‘Shame Upon Your Houses’

What the Winterbourne View Hospital Serious Case Review Does or Cannot Not Tell Us.

Robert j. Nisbet.
Article Summary:

The article is provided in response to the publication of the Serious Case Review report published by the South Gloucestershire Adult Safeguarding Board on the 7th August 2012, into Winterbourne View Hospital. The SCR was commissioned by the Board from CPEA, Social Care, Children’s Services & Management Associates, & written by CPEA Senior Associate Consultant, Dr. Margaret Flynn.

The review details the failure of the Castlebeck Ltd the owners of Winterbourne View Hospital, near Bristol, to provide adequate & affective safeguarding for those adults who resided at that hospital. The concerns came to the public’s attention following the transmission of a BBC-One TV Panorama programme¹, which filmed a succession of physical & emotional abuses upon patients by staff working at the hospital.

The article, whilst commending the SCR for much of it’s insight as to what went wrong, nevertheless raises concerns as to why the review appears to have been ‘constrained’ in enabling closer examination, analysis & comment as to the conduct of professionals in undertaking their statutory duties for patients detained at the hospital under sections of the Mental Health Act 1983 [Amended 2007]. Acknowledging that this may have been restricted by the SCR’s Terms of Reference, with the possible exception of:

‘d’: “the existence & treatment of other forms of alert that might cause concern such as might emerge from, inter alia....”

The article assesses whether the culpability for such oversights in protecting the human rights of those detained under the Mental Health Act, extends to the professional bodies who register such professionals & the Local Authorities & Health Authorities who ‘approve’ such professionals as being duly qualified & competent to undertake those statutory duties under the MHA.

To this effect, the article comes to a view that despite the SCR & the many other reviews undertaken prior to the SCR & referenced by the writers of the SCR there remain many questions as to other failures, particularly in regards to those approved for performing duties under the MHA. Questions that must surely lead to a lack of confidence that the appalling breech of those patients rights during their time at Winterbourne View will never happen again in another institutional setting. A time of gross abuse that afforded no respect or dignity & to value the uniqueness of each human whatever their disability, ability, or of the need for their protection from such abuse. Abuse, that the Mental Health Act, should have afforded those patients protection from, had the legal requirements of the Act been carried out.

Disclaimer: The views contained in this article are those of the author & do not necessarily represent those of the East Midlands Adult Safeguarding Board, BASW or any other body with which the writer is associated.

In addition the quotes used in this article & attributed to the person named do not necessarily represent those of their employer, BASW or any other body with which they are associated.

I would like to thank those who have contributed to this article through providing comment, suggested revisions & in noting inaccuracies in the various drafts that went before the completed article now submitted.

Any remaining inaccuracies or mistakes are those of the writer to whom full responsibility for such is noted.
‘Shame Upon Your Houses’. What the Winterbourne View Hospital Serious Case Review Does or Cannot Not Tell Us.

Article by Robert j. Nisbet.

On Friday, 3 August 2012, the final member of staff from Winterbourne View Hospital charged with ill treatment or neglect under the Mental Health Act [1983 – Amended 2007] pleaded guilty. Michael Ezenagu, along with his colleagues now awaits sentencing.

With 15 months having gone by since the expose by the BBC - One TV Panorama programme, the Serious Case Review [SCR] by the South Gloucestershire Adult Safeguarding Board, & written by Dr. Margaret Flynn was published on the 7th August 2012. A commendable report by a very experienced writer & one with a track record in the area of adult safeguarding that is fairly unique. The report stands alongside many other reports & internal investigations including those undertaken by the owners of Winterbourne View Hospital, Castlebeck Ltd.

Media attention has primarily focused upon the role & failures of the two regulatory bodies, who have the statutory responsibly for investigating complaints, concerns etc. & questioning why such areas of gross abuse as that filmed by the secret reporter for the BBC programme, occurred when information from a ‘whistleblower’ was known to them. The Care Quality Commission & the Mental Health Act Commission [which became part of the CQC at the same time as those of the Commission for Social Care Inspection and the Healthcare Commission] have acknowledged those concerns & in addition to undertaking their own review of Winterbourne View Hospital, have undertaken some 150 inspections of hospitals, both in the private & NHS sector who provide inpatient services for people with learning disabilities.
Concerns were expressed at the time the MHAC was transferred & incorporated into the CQC. Having a much wider brief would result in a loss of some of their ‘specialist’ experience. Essentially, that such a merger would ‘dilute’ the specific monitoring of the care of detained patients.

The question remains, in the opinion of the writer, as to how many professional organisations, associations, whose members undertook responsibilities & duties approved under the Mental Health Act at Winterbourne View, are intending or are actually putting their ‘own houses in order’ following the expose? With the exception of the social work professional bodies & press, namely BASW, Community Care and the College of Social Work, what is the evidence of a concerted and ‘soul searching’ response from organisations representing psychiatrists, psychologists, OT’s or for that matter the nursing profession?

Confidence in believing that some organisations will give serious consideration to their responsibilities & for making changes is I fear low. Serious Case Reviews are no ‘Leveson Inquiry’, afforded the powers of access to information & of summoning those required to give their evidence under oath. SCR’s are not statutory & as such are a voluntary process & not able to enforce individuals or agencies to attend for ‘examination’ or to provide information. Proposals for making them a statutory requirement are contained in the Government’s Care & Support Bill 2012, currently out for consultation.

The SCR reports informs us that:

- Castlebeck Ltd would not share certain information concerning complaints, disciplinary proceedings.
- Castlebeck Ltd declined to share information on how much they spent at Winterbourne View on patient activities, physical health, psychiatric input, nursing staff, support workers, heating & lighting and many other types of

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2 The Inquiry has been established under the Inquiries Act 2005 and has the power to summon witnesses. Two-part inquiry investigating the role of the press and police in the phone-hacking scandal, on 13 July 2011
information, on the basis that such information was ‘commercially sensitive’.

- Castlebeck Ltd declined to share the un-redacted report that they had commissioned from the company Price Waterhouse & Cooper [PwC]
- The GP contracted by Castlebeck to provide services to Winterbourne View Hospital patients did not share any information with the SCR on advise from the Medical Defence Union & the General Medical Council.
- Information concerning patients detained under the MHA was not sufficiently specific.
- There was a potential for counter –briefing as the Care Quality Commission [CQC] & the NHS South West undertook to share and/or publish their reports independently of the Serious Case Review.

In their statement issued on the publication of the SCR Castlebeck Ltd stated:

_The board and management team at Castlebeck welcomes the publication of the Serious Case Review and the findings of the panel under the independent chairmanship of Dr. Margaret Flynn. We hope that the lessons learned and the actions that flow from this rigorous report will mark the start of a new chapter for care in our sector._

_The actions towards people with learning disabilities by former members of staff at Winterbourne View Hospital were both wholly unacceptable and deeply distressing for all concerned and we are truly sorry this happened in one of our services._

_The criticisms that have been directed at the health and social care sector in general, and particularly those that were directed at our organisation and are highlighted in this report have been listened to and are actively being addressed. We believe we have responded in a way that demonstrates our resolve to ensure that the events of Winterbourne View will not be repeated._

Published 28th July 2012, the _BMA’s Safeguarding Vulnerable Adults Toolkit for GPs_ says legislation is in place to protect GPs who wish to sound the alarm over fears that vulnerable patients have been victims of abuse or neglect, but they should only

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3 Castlebeck Ltd. Statement issued on their website, following the publication of the SCR. http://www.castlebeck.com/family-and-carers/safety/where-we-are-now/
do so if they believe a cover-up is likely and once they have informed managers and/or regulators.

The toolkit aims to resolve “a lack of clarity' over the issue and support GPs to meet their 'obligation' to report abuse”, the BMA said.

The guidance, which highlights the differences between safeguarding adults and child protection, advises “GPs should be alert to identifying abusers, spotting ‘systemic healthcare failures’ and recognising signs of neglect, ranging from physical and mental abuse to financial exploitation”.

It also informs doctors as to the channels they can use to raise the alarm over patient safety fears - including raising concerns 'in good faith' with managers, employers or regulators - but should whistle-blow if they suspect a cover-up is likely.

It does appear that the SCR was possibly prevented intentionally or unintentionally from fully investigating as to how those patients detained under the Mental Health Act at Winterbourne View came to be not only abused, as witnessed in the BBC TV broadcast, but were also failed by a number of ‘approved’ professions in regards to undertaking statutory responsibilities under the Mental Health Act. Such is disappointing, as I am sure the report writer & the Safeguarding Board who commissioned the report would have wished to have ‘grasped this nettle’ with similar forensic scrutiny & authority that other parts of the report bears testimony to.

We are then left to speculate as whether if the terms of reference for an SCR gave a wider remit to question & if SCR’s carried statutory authority, would that have comprehensively revealed why “concerned curiosity and vigilance”, that the report writer comments upon as being lacking, in revealing the “clear failures of professional judgment”. Such that the systemic failures that were ignored, allowed, or passed by on, to so enable the abuse, eventually ‘caught on camera’, to have existed for such an extensive period of time.
Would have such access & powers to undertake this have enabled the report writer to have equally drawn attention as to the apparent failures of those ‘approved’ professionals in undertaking their statutory responsibilities and duties under the MHA, coupled with their ‘professional judgments’?

“Although some agencies were forthcoming in acknowledging their failings, irrespective of the public interest in the risk of such abuse recurring, concerns about individual & agency reputations & concerns of business viability prevailed. Such considerations do not sit easily with the distress & disbelief of Winterbourne View Hospital patients & 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 unnoticing hospital would have continued”4

Not only were many patients abused physically, and emotionally to such an extent that criminal prosecutions have been successful in bringing the perpetrators to justice, they also had their human rights and the protection that detention under the Mental Health Act should have afforded them ignored by those professionals whose responsibility it was to so carry out the law. Yet we don’t see them in any court, disciplinary hearing...as far as we are informed! There is no reference to such taking place either in the SCR or by those organisations – unless that is they now choose to make a statement to the contrary.

Perhaps then it is more understandable in the absence of the above, that the report aims both its ‘barrels’ to propel the strongest criticisms at the NHS commissioners who placed people at Winterbourne View. The report could be accused of firing without clear sight of ‘others’ who seemingly complicit in their failures of duty. Or was the reports sight of fire deliberately obscured?

Anyone with at least the minimal understanding of the legal powers and responsibilities that professionals have for their patients detained under the Mental Health Act, would be able to work out that there are some key individuals who worked or were required to be at Winterbourne View as may have been “let off”.

4 Flynn. M. Winterbourne View Hospital, Serious Case Review. South Gloucestershire Adult Safeguarding Board. Published 07/08/2012.
Raising concerns that if they have still have the ‘authorisation’, allowing them to carry out responsibilities under the Mental Health Act, as well apply standards of care their professional registration requires, tragedies such as Winterbourne View are likely, sadly, to occur again.

We may rightly ask whether the NHS Commissioners failed in their own duty of care. Or are they just easy targets & the least able to protect themselves, compared to say that of professional organisations & the company Castlebeck Ltd itself? How will the changes in commissioning when this becomes the responsibility of the Clinical Commissioning Groups with effect from April 2013, ensure that such ‘commissioning’ as in the past, does not happen again?

With limited knowledge to confidently explore the above, I’ll return to the focus of this article. The question, as to what priority of concern should we give to those who are ‘legally approved’ to carry out statutory professional responsibilities under the Mental Health Act [1983], & seemingly failed to so? Duties under the Act that provide (or should) a number of checks & balances to protect the detained patient & that are the least restrictive required for the detained person’s care & treatment.

I think it is highly unlikely that there is not a Commissioner in the land who has not already considered, if not acted upon, how contracts are placed and monitored with such companies as Castlebeck Ltd. Indeed many have worked tirelessly & over many years, way before the secret cameras of the undercover reporter for Panorama entered the doors of Winterbourne View, to reduce the use of such placements & to bring people back to their local communities & to be supported by local services.

By the SCR pointing it’s ‘longest finger’ at them does this not risk inadvertently protecting a number of other professionals who have not been in court, and as far as we know, placed under enquiry as to how they performed their statutory responsibilities under the Act, either by their professional body, or for that matter the Strategic Health Authorities who currently have that delegated responsibility
from the Secretary of State for Health for their approval, re-approval & removal of that approval of the Responsible Clinician. In the case of the Approved Mental Health Professionals, [again a defined statutory role under the MHA] by the relevant local authority that is required to grant that approval for their 'warrants', be they a social worker or another mental health professional. Noting in particular the training required to become an AMHP, is usually at degree level & can take up to 18 months to complete.

Calling upon the care services Minister Paul Burstow to “throw his weight behind the SCR and to call for a “commissioning challenge”, so as to find suitable support packages for the 51 former patients of Winterbourne, and hopefully many others detained in similar institutions around the country, is commendable.

My call to the Minister is to also ask him hold to account the professional bodies who have responsibility for the conduct and competence of those who they register to practice and the ‘licensing’ authorities who approve such professionals to carry out functions & responsibilities prescribed by the Mental Health Act. To send a clear message that such bodies must put their own “houses” in order, rather than to rely on any voluntary & insightful recognition that things must change.

Is it not unreasonable for those who commissioned services at Winterbourne View, to also have had some confidence that for the person the NHS has funded & placed, & if sectioned under the MHA, would be afforded the correct & proper safeguards that Act provides with regards to their human rights? That such being the responsibility of those who are authorized to do so under the Act as well as those that scrutinise the Act in being properly applied in that patient’s care & treatment?

My own experience of working in both medium, low secure & community services, albeit some seven years ago, was of the responsibility of clinicians & social workers of the local service, [determined by where the patient had ordinary residence], to attend MHRT’s, Care Plan Reviews, as well as keeping in touch with family members.
This would be for the duration of the ‘out of area treatment’. Whilst their placement were often in hospitals some distance away from their home, the responsibility of the ‘home service’ to ensure standards of care were adhered, for ensuring good co-ordination with that hospital was key. That such monitoring & contact was informed by the overriding question as to the appropriateness & necessity of their treatment continuing at that establishment & bringing them home at the earliest opportunity. This was fairly common practice across the country & is still referenced as the practice today.

Where we placed patients in specialist private hospitals we kept them under regular review with a view to bringing them back to alternative/local/less restrictive provision as soon as it was appropriate (including if they were not benefitting from the current placement). There was clearly a serious failure to adequately monitor the placements at Winterbourne and it seemed like a case of out of sight out of mind!

Ian Priddey - Approved Mental Health Professional

History has a lot to teach us, if only we had that memory to recall such similar tragedies to that of Winterbourne View & as to whether lessons really have been learnt & applied?

Not just a recall of previous investigations, but also to the wealth of published reviews, guidance etc. that should be essential reading for all in the health & social care professions.

In October 1997 the Social Service Inspectorate published their Inspection Report: ‘Services for Mentally Disordered Offenders in the Community’.

Standard 5 [of the 8 standards set by the inspection team] states:

The SSD [Social Services Department] provides a social work service & meets its obligations under the 1983 Mental Health in relation to mentally disordered offenders receiving treatment in psychiatric units, medium secure units & special hospitals.

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Standard 8:
Services for MDOs take account of the views & rights of users, carers & victims.

Though frequently referred to as ‘Mentally Disordered Offenders’ in the 90’s, this generic term was used to cover the full range of people with a mental disorder who either come into contact with the criminal justice system, leading in some cases to being convicted by the courts. Recognising that for some individuals assessed as having a severe learning disability, their ‘offending’, challenging behavior, would not have been appropriate to bring to the courts. As such many individuals would be detained under the civil sections of the MHA, and placed in such institutions similar in security to that of Winterbourne View.

The report ‘Mentally Disordered Offenders – Improving Services’, published by the Social Services Inspectorate in 1996, detailed examples of good practice for the field, as well as insights into the kinds of barriers to planning & service development which were commonly encountered. All seven who contributed to the report (Local Authorities & NHS services) had endorsed the five principles of the Reed Review [DH 1992].

“The Reed report will tax the ingenuity of managers in the NHS and in local authorities. It has not priced its recommendations, but emphasises the need to consider the costs to all agencies of “misplaced” patients and the costs incurred by denying early intervention. It emphasises the pernicious financial disincentives that influence agencies to deflect responsibility for mentally disordered offenders. Such a patient in prison or special hospital costs a district health authority nothing. It therefore proposes that each district health authority should accept financial responsibility for all the health care needs of its mentally disordered offenders (in common with the rest of its citizens) even if they are receiving specialist treatment outside the authority’s boundary. In planning services, NHS managers will need to work closely with general practitioners, local authorities, and agencies in the voluntary sector and criminal justice system”.

“Regional health authorities, too, have crucial roles in conducting assessments of need, ensuring the provision of services, and monitoring standards”.

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7 Reed Report 1992 Department of Health and Home Office
“Can the massive exercise in multiagency working which Reed proposes be implemented? It comes at a time of economic recession and when agencies are struggling with new funding arrangements and new roles. Some, such as the regional health authorities, face an uncertain future.’ We can see clearly the requirements for mentally disordered offenders, and Reed has done a masterly job in presenting them. But will the operation get afloat? Or will complex bureaucracy, the market economy in the NHS, and inadequate funding leave it dead in the water? We must hope not. JOHN BANCROFT. Consultant Psychiatrist.”

Just taking two of the key principles of the Reed report, to reinforce their relevance today as it was those years ago.

- With regard to the quality of care & proper attention to the needs of the individuals.
- As near as possible to their own homes or families, if they have them.

Twenty years on from the Reed Report, fifteen years since the SSI set clearly & unequivocal standards, the reports submitted to the Department of Health, led by Professor Jim Mansell at the Tizard Centre, University of Kent & the considerable work that the National Development Team undertook in making the late Professor Jim Mansell’s work a reality for some people, do we not have to seriously question why professionals failed to uphold the human rights & legal requirements for their patients detention? In addition, as to whether their practice complied with the standards required of their professional registration.

History unfortunately, informs us that we not only fail to learn the lessons from the past, but more tragically the principles of upholding rights, respect & dignity at the core of the caring professions is subverted or ignored over & over again, despite the massive industry of regulation, & the existence of many prestigious professional bodies.

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9 NDT & DH, Tough Times Project. A programme of work that raises the profile of adults with learning disabilities stuck in the secure care system.
These are not the poorly paid staff that form the main work force in our health & social care services. Such professionals, both in the NHS & independent sector, receive salaries of over £100k plus per year. So you can see why fees at such places as Winterbourne View are what they are! Assuming also that Castlebeck did at the time actually employ sufficient numbers of senior clinicians & with the required accreditation & evidence of competency in their practice. Not that they will tell us, as such is ‘commercially sensitive’. Shame that such sensitivity did not extend to the care of their patients! Adding in also that the hospitals registration by CQC is based on an assessment that the hospital has the right skill mix, sufficient qualified professionals on site to meet the needs of the patient group for whom they care for.

Should we not be concerned as a colleague commented to me?

“…why in 150 pages no space could be found to examine the inferred failures of key professionals who should have provided external checks and balances against internal failure at Castlebeck. If psychiatrists, AMHPs, tribunals and courts really were signing off MHA sections on a casual basis, they should have been reported to their respective registering bodies. Such referrals not mentioned (even on an anonymous basis) within the report”.

What we do know is that 35 patients were admitted under a section of the Mental Health Act, [4 people under S.37 & S.37 [41], 8 under Section 2 & 23 under Section 3]. Of the 13 were admitted informally 6 were detained after being admitted informally. As other commentators of this fact have noted, there are no details in the SCR regarding the Deprivation of Liberty Safeguards, [An amendment to the Mental Capacity Act, 2005,] and as such does raise the question as to how legal were those informal admissions?

“…the authors appear not to understand the Mental Capacity Act. The (un-numbered) recommendation and footnote (4) on p 126, they seem to suggest the DoLS regime should be used as a substitute for MHA. This is completely contrary to the MC Act, the DoLS code of practice and the function of the “eligibly test” under DoLS. Any AMHP or psychiatrist assigned to do the “eligibility assessment” who took F&C’s recommendation at face value, would in my opinion be acting contrary to the Code of Practice”. Dr Terry McClatchey.
In considering how the Mental Health Act should have made a significant contributed to the safeguarding & protection of patients at Winterbourne View, space in this article limits a thorough review & application of all the ‘checks & balances’ of this Act. The responsibilities of professionals, Hospital Managers, Mental Health Act Administrators, Tribunals, the Mental Health Act Commission & ultimately the Secretary of State, to be the essential ‘checks & balances’. Checks & balances focused on the patient’s treatment, appropriateness of detention under the Act, their overall welfare & at the core, the protection of the patient as well as others.

In this quick ‘whistle stop tour’, the essential question is why did these different checks & balances fail so catastrophically in respect to those patients detained at Winterbourne View? Further, what action will subsequently be considered by the various bodies responsible for the Act, the professionals carrying out duties under the Act & those with the right of inquiry & review to ensure that such failures do not happen again?

An in depth analysis of the Act’s requirements, matched against it’s application & interpretation applied to the patients at Winterbourne View, would I am sure raise many more questions & concerns that the limitations upon this article do not permit.

Patients detained under the Mental Health Act are required to have a  **Responsible Clinician**  [R.C.], who is ‘Approved’. Prior to the amendments of the Mental Health Act in 2007, this was the ‘providence’ only of psychiatrists, and known in the Act’s terminology as the ‘Responsible Medical Officer’ [RMO]. It is not noted as to whether the Responsible Clinician[s] at Winterbourne View continued to be drawn only from the psychiatric profession, or as the 2007 amendment permits from other professions, including nursing, social work & psychologists, as long as they meet the accreditation requirements for ‘approval’. The SCR references the ‘presence’ of a Consultant Psychiatrist at Winterbourne View.
When a detention under the Act nears its ‘expiry’ date, [all sections under the MHA have dates upon which the section expires unless renewed, otherwise the patient is no longer detained. At any time during the time-period the section can be lifted by the R.C. The exception to this is S37 (41), which since the amendments to the Act in 2007, can only be made ‘without limit of time’, and discharged either conditionally or absolutely by the Secretary of State or by a First Tier Tribunal – Mental Health. In addition all leave by the patient has to be granted by the Secretary of State on submission of a request/report by the R.C.

There is a requirement that if a renewal is being applied for by the RC, that the renewal application is considered by the Hospital Managers for approval [or not]. Hospital Managers should not be confused with the operational managers at Winterbourne View. Hospital Managers are appointed by the hospital trust or owners, in this case, Castlebeck and such persons, though they may not be mental health professionals in their own right, also have statutory responsibilities and duties under the MHA.

During the reform of the 1983 MHA it was envisaged that hospital managers would lose some of their powers, notably the power to discharge an unrestricted detained patient. When the Government withdrew the 2004 Mental Health Bill, and amended the 1983 Act, the role & the number of the Hospital Managers functions was significantly increased.

“They remain therefore one of the important safeguards built in to the legislation.”


Such now enables the Hospital Managers an increase in the number of occasions for automatic referral of patients to Tribunals & a requirement to provide [as from April 2009 in England] information in relation to the Independent Mental Health Advocacy Service. Hospital Managers are required to refer patients automatically to a Tribunal

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if six months has passed since the patient was first detained under whether under S.3, unless the patient has in their own right applied

Other responsibilities of the Hospital Managers include visiting the patient, considering reports at the time of the application to the hospital managers by the patient and renewal application by the R.C., reading reports on the patients ‘progress’ provided by professionals contributing to the patient’s care plan, [Nursing, OT, Psychology, Social Work] & having reached a decision, speaking directly the patient in private. Further, taking the views of family members, particularly the Nearest Relative’ with regards to the necessity and appropriateness of the detention under the Mental Health Act, and the enormous importance that by detaining under the Act this is “least restrictive” option, namely that restrictions & treatment are proportional & necessary to the patient’s individual treatment needs.

The amendments in 2007 to the 1983 Mental Health Act, also brought in a new right of advocacy for those detained under treatment sections of the MHA, such as that should have been available for patients at Winterbourne View. The role and responsibilities of the Independent Mental Health Advocate [IMHA] is an important addition to other requirements of reviewing a patient’s care and treatment. What we are not clear of is as to whether those patients detained under the Mental Health Act were even given the opportunity for such representation, or whether there was such a service available to the hospital to access. The commissioning & funding of the IMHA services is that of each Local Authority.

Efforts should be made by those responsible to seek alternatives to detention, such as arranging appropriate support in the community, in line with the principle of care in the least restrictive environment. Sometimes there are difficulties in determining whose responsibility this should be with regards to detained patients transferred from one hospital or area to another, as in the case of Winterbourne View.
The SCR references a ‘low threshold to S.3’ & would suggest that in examining the actions of those who are approved & undertook statutory responsibilities under the Act that we need to know a lot more as to what this comment implies.

“One cannot though let the second independent doctor and the independent AMHP’s off the hook either - they were signing legal forms contributing to what the report called "a low threshold to section 3" - and in consulting with relatives surely they heard some of these complaints? An independent doctor could surely have raised issues pertaining to frequency of restraints and medical response to such...” Craig Wilson

“AMHPs should be applying the least restriction principle and not signing s.3 applications unless they are convinced that it is necessary. However in the absence of community alternatives this may seem necessary, hence the reference to low thresholds? Also many admissions may not have involved an AMHP; for example transfer in from other hospitals, court use of s.37. Also AMHPs do not have any statutory role in any renewals”. Ian Priddey
Approved Mental Health Professional.

Detention undertaken under Part II of the MHA, such as a Section 3, do not require a court application or for that matter any reference to a court, whilst a Section 37, which comes under Part III, is made by a magistrates or Crown Court. Both sections require the recommendation of two psychiatrists, & for a Section 3, the application [agreement] of the AMHP. S. 37(41) requiring a Crown Court hearing but again on the recommendation of two psychiatrists.

What is so much at the heart of the Mental Health Act, & reinforced by the amendments & principles in the 2007 amendment, is the recognition & importance, that whilst for a person’s own safety and/or that of others detention, often referred to being “sectioned”, there is a right of an ‘independent review’. In addition to being able to request such a review from the Hospital Managers, there is also, within prescribed time limits, the right of the patient to make an application for a hearing by a First Tier Tribunal - Mental Health [Which replaced the former Mental Health Review Tribunal, MHRT] 11 Briefly such a body considers whether the person’s continued detention for treatment is required, being mindful that in some cases

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11 Tribunals & Courts & Enforcement Act 2007 a new tribunal framework was established. MHRTS’s were abolished in November 2008 as a free standing legal entity.
detention in some environments may exacerbate the condition or challenging behavior for which they were detained for in the first place.

A Tribunal is made up of a judge {a qualified lawyer particularly experienced in mental health law}, an independent medical member, usually a psychiatrist, and a layperson. The layperson having experience and knowledge both of the Mental Health Act and of treatment and care requirements of those patients detained under the Act.

The Tribunal may appoint a legal representative for a patient if it believes this to be in the best in the patient’s interests. This is in response of the State’s positive obligation to secure Human Rights under the European Convention, including the right of a fair trial under Article 6, [& Article 4] to everyone within it jurisdiction.

Medical examination of the patient before the hearing is now a ‘must’, whereas previously the Tribunal rules stated that this should take place ‘so far as practicable’

In addition to their own medical member’s report, various other reports would have been provided to the Tribunal. Alongside a medical report and a social circumstances report, the tribunal must now also be supplied with a nursing report.

A further comment by Ian Priddey:

“When I was based at a low secure forensic mental health hospital I did very few s.3s for our inpatients but was involved in appeal hearings a lot. So it does seem surprising that whoever was doing those social circumstances reports for the appeals (not an AMHP specific task) did not pick up on the concerns from patients, relatives and even some of the staff”.

In reviewing how the hospital themselves followed the principles & operated the Act, and which they seemingly undermined, should not questions be raised with how the external independent judicial body, the Tribunal, functioned in cases referred to it?
Noted are the discrepancies by Mental Health Act Commission in relation to their responsibilities in protecting the patient’s rights of those detained at Winterbourne View. Should enquiry also be made as to when did Tribunal’s take place at Winterbourne View? Did Tribunal members have concerns about what may have been going on? In the medical member of the Tribunal undertaking the ‘medical examination’ of the detained patient prior to the hearing, what did they report as to their findings to their Tribunal colleagues? Did the Tribunal appoint legal representation for a patient, if that patient did not have that representation?

The SCR rightly draws attention to the lack of advocacy, assuming this to be independent advocacy, being available for patients. Yet the MHA provides not only opportunities for such, but indeed requires it. When considering the particular needs & presentation of many of the patients detained at Winterbourne Hospital, you do have to question as to the frequency that advocates, solicitors & the like who visited Winterbourne View to take instructions from their clients, attend managers & Tribunal hearings etc.? I have a suspicion that changes to way law firms are funded for such work by the Legal Services Commission may have some bearing upon the time allowed & robustness representation of the legal profession to so undertake such complex work for this particular client group. Or were they & we not had the opportunity to hear about this?

In reviewing how the hospital themselves followed the principles & operated the Act, and which they seemingly undermined, should not questions be raised with how the external independent judicial body, the Tribunal functioned in cases referred to it. We have seen concerns as to the discrepancies by Mental Health Act Commission in relation to their responsibilities in protecting the patients rights of those detained at Winterbourne View. Should enquiry also be made as to when did Tribunals take place at Winterbourne View? Did Tribunal members have concerns about what may have been going on? In the Tribunal’s’ medical member undertaking the ‘medical examination’ of the detained patient prior to the Tribunal hearing, did they report as
part of their findings to their Tribunal colleagues any concerns with regards to the safety of the patient, use of restraint & the type & appropriateness of medication that patient was being prescribed?

Nor would I wish to brush aside the rights that the ‘Nearest Relative’ have as defined by the Mental Health Act. Such that they can also seek a review of their relatives care, treatment & level of restriction applied to their detention. First through application to the Hospital Managers. If discharge from section is not granted, to be able to apply to a First Tier Tribunal – Mental Health. That is assuming that they were informed of their rights, and were regularly updated in relation to any renewals, tribunal’s, care plan, care reviews, or informing what should have been a much closer scrutiny of the day-to-day care of that patient. By whom? Well if you are legally the Responsible Clinician, pretty obvious!

Whilst not expecting a busy senior clinician undertaking the role of the detained patient’s RC to do everything, delegation to junior doctors, or other staff members is permissible, but does not mean that you also delegate the legal responsibilities for which you are approved for. The patient’s day to day care, treatment & well-being is directly the RC’s responsibility, not the commissioner for the service. This may be one situation where those who ‘pay the piper call the tune’, does not stand up to too much scrutiny!

There are several other statutory requirements, responsibilities & whose specific duty this is to comply with, in addition to those detailed above. The question though remains the same. Was the Winterbourne View Hospital SCR in shifting through the information made available to them not able to ask more questions of those professionals, accrediting bodies, professional associations as to what appear to be such fundamental oversights if not failures of legal duty of those professionals responsible for patients at Winterbourne View who were detained under the Mental Health Act? The ‘lite touch’ applied to this area by the SCR review appears incongruous with many other creditable parts of the report.
“If Section 3s or 37s are genuinely needed and appeal mechanisms exhausted, then is follows that the professionals involved will have had to demonstrate a diagnosable mental disorder and a requirement for relevant treatment to be delivered in a hospital – if they have not done so, the section should never have been made or should have been deleted at the earliest opportunity’ Terry McClatchey

The SCR’s terms of reference, & noting previous comments upon the limitations of it’s role, did not specifically require for it to seek out those professionals approved under the MHA & who undertook those duties at Winterbourne View Hospital. Nor for that matter to make enquiries as to how those ‘approved’ persons carried out their duties, as part of the SCR’s ‘information gathering’.

Perhaps a clear recommendation in the SCR to those bodies with that responsibility that such should be required of them, be that in regards to the individual professional, the individual’s professional registration bodies, associations etc. to undertake such, would have sufficed? Not forgetting the ‘approving bodies’ that effectively ‘license’ these professionals to carry out such important functions under the Mental Health Act, & seemingly took no responsibility or action to protect their patients from what we witnessed happening in the Panorama programme. Assuming that they are not doing this already?

That this ‘approval’ is a delegated power vested with the Secretary of State, and whether such also places such concerns to require the Secretary of State’s to consider asking further questions of those who act on his behalf?

The MHA S. 118(1) does state a clear duty of the Secretary of State [and the Welsh Ministers] to:

*Prepare, & from time to time revise, a code of practice –*
  
  *(a) for the guidance of registered medical practitioners, Approved Clinicians, managers & staff of hospitals, independent hospitals & care homes & approved mental health professionals in relation to the admission of patients to hospitals & registered establishments under the Act & to guardianship & thereafter supervision community patients under this Act; and*
(b) (b) for the guidance of registered, medical practitioners & members of other professions in relation to the medical treatment of patients suffering from mental disorder.

Whilst not advocating any additional requirements or changes to the Act or Code of Practice as a consequence of what we seen take place at Winterbourne Hospital, maybe he should though ask those as listed what they did to comply with the Act & Code of Practice?

The report is also commendable for bringing to the attention of the reader as to the prescribing of certain potentially highly toxic drugs. Whether such drugs were administered to a person detained under the Act or not, they do raise concerns as to the prescribing competency of the doctor, be it the GP or psychiatrist. The prescribing of the drug Denzapine, for a patient who had only previously been taken of the same medication, but with a different brand name, ‘Clozaril’ six days before, due to a reduced white blood cell count, is deeply concerning.

The use of anti-psychotics in the management of behavior is also noted by the review, & of the informing need for being prescribed. It appears that no assessment was made & documented as to whether the medication was for treatment of a mental illness or for the management of a patient’s behavior. Whilst some such medications are licensed for both, clear records are required to inform of the prescribing clinicians rationale in using such when acting in the best interests of their patients.

Should such prescribing concerns be referred for investigation to the GMC? On the grounds that prescribing psychotropic medications to persons who do not need them is an unsafe practice.

Noting the limitations of Serious Case Reviews with regards to adult safeguarding & of enabling us to have some confidence that real change will be made from the lessons learnt, criticism must be reserved as to some professional associations.
Associations that have as members those clinicians who carried out duties advised above, and as to seeming lack of responses and commentary post to the publication of the SCR. I will though defend & commend my own professional organisations for their openness & commitment to making improvements.

I note that the Royal College of Psychiatry president, Sue Bailey, in her blog on the colleges website, [08\0812] commented with regards to the human rights of the executed prisoner Martin Wilson in Texas, & rightly the moral outrage that such an act by the State of Texas should bring. Whilst supporting ‘moral outrage’ about what is happening in someone else’s ‘backyard’ is to be applauded, does it not beg the question as to whether they should also be addressing what is happening in their own organisation’s backyard, with regards to upholding a persons human rights? Or are they addressing this? If so how?

The Royal College did issue a statement with regards to the Winterbourne View SCR, dated 8 August 2012, stating “the college will be ensuring all psychiatrists working to the highest professional standards in the care of people with learning disabilities who have challenging behavior” So can we expect the cleaning up of the College’s backyard fairly soon?

By contrast, nothing appeared from the BMA, GMC, the British Psychological Society, the Royal College of Occupational therapists, or even the Nursing and Midwifery Council & Royal College of Nursing.

However I do note that the GMC’s deputy and chief executive, Paul Philip, when giving evidence at the House of Commons Health Select Committee in June 2011, advised “there must have been doctors in the vicinity. We are working with Castle back, the police and the care quality commission to identify those doctors. So far we have a few names and we will be looking to follow that up”
The comments came in response to Stephen Dorrell MP, Chair of the Health Committee, who said a GMC investigation would “**send a powerful message into the system on professional accountability. GMC guidance states that doctors have a duty to act if they witness evidence of malpractice.**”

Last but not least something I came across on the web site of the **NHS Networks**, whose ‘strap line’ is ‘**Connecting people and ideas for better health**’, in which their Director of Development, Julian Patterson, blogged in an item titled “**Lessons from the banks for CCG’s**” [16th of July 2012]

“...**strong enforcement and clear regulation are mutually dependent. You cannot have one without the other. Punishing the guilty is only possible if you know who they are and they know what they are responsible for.**”

“**The report on Winterbourne View is just the latest excuse for an investigation to draw all the usual conclusions. Everyone meant well and tried hard, but things went wrong. We’ll try not to do it again. A few people like due in court to answer individual charges of brutality. Nobody responsible for the systematic failure at Winterbourne View and places like it will get anywhere near a court room, let alone a jail.**”