to their support. A family whose relative had been in placements throughout England observed that in their experience, “staff don’t take on board anything you tell them.”



- 12.4.** A family expressed anger that service commissioners making spot purchases to meet the needs of individuals do not know what they want to buy; they do not seek assurance that the service they believe they are buying can be delivered; and they do not follow up on what is being provided: “These firms say they can look after him, I’m in no doubt just to fill the bed so they can get the money. They are fully informed of how complex he is, that he has extremely challenging behaviour, then they realise after three weeks, two months or perhaps three months if he’s lucky, that they can’t do it. Then they appear to have no conscience about chucking him out. This beggars belief...Private companies operate on a shoe string although they are paid vast amounts of money...Their staff are really inadequate due to the fact that these companies pay the minimal wage attracting only those...[who] find it difficult to get work. These staff do not understand the complex behaviours of the people they are caring for...my son definitely needs trained staff...It’s the [units] that are private that are shit. They are. They are absolutely crap.”
- 12.5.** A family’s concerns about their relative’s medication were vindicated when his drugs were “finally tapered off [and] there were no ill effects confirming that, rather than drugs, we needed informed advice from specialists in autism.” The medication illuminated a pressing issue for this family, “Because our son was 18 we did not have the legal power to speak for him [and] he was not able, at this time, to speak for himself so the authorities became the prominent decision-makers. This was problematic because the authorities did not have enough information about him and we had a big struggle to get our voices heard...Throughout we found that our views were continually discounted...he needed a therapeutic environment but instead got Winterbourne View.”
- 12.6.** Another family expressed concern that their daughter’s post-Winterbourne View Hospital placement was “laid back” and that residents all go to bed “for an hour” in afternoon. They believe that their daughter is probably left in bed for at least three hours. “Ideally, we’d like to say, there’s a building, we’ll pick the staff that we know and trust...but then it’s not an ideal world.” They want to see their daughter “settled” in one place. They want trained and skilled staff, for whom the emotional demands of their work are recognised and who will encourage their daughter to be as active and as mobile as she can be. They want staff to be attentive to boundaries. (The parents ask staff not to hug and kiss their daughter because they become upset when she hits them.) They would like to have a social worker with care management responsibilities. They do not want to negotiate their daughter’s support with an untrained and contingent workforce. They would like the knowledge that they have acquired as family carers to be acknowledged and they want their daughter’s service reviews to deliver all that they promise. This family are concerned that the closure of Winterbourne View Hospital has led to a “lost friendship.” Their daughter had a reciprocal relationship which was not considered by the professionals responsible for identifying post Winterbourne View Hospital support plans.
- 12.7.** Ida’s family would like Ida to be supported in a small unit with staff who are trained in working with people with autism and have positive experiences of doing so, i.e. where the staff have goals to work towards, good role models and they are exposed to effective models of care and support settings. They want her to be geographically close to them. They especially want “somewhere where they are medically trained and know what they are doing – preferably NHS.” They are distressed by the barriers they have faced and by Ida’s life. They grieve that Ida, “has had no life” and that this has negatively impacted on them.

- 12.8.** Funding and funding arrangements mattered to families with one asking “The tax-payers were paying around £3.5 grand a week for one patient to be in Winterbourne View Hospital. 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?”
- 12.9.** As families recalled some of their distressing experiences, it was clear that they had no collective experience of being regarded as partners deserving of trust and respect or even of collaborating with paid carers. Two families had themselves paid employment experience of working with children and young people with learning disabilities, and another remained employed, even though it was hard to persevere because the time and energy demands of their caring were excessive.
- 12.10.** Even though the contexts of all families differed in terms of their experience of the nature and availability of their support networks, the nature and availability of services to assist them in managing the behaviour and mental health needs of their relatives, and their ability to influence these, were consistently wanting.
- 12.11.** On one occasion, a family whose relative had been detained by the police because of her destructive behaviour was told that because there was nothing they could do, that their relative would have to be released. This was the end of the road for the family and one parent took an overdose. “Nobody was helping...The last resort was calling out the police...I’d had enough...I just gave up...I used to get up at night and I could hear our daughter screaming, even when she wasn’t there and I’d think, oh no, not again. That was like a nightmare.”

### **13. Summary Points**

- Former Winterbourne View Hospital patients identified themselves with reference to place – mostly where they were born and where their relatives live – and to significant people
- Ex-patients’ personal relationships and their sense of belonging are of sustaining significance. These are not exclusively family relationships
- Ex-patients wanted to be involved in interesting and satisfying activities which were not consistently available at Winterbourne View Hospital
- The histories of some ex-patients revealed scant acknowledgement by professionals of the impact of lives interrupted by sexual assaults, bereavements and losses, or even of restoring a sense of living valued lives as men and women with different support needs
- The expertise of families, many of whom had gone to considerable lengths to sustain their relatives at home, was unacknowledged at Winterbourne View Hospital. Some had decided to end their caregiving; some wanted to continue; and of necessity, services had replaced the role of some families
- People’s families were deliberately excluded from having a full picture of what was happening in their relatives’ lives at Winterbourne View Hospital i.e. they received incomplete if any accounts of injuries arising from restraints; they could not visit their relatives’ rooms; and obstacles were put in the way of some families taking their relatives out – including those who were voluntary patients

- People's families had little understanding of the stated function of Winterbourne View Hospital as *assessment and treatment* and *rehabilitation* and what these entailed. One family believed that it was a care home
- Occasions when two families recalled clear progress in the lives of their relatives were characterised by professionals seeking to understand and getting to know patients as individuals over time. More typically however, families recalled the high turnover of young, untrained and inexperienced staff and inattentive managers

## Section 5: The Agencies

This Section provides a summary of what was expected of each agency, an outline of each Individual Management Review (IMR) and a commentary on the information provided by the agencies contributing to this Review. Although the BBC's Panorama focused solely on Castlebeck Ltd and the Care Quality Commission, this section also examines the role of other agencies. This includes the NHS which conducted a parallel review of their role in commissioning services from Winterbourne View Hospital, *as part of the NHS contribution to the Serious Case Review*. This was in addition to the IMR by NHS South Gloucestershire PCT (Commissioning) which undertook a coordinating role on behalf of nine NHS commissioning organisations.

### 1. Castlebeck Ltd

**The Statement of Purpose of Winterbourne View Independent Hospital (2009) noted, *the aim...is to provide a high quality specialist healthcare service for adults with learning disabilities and challenging behaviour. The treatment and support provided to each patient is based upon individual need and is aimed at assisting each person to achieve their full potential. Winterbourne View aims to promote the development of each individual through the application of the key principles of Valuing People: rights, independence, choice and inclusion.***

1.1. The *Individual Management Review for the Serious Case Review into Winterbourne View Hospital* was completed in November 2011. The IMR is brief - 14 pages – but contains annexes of 91 pages which include:

- Details of the author (2 pages)
- The safeguarding alerts from Winterbourne View (11 pages)
- Job descriptions of Care assistant, Senior care assistant, Staff nurse, Senior staff nurse, Charge nurse, Deputy manager and Manager (19 pages)
- Winterbourne View Hospital's staffing rotas during January - April 2011 (5 pages)
- *Staff on shift at Winterbourne View during the time Panorama reported abuse occurred* (7 pages)
- *Winterbourne View - timeline* from 16 August 2010 – 14 February 2011 (2 pages)
- *Staff named in letters investigations* (1 page)
- *Serious Untoward Incident – Root Cause Analysis Closed at National Clinical Governance 2011*, i.e. the cases completed (8 pages)
- Terry Bryan's 11 October 2010 email to the Manager of Winterbourne View Hospital (4 pages)
- The training undertaken by 25 staff members in respect of: MAYBO; MAYBO refresher; Safeguarding Adults and POVA; First Aid at work; and Fire training (3 pages)
- The *Winterbourne View Independent Hospital Statement of Purpose*, June 2009 (28 pages)
- *Winterbourne View Organogram*<sup>1</sup> (1 page)

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<sup>1</sup> A figure outlining the roles of Winterbourne View Hospital personnel and their connection to Castlebeck Ltd

- 1.2. Castlebeck Ltd spells out their position concerning the *whistleblowing email* i.e. *whilst serious issues are raised...it does not document the appalling abuse of patients subsequently aired on BBC's Panorama programme*. The IMR acknowledges the *limited executive oversight* of Winterbourne View Hospital and the drift towards a *culture where key performance indicators highlighting service failing went largely unheeded*. The geographical distance from the *corporate centre* (in Darlington) resulted in *calls for assistance from the Winterbourne View Management Team to go largely unheeded by regional management...Information that made it beyond this level was frequently down-played and therefore the Executive Team were not able to give it the attention it required*. In addition, a *fundamental failure...to recognise the employment difference in the North/South divide* resulted in *uncompetitive remuneration and benefits*. The hospital was plagued by *poorly implemented recruitment and selection processes...inconsistent staffing levels...weak management...high sickness levels and high staff turnover*.
- 1.3. Castlebeck Ltd associates the reports of *commissioners that their patients were improving* and their continued referrals with their own *resultant complacency*. *Commissioners were always invited to Care Programme Approach meetings*. In the view of Castlebeck Ltd, *Commissioners could and should have challenged the care regime*.
- 1.4. Castlebeck Ltd acknowledges that the South Gloucestershire Council Adult Safeguarding *assumed that Castlebeck's comprehensive policies and procedures around safeguarding would be translated into practice*. However, *there was a low and inconsistent threshold of reporting* and Winterbourne View Hospital staff were disadvantaged by the inconsistent communication of outcomes. Castlebeck Ltd asserts that the response of South Gloucestershire Council Adult Safeguarding to Terry Bryan's email failed to *robustly challenge or generate any urgency*.
- 1.5. The Management Review asserts that *in the main*, Castlebeck Ltd had addressed the requirements arising from the Healthcare Commission and, subsequently, the Care Quality Commission's assessment of compliance against standards. They believe that they *should have been able to rely on CQC, as the regulator, to highlight any failures...to allow both parties to work together to rectify failings...CQC...allowed ongoing failures to continue to exist...they have perpetuated the view that Winterbourne View was meeting the outcomes and legislative framework*. Castlebeck Ltd suggest that the transition from the Healthcare Commission to the Care Quality Commission may be associated with these failures and concluded that *CQC have significantly let Castlebeck down whom (sic), rightly or wrongly, sought and relied on their regulatory role*.
- 1.6. Castlebeck Ltd notes that although *discharge planning is evident from day 1 of admission...personal development plans for patients appeared to be done haphazardly*. Further, while the 'MAYBO' training (*British Institute of Learning Disabilities approved*) is *intensively used within Castlebeck...it would seem that within Winterbourne View the incidence of physical interventions does not reflect this teaching...there were a high number of interventions, these do seem to have been carefully reviewed by the Consultant Psychiatrist*.
- 1.7. The Management Review notes that *during the early part of 2011 the Senior Management Team at Castlebeck were not aware that the local hospital management team were struggling and that the catalogue of issues would lead to the now well documented care practices taking hold...recruitment to post (sic) was not as robust as it should have*

*been...there was a reliance on inexperienced staff...there are several instances where policies and procedure were not followed with staff starting before CRBs and references had been obtained and checked. Failure by Castlebeck to provide appropriate executive oversight...contributed to the poor recruitment practice. Induction training was a combination of e-learning with a reliance on...senior staff supervision.*

- 1.8.** Castlebeck Ltd describes Winterbourne View Hospital patients as being *of a considerably more difficult type...with extreme levels of challenge. Often patients have been in many different facilities.*
- 1.9.** The annexes concerning the *staff on shift at Winterbourne View Hospital* during the filming of Panorama confirm that people worked 12 hour shifts from either 8.00 a.m. to 8.00 p.m. or from 8.00 p.m. to 8.00 a.m. There does not seem to have been scope for handover meetings or for briefing agency staff. The staffing rotas confirm the image of a service in trouble with a lot of sickness absence among the support workers; management team, nursing and support worker vacancies, some arising from suspensions; barely any evidence of training; and a lot of *time owing*. Castlebeck Ltd's documentation endorses the critical role of staff supervision. However, as in other instances of institutional abuse, credible supervision does not take place i.e. the task of identifying individual targets relevant to individual members of staff as well as to the service. Thus a mechanism for meshing people's work programmes with the bigger picture of service provision was absent.
- 1.10.** The Management Review does not consider the acting manager's response to Terry Bryan's email, or the fact that, according to the email, some of the concerns highlighted had been discussed with the acting manager the previous month. It was 14 working days after receiving the email that it was shared with South Gloucestershire Council Adult Safeguarding. The date when the acting manager discussed the email with Castlebeck Ltd's Regional Operations Director and the Senior Manager is not known.
- 1.11.** The Management Review does not explain the seven months during 2008 when the hospital was without a Registered Manager. It is as troubling that during the hospital's final 18 months of operation, an acting manager was in post.
- 1.12.** The Management Review does not consider the police investigating allegations of criminal assault. Given that Castlebeck Ltd undertook a very detailed Serious Untoward Incident investigation relating to an alleged physical assault by a staff member during July 2008 (see Section 3) – which was one of many incidents – this did not cause the management to increase its oversight.
- 1.13.** The claim that discharge planning commences at the outset of a placement is not borne out by the duration and documentation concerning some patients' placements. It seems that the hospital's *Statement of Purpose*<sup>2</sup> had no operational relevance for Castlebeck Ltd.
- 1.14.** Castlebeck Ltd commissioned PwC to prepare a *Review of Castlebeck*. This was completed in November 2011. The document is redacted, including only an *Introduction and Background* (of 4 pages), the (47) *Recommendations and the Assuring Quality Care Action Plan* (26 pages) and five annexes dealing with the scope of their review, the documents reviewed, two *Clinical expert biographies*, Castlebeck Ltd's Management Structure and the PwC *Approach to selection of unannounced unit visits*. Given that more information was made

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<sup>2</sup> A registered hospital has to have a statement of purpose which should be updated and the regulator must be informed if circumstances change

available to PwC than to the Serious Case Review, their recommendations merit consideration.

**1.15.** The recommendations contain nine domains:

- 1.15.1.** Recommendations 1-9, concern *Operational and Clinical leadership*. These hinge on the recruitment of, (a) *a number of new regional directors...filled through external competition*, (b) *a Director of Nursing and Quality...responsible for quality governance*, (c) *a senior post to ensure the design and implementation of robust arrangements to cover appropriate assurance frameworks (clinical, operational, financial) internal compliance, regulatory compliance and risk management*, (d) *a Chief Operating Officer...to ensure that leadership of the operational management of units is balanced against the traditional leadership of the company*, (e) *a Turnaround Director...to provide additional support and capacity to the Internal Board* and (f) *five audit and governance co-ordinator posts*. In addition, it is recommended that operational and clinical leadership might be enhanced by the creation of nursing leadership roles *to provide unit led nursing staff with greater scrutiny and to develop practice consistency*. The final two recommendations relate to reviews of the roles of *Group Clinical Director...unit psychiatrists and therapists*.
- 1.15.2.** Recommendations 10-15, concern *Board engagement* and ways of securing greater connectivity between Board personnel and the quality of care provided to service users. This requires greater representation of health and social care personnel; the creation of a Board sub-committee, *responsible for seeking assurance that effective quality monitoring and clinical risk management arrangements are in place*; the development of a *quality assurance framework* and a *care quality strategy*; and ensuring the *visibility of the Board* at unit level.
- 1.15.3.** Recommendations 16-21, concern *Quality governance*. They assert the importance of reinforcing *policies and procedures in respect of reporting and recording incidents...with all relevant staff* and ensuring the *consistent and compliant recording/escalation of incidents*. In addition, a *compliance audit programme...that ensures compliance with key policies...a routine audit of actions in relation to significant incidents at unit level...and a clinical risk management approach* are advised. The *constitution, frequency and approach to Multi-Disciplinary meetings* should be *standardised and audited* and *where possible, local community learning disability teams from the area from which service users originate should be involved in the Care Programme Approach review meetings*. Furthermore, there should be an *electronic, online incident reporting system* and *thresholds on the duration and number of restraints should be established and properly monitored, and restraint training for staff should be updated to emphasise alternatives to restraint*.
- 1.15.4.** Recommendations 22-26, concern *Service user mix*. This advises *an audit trail system...to capture the decisions and underpinning discussion in relation to patients' admissions*; a mechanism for ensuring that the CEO is advised of the *discomfort* of clinicians and unit managers concerning *patient admission decisions*; *regular audits of the appropriateness of patient admissions and discharges across all Castlebeck units*; the implementation of the *major recommendations arising from Castlebeck's recent Activities Review*; and a *review of the size, location and function of each unit, jointly with external stakeholders*.
- 1.15.5.** Recommendations 27-35, are entitled, *Invest in staff*. These concern benchmarking induction and subsequent training with the NHS and other providers; reviewing the induction process of staff, including agency staff; *developing a strong and positive culture through active engagement with staff*; ensuring that *the barriers currently restricting staff*

*from receiving adequate training are removed...an increase in the quality and frequency of supervisions...adequate levels of staffing to be available to all unit managers; reviewing (i) the existing staff appraisal system, (ii) the current unit working practices across Castlebeck and (iii) reviewing and benchmarking the core competencies required of unit managers and deputy managers; and promoting, enforcing and monitoring a system to ensure compliance with key staffing policies and procedures.*

- 1.15.6.** Recommendations 36-40, concern *Service user/carer involvement*. These advise taking *demonstrable steps to engage with service users and carers; adopting a patient-led care planning process...the development of personalised care plans for all Castlebeck service users; monitoring patient and carer experience at unit level; and increasing the level of carer involvement in Care Programme Approach and Multi-Disciplinary Team meetings.*
- 1.15.7.** Recommendations 41-43, concern *Advocacy*. They advise that the *findings of the recently commissioned advocacy review* should be reviewed and an action plan developed; that the provision of advocacy should be reviewed *immediately*; and that the Board *should be appraised of the results of the advocacy programme.*
- 1.15.8.** Recommendations 44-46, concern *Stakeholder engagement* to manage the *short term risks to the current business*. This should include a *wide-ranging communications plan; dedicated time to the management of external relationships with external stakeholders; greater transparency and external scrutiny of...business decisions in relation to patient care and quality; and making available to carers and commissioners key governance and performance management information.*
- 1.15.9.** Recommendation 47, is titled, *Implementation of change programme* and advises that there should be a Programme Management Office *to oversee the implementation of the recommendations.*
- 1.16.** The PwC report places continuing faith in Castlebeck Ltd's in-patient hospital services for people who are on, and sometimes beyond, "the borders" of local service and professional competence (e.g. Flynn and Bernard 1999). The report seeks to ensure the recovery of the service model with the creation of more senior positions and reviews and audits to ensure that Commissioners will identify a flow of potential patients for Castlebeck Ltd's in-patient services. It accepts that Castlebeck Ltd should cast a wide and long net for patients.
- 1.17.** Hospital services for adults with learning disabilities and autism rely on the absence and failure of sustained support for people in their families and communities in which they are known. Castlebeck Ltd does not question their basic model of sourcing patients throughout the country: Commissioners collate assessments of individuals which provide the rationale (i) for urgent admissions, (ii) that detention under the MHA is required (iii) that an institution can no longer manage a prospective, Castlebeck Ltd patient. In turn, Castlebeck Ltd is one link in a service chain which typically admits and discharges people to and from institutional settings.
- 1.18.** Placing within two wards patients with diverse support needs under the supervision of poorly paid, untrained staff, and agency staff, who may not know the patients and who control them by ensuring that their favoured activities and contacts with their relatives are contingent on required behaviour, for example, are devoid of merit or promise. The approach of Castlebeck Ltd and PwC after the Panorama broadcast is that of refining the existing model of independent hospital provision rather than asking whether it works.



- 1.19.** The recommendation concerning restraint is significant: the approach is to revise the policy and ensure that restraint is the response of last resort. This approach to restraint has been consistent in all of the recommendations made since the Independent Inquiry into the death of David Bennett in 2003 (see Section 6). It has had an unpromising track record in terms of addressing the triggers to the use of restraint, the types of restraint, the duration of the restraint, and the fact that restraints were neither consistently documented nor authorised at Winterbourne View Hospital. The latter meant that patients were entirely powerless even though other staff were in knowing distance of physical assaults and abuses. How the recommendation rendering restraint the intervention of last resort will address the falsified recording of restraint events witnessed during the Panorama broadcast is not clear.
- 1.20.** The *systems* revisions recommended by PwC are premised on the various components seeking to be effective according to their own logic. Even though Castlebeck Ltd had a track-record in producing credible policies, procedures and quality audits, these had no bearing on the operational realities at Winterbourne View Hospital where a dangerous, self-replicating culture was sustained. Castlebeck Ltd was adept at appearing “quality assured” and knowledgeable about policy, for example, citing work with patients with learning disabilities, autism, behaviour which challenges and mental health problems in terms of *person-centredness* and *health action planning*; creating a *Dignity Champion* at Winterbourne View Hospital; and piloting its Unit-Led Clinical Governance Committee meetings at the hospital with two other locations owned by the company.
- 1.21.** The implications of austere times and the contracting economy for the NHS and local authorities are not acknowledged in either review. Overall, Castlebeck Ltd’s appreciation of events leading up to the transmission of Panorama is limited, not least because they took the financial rewards without any apparent accountability. The recommendations fail to address corporate responsibility at the highest level.
- 1.22.** It does not appear that in 2012, Castlebeck Ltd is being shaped by patients and ex-patients, or even by the tenacity of their families and/or persistent and competent advocates with whom Winterbourne View Hospital staff once had distant and even adversarial relationships.

## 2. The National Health Service

*Services for people with learning disabilities, challenging behaviour or mental health needs* was published by the Department of Health in 1993 and updated in 2007. They were written by Professor Jim Mansell. He advised that, *commissioners should stop using services which are too large to provide individualised support; serve people too far from their homes; and do not provide people with a good quality of life in the home or as part of the community, in favour of developing more individualised, local solutions which provide a good quality of life.*

*Early warning systems in the NHS* (Department of Health, 2010) states that *PCT commissioners...assure themselves that providers are meeting their contractual obligations, soft intelligence and other information. They have a statutory duty to secure continuous improvement in the care that they commission...*

*Strategic Health Authorities (SHA) are accountable to the Secretary of State for the operation of the NHS in their region. They do this by assuring themselves that PCTs are commissioning high quality services that meet the needs of their population and they are holding providers to account for performing against their contracts. They also directly manage the performance of NHS Trusts via the NHS Performance Framework.*

- 2.1. The **NHS South of England** (a cluster of three Strategic Health Authorities, NHS South West, NHS South Central and NHS South East Coast, created during October 2011) produced a ***Report of the NHS Review of commissioning of care and treatment at Winterbourne View***. The Report was based on fact finding carried out between July-October 2011, and was supported by self advocates, families and carer representatives. It is 70 pages in length and contains six sections and an Appendix.
- 2.2. The *Introduction* (3 pages) sets out the reasons for the Report: *NHS organisations in England were responsible for the commissioning of care and treatment for the majority of patients at Winterbourne View and, as such, there was a need to review the role that the NHS played in the commissioning of services from Winterbourne View*. Three Welsh patients were outside the scope of the NHS review since they were not the responsibility of English NHS commissioners.
- 2.3. The Terms of Reference of the NHS Review were: *to investigate the NHS processes that operated in relation to the role of the Primary Care Trusts, and their work with the NHS and other partners, in the organisation of the care of patients treated in Winterbourne View*.
- 2.4. The *Background* (nine pages) presents the *relevant policy, responsibilities of health and local government, commissioning in the NHS, the Care Programme Approach and Mental health legislation*. Briefly, these endorse: the importance of prioritising the development of readily responsive, community based services for adults with learning disabilities, behaviour which challenges and mental health problems, particularly in transition planning; *fair access to generic (including mental health) services*; the principles of rights, independence, choice and inclusion; knowledgeable leadership; skilled providers and support staff; evidence based commissioning; and flexibility in contracting. Furthermore, they underline the role of:
  - The Strategic Health Authority and Primary Care Trusts in the provision of a comprehensive health service. *It is the role of the PCT to plan strategically, specify*

*outcomes, procure services and manage demand and provider performance for all services that are required to meet the needs of all individuals who qualify for NHS funded healthcare, and for the healthcare part of a joint care package.*

- *Commissioning in the NHS with responsibilities ranging from assessing population needs, prioritising health outcomes, procuring products and services, and managing service providers. Although the SHA has no direct commissioning role it does need to be assured that PCTs are commissioning high quality services.<sup>3</sup>*
- *Local authorities in assessing those in need of community care services.*
- *The Care Programme Approach, regularly reviewed to support and coordinate mental healthcare for people with severe or complex problems, and overseen by the care co-ordinator.*
- *The Mental Health Act 1983, which provides for the hospital detention of people diagnosed with a mental disorder so that their disorder may be assessed and treated.*

**2.5.** Four pages describe the *Methodology* of the NHS Review. The *Overview of key information* spans five pages and concludes that:

- *over a quarter of referrals (13 out of 48) came from commissioners located less than 20 miles from Winterbourne View Hospital. Nine of these 13 referrals were from commissioners based less than ten miles away;*
- *the majority of patients had a mild learning disability, with just over a quarter...diagnosed with a severe to moderate learning disability...and approximately a third had been diagnosed with some form of autism;*
- *the majority of Winterbourne View Hospital patients were under the age of 50, with an equal number of men and women admitted during its five years of operation. In terms of their length of stay at Winterbourne View Hospital, the Review of NHS Commissioning noted that 13 admissions lasted for under six months;*
- *the longest stay was four years and five months and the shortest was a week. Eight patients were at Winterbourne View Hospital for over three years and of these, two were there for over four years. The average length of patient stay was 573 days - around 19 months. However, some of these timeframes are likely to have been extended had the hospital remained open.*

**2.6.** With regard to the NHS Review's findings (spanning 39 pages), six sets of information were considered in relation to: commissioning relationships and responsibilities; pre-referral checks and contracting; appropriateness of care; coordination and monitoring of care; involvement of families and advocates; and responding to concerns and issues.

**2.7.** Even though *most* (of the 14 NHS) *commissioners had some policy or procedures in place which sought to limit the number of out of area placements and to repatriate those staying far from home to facilities closer to (their) home*, typically these sought to respond to scenarios in which a person *could no longer be accommodated within local services*.

**2.8.** Commissioners distinguished between responsibility for (i) *agreeing and funding a placement* and (ii) the *ongoing coordination of care*. *In many cases these were carried out by parts of the same organisation or by different organisations*. However, there was a *lack of*

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<sup>3</sup> NHS South of England Response to draft SCR, April 2012

clarity in terms of the expectations of these roles and in communicating to commissioners about the care of patients.

- 2.9.** NHS Commissioners in England secured 44 placements at Winterbourne View Hospital. For 25 placements, NHS Commissioners checked that the hospital was registered and *some had also read the most recent inspection report*; for 10 placements there was no evidence of any checks having been made; for five placements, as well as *basic checks*, there was a recommendation from a clinician concerning the suitability of the hospital; and for four placements, *commissioners, care-coordinators or families visited* in advance of the referral. Accordingly, *beyond basic checks on registration with the regulator, there were few if any checks made*. The NHS Review noted that the commissioners *expected to be informed of any significant developments or concerns...but did not appear to have clarified the threshold beyond which an issue should have been escalated or shared for information*. The NHS Review noted that had commissioners been aware of serious incidents within Winterbourne View Hospital *they might have avoided some of the difficulties discussed later in this report*.
- 2.10.** The NHS Review questioned the lawfulness of perhaps four local authorities commissioning placements at Winterbourne View Hospital.<sup>4</sup>
- 2.11.** With reference to contracting, *the standard Castlebeck contract set the following expectations about the nature of the service to be provided for patients:*
- *2.6 The Placement shall commence from when the Patient commences their stay at the Registered Premises. From the commencement of the Placement, the Company will provide what it considers to be an appropriate multi-disciplinary care and treatment regime comprising (but not necessarily limited to):*
  - *2.6.1 24 hour nursing care (oversight within our Registered Establishments) by [RNLD/RNMH/RMN trained] nurses supported by a team of care staff;*
  - *2.6.2 Psychiatric clinical care by the Company's in-house team comprising (as reasonably required) consultant psychiatrists and specialists, consultant psychologists and behavioural therapists;*
  - *2.6.3 Neurophysiological assessment provided on a sessional basis, if deemed necessary by the Company's medical staff;*
  - *2.6.4 Positive programming comprising education by systematic instruction as needed in socialisation, occupation, diversion, rehabilitative therapy and training of daily living or other specific skills;*
  - *2.6.5 Access, where appropriate, to community services at a level consistent with the Patient's clinical condition and level of functioning;*
  - *2.6.6 Access to general practitioner and other generic services available under the NHS as required by the Patient;*
  - *2.6.7 Provision of full weekly board at the Company's Registered Premises deemed by the Company as providing an appropriate environment for the Patient; and*
  - *2.6.8 Recreational community outings and, where appropriate, a holiday (up to 7 days) within the UK both under the supervision of appropriately trained employees of the Company*
  - *The Company:*

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<sup>4</sup> The basis on which local authorities were commissioning Winterbourne View Hospital services is unknown i.e. it is not clear under what power they purported to act.

- 3.1.1 will ensure that all its Registered premises are run in accordance with the requirements of the Care Standards Act and meet all appropriate standards in respect of fire regulations and health and safety
  - 3.1.2 will allow access at all reasonable times and on reasonable notice by a nominated and appropriate representative of the Referrer to the Patient at the Registered Premises where the Patient has been placed...
  - ...3.2.1 will take appropriate steps to seek to ensure the honesty, integrity and reliability of all staff engaged by the Company. These steps will include the requirement to provide two satisfactory impartial, and where possible, written references and obtaining a satisfactory disclosure record from the Criminal Records Bureau for all staff...
  - ...3.2.5 will provide suitable and appropriate initial and refresher training to all its employees working in its Registered Premises; and
  - 3.2.6 will ensure that relevant employees will be fully trained to carry out, in appropriate circumstances, dignified restraint of residents in accordance with the guidelines and codes of practice issued by the relevant statutory bodies...
  - ...3.5.2 The Company will endeavour at all times to provide a safe environment for the Patient and employees of the Company. In the event of a significant assault on a Patient or employee, they each have the right to involve the police.
- 2.12.** Of 28 placements, 15 were covered by the standard Castlebeck Ltd contract; six by a local authority contract *as part of pooled arrangements for commissioning*; five placements (arranged by the same NHS Commissioner) were covered by the standard Castlebeck contract and a supplementary agreement based on the standard NHS contract; and for two placements, there was no evidence of any contract. The NHS Review found that there were no *tangible benefits* associated with any of the contracts used; *there had been no systematic monitoring of the terms of the contract, nor whether the expected level of service was being delivered*. The Review reports that *spot contracts with a private sector provider produced no collective overview of the quality of the whole service or outcomes being achieved for groups of patients*.
- 2.13.** When considering the appropriateness of care, patients were admitted to Winterbourne View Hospital through three principal routes:
- 2.13.1.** *the patient had an acute mental health need (and in particular needed to be detained under the Mental Health Act) but this could not be met within local NHS mental health inpatient services as the patient was assessed as too vulnerable, challenging or otherwise unsuitable either at the point that an admission was being considered or following an initial admission to a local NHS inpatient unit;*
- 2.13.2.** *the patient had a learning disability but their mental health needs and/or challenging behaviour meant that they could no longer remain within their existing social care service;*
- 2.13.3.** *the patient was already placed in a specialist hospital and a move to Winterbourne View represented one or more of the following:*
- *a move closer to home;*
  - *a planned step down in care;*
  - *a court requirement;*

- *a step up in care, because Winterbourne View was perceived to specialise in treating patients with challenging behaviour.*
- 2.14. The largest group of placements were the result of a transfer between specialist hospitals. *Approximately a third of these transfers were from other facilities operated by Castlebeck.* The NHS Review stated that the relatives of patients *could and should have been more involved in original commissioning decisions.* The second largest group admitted (a third of patients) were people from social care services.
- 2.15. With regards to the Mental Health Act, of the 48 English patients, 35 people were admitted under a section (4 people under S.37 and S.37/41; 8 under S.2 and 23 under S.3). Of the 13 patients *admitted informally*, only seven retained this status during their stay with the remaining six *being detained following their admission.*
- 2.16. The NHS Review identifies *either confusion or a lack of clarity about how the guidance on the Care Programme Approach should have been applied* which consequently led to a lack of challenge during patients' reviews. The latter were coordinated, chaired and led by Winterbourne View Hospital personnel and were based on information provided by the Responsible Clinician and the hospital team. Participants to the Care Programme Approach review meetings *were denied access to the ward areas of the hospital.* There was a *pattern of some patients staying in Winterbourne View for long periods of time after they were no longer detained under the Mental Health Act* and there appeared to be a *general lack of urgency in finding suitable alternative care options and planning discharge.*
- 2.17. Significantly, the NHS Review questions the independence of Responsible Clinicians employed by independent hospitals as demonstrated by the following quotation from a letter:
 

*[The Responsible Clinician] states that further work for at least another 6 months is required...to include specific anxiety management interventions and further fine tuning of medication. Team...do not believe that supported living is appropriate in the near future, however the Castlebeck step down facility being opened...in the near future may be appropriate.*
- 2.18. The NHS Review concludes *that there had been no formal process for commissioners in Primary Care Trusts to be informed directly of safeguarding alerts...reliance seems to have been placed on good informal communication...In some cases, commissioning managers became aware of serious historic alerts only during this review process.* There were examples of care coordinators, delegated by NHS commissioners to monitor placements, being aware of events which should have invoked South Gloucestershire Council's Adult Safeguarding procedures but they did not do so. The NHS Review determined that this *failure...demonstrated both lack of rigour...and failure of judgement by NHS staff.* Furthermore, the NHS Review reveals that, in relation to 28 patients, there were *10 examples of families, carers or other advocates raising some type of concern.* More broadly, *there was a failure on the part of commissioners to follow up important issues* against a background of the hospital providing *reassurance and plausible explanation.* It was a problem, however, that NHS Commissioners were individually and separately making 'spot' purchases. They were not in touch with each other and they did not benefit from any sharing of information about concerning events within the hospital such as injuries sustained during physical restraint. They had no means of identifying patterns of concern about quality and safety. In respect of 38 safeguarding alerts concerning 20 Winterbourne View Hospital

patients, the NHS Review found that *in the majority of cases the care coordinator for the patient was informed of the safeguarding alert. Commissioning managers were only made aware (either by a care coordinator or directly) of approximately one fifth of the alerts.* These were not escalated within the NHS as serious incidents. A conclusion of the NHS Review was that *the weaknesses of monitoring systems in place were compounded by the lack of clearly communicated information or alerts.*

- 2.19. Systems and processes should be in place to assure commissioners of the quality and safety of a hospital, even for one vulnerable patient. Given that *the number of patients referred to Winterbourne View by a single organisation ranged from 1-6*, with as many as nine patients from a single locality where the PCT and council were both commissioning, it is of significance that placing more than one patient does not appear to have enhanced contract monitoring, practice scrutiny or even increased contact with the hospital.
- 2.20. The ways in which professionals engaged in the role of *care coordination* - administration, contract monitoring, clinical monitoring, or all three - and how they related to multi-disciplinary teams were not considered by the NHS review. It is unclear whether or not the profession of the care coordinators, for example nurses or social workers, made a difference and if so, what are the implications for patients now and in the future?
- 2.21. The NHS Review highlights a potential conflict of interest for Responsible Clinicians employed by the NHS and private providers of services. Employed clinicians should not have a vested interest in a patient remaining in a hospital or being transferred to a facility belonging to and managed by their employer.
- 2.22. An NHS commissioner noted “instances in which commissioners would have acted differently if the information had been available”. There was no evidence presented to the Serious Case Review to support this assertion.
- 2.23. Although the NHS Review states that *some [commissioners] had seen positive outcomes in relation to previous patients*, neither the number of such commissioners nor any compelling examples of patient outcomes are reported.
- 2.24. The NHS Review asserts that *Primary Care Trusts are accountable to Strategic Health Authorities* and that the latter *have been engaged in the development of commissioning and also exercise an oversight role in respect of the performance of Primary Care Trusts.* In turn, the PCTs were focused on, *the re-provision of NHS campuses...tackling health inequalities faced by people with learning disabilities; ensuring that people with learning disabilities who are in services that the NHS commissions or provides are safe; and progress being made in implementing the service reforms and developments described in ‘Valuing People.’* It is not clear what action PCTs were taking proactively to ensure that patients’ physical health care at Winterbourne View Hospital received special attention (see Mencap 2007).
- 2.25. In 2006, the *Joint investigation into the provision of services for people with learning disabilities at Cornwall Partnership NHS Trust* (which included assessment and treatment services) concluded that, *The SHA did not...manage adequately the performance of the PCTs to commission good quality services for people with learning disabilities* (p63). Although three Strategic Health Authorities had specific accountability for the PCTs commissioning placements at Winterbourne View Hospital during the SCR’s timeframe, the *Annual Health Check* which included questions about commissioning assessment and treatment services raised no concerns. Therefore there was no escalation of the SHAs’ engagement with the

PCTs. This approach, which places the onus on PCT commissioning, did not work for the patients at Winterbourne View Hospital.

- 2.26.** The NHS review expresses no view about (i) the growth of assessment and treatment units or the placement of adults with learning disabilities and autism in such units even though the latter is incompatible with national policy and recommended practice (Department of Health 2012); or (ii) the placement of adults with learning disabilities and autism at Winterbourne View Hospital who were not subject to the provisions of the Mental Health Act. However, the NHS Review expresses concern that *these patients may have potentially been deprived of their liberty*. Winterbourne View Hospital would not exist were it not for adults with learning disabilities. Given that the commissioners responsible for 13 placements were based within 20 miles of the hospital, it is possible that it was favoured as a local resource. The NHS Review identifies that a *move closer to home* ranked second in the listing of *Primary reason for placement*. Since some of these patients were informal patients, i.e. not detained under the provisions of the Act, then Deprivation of Liberty Safeguards should have been a paramount consideration. Furthermore, the hospital had a record of transforming voluntary patients into detained patients and therefore protection from opportunities for such potentially self-serving practice was, and is, required.
- 2.27.** The legal basis of four patients' placements is not known. They were placed by local authorities. It is not clear under what powers they were purporting to act and it was outside the scope of the NHS Review and the Serious Case Review to resolve this.
- 2.28.** It appears that at least two of the NHS commissioners were conscious of safeguarding alerts and up to ten care coordinators (i.e. either community nurses or social work care coordinators), were aware of other alerts.
- 2.29.** The NHS Review does not consider Winterbourne View Hospital's *Statement of Purpose*, namely the provision of *assessment and treatment* and *rehabilitation*.

### 3. Primary Care Trust Commissioning

*There are...distinctive features of commissioning services for people with learning disabilities that require their own focus. A succession of reports, including that of Sir Jonathan Michael's independent inquiry last year, have highlighted basic and serious shortcomings in the way that services are provided for people with learning disabilities, contributing to poorer health outcomes, avoidable suffering and, at worst, premature deaths. All commissioners have a duty to promote equality for disabled people. This means commissioning services in ways that secure reasonable adjustments for people with learning disabilities and ensure a coordinated approach to communications, use of data and partnership working (Foreword to World Class Commissioning: Improving the health and wellbeing of people with learning disabilities). The recommendations for PCTs included: a comprehensive needs assessment which seeks evidence on the numbers, health needs and experiences of people with learning disabilities; PCT board members exercising their Disability Equality Duty by asking tough questions about how commissioned services are meeting the needs of people with learning disabilities; building capability so that all those involved in commissioning general health services understand and act on the needs of people with learning disabilities (p10, Department of Health, 2009).*



- 3.1. The NHS South Gloucestershire PCT (Commissioning) review, written on behalf of **NHS commissioning organisations**, is entitled *Health Serious Case Review Management Report into NHS services accessed and provided for NHS commissioned patients in Winterbourne View Hospital (Castlebeck Ltd)*. It was completed in November 2011. It is 29 pages in length and contains seven sections, including three appendices.
- 3.2. The *Introduction* (1 page) outlines the scope of the *Management Report*. To address the *Terms of Reference* (2 pages) of the *Health Management Report*, information was gathered from *South Gloucestershire Council, the Public Protection Unit, the Care Quality Commission, NHS South Gloucestershire PCT, who commissioned with the local authority under a S.75 agreement<sup>5</sup>, Primary Care Medical Services contracted by Castlebeck directly...Great Western Ambulance Service NHS Trust, University of the West of England...North Bristol NHS Trust, University Hospitals Bristol NHS Foundation Trust...and Avon and Wiltshire Mental Health Partnership Trust*. The information concerned the contacts between Winterbourne View Hospital patients and each of the above. The *Health Management Report* sought to identify the themes and learning from (i) these contacts and from (ii) a sample of 20 patient chronologies *through the SCR process*.
- 3.3. The *Author's Information* (1 page) explains that since Winterbourne View Hospital was located in South Gloucestershire, the NHS South of England *requested that...the PCT should act as the coordinating commissioner for the other nine PCTs/local authorities involved in placing people at Winterbourne View Hospital*. Two professionals were recruited to assist with the task of gathering information from the nine NHS commissioning bodies which had placed people at the hospital between January 2008-May 2011.
- 3.4. The *Methodology* (4 pages) describes three distinct phases:
- *a patient data base was developed drawing from information shared by Castlebeck Ltd concerning clinical records, incident and accident reports and safeguarding alerts. The data base included the 18 patients at the hospital during the Panorama filming. Their placements were commissioned either by PCTs or were jointly commissioned with the local authority;*
  - *a tabletop analysis of patients' contacts with NHS providers was developed'*
  - *the drafting of the health management report.*
- 3.5. The *Critical Analysis* (6 pages) reveals that the 78, A&E attendances were mostly the result of *epileptic seizures, injuries/accidents, self-harm including lacerations and treatment*. The majority of Winterbourne View Hospital patients were *treated and discharged*.
- 3.6. In the *Summary of findings* (4 pages), North Bristol NHS Trust noted: *on reflection, the rate of attendances was potentially suspicious, but it would appear that clinical staff would not have been aware of previous attendances as there was no system in place to alert them...a paper-based system is still in use...and there is currently no statutory obligation to undertake surveillance of adult attendances at A&E, i.e. a staff member seeing a patient has no record of their previous attendances and there is no record of tracking attendances from a specific institution*. In contrast, there is a system in place for the Trust to *raise child protection alerts*.
- 3.7. The Health Report suggests that *the client group may have masked problems because what they presented with often fitted with a clinical perspective of a learning disability/challenging*

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<sup>5</sup> S.75 of the NHS Act 2006 (formerly S.31 of the Health Act 1999) refers to the pooling of budgets and to the delegation of functions. It places a power on the NHS and the local authority to work jointly.

*behaviour client group. However, four patients were identified who possibly should have been reported as safeguarding issues: two for human bites...and two for fractures following the use of restraint.* There were no safeguarding alerts raised by the Trust's Neurology team, by the University Hospital Bristol NHS Foundation Trust, by the Great Western Ambulance NHS Trust, by Avon and Wiltshire Mental Health Partnership Trust, by Primary Medical Services and GP Practice, or by the University of the West of England. Although the GP (who was privately contracted by Castlebeck Ltd) had initially made weekly visits to Winterbourne View Hospital, during the hospital's final 12 months a system was introduced *where escorted patients would attend the practice for routine primary care visits.* The Health Report states that *there was evidence of appropriate medical referrals to specialist services and diagnostics services.*

- 3.8.** The *Conclusions* note that although *some commissioners were aware of safeguarding alerts when raised, the majority were not, and there was no mechanism...for each commissioner to alert each other...There is no 'supra' surveillance and notification system across all NHS and private providers...Community Psychiatric Nurses would have no input to a private acute hospital...this is not a route through which concerns could have been raised.*
- 3.9.** The *Appendices* (9 pages) contain the SCR's Terms of Reference; a template for the patient data base; and *Explanatory notes* concerning the Mental Health Act 1983.
- 3.10.** The Health Report notes that *the patient chronologies do provide a comprehensive overview of the healthcare delivered to them while at Winterbourne View Hospital...some of the findings have not been included in this report as they are outside the Terms of Reference set for the health management SCR but may be of interest to the SCR Panel.*
- 3.11.** The Health Report does not consider the use of psychotropic medication, or the occasion when a Winterbourne View Hospital patient's repeated A&E visits during 2010 for self harm, resulted in the documented statement that *A&E staff not happy to see patient back again with the same cuts, may refuse to give treatment in the future.* Separately, the occasion when a patient with infected arm lacerations belatedly attended A&E, no alerts were raised by the hospital.
- 3.12.** The Report acknowledges that *a more robust multi-agency approach* is required if the adult safeguarding practices of A&E departments, for example, are to be enhanced. It holds back from proposing that commissioners should invest time in visiting placements, asking about hospital discharge at the point of admission, asking questions about staffing levels, staff training and supervision, prescribing practices and their oversight, and as crucially, patients' physical and dental health care.
- 3.13.** **The Serious Case Review Panel considered 20 patient chronologies.** What is not clear is whether a "baseline view" of patients' health status was secured at the time of admission, or even whether patients' physical health concerns were followed up. Since the GP contracted<sup>6</sup> to provide a service to the hospital's patients declined to share their medical records, it is possible that Primary Care had such a baseline for all patients and it is possible that physical health concerns were followed-up. However, given that it was over a month before one patient was registered with the GP, the information in the hospital's nursing and medical notes suggest that there was an incomplete baseline and a limited tracking of medical

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<sup>6</sup> The 2006 Contract states that a fee of £10 per week, per patient was reimbursed to the GP practice. At full capacity (24 patients), this equates to £12,480 per year.

events. For example, there is no recording indicating that a young patient who disclosed a testicular lump received the urgent examination required. Another patient whose weight loss became a source of concern did not benefit from a detailed nutrition audit. (The latter was described by a reviewer as “poorly completed.”) The same patient’s blood count was monitored and when a markedly reduced white blood cell was noted, Clozaril was appropriately discontinued. However, six days later, an entry in the records states *registered for Denzapine*. These two medications are identical being branded names for the generic Clozapine. Similarly, records of prescribed medication also suggested the possibility of duplication concerning Tegretol and Carbamazepine. It was difficult to determine whether or not the duplication was in the recording or in the administration of the drugs. The latter would increase possible toxicity. The ways in which the medication was recorded may have resulted in the duplication of some medication for one patient.

- 3.14. Some patients had a multiplicity of physical and mental health problems. It is not known whether or not the monitoring of patients’ physical problems was routine. It appears that the behaviour of some patients was more likely to be attributed to psychiatric problems, e.g. a patient described as having *pseudo seizures* was taking, *inter alia*, anti-psychotic medication with side effects including Parkinson-like symptoms. It seems that the risk of “diagnostic overshadowing” prevailed in Winterbourne View Hospital, i.e. the tendency to attribute changes in physical wellbeing to the behaviour of a person with a learning disability, autism and/or a mental health problem, rather than physical pain or a significant illness. The nursing record of the same patient states, *arms purple and red blotches. Sore neck*. If these symptoms were followed up, there was no record of the outcome at the hospital.
- 3.15. There is an example of discrepant recording on an occasion when a patient self harmed, e.g. the *incident and accident forms state ‘staples to wound’* and the notes from A&E state *no sutures required. Discharged with advice*. A patient who became restless, beating his chest (with implied breathing problems) with high blood pressure was not taken to A&E. The staff were advised to give oxygen.
- 3.16. Constipation plagued many patients with one patient requiring hospital admission for an enema. Nothing can be discerned about the quality of patients’ diets or the opportunity to physically exercise by going for walks, for example, both of which may have offered some relief to patients.
- 3.17. There would appear to be a consistent lack of clarity in prescribing rationale with many of the patients taking anti-psychotic and anti-depressant medication with no diagnosis of serious mental illness to support their use. The records, albeit with their limitations, suggested that patients with “mild learning disabilities” and/or without a mental health diagnosis were taking a lot of anti-psychotics and anti-depressants.
- 3.18. The GP was responsible for prescribing all medication for all patients at Winterbourne View Hospital, i.e. the cost of patients’ medication was borne by NHS South Gloucestershire PCT. It is not known whether the PCT was aware of this prescribing arrangement. The CQC’s responsive review confirmed that the medicines for all Winterbourne View Hospital patients were prescribed by the GP and that prescriptions were dispensed by a local pharmacy. The psychiatrist wrote the *medicines administration record sheets for nurses to complete when they gave the medicines*. Some gaps and discrepancies were noted and the medication auditing system *had not been completed fully*. Winterbourne View Hospital was a *designated*

body for controlled drugs as defined in the *Controlled Drugs (Supervision of Management and Use) Regulations 2006*. The Regulations require the appointment of an Accountable Officer for organisational responsibility of controlled drugs. The Accountable Officer registered with the CQC was the former registered manager i.e. there was no Accountable Officer. *There was a lack of clarity as to how these responsibilities were being fulfilled resulting in controlled drugs not always being handled safely.* Although the PCTs which commissioned placements at Winterbourne View Hospital typically did not seek a breakdown of the weekly charges, one PCT noted that *drug therapies were recharged at cost.*

- 3.19.** Given that the GP was advised not to share the medical records of Winterbourne View Hospital patients without their consent with the author of the *Health Serious Case Review Management Report*, the hospital's records were the primary information source. It appeared that one patient was not receiving medication for either epilepsy or hypothyroidism, irrespective of documented diagnoses. The same patient was taking a lot of medication even though the records stated *no evidence of mental illness*. The extent to which this patient's problems were induced by medication, or the patient's behaviour was medicalised, were not considered in the notes available. Another patient, about whom the records state, *no evidence of mood or psychiatric disorder...does not appear to suffer from mental illness/psychotic disorder* was treated with anti-psychotics. There was no detailed rationale for this. Similarly, a woman patient acknowledged to have *no psychiatric illness* was taking anti-psychotics, sleeping medication and tranquilizers and was on occasion given intramuscular PRN<sup>7</sup> after having been restrained. During a visit, the relative of one patient expressed concern about the patient's *hyper-salivation and poor swallow. Thought it may be an adverse effect of Zuclopenthixol.* This was discussed with the psychiatrist and a referral was made to a Speech and Language Therapist. When the medication was discontinued 11 days later it was noted that *swallowing improved, no longer at risk of choking.*
- 3.20.** The Disability Rights Commission (2006) noted *Studies have estimated that between 20% and 66% of people with learning disabilities are given psychotropic medication. It is often used as a form of chemical restraint for behaviour management rather than to treat mental health problems. Its effectiveness in addressing challenging behaviour is questionable and there are strong arguments for stopping or reducing its use for many people.*
- 3.21.** Patients' dental problems were extensive. One patient required *total extractions* over 12 months after admission to Winterbourne View Hospital and another was acknowledged to be in a lot of pain resulting in excessive and severe head banging. Ten days after admission, a patient complained of toothache and *staff advised it would be left until Monday* i.e. two days later. Ten days later, the patient was treated for an abscess and the tooth was extracted the following month.
- 3.22.** On the occasions when referrals were made, the rationale for these was not consistently cited in either the hospital's nursing or medical notes e.g. *ECG<sup>8</sup> performed*; also, the rationale for such major tests as EEG and CT<sup>9</sup> for one patient were not noted in the available records. While there were examples of the appropriate requests for both GP and Out Of Hours, on call doctors to attend to patients, the information did not suggest that this was

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<sup>7</sup> Pro re nata refers to medication that should only be taken as needed

<sup>8</sup> An electrocardiogram records the electrical activity of the heart

<sup>9</sup> A Computerised Tomography scan is a type of X-ray which produces cross sectional pictures

consistently recorded. In contrast, there was evidence that one patient who was in a very neglected state on admission was physically much improved within a few months and acknowledgement that her self-harming might have physical origins i.e. it was noted that *changes to behaviour may be due to dental pain*. Another patient's records are striking because of their atypical detail and evidence of clinical oversight. The patient appeared to have an interesting timetable of daily activities. There were 39 psychiatric reviews documented between October 2007 and February 2009. It is not clear why this patient received such attentive oversight or why the almost daily use of restraint at the outset of the placement faded over time.

- 3.23.** Winterbourne View Hospital's medical and nursing records confirmed the misuse of restraint, i.e. it appeared extraordinary, excessive and as the BBC Panorama noted, dangerous. The higher levels of unmet physical healthcare needs of adults with learning disabilities, including those arising from obesity and heart problems, for example, could adversely affect those subject to prone or t-supine restraint. In addition, the trauma for adults who have endured sexual assaults of being pinned to the floor, and the possibility that people with communication problems may not understand or respond to requests before and during restraint mean that people with learning disabilities and autism are uniquely disadvantaged by this procedure. Castlebeck Ltd's IMR noted that *during 2010, there were a total of 379 physical interventions recorded. In 2011, for the first three months of the year there were 129 physical interventions recorded*. Some methods appear to be unique to Winterbourne View Hospital e.g. *Incident form completed to manage aggressive behaviour, use of MAYBO and half fire blanket technique reported*; on one occasion the restraint involved the use of *cradle and blanket*. Another patient was described as having been *restrained in duvet for 20 minutes*. A commissioner stated of one patient: *There is reference in the care plans to the MAYBO technique...this was deemed an appropriate method of restraint for staff who have received training in the technique...it was used to immobilise* (the patient funded by the commissioner). *It is also documented that a mask was used on two occasions. The use of this approach is not written in care plans as being agreed to, and there were no explanations or rationale for its use. There was no paperwork included within the records with regard to either of the above.*
- 3.24.** An accident form completed on behalf of one patient noted *carpet burns to face following restraint*. On another occasion it was noted that *restraint used for own safety 25 minutes for verbal abuse and aggression*. A psychiatrist advised the avoidance of *heavy physical restraint* of a patient who had experienced some breathing problems. The following day the nursing records stated, *kicking doors in corridor, lay on floor and scratched his face, restrained by staff for 10 minutes, p.r.n. medication administered*; and three days later, *patient demanded to be taken out for a walk, self-harming behaviour restrained for 15 minutes*. Restraint appeared to be the default response since it was a daily occurrence at Winterbourne View Hospital.
- 3.25.** One patient described as *tearful* on the date of her admission was restrained for 50 minutes on the same day. Patients were even restrained on their beds and on sofas e.g. *Attempts to abscond...restrained on sofa in the foyer, when calm returned to top floor*. Three days later, *request by GP for an x-ray of right shoulder due to pain and restriction to abduction*. Another new patient initially described as *tearful on arrival* at Winterbourne View Hospital was subsequently described in nursing records as *unsettled* and five days later was subject to

- Restraint for 4 ½ hours Lorazepam given. Ten days later this patient was observed to be limping by night staff. She explained that the limping was due to being restrained.*
- 3.26.** Another patient *twisted and fractured her right wrist during a restraint. Restraint stopped and patient taken to A&E for treatment.* The same patient sustained a *cut to left ear* and on another occasion, *carpet burns to left knee and marks on upper right arm and scratches to face.* Both sets of injuries arose from being restrained. A patient *sustained scratches to neck during a restraint* because a staff member *held the patient with keys in their hand.* Another patient, about whom it was documented, *recurrent dislocation of knee – need to be mindful when using restraint,* was restrained after an attempt to abscond. After this it was noted that *knee dislocated and then went back into place, patient crying with pain, leg raised.* On an occasion when this patient was restrained, an incident form noted that *patient started crying stating that her knee had ‘popped out’ and popped in again. Patient constantly crying but able to walk from small lounge to nurse’s station with a limp to let staff know the pain she was in...ice applied to knee and elevated. A little swelling to knee 24 hours later.* On other occasions this patient sustained a *carpet burn to forehead from headbanging during restraint. Olanzapine given....scratches on chest and bruises...documented on body map.*
- 3.27.** The frequency of restraints was under-reported. The notes of one patient stated, *no restraints recently* – when no restraints at all featured in either nursing or incident records. The records confirmed that there were many more *incidents* documented by Winterbourne View Hospital staff than were known to external agencies e.g. there were 286 incidents documented and 12 Serious Untoward Incident records concerning one patient between July 2008-June 2011; and over 100 incidents documented, with seven Serious Untoward Incident records, concerning a patient between July 2009-June 2011. It is significant that the number of incident forms do not tally with reference to incidents in the hospital’s nursing and medical records. It does not appear that the frequency with which some patients were restrained was shared during review meetings, with South Gloucestershire Council Adult Safeguarding or with the commissioners of hospital placements.
- 3.28.** The hospital’s nursing and medical records of seven patients indicated that physical restraint was accompanied by the use of tranquilizers e.g. *Incident with TV remote in lounge, dragged to floor off settee by staff, taken to quiet lounge. Restrained for 10 minutes. Chlorpromazine 100mg given.* More generally, the indications, type and dosage of PRN medication were not consistently recorded in the nursing notes. The duration of patient restraints was not always noted, although on at least one occasion a patient was restrained for 6 hours. The records suggested that some patients sought restraints, e.g. *As night staff came on, the patient being restrained...requested staff to be held on the floor...asked to be restrained by staff.* It is not known whether or not this was a means of taking some slight control and/or self-protective action by getting to the floor without being forced down.
- 3.29.** As the Care Quality Commission’s responsive review confirmed, it does not appear that the *recorded recommendations* arising from at least one incident involving restraint were acted upon.
- 3.30.** The nursing and medical records at Winterbourne View Hospital suggested that there appeared to be a low threshold for putting patients on a Mental Health Act section e.g. a patient admitted *for further support around his challenging behaviour and epilepsy* was described within a week of admission as *very confrontational. Not able to see GP at surgery as behaviour is too challenging at present. Complaining of a sore throat.* Seven days after

admission an *Assessment under the MHA* resulted in detention under *Section 3*. On another occasion, notes regarding a First Tier Tribunal – Mental Health hearing stated that the hospital’s psychiatrist applied for a Barring Order *as patient still suffering from mental disorder and detention in hospital still necessary due to probability of serious physical injury or lasting psychological harm. Step down within Winterbourne View offered...patient agreed to remain in hospital as a voluntary patient.* This suggests that had the placing commissioners scrutinised patient records, evidence of a possible conflict of interest for Responsible Clinicians identified by the NHS South of England may have been identified sooner.

- 3.31.** It does not appear that Winterbourne View Hospital was a peaceful place. One patient was known to react *badly to loud noises and people shouting* and another required *a quiet setting as noise triggers behaviours*, and yet the sheer volume of restraints and the alarms associated with these would suggest that this hospital could not deliver the silence these patients favoured. Four forms of violence prevailed within the hospital – destruction of property, fighting between patients, the struggles associated with restraint, and self-harming, which sometimes required A&E treatment e.g. *punched (another patient) in the face; punched (by another patient) in the stomach; Became agitated and paced about, tried to strangle himself with the string of his hoodie. Restraint used for about 20 minutes – reported to be extremely distressed. Restrained again for another 20 minutes.* The ‘removal’ of patients who had been restrained, and those who were to be restrained to the *quiet lounge*, would suggest that this room’s name was unrecognisably remote from reality. Having restricted access to bedrooms was stressful for patients who very much wanted time to themselves and disliked having to be part of a group and engage in group activities.
- 3.32.** Typically, treatment at Winterbourne View Hospital hinged on a misunderstanding of behavioural methods. While there is little doubt that the behaviour of some patients had origins in traumatic events and circumstances which pre-dated their admission to the hospital, and appeared persistent over time, there did not appear to have been records clearly describing a “target” behaviour in terms of frequency, duration or intensity, the events predicting these over the course of a day, the development of hypotheses linking a particular behaviour with consequences, and/or the collection of observational data to confirm or refute hypotheses, e.g. *seriously irresponsible and aggressive behaviour shown, risk of coming to harm; (the patient is) verbally and physically aggressive, anxious, tense and tearful; ongoing OCD<sup>10</sup> with environmental triggers; shortly after episode of restraint (the patient) became aggressive; behaviour escalated ending in restraint and prn lorazepam; ...sexual behaviour reported and inappropriate use of language.*
- 3.33.** Hospital staff demonstrated a limited understanding of the use of punishment and reinforcement. This was evidenced in such nursing and medical notes as, *aggressive after cigarette break withheld, crying. Calmed down in quiet lounge. Restrained for 10 minutes.*
- 3.34.** It appeared that the behaviour of patients was rarely interpreted as a response to being subject to the routines and practices of Winterbourne View Hospital or even the behaviour of nursing and support staff whose principal task appeared to be controlling patients. Winterbourne View Hospital’s nurses and support staff rarely made the connection between the behavioural disturbance of some patients and (i) their physical healthcare problems - a

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<sup>10</sup> Obsessive Compulsive Disorder

patient reporting arm pain during December 2010, continued to do so during February 2011; (ii) the demands placed on them, (iii) the limited environmental stimulation within the hospital, and (iv) the unsafe grouping of patients - several patients sustained bite injuries from other patients. For one man this resulted in a *right breast abscess requiring surgical drainage* and ultimately, the *removal of five sutures*.

**3.35.** The patient chronologies abstracted from Winterbourne View Hospital's records suggest that:

- there was more evidence of absconding than was known to either the police or to South Gloucestershire Council Adult Safeguarding;
- mostly patients had contact with professionals from their placing authorities i.e. the commissioners. However, there was no evidence that the responsible commissioner ensured that an external care coordinator was proactive in challenging practice at the hospital;
- staffing levels led to patients being contained and their behaviour being suppressed.

#### **4. South Gloucestershire Council**

*According to their website, The safeguarding adults Policy and Procedures aim to safeguard all adults resident in South Gloucestershire...Safeguarding adult concerns will be given a high priority by Community Care and Housing. Community Care and Housing has a duty to coordinate the interagency responsibility to safeguarding adult concerns and will consult with the Care Quality Commission, the Police and other agencies as appropriate. If an investigation is required a strategy meeting or discussion will be convened to decide who does what, by when and who they should report to. A team or District Manager will be responsible for coordinating the investigation.*

**4.1.** The local authority **Safeguarding Review** (of 28 pages) was completed in November 2011. The *Safeguarding Review* consists of an *Introduction* (3 pages); a section about *Working with Individual Alerts* (8 pages); a section concerning *Patterns* (4 pages); followed by a section about *Whistleblowing* (4 pages). The penultimate section discusses a *Wider Sample* (4 pages) and the Review ends with a *Summary of key findings and conclusions* (3 pages) and *recommendations* (2 pages).

**4.2.** The *Introduction* provides the contextual framework. Between October 2007 and April 2011, there were 40 safeguarding alerts involving Winterbourne View Hospital patients. Rather than focusing solely on these, the *Safeguarding Review* also took into account a *wider sample of 36 alerts* relating to *all care groups and a range of local teams*. The alerts concerning Winterbourne View Hospital were dealt with by South Gloucestershire Council Safeguarding Adults, a screening officer, social work and practitioner staff of three Community Learning Disability Teams and their District Managers.

**4.3.** The section *Working with individual alerts* establishes that the only relationship that South Gloucestershire had with Winterbourne View Hospital was as its local safeguarding authority. In most cases, safeguarding investigations at Winterbourne View Hospital tended to include the Council (i.e. safeguarding personnel and specialist learning disability staff), the



Police and the hospital only. The *Safeguarding Review* found that South Gloucestershire Council's safeguarding policy and procedures were inconsistently applied and that investigation management was sometimes poor.

- 4.4. *Of the 40 alerts, 10 related to incidents between patients...27 involved allegations of staff to patient abuse. In only 19 of the alerts were patients that were the subject of alerts seen by the police and/or social workers. The remaining 21 cases were largely the subject of internal investigation...this included 13 concerned with staff-patient allegations.*
- 4.5. The documentation suggests that (i) Adult Safeguarding would inappropriately *defer to the police*, even though they acknowledge that safeguarding practice has to span professions and organisations, and that (ii) rather than coordinating and consulting safeguarding activities, there were occasions when no action resulted from very concerning events e.g. *a patient has two teeth pushed into his mouth 'consistent with a severe blow or blows...consistent with a fight' according to a Doctor at the Dental Hospital. The patient was not interviewed by the police, who said that it was clear staff had punched him in the face but that this seemed 'understandable' (on the basis of everyday understanding of self-defence); on another occasion, a patient allegedly assaulted by another patient wanted to complain to the police. The police cancelled the interview...at the request of a Winterbourne View psychiatrist who argued it was not in the public interest to interview him.* These incidents, which glimpse the effectiveness with which Winterbourne View Hospital staff deflected concerns, confirm that the collective shortcoming of all agencies required assertive challenge by Adult Safeguarding.
- 4.6. There were at least five occasions when Winterbourne View Hospital managers were asked to investigate allegations and report their findings to Adult Safeguarding. However, *they failed to produce required reports and there was not an effective system in South Gloucester to progress chase.* Furthermore, there was an *over-reliance on telephone discussions*, albeit multi-agency ones, rather than meetings followed by the timely distribution of minutes. When meetings were convened, which did not occur as often as they should, representatives from placing authorities and clinicians from outside the hospital were not always present.
- 4.7. Some of Winterbourne View Hospital's alerts were subject to unexplained delays. In addition, the *Safeguarding Review* found that *too many cases appeared to tail off inconclusively, with no clear decisions, or no clear rationale for decisions.* While there is evidence that *South Gloucestershire staff made considerable efforts to establish communication with commissioners...they might have been clearer in asserting the need to follow up particular issues.* In fact, *interviewees suggested that there was a strong temptation to close down cases as a 'host' safeguarding authority so that work outside of this role was not undertaken by default.* It was found that, *local case holders, such as nurses, did not routinely communicate with their PCT Commissioners so information that it was presumed had been passed on had not been shared.*
- 4.8. Other safeguarding cases appear to have been closed prematurely i.e. without a clear rationale or without even a questionable rationale for doing so, e.g. a patient alleging physical assault by a staff member, repeated her account to a social worker and reported being *scared* of the staff member. The case tailed off and was closed by the manager almost six months later because *there were no witnesses, staff denial and the view that 'nothing was to be gained from further investigation.'* On another occasion, the Manager advised that

*as the member of staff has admitted hitting the patient, and the police have concluded it was self-defence (head butt causing a broken nose), there is no further action required.*

**4.9.** With regard to *Patterns*, beyond brokering a meeting with Winterbourne View Hospital and the commissioning PCT about a patient who was believed to be making unfounded allegations, South Gloucestershire managers did not identify a pattern of concern within specific time frames. In addition to the pressure of competing work, the following explanations were considered:

- the proactive contacts with Adult Safeguarding initiated by the hospital manager and *growing confidence in the establishment*;
- when alerts were made, Adult Safeguarding was reliant on the hospital for patient information and clinical input, including scenarios where staff were alleged to have abused patients;
- most alerts were made by the hospital;
- the hospital was the *only establishment of its type locally. Its patients were unknown to council staff outside of safeguarding investigations.* Furthermore, detained patients *could be seen to present a threat to themselves or to others*; it was perceived as a hospital of ‘last resort.’

**4.10.** Thus low expectations of what might be expected of conduct and standards at Winterbourne View Hospital *may have led investigators to probe alerts less thoroughly.* The case audit system was ineffective in alerting the Safeguarding Adults Board to the emergent pattern of concerns at the hospital and no one assumed responsibility for monitoring and reviewing action plans arising from individual safeguarding cases.

**4.11.** With regard to *Whistleblowing*, the *Safeguarding Review* discusses the chronology of events between 11 October 2010 and 17 March 2011. Terry Bryan’s email was forwarded to the South Gloucestershire Safeguarding Adults by the hospital’s acting manager. Safeguarding Adults acknowledged the email, posed a set of questions and comments and sought to arrange a meeting. During late November, Safeguarding Adults forwarded the email to the CQC’s Compliance Inspector. The hospital acting manager’s leave and safeguarding investigations concerning four Winterbourne View Hospital patients led to further delays. Safeguarding Adults linked the need for strategy meetings with the Terry Bryan’s email and indicated that the safeguarding investigations would be considered at the whistleblowing meeting. Safeguarding Adults believed that the hospital’s acting manager, the email’s recipient, was addressing the matters concerning the 3-4 staff cited in the email and was unaware that there were previous investigations at the hospital which had not been taken to a conclusion. In addition, Safeguarding Adults’ simultaneous involvement in four other institutional cases, at a time when a post was vacant, resulted in a lack of urgency in responding. These difficulties were not disclosed to senior council managers. The hospital had not been challenged to act in a timely manner and its tardiness was not challenged.

**4.12.** The *Safeguarding Report* considers whether the compromised safeguarding practice regarding Winterbourne View Hospital’s patients existed elsewhere. A sample of 25 cases from 2010-11, and 11 cases from 2011-12, were drawn from *a range of care groups*. They had been dealt with by eight teams from across the council and reveal *generally very sound practice* e.g. the casework was sensitive, procedures were followed, decision-making was appropriate and evidenced, advice was appropriately sought, and plans were clear and detailed. While there was scope for improvement concerning the timely distribution of

minutes, the slow responses of some partners to agreed actions, and evidence of variation in the quality of some team responses, such shortfalls did not fall into the same category as those associated with the council's response to Winterbourne View Hospital.

- 4.13.** The *Safeguarding Review* concludes that *it is uncertain whether consistent application (of safeguarding procedures) would have prevented the behaviours and attitudes amongst staff at the hospital...it is possible that the circumstances of some individual patients might have been better safeguarded, and that a more coherent picture of what was happening at the hospital, and the opportunity to identify the hospital as failing its safeguarding obligations could have been assembled sooner.* The whistleblowing episode was ineffective and signalled a failure to hold Winterbourne View Hospital to account.
- 4.14.** The Council's review is thorough and reflective. It was written by a social care consultant who is independent of the Council. The *Safeguarding Report* confirms the complexities which arise in safeguarding adults and the tensions which exist between over-reaction and neglect. There must be an expectation that services supporting vulnerable adults will report, and sometimes take the lead in, investigating allegations of abuse.
- 4.15.** South Gloucestershire Council acknowledges that because alert information from Winterbourne View Hospital was treated as discrete in each case, safeguarding staff did not have a coherent overview of the crimes and the array of abuses. Although there was concern in relation to the potential for physical restraint to disguise intimidation and cruelty, Council Adult Safeguarding had no sense of the culture of perverse loyalty in which hospital staff appeared to collude in the indiscriminate use of restraint.
- 4.16.** Safeguarding work has to cross professional and organisational boundaries and the task of developing and maintaining relationships is paramount. South Gloucestershire Council Adult Safeguarding acknowledges that they should have challenged some of the assumptions of the police, for example by pressing for fuller explanations of decisions. As their concern about such decisions increased, these should have been referred to the Safeguarding Adults Board for multi-agency consideration.
- 4.17.** South Gloucestershire Council's consideration of whether or not safeguarding in its entirety was flawed is encouraging.
- 4.18.** Although there were shortcomings in overseeing, coordinating and in responding to safeguarding concerns at Winterbourne View Hospital, there is no evidence that these prevailed elsewhere.

## 5. Avon and Somerset Constabulary

Avon and Somerset Constabulary's website outlines the work portfolio of the Public Protection Unit as:

*providing a holistic service to the most vulnerable members of society...identifying vulnerable people early...making the safeguarding of children and other vulnerable people everybody's business and key to everything we all do...when crimes are committed, investigating them with skill, thoroughness and sensitivity and bringing offenders to justice...providing expertise in the management of investigations involving vulnerable victims.*

- 5.1. The **Individual Management Review** was completed in November 2011. The contents include an *Introduction* (2 pages); *Methodology* (2 pages); *Analysis of Police involvement with Winterbourne View Hospital, Staff and Patients* (25 pages); *Analysis of non-incident related police procedures* (3 pages); *Diversity concerns* (1 page); *Summary of findings (Good practice and issues of concern)* (3 pages); *Response to points raised in terms of reference* (4 pages); *Recommendations* (2 pages); *Appendices: chronology* (16 pages); *letter to Winterbourne View Hospital from the PPU* (2 pages); *Officer response to an incident* (5 pages); *South Gloucestershire District Training Provision* (2 pages).
- 5.2. The Police IMR is based on computerised data bases and interviews with individual officers. The incidents reported to the Police concerning Winterbourne View Hospital are considered in terms of their compliance with eight criteria, including for example, national recording requirements for both crimes and incidents i.e. *whether the response was appropriate according to the information provided and to the identified need* for both crimes and incidents.
- 5.3. There was no record of any Police contact with Winterbourne View Hospital before January 2008, whereas between January 2008 and May 2011, there were 29 Police contacts. Nine of these contacts concerned *carer on patient* reported incidents; five contacts concerning *patient on patient* reported incidents; three contacts concerned *patient on carer* reported contacts; and 12 reported contacts concerned *other incidents*.
- 5.4. In relation to the *carer on patient* incidents, three women patients were the focus of five separate incidents and four male patients were the victims of four separate incidents. Three referrals originated from Adult Social Care and three from the Manager of Winterbourne View Hospital. The remaining three were from the hospital's deputy manager, from a nurse at the hospital and from a patient's parents. The Public Protection Unit investigated two of five reported incidents of *carer on women patient* assaults.
- 5.5. All but one of the alleged assaults of *carer on women patients*, were associated with the use of restraint as practised at Winterbourne View Hospital. The exception concerned an assault by a woman carer which was witnessed by another carer. This carer was charged with common assault, given a 12 week suspended prison sentence, fined £200 and dismissed. With regards to the other women: the attending Police officer stated that one woman's assault complaint *occurred as a result of having been lawfully detained whilst trying to escape* and that the technique of restraint *appeared proportionate*. This was based on the

officer's meeting with the patient, *staff present and a social worker*. The second occasion on which this woman was restrained, *the allegation was not fully investigated as the victim retracted her allegation*. The member of staff concerned did *not appear to have been arrested or interviewed by the police* because of this retraction. Since the patient was assisted by a staff member to withdraw her allegation, *the police and others made considerable efforts* to establish whether or not the patient had been coerced to withdraw the allegation. This could not be established. The third woman was *believed* on one occasion, following investigation, to have made *a malicious allegation* of sexual assault because she had been restrained. The second occasion that this woman alleged that she had been assaulted, the member of staff concerned denied assault and, irrespective of an investigation which included a video interview, there was no prosecution. However, the police did note that *insufficient documentation had been completed* concerning the *level of restraint*.

- 5.6. The police acknowledge that revisiting these incidents highlights limitations in their own recording practice i.e. their Review reflects uncertainty whether or not multi-agency meetings resulted from some allegations – even though South Gloucestershire has evidence of the police contributing to such meetings.
- 5.7. The first of the four male patients whose alleged assault was reported to the police was questioned by an officer who was not part of the Public Protection Unit. The patient had been restrained in a van. He gave *several different accounts of what had happened* and did not appear distressed. In contrast, the member of staff had described how he had *pinned the service user in a restraint, which staff are trained to do*. Having explained to the patient that *he was aware that the use of force was necessary* the officer read this back to the patient. Before the officer left, the two individuals were invited to sign the notes and discuss the incident. On leaving, the officer saw the two men embrace. The officer's own reflections confirm the lengths to which she went to establish not merely whether or not a crime had occurred but the extent to which the patient understood the questions and the outcome. Although the steps taken by this non-specialist officer were sensitive, she did not involve the Public Protection Unit or generate an intelligence report.
- 5.8. The second male patient was alleged to have *grabbed* the wrists of a staff member *purportedly leaving him with no other way to escape...than to head butt* him. The patient sustained a broken nose. Following an investigation *it is documented that no criminal offence occurred*.
- 5.9. The third man, *with significant learning difficulties*, had touched the breast of a woman staff member, *then became very aggressive...at some point he suffered a broken tooth*. The incident was investigated by the Public Protection Unit.
- 5.10. The fourth male patient was alleged to have bitten a staff member who then *punched* the patient *in the face*. It was decided that the staff member had *acted instinctively in self defence*.
- 5.11. With regard to the *patient on patient* incidents, two concerned sexual assaults, (i) a woman patient was sexually assaulted by two male patients; and (ii) another woman patient was sexually assaulted by a male patient. Both incidents resulted in arrests and one man was prosecuted. There was *insufficient evidence* for further prosecutions. At the multi-agency meetings, concerns were raised about, the absence of risk assessments revealed by both investigations and levels of supervision at the hospital i.e. the patients should have been

within sight of a staff member at all times. At the strategy discussion concerning (ii) the acting manager was *tasked with conducting a full investigation* i.e. how did this occur given the observation levels which were supposed to be in place for the patients concerned?

- 5.12. The Public Protection Unit investigated when a male patient was bitten by another male patient. *However, no formal police investigation of the incident took place due to the identified mental capacity issues...This stance was supported by a hospital doctor who advised that it was more appropriate to deal with the matter internally.* There is no record of a strategy meeting. On another occasion, the same male patient bit a woman patient. An officer spoke to a staff member on the telephone. The latter confirmed that *the victim had autism and a mental age of 6 or 7* and (the perpetrator) *was detained under the Mental Health Act.* The incident was not recorded as a crime. The Management Review acknowledges that a report of assault should have been made and an investigation carried out.
- 5.13. With regard to the four, *patient on carer* incidents, the first concerned a woman patient who scratched and bruised a woman staff member who was restraining her. The staff member *reported it for recording purposes only* and consequently, *the allegation was not fully investigated as the carer apparently did not wish to pursue a complaint.*
- 5.14. The second incident concerned a male patient touching the breast of a woman staff member. This was not recorded as a sexual assault. In responding to the breast-touching, the patient was assaulted by two male staff members and he lost a tooth. The two incidents were investigated by the Public Protection Unit. The police acknowledge that the response *was not appropriate.*
- 5.15. The third incident concerned the physical assault of a woman staff member by a male patient. The woman sustained a sore jaw and bruised arm and *just wanted the matter to be recorded by the police.* Police officers went to Winterbourne View Hospital and *from enquiries,* decided that the patient *has no capacity due to his mental health issues.* The police acknowledge that a crime of assault should have been recorded.
- 5.16. The fourth incident concerned the physical assault of a woman staff member by a woman patient. The staff member rang the police to report that she had been bitten on the head, scratched and had some of her hair pulled out. The attending officer spoke to the member of staff and the hospital manager. The police acknowledge that their response was wanting. There was no Public Protection Unit involvement.
- 5.17. Of the 12 *other incidents,* two are *intelligence reports* about the pre- Winterbourne View Hospital behaviour of two patients. Two further reports concerned the *financial abuse* of a patient by relatives and the parent of another patient *behaving aggressively outside Winterbourne View Hospital.* A further incident concerned the sexual assault of a woman patient by a relative during a hospital visit. The police investigation and resulting multi-agency meeting *highlighted concerns over how an opportunity to commit the offence could have occurred during a visit.* Once again, the police raised concerns about the adequacy of patient supervision at Winterbourne View Hospital.
- 5.18. There were four occasions when the police were informed that women patients were missing from the hospital. Since on one occasion the patient was found within minutes, the police did not attend and there is no record of Public Protection Unit involvement. On the second occasion, the police attended and found the patient, noting that she made reference to *staff shortages,* and yet there was no safeguarding alert which closed off the possibility of

- (i) multi-agency involvement and (ii) a review of supervision arrangements at the hospital. When the same patient was reported missing on a further occasion, there was no debriefing either with the patient or with professionals outside the hospital. On the third occasion that this patient was reported missing she was with another woman patient. The police attended and the women *stated that they did not wish to return* to the hospital. Crucially, the police could not have known (because the hospital did not inform them) that this patient had attempted to abscond on three occasions and absconded on 12 occasions in total.
- 5.19.** When a woman patient held a plastic knife to her throat, which staff took from her, she thrust the knife at a staff member. A police officer attended the hospital. Neither the patient nor the staff member sustained injuries and the staff member made *no formal complaint*.
- 5.20.** Two reported incidents, separated by 18 months, highlight particular concerns about Winterbourne View Hospital staff. A patient rang the police one evening to report his distress. A few minutes later he rang again to report that *things had been kicking off* at Winterbourne View Hospital. A communications officer spoke to a staff member and was reassured that there was *no requirement to send an officer*. The police concede that *if another vulnerable person, such as a child, had made this phone call it is likely the police would have attended to check that everything was in order*. The second incident arose from an altercation between three patients which led to damage to the hospital. Since attempts to restrain the patients were unsuccessful, the police were called. They used *handcuffs and leg restraints...to restore order*. The police acknowledge that *this incident should again have identified concerns about the practices and supervision at the hospital with led to a major public disorder...highlights concerns in relation to the safety of both service users and staff at the hospital*.
- 5.21.** Finally, the IMR contains a letter from the Public Protection Unit in 2009, *requesting the introduction of CCTV* to address the want of evidence when patients alleged assaults which were not witnessed.
- 5.22.** The IMR states that *there is some evidence of police decision-making having been indirectly affected by a lack of understanding of the complex medical issues of some service users and a possible over reliance on the information provided by professionals working at the hospital...there are failures on police recording and subsequent investigation of apparent crimes...incidents seem to have been dealt with in isolation...outside of the specialised Public Protection arena there appears to be a lack of understanding of vulnerable adult alerts and referral mechanisms...a lack of corporate understanding and oversight of the pattern of vulnerable adult safeguarding across the constabulary...insufficient recognition of the "voice of the service user"...and relatives of victims were not always informed of criminal investigations involving their next of kin or the outcomes*. In contrast, there are examples of multi-agency co-operation in response to incidents; the prosecution of a staff member resulting from police investigations; and the police drawing attention to the absence of risk assessments concerning the protection of women patients.
- 5.23.** The Police Management Review does not explain the role and specific functions of the Public Protection Unit and how, on occasions, this was responsible for investigating allegations when on other occasions, non-specialist officers assumed this role. Typically, non-specialist or uniform officers are sent to deal with incidents by a police call taker. The attending uniform officers record their decisions on a system which should be monitored by the PPU. Public Protection Unit investigators are more likely to respond to direct notifications and

referrals from Adult Social Care for example. With regard to restraint, for example, minutes of a 6 November 2009 meeting at Winterbourne View Hospital stated that a *Public Protection Unit* (investigator), *has been involved in the responses to allegations around the use of restraint...(who was) satisfied that it was not appropriate to treat the incidents reported as assaults*. It should be noted that notifications to the HSE concerning patient injuries sustained during restraint typically indicated that hospital staff were appropriately using MAYBO techniques and that they were competent to do so. Prior to the transmission of *Undercover Care: the Abuse Exposed*, this may have appeared plausible to other agencies and professionals.

- 5.24. The police acknowledge that poor recording practice suggests uncertainty about the nature of the multi-agency meetings associated with the allegations. More importantly however, they acknowledge that there should have been crime reports; that the level of force used during restraint and the recording of restraints at the hospital should have been challenged; that patients should have been formally interviewed; and that actions should have focused on *reducing the opportunity for further incidents to occur*.
- 5.25. The police appeared to have assumed a lead role in a multi-agency process in advising Winterbourne View Hospital when its manager was asked to undertake an internal safeguarding investigation. It is not known why this occurred on the occasions when patients were distressed and harmed during restraint. The police are primarily crime investigators. This primary obligation, as a basis for explaining decision-making, is not consistently clear i.e. when a decision has been reached that an incident is not a criminal act, the rationale for the decision is not always apparent. For example, on an occasion when a patient was alleged to have been *kicked and threatened by staff*, the Public Protection Unit *advised that it was too late to pursue anything criminally*. This should have constituted a safeguarding alert. In contrast and as the IMR acknowledges, a hospital staff member alleged to have assaulted two patients did not appear to have evoked any particular concerns.
- 5.26. A Winterbourne View Hospital psychiatrist, a Castlebeck Ltd employee, should not have advised the police that it was better to deal with a patient on patient assault *internally*. The uniformed officer concerned did not (i) consult with South Gloucestershire Council Adult Safeguarding or (ii) consider the appearance of influence, because they took the advice of a psychiatrist employed by Castlebeck Ltd.
- 5.27. Patients at Winterbourne View Hospital who became known to the police did not appear to benefit from the services of independent professionals.
- 5.28. The Public Protection Unit does not routinely record all telephone contacts from partner agencies. However, there was a disparity in partner agencies' understanding of the status of the telephone calls – were agencies seeking informal advice or sharing ideas? As a result, information from South Gloucestershire Council Adult Safeguarding suggests that the police had greater involvement in safeguarding concerns arising from the hospital than is indicated by their IMR i.e. an officer undertook police checks on a hospital staff member who had threatened a patient with assault; and two officers *gave advice* with regard to interviewing patients.
- 5.29. Although the police were informed when patients were missing from Winterbourne View Hospital, and on at least one occasion knew that they did not wish to return, this valuable "intelligence" was not shared with South Gloucestershire Council Adult Safeguarding. It is possible that it was not regarded as significant since the scale of absconding and attempted



absconding from the hospital was not disclosed to the police, to the Care Quality Commission or to South Gloucestershire Adult Safeguarding.

- 5.30. Safeguarding practice is not static. Developing and maintaining trust in partnership working is critical to considering the emergence of patterns and pooling “intelligence.” Discussion about when services may investigate safeguarding allegations themselves should be undertaken in partnership. Assumptions concerning the (i) perceived impairments of patients and (ii) the legitimacy of restraints which resulted in injuries e.g. the loss of a tooth, should have been subject to multi-agency challenge.
- 5.31. The police suggested permanent video surveillance or “prophylactic technology” within the hospital’s communal areas to address concerns about the allegations and counter allegations of patients and staff. However, questions concerning *inter alia* patients’ consent to being permanently monitored, the diminution of their privacy, access to the monitors and the time frame for storing the resulting films (see Desai, 2011; Foucault 1975) meant that the suggestion was set aside.

## 6. The Care Quality Commission

*The Care Quality Commission’s (2010) Guidance about Essential Standards of quality and safety states of the Commission, the Care Quality Commission is the independent regulator of health and adult social care services in England. We also protect the interests of people whose rights are restricted under the Mental Health Act. Whether services are provided by the NHS, local authorities, private companies or voluntary organisations, we make sure that people get better care. We do this by: driving improvement across health and social care; putting people first and championing their rights; acting swiftly to remedy bad practice; gathering and using knowledge and expertise, and working with others.*

- 6.1. The CQC (i) **Compliance Review** and (ii) **Internal Management Review of the Regulation of Winterbourne View** were completed in July and October 2011. The Compliance Review was published online in July 2011.
- 6.2. The **Compliance Review**’s overarching conclusion was that Winterbourne View Hospital was *not meeting 10 essential standards*, resulting in *enforcement action to remove Winterbourne View from the registration of Castlebeck Care (Teeside) Ltd*. The Summary of the findings spans six pages.
- 6.2.1. The trigger for the review was the prospective transmission of the Panorama programme, the evidence obtained by the BBC in advance of this and Terry Bryan’s email. Specifically, the review focused on *eight aspects of the essential standards of quality and safety: Care and welfare of people who use services; safeguarding people who use services from abuse; management of medicines; requirements relating to workers; supporting workers; assessing and monitoring the quality of service provision; complaints; and records*.
- 6.2.2. An unspecified number of compliance inspectors visited Winterbourne View Hospital on 17, 18 and 24 May and on 2 June 2011. They met with patients, staff, the acting Manager and Regional Director and they collected and scrutinised records. They undertook a *short observational framework for inspection...to establish, for a small number of people, what*

*their experience of living at Winterbourne View Hospital was like.* The Summary takes the *aspects of essential standards* and reproduces the *judgement* from each of the sections of the report.

- 6.2.3.** With regards to the *Care and welfare of people who use services* (pp12-16) the compliance inspectors noted that risks arising from self harm, for example, had not been assessed. While the hospital had documented that *all staff* were to receive first aid training, *only nine of 53* had done so. There were *many examples* of the hospital failing to review and update risk assessments *following serious incidents*. The reviewers noted the use of disrespectful language in daily care records and incident reports and concluded that *staff had a controlling approach to managing people*.
- 6.2.4.** The Compliance Inspectors noted under *Safeguarding people who use services from abuse* (pp17-19) that *staff lacked the knowledge and expertise to support people* and that *the use of restraint was not always appropriate, proportionate, justifiable to the individual or considered as the last resort*. Some records contained inconsistent accounts of events surrounding the use of restraint and there was no evidence of post event learning... *The registered person had not made suitable arrangements that were effective to identify and prevent abuse from happening*. The resignation of staff subjected to disciplinary proceedings, without reporting them to the Independent Safeguarding Authority or the Nursing and Midwifery Council, did not safeguard patients.
- 6.2.5.** The compliance review consistently refers to patients as ‘people’ and appears to distance itself from labelling patients as such, e.g. *he was concerned to note that the ‘patient’ was not offered an opportunity to seek legal or advocacy advice* (p18). Similarly, the report slips into describing Winterbourne View Hospital as a *home* (p20). These were unintentional errors. While such sensitivity may chime with the preferences of people with learning disabilities and their families, it is problematic. Winterbourne View Hospital’s Statement of Purpose hinged on *assessment and treatment* and *rehabilitation*. The label of ‘patient’ may not be value free in this context. It carries with it reminders of long-stay hospitals. Nevertheless it was warranted in this instance, since Winterbourne View Hospital was an independent hospital providing services principally to patients detained under the Mental Health Act 1983. The people placed there were NHS patients.
- 6.2.6.** The responsive review makes several references to patients *living in* Winterbourne View Hospital as though this was a residential service providing a home. It appears unlikely that the review is referring specifically to residents who are no longer subject to the provisions of the Mental Health Act 1983.
- 6.2.7.** The *Management of medicines* (p20-22) at Winterbourne View Hospital was found to be wanting because the auditing system contained records which were incomplete.
- 6.2.8.** The *Requirements relating to workers* (p23-24) examined the records of 23 staff members. The Compliance Inspectors found that the hospital’s recruitment practices were wanting insofar as some staff were appointed in advance of the hospital receiving their Criminal Record Bureau checks. Also, where references had been obtained, these were inadequate. The hospital failed to inform the regulatory and professional bodies about staff deemed *unfit to work*.
- 6.2.9.** The Review of the standard, *Supporting workers* (p25-29) refers to the hospital’s *Statement of Purpose*, i.e. staff are *specifically trained in the use of legislation and on protecting the rights and principles of those people detained*. This does not tally with the hospital’s training

records. Furthermore, staff supervision did not take place according to the required frequency and the notes resulting from this were not linked to appraisal, to specified objectives or to events at the hospital. Such findings led the Compliance Inspectors to conclude that Winterbourne View Hospital patients *do not have their needs met by competent staff*.

- 6.2.10.** The Compliance Inspectors found evidence of *a lack of leadership and management and ineffective operation of systems for the purposes of monitoring of the quality of service that people receive* (p30-33). They expressed misgivings about Castlebeck Ltd's *Quality Manual* since the processes it contained were not followed. Failure to review and follow-up incidents at the hospital and to inform the regulator of incidents compromised the safety of patients.
- 6.2.11.** At Winterbourne View Hospital *Complaints* (pp34-35) were notable by their absence. Irrespective of the Compliance Inspectors' request for *a copy of any complaints made*, they were informed that the service *had not received any complaints since 2009*. Complaints either embedded in a patient's care notes or logged during the *unit-led clinical governance committee meetings* were not investigated.
- 6.2.12.** The Compliance Inspectors found that the hospital had failed to notify the Care Quality Commission of (i) the unauthorised absences of detained patients (p36-38) and (ii) *important events* affecting the welfare, health and safety of all patients (p38-40).
- 6.2.13.** The Compliance Inspectors found failings in the records scrutinised. The CQC produced the Compliance Review within two months of the Panorama transmission. While it bears some signs of being produced in haste, it includes such a range of topics that a single Inspector could not possibly address them all. While the review has gaps, e.g. the experience of visiting relatives, staff 'turnover' and the use of agency staff; attention to people's physical healthcare; and injurious restraints, it was more challenging of the hospital and provided a stronger impetus for taking action than previous inspections by the Healthcare Commission, the Mental Health Act Commission and the CQC.
- 6.3.** The ***Internal Management Review of the Regulation of Winterbourne View*** spans 48 pages and includes three Appendices containing the Terms of Reference of the Serious Case Review, the Recommendations and a Glossary of terms used.
- 6.3.1.** The Foreword by the Chief Executive, Cynthia Bower acknowledges that the CQC *failed to respond to the whistleblower* and stated that it, and its predecessor organisation, *failed to routinely follow up on the outcomes of safeguarding alerts and incorporate these into regulatory records*. The Foreword concedes that events at Winterbourne View Hospital *revealed a number of system weaknesses...process and management failures*.
- 6.3.2.** The Introduction (of 2 pages) sets the scene: Castlebeck Ltd was registered with Companies House in 1986. It is a specialist provider of healthcare and support for people with learning disabilities, complex needs and challenging behaviour in locations in the Midlands, North East England and Scotland. Winterbourne View Hospital and Rose Villa (in Bristol) were the only two services located in the South West.
- 6.3.3.** The Background (5 pages) considers Policy, Commissioning Guidance for learning disability services, Safeguarding and Whistleblowing.
- The Policy considered (Mansell/Department of Health 1993 and 2007) and the *failure of commissioners to develop the right kind of services*. In terms of service models, Professor Mansell advised:

*Commissioners should stop using services which are too large to provide individualised support; service people too far from their homes; and do not provide people with a good quality of life in the home or as part of the community...developing more individualised, local solutions which provide a good quality of life.*

- The Care Quality Commission cites the Department of Health's (2007a) commissioning guidance which acknowledges that commissioning specialist health services by Primary Care Trusts should be driven by the principles of *Valuing People* (Department of Health, 2001). The guidance acknowledges the use of *outdated service models...an over-reliance on bed based services...and distant NHS and independent sector placements*. The guidance goes on to identify such problems as people with learning disabilities becoming *stuck in the NHS system or independent health placements often for many years and many miles from their homes...at serious risk of neglect, and at worse, abuse*.
- The Care Quality Commission summarises the key findings of the report of the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission (2009) concerning support for people with learning disabilities and complex needs, i.e. *access to and treatment from mental health services was poor...many staff, in particular non-specialist health staff, require development to obtain specific skills, knowledge and attitudes to work with people with learning disabilities and complex needs...there were significant numbers of people living outside their home areas...*
- With regards to safeguarding, the Management Review acknowledges the challenges of a service under-reporting harm since *a high referral rate may indicate an awareness and sensitivity to safeguarding*. The section concludes with a summary of the legislation and guidance concerning whistleblowing.

**6.3.4.** A section on the *Roles of the different regulatory bodies involved with Winterbourne View* (a single page) considers the Healthcare Commission, the Mental Health Act Commission and their absorption into the Care Quality Commission during April 2009. The role of the Healthcare Commission was to assess the performance of NHS organisations and to regulate independent health sector providers. Accordingly, their *Annual Assessment of Performance* considered the commissioning performance of Primary Care Trusts. The Healthcare Commission's resources were skewed towards annual assessments. The Mental Health Act Commission was responsible for producing an annual statement for each service and an annual report on the use of the legislation nationally. The CQC assumed *most of the functions of the predecessor regulators*. Since 2010, the CQC has been immersed in registering all providers of health and social care.

**6.3.5.** The following 30 pages track the regulation of Winterbourne View Hospital from its initial registration to its closure in 2011. The key events feature in the chronology (Section 3). In brief, the initial self-assessment of June 2007, *submitted as part of the annual review process* was *assessed as not needing an inspection under the Care Standards Act for 2007-08*. Subsequent assessments and visits by Mental Health Act Commissioners, Healthcare Commission Inspectors and ultimately CQC Inspectors identified concerns and proposed recommendations which resulted in responsive action plans from Winterbourne View Hospital.

- 6.4. One condition of the registration by the Healthcare Commission was that the hospital should be *split...into two, 12 bedded facilities*. The Care Standards Act 2000 required on-site inspections to make *assessments of standards only where they did not have sufficient evidence of the required level of performance...the Healthcare Commission was required to inspect establishments only once every five years...with a total of 10% of inspections in any one year being carried out on a random basis*. Their methodology was an annual, desk-top assessment of all independent healthcare establishments which required providers to demonstrate their compliance with regulations.
- 6.5. A report of the learning disability services provided by Cornwall Partnership NHS (Healthcare Commission and Commission for Social Care Inspection, 2006) resulted in a national audit of specialist in-patient services for patients with learning disabilities in England. A visit to Winterbourne View Hospital recommended that staff should be trained in physical intervention and that whistleblowing and adult protection policies should feature in the staff handbook.
- 6.6. Restraint and access to advocacy were identified as concerns by the Mental Health Act Commissioner during 2007. It is significant that *there was no mandatory requirement for Winterbourne View to submit an action plan to the Mental Health Act Commission and none was submitted voluntarily*. Irrespective of a *concordat agreement* between the *Healthcare Commission* and the *Mental Health Act Commission*, Winterbourne View Hospital was not the subject of any information exchanges between either of these commissions. In contrast, there was *an ongoing dialogue between the Healthcare Commission and South Gloucestershire Safeguarding Adult Team*.
- 6.7. Winterbourne View Hospital's second, annual self-assessment (of September 2008) confirmed, *inter alia*, that there was no Registered Manager in post. During the following year the Mental Health Act Commissioner recommended an audit of the restraint of detained patients. Once again, the hospital did not submit an action plan setting out how it would address these requirements. It did not have to do so. The content of the Mental Health Act Commission's Annual Reports about Winterbourne View Hospital and the safeguarding concerns highlighted, were not known to South Gloucestershire Council Adult Safeguarding.
- 6.8. When the Care Quality Commission was established on 1 April 2009, it was required by government to *undertake a substantial programme of registration of regulated providers. The NHS were to be regulated for the first time in their history by April 2010, the providers of adult social care and independent healthcare...re-registered by October 2010, dental practices by April 2011 and primary medical services by April 2012*.
- 6.9. The Management Review lists the statutory notifications made under Regulation 28. These feature in the chronology (see Section 3). The CQC acknowledge their *notable shortcomings* in terms of failing to *follow-up and ascertain...the outcomes* associated with the safeguarding alerts at the Winterbourne View Hospital. The CQC acknowledges too that during the transition from desk-top analysis and annual self-assessment of the Healthcare Commission, matters were raised which *tested the Care Quality Commission's systems*. Although the Mental Health Act Commission was assimilated into the Care Quality Commission, there is *no evidence* of sharing concerns about injuries arising from restraint and inadequate Serious Untoward Incidents reports for example. Furthermore, the Healthcare Commission *failed to follow-up on the outcomes* of statutory notifications.

- 6.10.** Once the CQC learned of the correspondence from the BBC regarding the abuse witnessed by their undercover reporter, they embarked on the *responsive compliance review*, followed by the decision to *undertake a compliance review of services at all 19 locations registered by Castlebeck (Teesdale) Ltd in England*. They note that, *we now know that, in spite of the commitments from Winterbourne View’s management and staff that they were responding to the issues raised by the Care Quality Commission’s previous inspections including the Mental Health Act Commissioner visits, there were in fact on going failures by management and staff to protect those in their care*.
- 6.11.** The Management Review states that, *there are no obvious indications...about the extent to which the Healthcare Commission and the Mental Health Act Commission were routinely providing information about Winterbourne View to commissioners of the service and the system performance managers. Similarly, there is no evidence that the commissioners or system performance managers routinely or systematically sought information about Winterbourne View from either the Mental Health Act Commission or the Healthcare Commission*.
- 6.12.** The Management Review confirms that the acting manager at Winterbourne View Hospital did not share Terry Bryan’s email directly with the CQC. The CQC received this on 29 November 2010. Terry Bryan wrote to the CQC on 6 December, attaching his email and also made telephone contact on 31 December. This was not identified as whistleblowing. The correspondence was forwarded to the hospital’s Compliance Inspector. The Compliance Inspector was not informed of the telephone contact. The CQC did not contact Terry Bryan, irrespective of his request for contact with CQC personnel because it *was assumed* that his Winterbourne View Hospital employers or South Gloucestershire Council Safeguarding Adults *was doing so*. During February 2011, the CQC received a call from *the relative of a staff member* (at the hospital) concerning *the staffing levels and...restraint procedures*. The details were forwarded to the Compliance Inspector.
- 6.13.** At the same time, there were *ongoing discussions between the Care Quality Commission and the South Gloucestershire Council Safeguarding Adults* concerning the email. Ultimately there was a meeting of South Gloucestershire Council Safeguarding Adults, the acting manager, Castlebeck Ltd’s operations manager and the CQC on 1 February 2011. This resulted in a request to undertake *an internal review of the specific concerns*. Regrettably, *no dates were set for the actions to be completed*.
- 6.14.** The regulator’s self-scrutiny is refreshingly honest. The assimilation of the regulatory roles into the CQC was a major and disruptive undertaking insofar as it impacted on the programmed inspection of services. Given that Compliance Inspectors have portfolios of *between 40-55 providers*, there is keen awareness of the challenges of checking on the standards compliance within so many diverse services.
- 6.15.** Regulators operate within the terms and requirements set out in legislation and the Department of Health commissions the CQC. The regulators have been disadvantaged by the public perception of their nature and role. It no longer fields teams of specialist inspectors (even though the Compliance Inspection highlights what can be uncovered when Inspectors invest time in scrutinising practice), irrespective of the nature of the service being inspected.
- 6.16.** It is difficult to make sense of the “tick-box” standards-compliance of the Healthcare Commission and the Mental Health Act Commission. The Department of Health requires the Care Quality Commission to ensure that providers comply with the S.20 regulations of the

Health and Social Care Act 2008. How useful is compliance? At what point can it be determined that a degree of compliance is poor or good? Concerned vigilance, as seen in unannounced inspections, is essential in a hospital where detained patients are being physically and chemically restrained. Compliance with standards neither detects the abuse of restraints nor scrutinises the circumstances in which restraint occurs.

- 6.17.** Engaging with patients and their relatives about the wellbeing and safety of patients is essential. Patients did not share much information with the Compliance Inspectors, even though in terms of their behaviour, some energetically railed against the hospital's regime. It is possible that patients were wary of the consequences of disclosing events. The growing disquiet of their relatives, some of whom were frequent visitors to Winterbourne View Hospital, was not known to the CQC.
- 6.18.** Winterbourne View Hospital's notifications to the Health and Safety Executive were not known to the CQC or to South Gloucestershire Council Safeguarding Adults. There is surely scope for making HSE notifications available to the CQC and rationalising notifications and intelligence.

## Section 6: The Findings and Recommendations

### 1. Overview

- 1.1. We have been here before. There is nothing new about the institutional abuse of adults with learning disabilities and autism.<sup>1</sup> Events witnessed at Winterbourne View Hospital recall the custodial treatment associated with decommissioned, long-stay, NHS hospitals. However, unlike the hospitals and institutions described in previous inquiries and reports of institutional abuse, Castlebeck Ltd was not starved of funds. The financial costs of out-of-area services for people with learning disabilities, autism and/ or mental health problems are considerable, as reflected in the weekly average fee charged.
- 1.2. NHS commissioners did not ask searching questions about (a) what the benefits would be for individual patients or (b) the hospital's record in turning patients' lives around. The hospital's existence was entirely dependent on public – principally NHS – contracts; nevertheless, NHS Commissioners did not press for, or receive detailed accounts of how the average weekly fee was being spent on behalf of individual patients. It appears that the cost of patients' medication was borne by NHS South Gloucestershire PCT, even though one PCT was *recharged at cost* for *drug therapies*. This suggests that Castlebeck Ltd, a profit making body, did not expect to be 100% accountable for its income streams, nor to demonstrate the efficient use of its resources and cost effectiveness.
- 1.3. The offences committed at Winterbourne View Hospital raise fundamental questions about how local services seek to prevent mental health problems among people with learning disabilities and autism. This is particularly relevant given that some patients had been violated in their family homes, and some had endured bereavements and lost contact with relatives and friends because they were removed from their localities. Some patients expressed their distress in disguised ways – suicidal gestures and criminal activities - which their families and local services struggled to manage. Events at Winterbourne View Hospital raise questions too about the use of the mental health legislation, most particularly when voluntary patients became detained patients. Although some voluntary patients were subject to locked doors and wards and to threats of being sectioned, they were not protected by the safeguards of the First Tier Review-Mental Health.
- 1.4. The unplanned development of assessment and treatment provision for adults with learning disabilities and autism, and the corresponding problem of regarding these as long term solutions to addressing the needs of adults whose circumstances present as crises, have been growing concerns (e.g. Mackenzie-Davies and Mansell, 2007; Mansell, Ritchie and Dyer, 2010; Grieg and Cameron, 2011). As Paul Burstow noted in the Foreword of *Department of Health Review: Winterbourne View Hospital – Interim Report (2012)...with the closure of long stay hospitals and the campus closure programme, a new form of institutional care developed: what we now know as assessment and treatment units. Not part of current policy, and certainly not recommended practice, these centres have sprung up over the past*

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<sup>1</sup> No Secrets (Department of Health, 2000) stated, *Neglect and poor professional practice...may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as institutional abuse* (p10).



*thirty years. Containment rather than personalised care and support has too easily become the pattern in these institutions (p4).*

- 1.5. People with learning disabilities, autism and mental health problems have a right to services characterised by social inclusion, respect, dignity and choice<sup>2</sup>. An examination of the performance of Winterbourne View Hospital and its staff (Sections 2 and 3) illustrates unacceptable weakness in furthering the goals of assessment and treatment – most particularly in terms of credibly engaging with social work, advocacy, therapies (including psychotherapy), general practice, pharmacy, dentistry, dietetics, mental health nursing, allied health, education and supported employment professionals for example. A service which should have been remarkable for its exemplary multi-disciplinary and multi-agency working, coordinated by a lead professional, limited itself to learning disability nursing and psychiatry.
- 1.6. The goals of *Valuing People* (Department of Health, 2001), *Valuing People Now* (Department of Health, 2009) and *Fulfilling and Rewarding Lives* (Department of Health, 2010) concur with mental health promotion and with current debates concerning happiness and wellbeing. Arguably people with learning disabilities, autism, and mental health problems are receiving less favourable treatment than non-disabled adults by being placed in specialist, in-patient settings for periods which are inconsistent with descriptions of assessment and treatment (CQC 2012a), where they are managed by learning disability nurses and support workers. They are not being offered treatments available to others, such as family and community based support which emphasise social inclusion and recovery. Such treatments are likely to be more economical than treatment in a hospital setting. Mental health crisis interventions should be characterised by brevity of placement (if this is required) and the maintenance of people's local ties. The current system, as glimpsed at Winterbourne View Hospital, appears to have arisen from poor commissioning (see Department of Health, 2007a).
- 1.7. An exploratory survey of England's assessment and treatment units for adults with learning disabilities and behaviour which challenges (Mackenzie-Davies and Mansell, 2007) anticipated the concerns identified by the Department of Health (2012). Mackenzie-Davies and Mansell established that 15 (out of 38) were located on their own site, the remainder being located with other learning disability services, mental health services or health or social services. The authors found that the number of units had doubled during the period after 2000, as compared to the period from 1990-1999. Mackenzie-Davies and Mansell suggested this may reflect: the difficulty for the health service of improving the capacity and resilience of community based services mainly provided in the social care sector; the loss of long-stay hospital places which could be used as a back-up for failed placements; and the targeting of development monies associated with *Valuing People* (Department of Health, 2001) on services for people with behaviour which challenges. The authors concluded that because healthcare facilities are the most expensive type of placement, *it is particularly important to ensure that they provide value for money...this model of service provision is*

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<sup>2</sup> Arguably the nature of mental health services renders it implausible for patients to exercise choice. Not only do people who are detained under the MHA lack choice over the type of treatment they receive and the professionals who treat them, they can be without support from professionals outside the medical arena. An enduring theme is the tension between controlling people who are perceived as being a risk to themselves and/or others and their right to the options available to others not detained.

*becoming more widespread, [and] the potential problems identified 20 years ago – that units would not help develop the capacity of community services, would fill up with people for whom no other suitable, long term placement could be found, and would mix residents with very different needs – are still present (p809).*

- 1.8.** The Government published a National Planning Policy Framework in March 2012. This Framework is a material consideration in local planning decisions. It strengthens requirements in terms of taking account of local health plans. One of its core principles is that planning should support local strategies to improve health, social and cultural wellbeing for all and deliver sufficient community and cultural facilities and services to meet local needs. Local planning authorities are required to work with health organisations to understand and take account of the health status and needs of the local population, and any information about relevant barriers to improving health and well-being.

**Recommendation:** Clinical Commissioning Groups, local authorities and the NHS Commissioning Board should be commissioning services with regard to the needs identified in the Joint Strategic Needs Assessment, the priorities agreed in Joint Health and Wellbeing Strategies and where appropriate, the health aspects of the National Planning Policy Framework. The presumption should be to address the needs of the whole population within the geography of the local area, with the aim of reducing the number of people using in-patient assessment and treatment services in line with the policy set out in the Department of Health (2012) Interim Report.

**Recommendation:** The principle of investing in and promoting *good quality, local services...providing intensive community support with only limited use of in-patient services* (Department of Health 2012) should be adopted and monitored by Clinical Commissioning Groups and the NHS Commissioning Board.

**Recommendation:** Clinical Commissioning Groups should require generic mental health services, as part of their annual contract monitoring, to identify the steps taken to enable citizens with learning disabilities and autism to be supported in their own communities and familiar localities.<sup>3</sup>

**Recommendation:** In its direct commissioning responsibilities and perhaps as part of contractual arrangements, the NHS Commissioning Board should take appropriate steps to require hospitals and assessment and treatment units for adults with learning disabilities and autism to publish information concerning (i) direct patient related costs (ii) their service costs (iii) the specific rehabilitation gains of individual patients (iv) the detention status of patients at the point of discharge, and whether or not discharge is to a within-service transfer to a facility owned by the same company, an associated company or an NHS Trust.

**Recommendation:** the guidance associated with the legislative framework for placing Safeguarding Adults Boards on a statutory footing, and any subsequent review of safeguarding guidance, should reflect the findings of all the reviews associated with Winterbourne View Hospital.

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<sup>3</sup> Such services have a duty under sections 20 and 21 of the Equality Act 2010 to take such steps as it is reasonable to take to ensure that disabled persons, including adults with learning disabilities, are not placed at a substantial disadvantage. Such services also have a duty under section 149 of the EA 2010, in the exercise of their functions, to have due regard to the need to eliminate discrimination, advance equality of opportunity between disabled and non-disabled persons, and foster good relations between disabled and non-disabled persons.

## **2. The role of commissioning organisations in initiating patient admissions to Winterbourne View Hospital**

- 2.1.** Who is best placed to commission services for people with learning disability, autism and mental health needs? There was no overall leadership among the NHS commissioners of Winterbourne View Hospital's services in seeking to secure and deliver valued outcomes for patients. The three Strategic Health Authorities involved did not demonstrate a proactive, performance management role in ensuring the effective physical health care and mental health care of Winterbourne View Hospital patients.
- 2.2.** Commissioning is a professional activity that should be led by trained specialists who know and develop the market according to existing public policy. The Mansell report (Department of Health, 2007) stressed the importance of sustaining people with learning disabilities in their own homes, and within the community wherever possible, and it is clear that this can be achieved in almost all instances. Commissioning is not solely about procurement and contracting. It is about ensuring the availability of quality choices that draw on local strengths and build assets to strengthen community support and care. It involves working with adults with learning disabilities and their families, including the potential users of mental health services and services for people whose behaviour challenges. It involves working with the providers of generic and specialist services in the market place/community, as well as with social workers.
- 2.3.** Commissioners funding placements cannot remain within their offices. They must see, know and feel what is required. In the case of adults without capacity or purchasing power, commissioners are their agents and keepers of the public purse. There is no case for them to propose or endorse the building of independent hospitals for people with learning disabilities and autism. There were echoes of 'out of sight, out of mind' commissioning at Winterbourne View Hospital and evidence of uncertainty about which agency was responsible for commissioning services.
- 2.4.** The NHS is the commissioner of hospital services. Primary Care Trusts can commission health services in partnership with local authorities. *Valuing People Now* (Department of Health, 2009) transferred responsibility for commissioning most services for people with learning disabilities and the associated finance to local authorities. However, it was not envisaged that the NHS would continue to commission hospital services and that local authorities would therefore need to collaborate with them.
- 2.5.** In terms of contracts for services, the NHS South of England Review showed that *of the 28 placements 15 were covered by a signed contract provided by Castlebeck Ltd* (i.e. over 50%). As the Department of Health (2012) notes, *This is inappropriate. NHS Commissioners are required to use the NHS standard contract for providers of NHS funded care and avoid "spot purchased" patient placements.* This would have ensured that the commissioner was informed at the same time as CQC of any notification of a serious incident concerning a patient.
- 2.6.** Reviews for patients at Winterbourne View Hospital were ineffective and did not bring to light either concerns about the quality of assessment and treatment or detail of abusive practices. Care Programme Approach (CPA) reviews were driven by Winterbourne View Hospital which arranged and chaired meetings, thus undermining the vital safeguards of the process. Important events such as First Tier Tribunal-Mental Health meetings were not taken into account in the timetabling of the CPA, nor were meetings arranged in response to

incidents or concerns. This was wrong. As the NHS South of England Review notes, the CPA did not include wider quality and performance monitoring of the service or any wider perspective of the welfare or needs of the patient. It would therefore appear that the care coordinators were operating outwith national CPA guidelines.

- 2.7. In their *Statement of Purpose*, Castlebeck Ltd indicated that *all patients could make their views known in the form of attendance at weekly patient forums to discuss activities, meals, food environmental issues and their Incentive Programmes. In addition, the Service User Survey was completed annually for each unit and all patients were asked to participate...There was also a complaints procedure that could be accessed by patients and/or their families and professionals. The Advocacy service provided a 'drop in' surgery every 6 weeks. Access to this was via the Nurse in Charge who would make an appointment.*
- 2.8. This suggests that the limited form of advocacy nurtured within Winterbourne View Hospital depended on the knowledge and skills of learning disability nursing and support staff. Reference to the Chronology (see *During May 2008*) suggests that most commissioners did not fund advocacy support. Having to access advocacy via the Nurse in Charge was an obstacle. As the Chronology indicates, there was little evidence of patients being listened to or their complaints being addressed.
- 2.9. Individual patient records gave rise to concerns in that they did not accurately convey patients' mental health status and whether Deprivation of Liberty Safeguards were considered.
- 2.10. Winterbourne View Hospital patients lacked any means of asserting or protecting their rights. The clarity with which they told staff, hospital managers, visiting professionals, police officers and their own relatives about entrenched practice in Winterbourne View Hospital did not result in effective intervention. Apart from *forum meetings*, which failed to address the concerns of at least two patients (see Chronology, 3 July 2010), there is no evidence that the views of patients were authentically sought. They were without voice or representation. As a result, punitive treatment existed for an unknown length of time. Patients found it difficult, if not impossible, to navigate the inconsistent expectations of being at Winterbourne View Hospital.
- 2.11. The relatives of Winterbourne View Hospital patients were not allowed to be fully involved in their lives. Those families who contributed to the Serious Case Review recalled concerns regarding the excessive use of medication, the use of restraint, limited access within the hospital and the hold which staff had over patients. Complaints were not addressed, resulting in one family reporting the physical restraint of their relative directly to the police.

**Recommendation:** Adults with learning disabilities and autism, who are not subject to the provisions of the Mental Health Act 1983, should not, by law, be the subject of restrictions in the same way as with patients who are subject to the provisions of mental health legislation<sup>4</sup>.

**Recommendation:** Commissioners should commission the model of care as set out in the Department of Health (2012) *Interim Report*, to ensure that people only go into in-patient services

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<sup>4</sup> Each patient subject to the Mental Health Act 1983 should have the minimum restrictions imposed on their liberty in line with the purposes for which the restrictions are imposed and blanket restrictions imposed on groups of patients may breach their human rights. In deciding whether to detain patients; doctors and AMHPs must always consider less restrictive ways of providing the care or treatment patients need and it may be possible to use the Mental Capacity Act 2005 Deprivation of Liberty Safeguards.

for assessment and treatment where they cannot get the support that they need in the community. Local authorities should only commission such services where they are the lead commissioner and there are valued services and pooled budgets in place.

**Recommendation:** The Department of Health should take steps to ensure there is clarity across the health and social care spectrum about commissioning responsibilities for hospital based care for people with learning disabilities.

**Recommendation:** Adults with learning disabilities and autism, who are currently placed in assessment and treatment units, should have the full protection of the Mental Capacity Act 2005.

**Recommendation:** The Department of Health should assure itself that CQC's current legal responsibility to monitor and report on the use of Deprivation of Liberty Safeguards provides sufficient scrutiny of the use of DoLS.

**Recommendation:** The NHS Commissioning Board should seek ongoing assurance that the practice of commissioning of NHS services for adults with learning disabilities, autism, behaviour which challenges and mental health problems is explicitly attentive to reducing inequalities.

**Recommendation:** Commissioners funding placements should ensure that they have up to date knowledge of services e.g. (a) adverse incidents/serious untoward incidents, including the injuries of patients and staff, (b) absconding, (c) police attendances in the interests of patient safety, (d) criminal investigations, (e) safeguarding investigations, and (f) the occurrence of Deprivation of Liberty Safeguards applications and renewals.

**Recommendation:** A commissioning challenge is required. There are 51 former patients of Winterbourne View Hospital, some of whom have transferred to other hospitals and secure settings. Commissioners ought to use their best endeavours in relation to ex-patients transferred to hospitals (who are not detained under the Mental Health Act 1983) to return them home or to suitable placements within their local communities. The treatment of those who are detained under the Mental Health Act 1983 should be focused on recovery and support with a view to returning them to their local communities. This will require more than keeping tabs on where they are now - political support, the engagement of generic mental health services, as well as the First Tier Tribunal – Mental Health, and capable managers and staff are essential if competent and humane forms of local provision are to develop.

### **3. The circumstances and management of the whistleblowing notification**

**3.1.** Terry Bryan's four page email of 11 October 2010 was addressed to the acting manager of Winterbourne View Hospital. It was entitled "I've had enough." It set out his *grave concerns* about *Winterbourne View's version of the "Castlebeck Way..."* Terry Bryan observed that the latter *seems to be confrontational and aggressive*, and that the service was responding to complex patients with *containment*. The email recalled an incident in September 2010, when a support worker reported to Terry Bryan that a patient *was being inappropriate in his (telephone) conversation*. The patient was distressed that the call was being monitored by two members of staff. Later, as Terry Bryan was talking to the patient, he could hear the support worker repeatedly referring to him, the Charge Nurse, as *a, f\*\*king c\*\*t to other staff members*. A subsequent attempt to discuss the events with the support worker was unproductive. The latter asserted that the patient's call *should have been stopped and that we should have restrained him there and then*. Terry Bryan provided 18 further examples of unprofessional and disrespectful exchanges which he associated with the "Castlebeck Way."

- i. Staff waited for incidents *to develop*, so that they might be managed by restraining patients.
  - ii. *Certain established staff members seem to relish restraint procedures.*
  - iii. *There was no evidence of service users being treated with respect from certain established team members.*
  - iv. *A patient was shown the first floor by a nurse, as a threat of what would happen if he did not behave himself; a staff member shouting at two patients who were arguing...she admitted she shouldn't have done it.*
  - v. *A patient who self harmed was left without treatment (see 10 October 2010, Section 3).*
  - vi. *Not all staff believed that allowing a distressed patient to cool off was necessary.*
  - vii. *A patient who was angry dropped to the ground when approached by 2 established staff members...with her arms in a T-supine position (as taught on the Maybo course) see 5 October 2010, Section 3.*
  - viii. *There was scant regard for the person's feelings, or even their physical safety during restraint.*
  - ix. *A staff member managed situations by threatening patients with the withdrawal of agreed activities (see 20 September and 5 October 2010, Section 3).*
  - x. *Patients discussed absconding with Terry Bryan. A staff member shouted to both...to get back in the lounge.*
  - xi. *Having a service with up to 12 service users on each floor, many of whom are detained and on Level 3 observations, required all service users to be in sight at all times. One patient's sensitivity to noise was ignored, as evidenced by requests to join the group.*
  - xii. *The shift patterns...are not conducive to optimum work practices with long hours (8-8), usually 3 in a row.*
  - xiii. *Students and staff nurses were witnessing poor practice.*
  - xiv. *There is limited or no therapeutic input...the service users urgently need psychology input but I have been told by the Area Manager that Castlebeck is a "Nurse-led Service...psychologists are not needed."*
  - xv. *There are still no Risk Assessments or Care Plans in the offices to refer to.... (some) staff don't need them...they do what they like.*
  - xvi. *We have no idea how many keys, alarms and fobs there are in circulation at any one time.... (similarly) lighters.*
  - xvii. *Incident forms are detailed, and archived without fully obtaining the information they contain.*
  - xviii. *Regimented routines have developed that do not reflect the service users' needs, for example, queuing up for medication is an archaic practice...people have to stay in the dining room even if they are unwell or not eating.*
- 3.2.** The email concluded that, rather than taking a resignation route, Terry Bryan opted for raising these matters, *as a whistleblowing concern instead*, because of the *substandard care practices employed at the service.*
- 3.3.** Within Castlebeck Ltd, the email was known to the Regional Operations Director, the Senior Manager (the former Registered Manager of Winterbourne View Hospital) and the Human Resources Officer. The concerns listed within the email were neither reflected in the minutes

of the monthly *Unit Led Clinical Governance Committee*, nor entered onto the *Serious Untoward Incident Log* as per policy and procedure for any safeguarding alert. Castlebeck Ltd observed that their *Whistleblowing policy...clearly stated that the Director of Governance should be informed of any whistleblowing complaint raised – this did not occur*. Castlebeck Ltd noted that *the Regional Operations Directors often worked without consultation or engagement with HR and the Company's Corporate Governance structure. A proportion of the (Group Operations) team were promoted through the ranks, irrespective of their experience or ability, in line with the company ethos of recruiting from within...Castlebeck Ltd recognises that opportunities for change were missed. Given this failure of Senior Management, it had the effect of sanitising any unfavourable information. Information was not passed to senior staff and so the external perspective and Board perspective remained positive.*<sup>5</sup>

- 3.4.** Since Castlebeck Ltd's managers did not prioritise any action, Terry Bryan forwarded his email of 11 October 2010, to the Care Quality Commission - seven weeks after drafting it.
- 3.5.** The hospital's acting manager forwarded the email to South Gloucestershire Council Adult Safeguarding after 16 days, clearly recognising that patient safety was being compromised. Castlebeck Ltd did not inform the Care Quality Commission about the email, South Gloucestershire Council Adult Safeguarding did so, (35 days after receiving it), having added a series of thoughtful questions. A meeting with Winterbourne View Hospital's acting manager to discuss the disparate forms of harm detailed in the email was postponed by the acting manager. This precluded a consideration of the email against the accumulation of individual alerts known to South Gloucestershire Council Adult Safeguarding. This meeting did not take place until 1 February 2011. There had been unchecked assumptions by Adult Safeguarding and the Care Quality Commission about who was taking action. Accordingly, there was no inter-organisational acknowledgement that the email provided confirmation about the fact and extent of institutional abuse. As a result, Winterbourne View Hospital was not held to account.
- 3.6.** The events and conditions described by Terry Bryan reflected his frustration. It is remarkable that neither the hospital's acting manager nor Castlebeck Ltd's managers regarded this as valuable feedback about Winterbourne View Hospital. The email confirmed that the use of restraint, for example, was not a short term anomaly at the hospital. It characterised an excessively restrictive regime which dated from the hospital's first year of operation. Also, it confirmed the deficiencies of management, the low status of patients, the isolation of employees and, more generally, blockages and dislocations in company accountability.
- 3.7.** There are three levels of whistleblowing: raising the matter of concern with the employer through management – which Terry Bryan did; contacting a regulatory body – which Terry Bryan also did; and involving the media. However, Terry Bryan was not the only employee to report concerns to the hospital's managers. These were not addressed despite Castlebeck Ltd's explicit whistleblowing policy. Simply reporting concerns to managers was ineffective as a means of attending to critical matters of patient safety.

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<sup>5</sup> Castlebeck Ltd's IMR

**Recommendation:** There should be a condition of employment on all health and social care practitioners (registered and unregistered) to report operational concerns to (i) the Chief Executives and Boards of hospitals, (ii) the regulator.

**Recommendation:** All registered health and social care employers should be required to advise their employees in their contracts to whom they can whistleblow, the response that the employee can anticipate from the employer and what to do if this is not forthcoming. This should include information about provision in the Employment Rights Act 1996 which gives protection to those making disclosures in the public interest.

#### **4. The multi-agency response to the safeguarding referrals from Winterbourne View Hospital**

**4.1.** The multi-agency response was ineffective. There were elements of what is recognised as constituting effective practice, e.g. a formal allocation of the investigation process; meetings and discussions to provide a framework for shared decision making; and efforts to balance the support needs of patients against improvements within the hospital. However, this response failed to ensure the protection of all patients. South Gloucestershire Council's policy and procedures for the management of safeguarding alerts are clear and uncontroversial.

**4.2.** When the policy and procedures were invoked, there were missing elements:

- a shared multi-agency safeguarding objective: Winterbourne View Hospital focused on dealing with the immediate incident; the police focused on crime and evidence gathering and offered generic advice; commissioners were concerned with allocating funding and devolved responsibility for monitoring placements; A&E were concerned to "see and treat;" and South Gloucestershire Council Adult Safeguarding were focused on ensuring that the multi-agency policy and procedures were appropriately invoked and used. Interactive learning, which is associated with inter-professional work, was not apparent;
- information sharing and retention: the total number of police attendances at Winterbourne View Hospital was not known to South Gloucestershire Council Adult Safeguarding and the police have no documented record of their own contributions to meetings;
- professional challenge: deference characterised the stance of South Gloucestershire Adult Safeguarding towards the police and the stance of the police towards Winterbourne View Hospital clinicians. All safeguarding practitioners, should look outwards to learn from domestic violence, racial harassment and victim support<sup>6</sup>, for example, as well as being alert to inferior judgements;
- clear rationale for professional safeguarding judgements and decisions: safeguarding requires the synthesis of imperfect information and yet the decisions and actions of some lead professionals responsible for investigations at Winterbourne View Hospital would perplex a lay audience;
- concerned curiosity and vigilance: most local authorities are not responsible for, and have no experience of coordinating safeguarding activities at an independent

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<sup>6</sup> See for example various guidance on Multi-Agency Public Protection Arrangements (MAPPA) and Multi-Agency Risk Assessment Conferences (MARAC)



hospital. Consequently, as South Gloucestershire Council acknowledges, there was a markedly different safeguarding response to Winterbourne View Hospital as compared to their response to other services;

- a wider framework within which to interpret the incidence of alerts and events.

- 4.3. South Gloucestershire Council Adult Safeguarding, the police and the CQC assumed that Winterbourne View Hospital's managers and staff were honestly reporting the facts concerning single referrals. This was not so. It is both necessary and appropriate for employers to assume a prominent role in investigating safeguarding concerns. However, when there is evidence of partial and/ or delayed investigations a local authority should assume this responsibility.
- 4.4. Social workers and the police with responsibility for investigating allegations at hospitals for adults with learning disabilities and autism should bring a more challenging filter and lens to the task of safeguarding patients. This is the case most particularly when anti-therapeutic outcomes come to light e.g. physical harm resulting from being restrained.

**Recommendation:** Council Safeguarding Adults personnel must ensure that hospital patients, subject to Deprivation of Liberty Safeguards and Mental Health Act detention, who are restrained and/or make a complaint, have opportunities to access, in private, independent professionals such as social workers, local authority Deprivation of Liberty Safeguards assessors, Independent Mental Capacity Advocates or Independent Mental Health Advocates and Mental Health Act Commissioners for those detained under the Mental Health Act 1983.

**Recommendation:** When a hospital fails to produce a credible safeguarding investigation report within an agreed timeframe, the host Safeguarding Adults Board should consult with the relevant commissioners and the regulator to identify remedies.

## 5. The volume and characteristics of safeguarding referrals

- 5.1. It has long been recognised that adult protection procedures and approaches have been slow to impact on mental health services (e.g. Brown and Keating, 1998; Commission for Health Improvement, 2003; NICE 2005). Even the ethos of safeguarding is limited, regardless of the repetitious nature and continuing relevance of recommendations from inquiries since the 1980s. Mental health services are underpinned by the dynamics of control and coercion and the implications of the treatment regime of sedation, seclusion and/or restraint are far reaching (e.g. Keywood, 2005).
- 5.2. South Gloucestershire Council Adult Safeguarding received 27 allegations of staff to patient assaults; 10 allegations of patient on patient assaults; and three family related alerts. Avon and Somerset Constabulary recorded *nine carer on patient* incidents, five *patient on patient* incidents, three *patient on carer* incidents and 12 other incidents. Reference to the chronology would suggest that these numbers do not reflect the full extent of assaults and abusive practice at Winterbourne View Hospital.
- 5.3. Castlebeck Ltd recorded a total of 379 physical interventions during 2010 and 129 for the first quarter of 2011. It is recognised that these figures underestimate the true extent of restraint at Winterbourne View Hospital. This recurrent practice was observed in *Undercover Care: the Abuse Exposed* and was reflected in individual patient records. Some staff who restrained patients were untrained and none followed Castlebeck Ltd's policy and procedures. An external trainer reported concerns in writing to the hospital's acting

manager about the misuse of restraint. The overall volume of restraints was not known either by the Police or by South Gloucestershire Council Adult Safeguarding who were therefore unable to regard these as a body of significant concerns rather than individual episodes. There is no evidence that anyone within Castlebeck Ltd queried these alarming figures, or sought to ensure that restraint practice at the hospital was scrutinised, most particularly when patients required Accident and Emergency treatment. One family have documented evidence that their son was restrained 45 times in five months and that on a single day, he was restrained “on and off” all day. Another family were very concerned about their son’s unabated confusion, fear and desire to be back home. Although they were “desperate to get him out of there [they] were told that if [they] did not return him after a home visit, he would be sectioned.” The practice of restraining patients impacted on their telephone calls to their son. One evening when they could not speak to their son, he explained later that it was because “somebody was kicking off.” He became “fixated and talked continually about restraints” which staff acknowledged - to the family - characterised daily events. Restraints incurring physical pain and injuries, including those requiring dental repairs, are never proportionate and always require investigation. The concerns of these families were not communicated to South Gloucestershire Council Adult Safeguarding.

- 5.4. It is shocking that the practice of restraint on a daily, routine basis was not identified as constituting abuse by any professional.
- 5.5. There were many *incidents* noted in the patient chronologies which were based on the dispersed records of 20 former patients. For a single patient, 286 incidents were documented and records of 12 Serious Untoward Incidents over three years. Another patient’s records document 100 incidents with seven Serious Untoward Incidents over two years. The extent of such incidents does not appear to have been shared during review meetings. Although Serious Untoward Incidents are pertinent to adult safeguarding, the hospital did not disclose their existence to South Gloucester Council Adult Safeguarding.
- 5.6. Winterbourne View Hospital did not disclose to the regulator, Adult Safeguarding or the Police the frequency with which patients absconded or the occasions when the Police were called to deal with allegations. With regards to absconding, scrutiny of one patient’s records confirmed that she absconded on 12 separate occasions and attempted to abscond on at least three occasions. Separately, information submitted to the Health and Safety Executive by Castlebeck Ltd was not known to the CQC or to Adult Safeguarding. Crucially, information from Castlebeck Ltd’s Human Resources personnel suggested that although they were aware of such unprofessional and harmful practice as picking up hitch hikers whilst transporting detained patients, their responses were wholly ineffective.

**Recommendation:** the National Quality Board should devise a mechanism for aggregating pertinent safeguarding information for NHS patients with learning disabilities and autism as part of its consideration of *actions to correct actual or serious failure* (Department of Health, 2012).

**Recommendation:** the Department of Health should consult the National Quality Board about how to rationalise the notifications which hospitals providing services to adults with learning disabilities and autism should make, and confirm which agency should “hold” this information.

## 6. The existence and treatment of other forms of alert that might cause concern

- 6.1. Drawing together information from patients' complaints, their relatives and visiting professionals, commissioners, from Health and Safety Executive notifications, from restraint practices, from the duration and authorisation of such restraints, from concerns known to the CQC and its predecessor, from patient attendance at Accident and Emergency, from police attendances at Winterbourne View Hospital, and from the First Tier Tribunal – Mental Health, would have identified the risks to which patients at Winterbourne View Hospital were subject. Given that many patients were isolated and disconnected from sustaining relationships, the case for aggregating such information sources is compelling.
- 6.2. As a parent observed:  
*Because our son was 18 we did not have the legal power to speak for him [and] he was not able, at this time, to speak for himself so the authorities became the prominent decision-makers. This was problematic because the authorities did not have enough information about him and we had a big struggle to get our voices heard...Throughout, we found that our views were continually discounted...He needed a therapeutic environment but instead got Winterbourne View.*
- 6.3. The *Statement of Purpose* noted that *Castlebeck operates a comprehensive Complaints and Grievance Procedure...complaints may be made either verbally or in writing...elements of Castlebeck's procedure are: to resolve problems and complaints as quickly as possible; to ensure that residents and relatives know about the Complaints procedure...ensure residents have access to outside agencies; to take effective action and learn from and improve Castlebeck's services...all complaints are always taken seriously.*
- 6.4. The chronology provides no reassurance that patients' **complaints** were taken seriously (e.g. see August 2009; 11 September 2009; 22 March 2010; 20 April 2010; 17 July 2010; 21 October 2010) or even those of their relatives (e.g. see 31 July 2010; 16 November 2010; 11 December 2010; 3 March 2011). On occasions, the allegations of particular patients were attributed to their distress or condition (see, for example, 3 May 2011). Such examples confirm the ineffective and inefficient complaints procedure at the hospital and the necessity of external and independent scrutiny if essential protections for detained patients are to prevail.
- 6.5. The Local Authority and National Health Service Complaints (England) Regulations 2009 [SI 2009; No 309] apply to "an independent provider about the provision of services by it under arrangements with an NHS body" [the definition of which includes a PCT]. This would seem to cover the PCT arrangements with Winterbourne View hospital and, if so, would seem to place it under a duty to follow the 2009 regulations. The regulations do not cover providers funded by local authorities, although they do cover the authority themselves with regard to adult social care. This raises the question of why there is no reference to the statutory duty with regard to PCT funded care, and whether the Castlebeck Ltd. Complaints and Grievance procedure met the statutory requirements regarding NHS-funded care. Under the regulations, for example, there should be annual report on complaints handling forwarded to the PCT.
- 6.6. **Commissioners** did not have a significant role in advancing safeguarding practice. It does not appear that the health and social care professionals responsible for monitoring patient placements were contractually required to forward concerns about abuse to the

commissioning organisations responsible for funding the placement<sup>7</sup>. The Root Cause Analysis concerning the dangerous restraint methods deployed by a staff member who was untrained in restraint, and which injured a patient, was shared with the commissioner responsible for the placement.

- 6.7.** Of the 12 incidents reported to the **Health and Safety Executive** between 2008 and 2011, all but two were regarding staff. Of the two patient incidents, one appeared to be non-reportable, i.e. it concerned a patient's fall arising from an epileptic seizure.<sup>8</sup> The "injury severity" is a crucial HSE criterion. An injury severity rated 2 is classified as a major injury as defined by the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. There was one such injury relating to a patient and three relating to staff. An injury severity rated 3 means that these were *over 3 day (duration) injuries*. There were seven such staff injuries. The Health and Safety Executive has confirmed that none of the injuries reported by Winterbourne View Hospital met their investigation selection criteria.<sup>9</sup> <sup>10</sup> This would explain why none were investigated at the time of their receipt.
- 6.8.** The Mid Staffordshire Public Inquiry is reviewing processes of regulatory accountability. Including that of the Health and Safety Executive and their findings will be reported later in 2012.
- 6.9.** The sample of patient chronologies and patients' relatives confirmed that **restraint** occurred more frequently than the hospital's own recordings and notifications to the regulator suggest. The Panorama broadcast showed patients immobilised by body weight and objects. It showed the restricted movement of their legs and arms during restraint; their heads covered; and the use of considerable force. The injuries sustained by patients during restraint and the findings from Castlebeck Ltd's own Root Cause Analysis concerning the restraint of a patient (see Chronology 8 July 2008) raise questions about (i) the necessity of the T-supine/ horizontal restraint of adults with learning disabilities, autism, and or mental health problems and (ii) the deprivation of liberty of adults who were not detained.
- 6.10.** Winterbourne View Hospital patients attended **Accident and Emergency** on 76 occasions, between January 2008 and May 2011. Although some patients attended with several symptoms, 27 attendances were for *epileptic seizures*; 18 for *injury/accident*; 14 for *self harm*; 14 for *lacerations*; 14 for *studies/treatment*; 9 for *dressing change/wound review*; 8 for (removal of) *foreign body*; 8 for *other*; 7 for *head injury*; 4 for *illness/unwell*; 2 for *cardiac/respiratory arrest*; and 1 for a *fall*. Putting to one side emotional, verbal and psychological harm, although there is no comparative data on which to draw, there was considerable visible, physical and quantifiable violence at Winterbourne View Hospital for

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<sup>7</sup> Policy and practice guidance is laid out in Refocusing the Care Programme Approach: policy and positive practice guidance (DH 2008)

<sup>8</sup> HSE policy regarding the application of S.3 Health and Safety at Work etc Act 1974 (this section applies to health and safety risks to non-employees) <http://www.hse.gov.uk/enforce/opalert.htm> (accessed 11 March 2012)

<sup>9</sup> Incident selection criteria

<http://www.hse.gov.uk/foi/internalops/og/ogprocedures/investigation/incidselcrits.htm> (accessed 11 March 2012)

<sup>10</sup> It is of note that the guidance on reporting injuries etc in health and social care setting

<http://www.hse.gov.uk/healthservices/riddor.htm> (accessed on 11 March 2012) designates acts of self harm and patient on patient injury as *not reportable*.

which patients required hospital treatment and yet there were no safeguarding alerts from Accident and Emergency.

- 6.11.** It does not appear that (i) the **General Practitioner** contracted to attend to the physical healthcare of Winterbourne View Hospital patients (ii) the **psychiatrists** employed by Castlebeck Ltd or (iii) professionals attending CPA reviews were aware of the nature or frequency of the assaults to which patients were subjected and/or the trauma associated with these. There was no evidence of clinical leadership.
- 6.12.** It does not appear that members of the First-tier Tribunal - Mental Health, whose purpose is to consider whether continued detention of a patient under the Mental Health Act 1983 is justified, highlighted concerns about individual patients or the treatment provided at the hospital. It is not clear from the sample of patient chronologies whether concern about the quantity and appropriateness of restraints was expressed. The Chief Medical Officer of the First-tier Tribunal - Mental Health, has confirmed that no complaints were received from patients or their representatives concerning the care of patients at Winterbourne View Hospital; and no concerns were reported to the tribunal administration by tribunal panels sitting in hearings at Winterbourne View Hospital. However, it was noted that, *Tribunal members have commented that patients placed there often appeared abandoned by their home authorities*. Although it is not the role of the First Tier Review – Mental Health, to look at complaints, but to test the detention decision, it is surprising that none of the Tribunals recommended discharge.

**Recommendation:** Commissioners should ensure that all hospital patients with learning disabilities and autism have unimpeded access to effective complaints procedures - in the case of NHS-funded care, these arrangements must meet the statutory requirement laid down in the 2009 Local Authority and National Health Service Complaints (England) Regulations 2009

**Recommendation:** The Department of Health, Department for Education and the Care Quality Commission should consider banning the t-supine restraint of adults with learning disabilities and autism in hospitals and assessment and treatment units. An investment comparable to the banning of the corporal punishment of children is required. The use of restrictive physical intervention “as a last resort” characterises all policies and guidance and yet made no difference to the experience of patients at Winterbourne View Hospital.

**Recommendation:** Clinical Commissioning Groups should explore how Accident and Emergency can detect instances of re-attendance from the same location as well as by any individual. The Department of Health may wish to highlight this to A&E departments, including it in their annual review of Clinical Quality Indicators.

**Recommendation:** Commissioners responsible for funding placements should be proactive in ensuring that patients are safe. If responsibility for monitoring a placement or the ongoing coordination of care is delegated to nurses or social workers, then commissioners should ensure that they are informed about safeguarding concerns and alerts. Decisions about funding placements should be based on outcome data. Arrangements should be in place to share information about safeguarding incidents and alerts between those responsible for monitoring patient safety, the provider and commissioners and this should be routinely monitored through contacts.

## 7. The role of the Care Quality Commission as the regulator of in-patient care at Winterbourne View Hospital

- 7.1. As a service, Winterbourne View Hospital was ill suited to regulation by standards of compliance. Low cost, light touch regulation did not work. Neither did the scrutiny of such documentation as policies, procedures, care plans, nursing plans, complaints and incident reporting.
- 7.2. Winterbourne View Hospital was known as a hospital to Castlebeck Ltd, to the Care Quality Commission, to NHS commissioners, NHS South Gloucestershire PCT, South Gloucestershire Council and Avon and Somerset Police. Castlebeck Ltd's own documentation, its policies and procedures use the term "service users" as well as "patients." Similarly both terms were used by the CQC in their *Review of Compliance* (July, 2011). One family believed that their relative was in a residential home rather than a hospital and this confusion has prevailed in the media coverage of the arrests and trial of staff members.
- 7.3. The compliance review approach of the Care Quality Commission was over reliant on self-assessment and on an unclear approach to monitoring *outcomes*. Although the promotion of outcomes by CQC is significant, the single outcome for Winterbourne View Hospital patients was more of the same. A better model for this type of service is the more traditional inspection style which has a rounded approach to inputs (workforce and environment), process (leadership, management and models of care practice), outputs (such as the demonstration of quantitative results) and outcomes (patient and family, where possible, determined evidence of quality). Light touch is not suited to closed establishments. The CQC does not specify its position on clinical governance. It simply states that there should be a strong system for establishing the essential standards of quality and safety. It describes most of the outcomes as being of 'particular importance'. There is a need for some prompts on what constitutes a strong system – what it looks like and what evidence establishes that its purpose is being achieved. On paper, Castlebeck Ltd had a 'strong' system that was commended. There were missing ingredients: independent visitors, service evaluation involving leadership from patients and their relatives (some of whom were frequent visitors), open access, independent professional scrutiny, external management challenge and the voices of patients and advocates.
- 7.4. Castlebeck Ltd is primarily responsible and accountable for the neglectful and inhumane treatment at Winterbourne View Hospital. However, Castlebeck Ltd's organisational hierarchy is spared the attentions of the criminal justice system. Legislation does not challenge the denial of responsibility. There is no process of accountability for scrutinising the performance of Castlebeck Ltd's Board.
- 7.5. The catalogue of restraint of patients at Winterbourne View Hospital sheds an unflattering light on regulation. CQC's work was not focused on the day to day experience of patients. "Care Quality" is a misnomer if inspectors focus solely on compliance with standards, not all of which are inspected in single and infrequent visits.

**Recommendation:** Local Adult Safeguarding Boards, CQC and all stakeholders should regard hospitals for adults with learning disabilities and autism 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.

**Recommendation:** Monitor, as the sector regulator of all providers of NHS-funded services, should consider the inclusion of internal reporting requirements for the Boards of registered provider services in their provider licence conditions.

**Recommendation:** The mental health arm of CQC should have characteristics akin to HM Inspectorate of Prisons in terms of standards. The hospital managers as defined by the Mental Health Act 1983 have the primary responsibility for ensuring that all requirements of the Act, including all the safeguards to ensure detention is necessary in the first place (3 independent professional assessments) and needs to continue. CQC and the First Tier Tribunal should ensure that these responsibilities are discharged for all detained patients. All decisions taken on the use of the Mental Health Act 1983 must be guided by that Act's guiding principles, including the purpose principle and the least restriction principle.

**Recommendation:** The requirements concerning a service's *Statement of Purpose* and the supporting guidance should be strengthened to aid clarity. The CQC, through its Mental Health Act monitoring responsibilities, should consider giving particular focus to (i) the way in which hospital managers (as defined in the MHA 1983) discharge their responsibilities, and (ii) evidence that hospitals are engaged in the activities they are registered to provide.

**Recommendation:** There is a compelling case for mandatory visits by the Nominated Individual/Board Member reported and brought together in an annual report accompanying the accounts. The Department of Health should consider amending registration requirements to require such mandatory visits and public reporting.

**Recommendation:** The Care Quality Commission should collaborate with the Health (and Care) Professionals Council, plus the Sector Skills Councils for both Health and Care, in providing advice and guidance on the qualifications and continuing professional development requirements for Registered Managers and for the practitioners they supervise. It is of concern that managers, registered to operate services across residential, nursing home, hospital and home care, are not required to be distinct registered professionals individually accountable through a governing body and code of ethics.

**Recommendation:** The Care Quality Commission should take appropriate enforcement action where registered managers are not in place.

**Recommendation:** Inspection is a term that the public understands and expects to be in place for an establishment such as Winterbourne View Hospital. The Care Quality Commission's Compliance Inspectors did not identify the abuse. CQC should ensure that inspections are carried out by sector specialists and experts by experience so that warning signs may be identified earlier (i.e. the approach effectively implemented for the inspection of 150 services for adults with learning disabilities in England). Inspectors should be qualified and competent to carry out inspections, and demonstrate that they have sufficient knowledge about (i) the services that they inspect and (ii) the abuse of vulnerable adults, including the crime of assault.

**Recommendation:** the CQC must encourage whistleblowers to raise the alarm and then securely receive, log and take action when concerns are raised. They should report on actions arising from whistleblowing notifications in its annual *State of Care* report.

**Recommendation:** the CQC and the commissioners should ensure that a service is providing care which is consistent with its *Statement of Purpose*, i.e. in the case of Winterbourne View Hospital, assessment and treatment, and rehabilitation.

## 8. The policy, procedures, operational practices and clinical governance of Castlebeck Ltd in respect of operating Winterbourne View as an independent hospital

- 8.1. Although Castlebeck Ltd stated that they operate a **Quality Management System (QMS)** as set out in their Quality Manual the Care Quality Commission's (2011) responsive review noted that *the integrity of this...cannot be assured e.g. the manual refers to previous legislation, the Care Standards Act and National Minimum Standards*. Furthermore, *information recorded within the unit-led clinical governance committee meetings was not robust and lacked enough detail to inform a quality review of the clinical and nursing interventions...minutes were brief with no clear action plan or evidence of clinical lead and direction for staff* (p31).
- 8.2. Castlebeck Ltd highlighted the expected outcomes of its *Clinical Governance Policy and Procedure: Clinical quality improvements at ground level are integrated with an overall quality improvement programme; good practice is systematically disseminated; clinical risk reduction programmes using action plans and incident analysis mechanisms are in place; evidence based practice systems are in place; adverse health care events and near misses are detected and openly investigated within a non-blame culture; their root causes are analysed and lessons are learned; complaints are dealt with positively and the information is used to improve the organisation and its care delivery; high quality data is used to monitor clinical care and support professionals in delivery and quality care; clinicians are encouraged to develop clinical leadership skills and monitor performance, as part of self-regulation and assessment; clinicians embrace continuing professional development and relevant revalidation requirements (where applicable); staff are supported in their duty to report concerns about colleagues' professional conduct and early action is taken to support the individual and remedy the situation*.
- 8.3. The Clinical Governance policy explains that *Clinical Governance is a framework through which we are accountable for continuously improving the quality of our services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish*. The policy states that...*accountability for clinical quality lies with the Chief Executive and the Castlebeck Board, as it is recognised that clinical performance has equal status alongside financial performance*.
- 8.4. The Clinical Governance policy states, *It is the Clinical Governance Team's endeavour to promote Castlebeck's aims regarding the changes to people's behaviour i.e. least aversive, least restrictive, most effective, most clinically valid and socially acceptable means*.
- 8.5. Is it credible or plausible to rely on self-governance when the service providers' priorities are those of a private company limited by guarantee? It is true that the motives of **profit** should be synonymous with those of customer care in all businesses; however in scenarios of imperfect competition, here the customer being the state acting on behalf of vulnerable citizens, then the system of governance must have overt and strong features of challenge to both state and provider.
- 8.6. Castlebeck Ltd stated of the hospital's **detained patients** that they *had regular Mental Health Tribunals and Managers Hearings to ensure that their detention under the Act was lawful, necessary and appropriate*. *Patients also had access to regular CPA meetings which were designed to ensure that the patient, their families/carers and the people who were responsible for their care came together to discuss that care, its appropriateness and*



*ongoing plans to ensure that the discharge planning is evident from day 1 of admission. However, personal development plans appeared to be done haphazardly.*

- 8.7. One patient's section was altered from section 3 to section 37 in December 2010, *due to an alleged assault on a staff member, which went to court.* South Gloucestershire Council Adult Safeguarding and the commissioners were *unaware* of the patient's altered status and the circumstances which occasioned this until the First-tier Tribunal-Mental Health during April 2011, *where Mental Health Act paperwork was found to be incorrect.* The patient explained to his social worker that the reason he bit the staff member was *because medication was forced against his will.* The Public Protection Unit *felt it was poor practice but not criminal.*
- 8.8. Since 2002, there have been rhythms of activity and assertions concerning restraint. Department of Health (2002) guidance concerning restrictive interventions with people with learning disabilities and autism underlined the position that physical interventions should be used as infrequently as possible. The *Independent Inquiry into the death of David Bennett* (2003) recommended, *inter alia, under no circumstances should any patient be restrained in a prone position for a longer period than three minutes.* The NICE evidence based guidance (2005) re-iterated the Department of Health (2002) advice concerning the potential legal consequences of the inappropriate use of restraint. *The Mental Capacity Act – Making Decisions: A guide for people who work in health and social care* (2007) asserted that two conditions must be satisfied in order for protection from liability for restraint: there must be a reasonable belief that restraint is necessary to prevent the person without capacity coming to harm; and the restraint must be reasonable and in proportion to potential harm. The Royal College of Nursing (2006) made the distinction between the roles and responsibilities of registered nurses, nursing students and health care assistants vis a vis restraint, and the MHA Code of Practice (2008) asserted that physical restraint should only occur when de-escalation has been insufficient. SCIE (2009), and the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, highlighted what constitutes unlawful and excessive restraint. The British Institute of Learning Disabilities (BILD) launched its Physical Intervention Accreditation Scheme in 2002. Castlebeck Ltd was a BILD accredited provider.
- 8.9. Winterbourne View Hospital provides compelling evidence that citing guidance and legislation, having a policy concerning restraint, and being accredited do not result in safe restraint.
- 8.10. One family's concerns regarding their son's **medication** encapsulate the resilience of an overly medicalised service. They were vindicated when their son's drugs were *"finally tapered off [and] there were no ill effects confirming that, rather than drugs, we needed informed advice from specialists in autism."*
- 8.11. As the Disability Rights Commission (2006) reported, *The adverse effects of some medication...cause poor physical health. Anti-psychotic drugs can lead to major weight gain and obesity, heart problems, low blood pressure, osteoporosis, seizures, Parkinsonism, tardive dyskinesia (involuntary movement disorders) and a range of other problems...(p43)*
- 8.12. In terms of how patients spent their days, Castlebeck Ltd's *Statement of Purpose* concerning Winterbourne View Hospital stated that it offered....*a full, structured **programme of purposeful activities** to each of its patients.* This was not delivered. Two families recalled their knowledge of their relatives' activities. One noted that their son's "highly structured timetable" did not materialise. A nurse disclosed to the family that she was unable to "...commence any useful programme because of the high number of restraints that took

place in the hospital and that she believed that he would be better off elsewhere.” Another family asked if their relative’s activities could be written down but this did not happen. When they asked the staff what he had actually done they were told that he “may have been to a farm, or may have gone for a drive... and there was nothing.” They know that their son spent a lot of time sitting in the TV lounge. The staff were ‘always asking for money’ for him to do things – but it was never clear to them what he was doing. The family believe that their son was under-occupied at Winterbourne View Hospital because there was nothing documented that suggested he had taken part in any training.

- 8.13. A family recalled that when they visited their son in Winterbourne View Hospital he was often in a mess. They **complained** “many times” about the mess he was in. Once when they arrived to take him out he was in a “disgusting’ state, covered with food,” and the staff were asked to change him. The staff used to say they didn’t know the family were coming, but they knew that they visited [at the same time each week]. When they brought him back the staff often took a long time to answer the door. On one occasion the family waited for 15 minutes. Once, their son had an accident (he wet himself) because no one came to the door. On another occasion, one of his parents got stuck in reception and no one answered the buzzer. They had to get the attention of someone in the kitchen.
- 8.14. Such carelessness was evidenced in other hurtful ways. A family remembered an occasion when they took a Mother’s Day present into Winterbourne View Hospital for their son to give to his mother the following day. Even though she visited on Mother’s Day there was no present and “no one seemed to know anything about it.”
- 8.15. Winterbourne View Hospital made exacting demands on its **workforce**. Ultimately, Winterbourne View Hospital appeared to operate as a support-worker led facility. Staff worked 3-day, 12 hour shifts. The presence of untrained and unsupervised staff in a specialist facility is known to be detrimental. They witnessed unprofessional practices and some acquired skills in self-censorship, neither of which were challenged.
- 8.16. The crucial roles of **leadership and management** in Winterbourne View Hospital were disconnected from those of Castlebeck Ltd and the management of practice within the hospital. The internal management and reporting system was over lengthy and there was no ethos of either reflective supervision or clear channels of communication. The Registered Manager was absent during the hospital’s final months of operation.
- 8.17. **Recruitment and retention** were conspicuous problems for the hospital, not least because of the lapses in recruiting which resulted in two migrant workers being arrested by the UK Border Agency. It is not clear how recruitment was undertaken or even what Winterbourne View Hospital’s connection was with the local labour market, colleges and schools. The turnover rate was lamented by Castlebeck Ltd and it was resolved locally by the use of agency staff. The problems with staff recruitment and retention, their extensive use of agency and bank staff and inexperienced staff are familiar to inpatient psychiatric provision (e.g. Heathcare Commission, 2005, Mackenzie-Davies and Mansell 2007).
- 8.18. With reference to capability, the Castlebeck Ltd documentation expresses no view about probation periods, appraisal and how staff knew what they were supposed to do and whether or not they were doing well.
- 8.19. The adequacy of the hospital’s training plan and e-learning packages is not known. What is clear is that professional standards and codes of practice had no bearing on patient care. Although different workgroups are subject to differing standards and regulators, the largest

group of staff – the support workers – were, and remain, outwith any professional regulation.

- 8.20.** The CQC's responsive review reported that the hospital's acting manager had stated that staff training *had not been available, "due to the organisation's training department being in the north of the country and trainers were not prepared to travel to the south west."*
- 8.21.** The CQC reported finding *evidence of disciplinary action being commenced but stopped if staff resigned, with no reporting to the Independent Safeguarding Authority or Nursing and Midwifery Council.* Furthermore, the CQC scrutinised the records of 23 staff members. The recruitment records showed that the hospital employed some staff members in advance of receiving their CRB checks and references. One staff member was appointed irrespective of a conviction. The hospital had no record of an accompanying risk assessment. With regard to references, *many...were simple statements of dates employed with no reference to conduct, suitability or capability. For one person there was reliance on two telephone references from friends of the applicant...at least five staff had no previous experience of working...within any care setting.*
- 8.22.** There is a gap to bridge between bystander inaction and a willingness to intervene or offer help. There is little doubt that some staff were scared of the patients and of their peers with some adopting the behaviour of their peers. However, not everyone did so. Some opted to leave having disclosed their concerns to their managers, to patients' relatives and/ or to their own relatives. Some elected to remain at Winterbourne View Hospital to assist in the task of preparing patients for transfer to other services. It was noted by NHS South Gloucestershire PCT, which proactively assisted in the relocation of hospital patients, that the remaining staff became more effective practitioners as a result of having positive role models and being managed and supervised. It is dismaying that the ordeals and concerns of such staff as well as those who chose to leave were not harnessed as a catalyst for improvement. It is dismaying too that the staff's personal sense of what was the right thing to do in delivering safe and effective care did not prevail. To its cost, Winterbourne View Hospital did not nurture a culture in which staff were encouraged to do the right thing. Such a culture, with a human rights based model that balances patients' legal and therapeutic needs, is essential.

**Recommendation:** To meet their statutory obligations all providers of residential, nursing home and hospital care should require that their registered managers' normal place of work is one where they can become known to patients/service users and are routinely visible and accessible for the staff who are working 365 day rotas

**Recommendation:** The Care Quality Commission through its Mental Health Act monitoring responsibilities should consider giving particular focus to the way in which hospital managers (as defined in the Mental Health Act 1983) discharge their responsibilities.

**Recommendation:** The CQC, in discharging its responsibilities to monitor the use of the Mental Health Act, should ensure that all the requirements of the Act are applied when a patient moves from being an informal patient to being detained under the Act in the same hospital.

**Recommendation:** The CQC and Health Professions Council should work together to describe in guidance what effective systems of clinical supervision look like in hospitals for people with learning disabilities and autism. The guidance should identify the roles of registered managers and nominated individuals in developing such systems in practice.

**Recommendation:** Organisations providing NHS funded care should be required to demonstrate accountability for effective governance to commissioners and Council Adult Safeguarding.

**Recommendation:** Commissioners should encourage hospitals and assessment and treatment units for adults with learning disabilities and autism to ensure that their employees are signed up to the proposed *Code of Conduct and minimum induction/ training standards* for unregistered health and social care assistants commissioned by the Department of Health.

**Recommendation:** Reducing the use of anti-psychotic medication with adults with learning disabilities and autism requires attention. An outcome of the National Dementia Strategy (Department of Health, 2009) was an investment in reducing anti-psychotic medication for patients with dementia (Banerjee, 2009). Adults with learning disabilities require no less.

**Recommendation:** Commissioners of assessment and treatment services should ensure that there are pharmacist led medicines reviews both for individual patients and for the service as a whole.

**Recommendation:** The Care Quality Commission should consider including pharmacist led medication reviews in future inspections.

**Recommendation:** In the light of the harm sustained by former Winterbourne View Hospital patients, Castlebeck Ltd should consider funding

- (i) independent psychotherapeutic provision for all former Winterbourne View Hospital patients – in negotiation with each person and their families; and an evaluation of the effectiveness of this intervention, and
- (ii) the costs associated with this Serious Case Review.

## Section 7: Conclusions

1. The development of Winterbourne View Hospital was contingent on Castlebeck Ltd's business opportunism, the encouragement of NHS commissioners and their willingness to buy its services. Unwittingly the hospital has become a case study in institutional abuse.
2. Although "person-centred" care, participation and empowerment characterise national policy priorities, these were alien to the experiences of Winterbourne View Hospital patients and their families. Their silencing was scandalous. Regardless of their eloquent first-person accounts and the concerns of their families, the experience of Winterbourne View Hospital patients was ignored. They did not receive customised support from skilled professionals. Their relatives were rendered invisible or impotent by Winterbourne View Hospital's harassed workforce, to whom they appeared to have a high nuisance value. There was no evidence that families were perceived as partners with a key stake in the health, well-being and safety of their relatives.
  1. The parents of children and young people with learning disabilities, autism or behaviour which challenges do not aspire to them being detained or 'stuck' in specialist hospitals. They want timely, professional help, characterised by skilled competence which connects with their own motivation. They want empathy and respect for their experience, insights and history. Such a strengths-based model of support is light years from that of a professional undertaking a risk assessment who advises a parent that their child – a special-school leaver - requires "two to one support outside the family home" and leaves the family to manage. Families want the interdependence of their children to be valued and they want their children to be known primarily as unique individuals, albeit with support needs which will vary over their life course. They want to be optimistic about the future prospects of their children, most particularly when their family circumstances mean that they can no longer offer sustained support. At such times families require knowledgeable and timely support which is attuned to their own priorities i.e. early enough so that they may continue to function without compromising the employment and/or health of any family member. Preventive services are essential if families are to help their relatives manage the consequences of feeling different – because they are bullied, unemployed, and without a girlfriend or boyfriend – with compassion and ingenuity.<sup>1</sup> The human as well as care costs of failing to do so are too great.
  2. The review has demonstrated that the apparatus of oversight was unequal to the task of uncovering the fact and extent of institutional abuse at Winterbourne View Hospital. Taken section by section, this Serious Case Review builds a bleak collage of the phenomenon of institutional abuse. That the whole is greater than the individual sections is no cliché. The insights arising from the efforts of the individual agencies, sharing a common geographical and political context, confirm the difficulties of responding to the highly situational needs of patients when information about concerns, alerts, complaints, allegations and notifications are either unknown or scattered across agencies.

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<sup>1</sup> See Kate Billingham's *Health Conversations – A blog about Family Nurse Partnerships*  
<http://familynurse.dh.gov.uk/>

3. It is concerning that Winterbourne View Hospital strayed far from its purpose of providing *assessment and treatment and rehabilitation*. A service's reputation is no substitute for interventions with a credible conceptual basis which result in successful outcomes. The restricted and isolated model (Nolan 2001) exemplified by Winterbourne View Hospital has nothing to offer adults with learning disabilities and autism.
4. It is clear that at critical points in the wretched history of Winterbourne View Hospital, key decisions about priorities were taken by Castlebeck Ltd which impaired the ability of this hospital to improve the mental health and physical health and wellbeing of its patients.
5. Castlebeck Ltd appears to have made decisions about profitability, including shareholder returns, over and above decisions about the effective and humane delivery of assessment, treatment and rehabilitation. They did not prioritise:
  - delivering what commissioners believed they were purchasing for patients, not least in terms of the supervision of patients
  - recording accurately information concerning how patients arrived at Winterbourne View Hospital, including the Section under which some were detained
  - understanding the inventive and protesting voices and behaviour of patients
  - challenging the frequency with which restraint practices at the hospital were deployed, or even their legality
  - undertaking mental capacity, best interests or Deprivation of Liberty Safeguards assessments
  - ensuring the continuity of Registered Managers and that all senior managers with responsibility for Winterbourne View Hospital were effective communicators and decision-makers
  - connecting the day to day events at Winterbourne View Hospital with clinical governance and quality assurance processes
  - disclosing the operational realities at Winterbourne View Hospital (their *best performer in the group*) to Board members and shareholders
  - acting on the feedback of Mental Health Act Commissioners, the Healthcare Commission or the Care Quality Commission
  - learning from the complaints and concerns of patients and their relatives and visiting professionals
  - acting on the concerns arising from their own Human Resources personnel and authors of Serious Untoward Incident documentation e.g. about the adequacy of staffing levels, about the abuse of restraint practices and about staff training and supervision.
6. Castlebeck Ltd made ungrounded claims about what could be provided at Winterbourne View Hospital and the expertise of hospital staff. Although Castlebeck Ltd claimed high ideals, it has subsequently claimed little knowledge of events in Winterbourne View Hospital. This plea is not compelling. Castlebeck Ltd's business has contributed to the development of hospital provision for adults with learning disabilities, autism and mental health problems without reference to South Gloucestershire's local health planning for local citizens or to national policy and guidance. The isolation of patients at Winterbourne View Hospital reinforced their isolation from their families, communities and the public gaze.

7. NHS Commissioners were not effectively challenged by their Strategic Health Authorities to question the adequacy of assessment, treatment and rehabilitation for the patients whose Winterbourne View Hospital places they funded. They should have been purchasing competent technical care complemented by excellent interpersonal care. Yet the majority of patients were geographically distant from their communities of origin and they had no person to person contact with the placing commissioners. The latter were unfamiliar with the mental health and physical health outcomes for patients.
8. Winterbourne View Hospital has confirmed that the level of funding for a service is no guarantee of patient safety or a service's quality. In resource-lean times, an average weekly fee of £3500.00 is a lot of money. From an NHS commissioning perspective, however, it is unexceptional. Payment by results, which holds services to account for the outcomes that they achieve for individual patients, would provide much needed purpose to the out-of-area, assessment and treatment drift identified by the Care Quality Commission (2012a). Providing timely expertise and reliable social care support to people whose behaviour may challenge their relatives, colleagues and services in their homes and/or localities of origin has to become the default commissioning stance. The long-stay hospitals demonstrated that medicalising people's lives under the supervision of nurses and psychiatrists produces poor physical and mental health outcomes. These are far removed from the known aspirations of people with learning disabilities and autism.
9. The physical health care of Winterbourne View Hospital patients was unacceptable. This Review's consideration of a sample of the hospital's nursing and medical records confirms that there was insufficient focus on patients' general health status. It is very much hoped that what has been learned about the compromised health status of people with learning disabilities and autism at this hospital is a bridge to reaffirming the importance of non-discriminatory healthcare. *Valuing People* (Department of Health 2001) acknowledged the consequence of *NHS specialist learning disability services seeking to provide all encompassing services on their own. As a result, the wider NHS has failed to consider the needs of people with learning disabilities. This is the most important issue which the NHS needs to address for people with learning disabilities* (p60). This is as relevant and urgent in 2012.
10. The foundational value of nurturing local services for local citizens, most particularly those who are perceived to be "hard to place," will need to be asserted by Clinical Commissioning Groups. Individual healthcare practitioners in dentistry and Accident and Emergency services expressed concerns about the compatibility of patients' injuries with the explanations of the accompanying Winterbourne View Hospital staff and yet did not take these further. They should have done so.
11. South Gloucestershire Council should have led all the safeguarding investigations which concerned staff on patient assaults and ensured that patients who were the subjects of safeguarding alerts were always seen by a social worker or police officer. They should have managed all meetings and investigations with the confidence to challenge other professionals and rigorously "quality assure" the resulting processes.
12. Avon and Somerset Constabulary should have collaborated with South Gloucestershire Adult Safeguarding in terms of reporting all of their contacts with Winterbourne View Hospital and negotiating the safeguarding approach to be adopted in addressing the growing number of allegations of abuse when they could not proceed with criminal investigations.

13. The role and function of the Care Quality Commission should enable it to identify credibly institutional abuse in hospitals for adults with learning disabilities and autism. This is a matter for the Department of Health to consider. It is essential that the regulatory apparatus (i) adopts a historical approach to inspection e.g. has this hospital attended to the gaps in staff training identified x months ago? and (ii) triangulates what their inspections reveal with information from current and former patients, from the relatives of patients and visiting professionals including Councils' Safeguarding Adults.
14. Most crucially however, the BBC Panorama programme showed beyond doubt the magnitude of Castlebeck Ltd's failings in operating Winterbourne View Hospital. Although the Serious Case Review has not benefitted from the knowledge-advantage of the BBC, it has sought to understand the bigger picture. The BBC captured iconic images with which to illuminate the phenomenon of institutional abuse. As Brown (2007) observed:

*Not really a "type" of abuse, or even just a "site" of abuse, but a constellation of factors that interact to produce poor care, insensitive practice and to either provoke or condone individual or collective acts of cruelty.*

This is an accurate summary of what happened at Winterbourne View Hospital.



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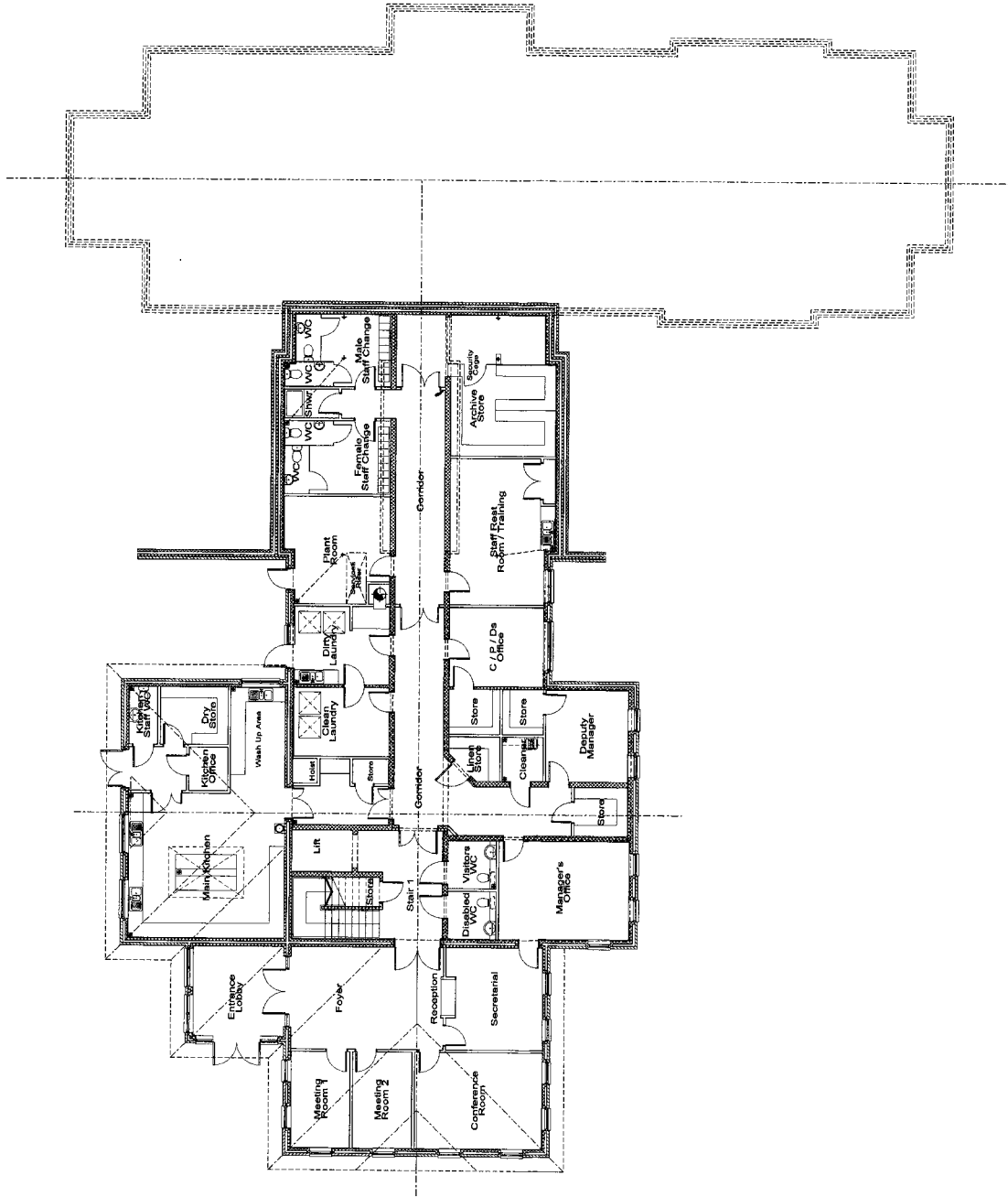
Walsh, P., Emerson, E., Lobb, C., Hatton, C., Bradley, V., Shallock, B. (2008) *Supported Accommodation Services for People with Intellectual Disabilities: A Review of Models and Instruments used to Measure Quality of Life*. Dublin: National Disability Authority

# Annex 1

SOUTH GLENS COUNCIL  
 1 - APR 2005  
 RECEIVED  
 THORNBURY

APPLICATION NO:  
 P 105 / 1266 / RM

APPLICATION NO:  
 P 105 / 1266 / RM



APPROVAL  
 20 APR 2005  
 RECEIVED  
 THORNBURY



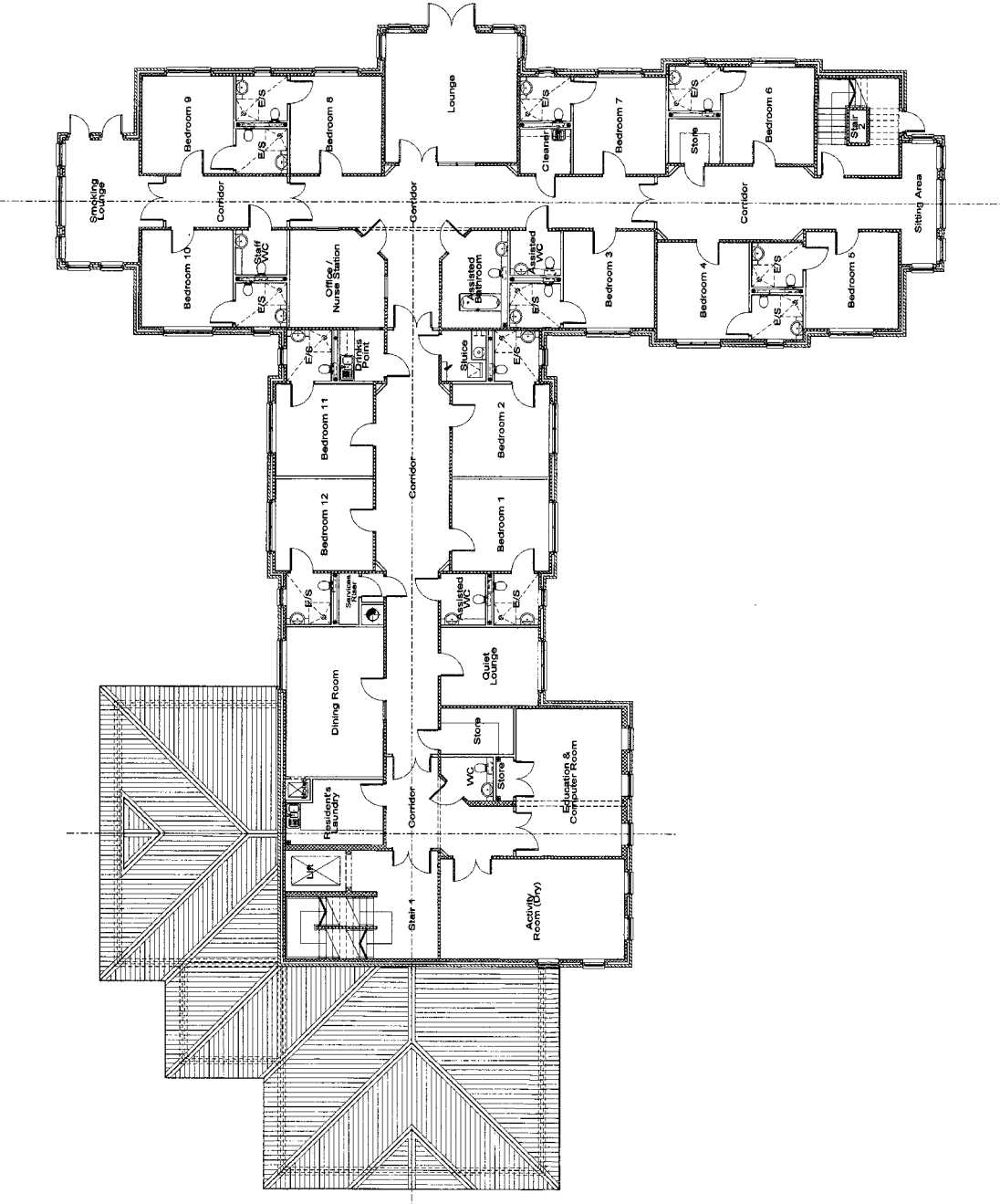
**AUFORA**  
 Aurora Partnership Ltd  
 2 Backley Street, Clifton  
 Bristol, BS8 1HT  
 Tel: 0117 927 7711  
 Fax: 0117 927 7811

Site: 22.03.05  
 Date: 22.03.05  
 Scale: 1:500  
 No: 105/1266/RM

REVISIONS TO BE MADE AND CLIENT DESIGN REVIEW:

NO.	DESCRIPTION	DATE	BY	CHK

SOUTHGLAISE COUNCIL  
 1 - APR 2005  
 RECEIVED  
 TICEBURY



APPLICATION NO:  
 P105 / 1266 / RM

20 APR 2005  
 RECEIVED  
 TICEBURY

Aurora Partnership Ltd  
 2 Berkeley Square, Clifton  
 Bristol, BS8 1HL  
 Tel: 0117 927 7711  
 Fax: 0117 927 7811

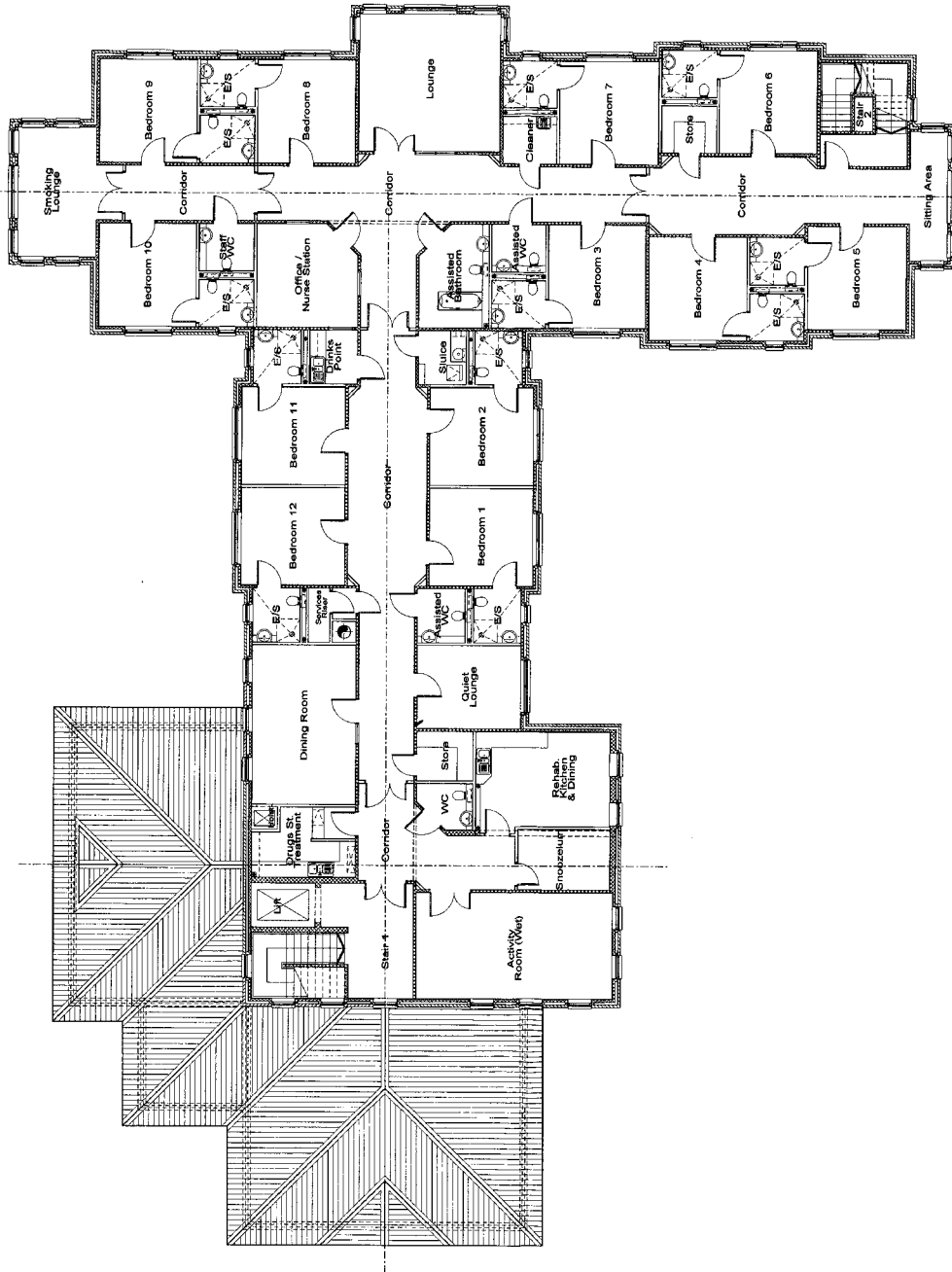


REV	DATE	BY	CHK	APP	DESCRIPTION
A	23.03.05	CS			Revisions to suit elevations, and client design

SOUTH GLASGOW COUNCIL  
 PLANNING AND BUILDING CONTROL  
 1 - APR 2005  
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 THORNHURRY

2004  
 20 APR 2005  
 RECEIVED  
 2004/39/203

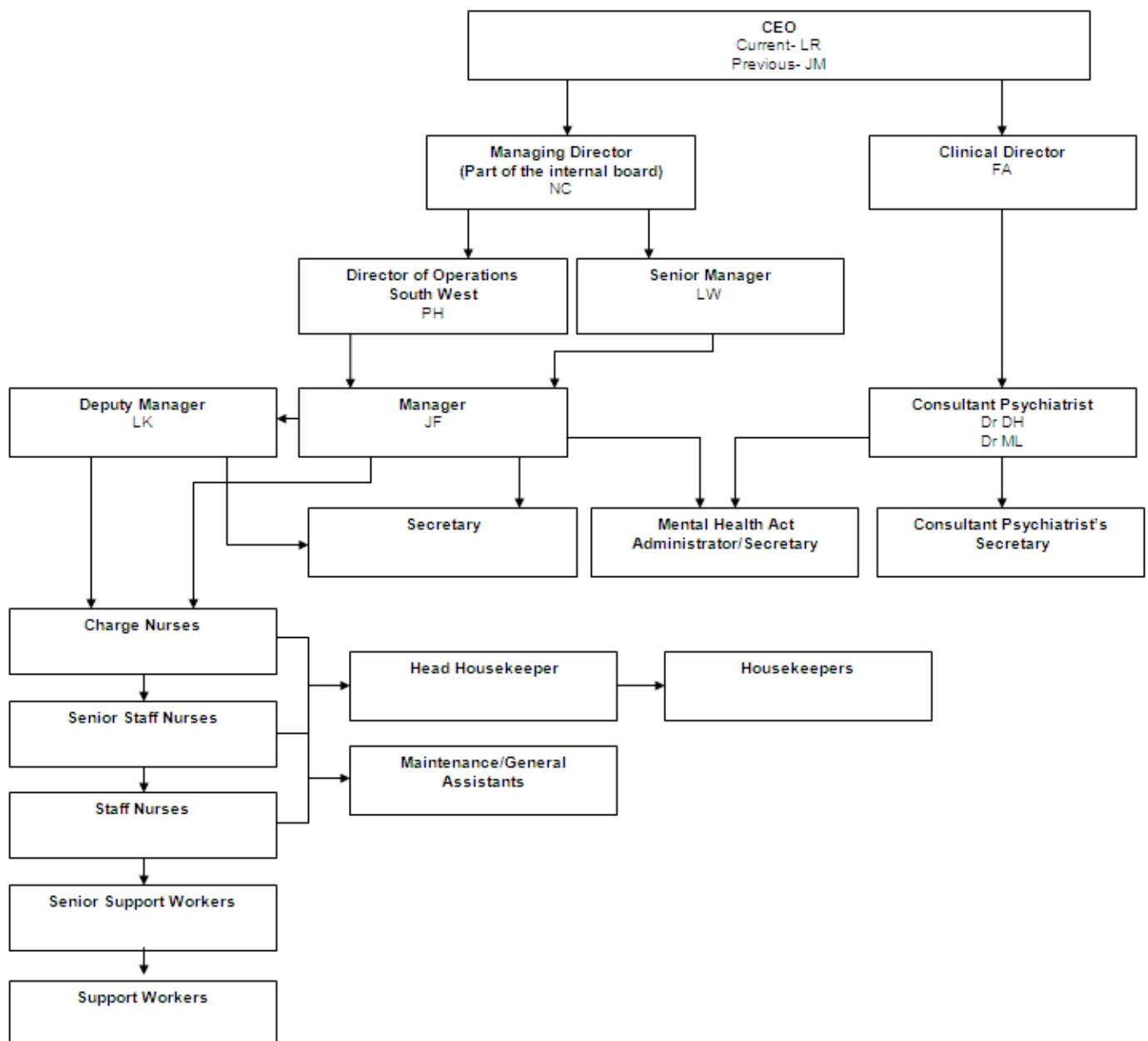
APPLICATION NO:  
 P 105 / 1286 / RM



22.03.05 CS  
 Revisions to suit elevations, and client design review.  
 20 APR 2005  
 RECEIVED  
 2004/39/203  
 Aurora Partnership Ltd  
 2 Berkeley Square, Clifton  
 Bristol, BS8 1HL  
 Tel: 0117 927 7711  
 Fax: 0117 927 7811  
 8.000 A

# Annex 2

## Winterbourne View Organogram







If you would like this information in a different format  
or language, please contact: **01454 868009**