South Gloucestershire Safeguarding Adults Board

Winterbourne View Hospital

A Serious Case Review

By Margaret Flynn
What happened?

Winterbourne View was a hospital in South Gloucestershire for people with learning disabilities and autism whose behaviour sometimes made their families and professionals worry.

It was meant to help by assessing and treating patients so that they could have ordinary lives in their own homes.

Winterbourne View Hospital was owned by a company called Castlebeck. The NHS paid Castlebeck a lot of money to look after people there. It had 24 beds.

In 2011, a TV programme showed some staff at Winterbourne View Hospital slapping and hurting patients and getting them on the floor. They sat on them and lay on them so the patients couldn’t move. Sometimes they used chairs to stop them from getting up.

Patients were bullied. They had water thrown at them. One woman was put in a shower wearing her clothes.

Winterbourne View Hospital has now closed.
The Serious Case Review

The council, the NHS, the Police, the Care Quality Commission and other organisations work together to make sure that adults who need help are safe from harm. They call themselves the Safeguarding Adults Board.

They asked Margaret Flynn to find out what had happened at Winterbourne View Hospital. They wanted to make sure it couldn’t happen again. This is called a Serious Case Review.

Margaret Flynn does research. She has a brother with a learning disability. She learned about what had happened at Winterbourne View Hospital from the people who had been patients at Winterbourne View and their families.

She talked to Castlebeck, to the Department of Health, the NHS, the Care Quality Commission and to the Safeguarding Adults Board.

What did Margaret Flynn find?

Margaret found that lots of patients had been hurt at Winterbourne View Hospital. Some had been poorly when they were there.

Some patients had needed to go to Accident and Emergency because they hurt themselves or they were hurt by hospital staff.
Sometimes the police had been called when patients were hurt or had tried to run away.

Some patients had complained to their families, friends, to staff, the hospital’s managers and to other professionals about being hurt. They were not believed.

A nurse called Terry Bryan told the hospital’s manager about patients being hurt at Winterbourne View Hospital. Because nothing changed he wrote to the Care Quality Commission. This is called ‘whistleblowing’.

Terry Bryan then told the BBC and they made a TV programme about it.

**Why did it happen?**

Margaret said that even though Castlebeck had rules about how patients should be treated, staff didn’t follow the rules.

Castlebeck didn’t train its staff properly and the hospital’s managers didn’t do their jobs properly.

Sometimes when patients were hurt, the hospital did not tell their families, the professionals who were checking how they were getting on, the Care Quality Commission or local safeguarding staff.
Why wasn’t it stopped sooner?

No one stopped the abuse because they needed the hospital’s managers and staff to tell them what was really happening.

The NHS organisations that put people in Winterbourne View Hospital thought that patients were being cared for properly.

The Care Quality Commission, thought that managers at Winterbourne View Hospital were following the rules.

The Safeguarding Adults Board didn’t know that patients were being hurt at Winterbourne View Hospital.

This was because when the Council’s safeguarding staff and the police asked Winterbourne View Hospital’s managers and staff about problems, they said everything was OK.

They should have asked more questions when patients and staff reported problems at Winterbourne View Hospital.
The NHS organisations that put people in Winterbourne View Hospital, the council’s safeguarding staff, the police and the Care Quality Commission should have talked to each other about the problems at Winterbourne View Hospital. It might have helped them to spot there was a big problem sooner.

What should be done now?

The Safeguarding Adults Board asked Margaret Flynn to say what should be done to make sure that patients aren’t hurt like this again.

She said that the best place to care for people with learning disabilities and autism is in their homes and communities where they are known.

When people go into hospitals for assessment and treatment, there are risks: they may get hurt, they may be there for a long time and they may lose touch with people who matter to them.

There should be better ways of checking hospitals for adults with learning disabilities and autism to make sure that patients are safe.
Staff should always listen to patients, even those who may be difficult to understand. The patients who tried to run away were very good communicators.

Patients who have been hurt should always be given the option of talking to somebody who does not work at the hospital.

When a patient is hurt, or ill, or goes to Accident and Emergency, or becomes known to the police, or makes a complaint, or their relatives complain, the NHS organisations which placed them should be told.

Margaret said that families should be helped to support their relatives with learning disabilities and autism so that they do not have to be sent to hospitals for assessment and treatment.

She said that people with learning disabilities and autism should not be held on the floor by staff.

She wants organisations to find how helpful these hospitals are before placing people with learning disabilities and autism in them.
Finally, Margaret said that Castlebeck and organisations with responsibility for the people who were at Winterbourne View Hospital should make sure that they are given lots of help to recover from their experiences of being patients at Winterbourne View Hospital.

All this will help us all to learn about better ways of supporting adults who have had bad experiences and are at risk of hurting themselves or others.
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