Safeguarding Adults Review - Long Leys Court

Overview Report

What barriers prevented the multi-agency system from keeping adults with learning disabilities and complex health needs in a supposedly safe in-patient setting, free from abuse and ensuring they received good care and treatment?

How can Lincolnshire Safeguarding Adults Board promote a safeguarding system that delivers safe and person-centred care for this group of the county's residents in the future?

Lead Reviewer: Fran Pearson

1 Why the Lincolnshire Safeguarding Adults Board initiated this Review

1.1 In June 2015, the Lincolnshire Safeguarding Adults Board received two notifications raising concerns about 12 adults with learning disabilities and mental health issues. The allegation was that they had been emotionally and physically abused while NHS in-patients. Long Leys Court, a 16-bedded assessment, treatment and rehabilitation centre for patients who had learning disability with mental health problems, provided by the Lincolnshire Partnership NHS Foundation Trust, was the setting where they were all patients and where this abuse and neglect was alleged to have happened. It was LPFT that sent the notifications.

1.2 The first notification set out that: From 17th January 2014 to 30th August 2014 there were 4 separate incidents of abuse towards patients at Long Leys Court [and detailed the resulting action against staff].

1.3 The second notification set out incidents involving five patients between 6th April 2015 and 2nd June 2015. These ranged from a possible case of physical neglect which may have contributed to the death of the oldest of the five patients, to the misuse of restraint, and incidents of neglectful and abusive behaviour by staff towards the three other patients named in the notifications.

1.4 It is an expectation as soon as any safeguarding concern is raised, that all organisations and their leaders will move quickly to address things that have gone wrong and continue to do this as new issues emerge. This was quite rightly the case in Lincolnshire. One of the things that the LPFT and NHS Clinical Commissioning Group agreed, in June 2015, was to close Long Leys Court. By that time, a range of assurance and investigative processes were under way, the purpose of which was to protect the adults at risk in Long Leys Court, and to establish how previous in-patients had been affected. As a result, the notifications into the Board were expected, and known to be on their way. Early reviews of information known by agencies around the initial 12 individuals suggested that a further 43 adults at risk may have been subject to abuse whilst admitted to Long Leys Court. All 55 residents were reviewed against the Care Act criteria for Safeguarding Adult Reviews and it was agreed that a cohort of 39 individuals were considered to meet the criteria to undertake a review under S 44(4) Care Act 2014.

This report notes instances of correspondence about safeguarding risk to individuals not being logged. The NHS Clinical Commissioning Group, the local authority, and Lincolnshire Partnership NHS Foundation Trust provided a joint statement to the independent reviewer. They are now able to say with confidence that things are different and all correspondence

between their organisations about safeguarding concerns is logged appropriately by each of the three organisations.

1.5 It was subsequently agreed that 12 out of the 39 individuals represented an appropriate cross section of the residents and these 12 would be the subjects of the review.

1.6 Lincolnshire Police led a criminal investigation into a number of incidents including those referred to above, that were set out in the notifications of June 2015. The investigation was concluded, and it did not result in any professionals being charged with criminal offences. Registered nurses working on the unit at Long Leys Court were referred to their professional body. Other professionals on the unit received appropriate sanctions overseen by the local authority via the safeguarding adult process, which included the Care Quality Commission and commissioners of Long Leys Court.

The Care Act: law and guidance on Safeguarding Adults Reviews

1.7 The Care Act requires Safeguarding Adults Boards to arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

there is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other persons with relevant functions worked together to safeguard the Adult and the adult dies as a result of abuse or neglect, whether or not it was known or suspected before the adult died (s44 (2))

OR,

if the adult is still alive and the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect (44(3)). In addition, Safeguarding Adults Boards are free to arrange for a Safeguarding Adults Review in any other situations involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) (s.44(4)).

The purpose of a Safeguarding Adults Review is to:

- Identify the lessons to be learnt from the adult's case, and
- Applying those lessons to future cases

This review was commissioned under (S44(4)).

2 The Process in this Safeguarding Adults Review – Rationale and Methodology

Methodology

2.1 The Serious Incident Review Group of Lincolnshire Safeguarding Adults Board recommended, and the Independent Chair of the Board agreed, that a thematic approach would best suit this case. It was also accepted by those agencies involved that this was not the sort of methodology that would lend itself to a practitioner event, as agencies would provide analysis of what was increasingly in the past, and the focus of this review would be on what was different now and what the implications were at an adult safeguarding strategic partnership level in Lincolnshire. However, there was recognition that on some points, staff who were involved in events covered by this review, might be best-placed to provide clarifications.

2.2 This approach is based upon the need to undertake a proportionate review to derive the key learning from these cases. Statutory Guidance is clear about the importance of such an approach.

2.3 It was agreed by the review author, after discussion with all agencies involved, that a chronology for each individual would not be required, but that the independent reviewer would construct a framework of key of dates covering the period under review. This table of key dates is included in the report at **Section 5**. One of the main sources of data for the reviewer to analyse were the Individual Management Reports from each organisation.

The period to be reviewed, and the rationale for this

2.4 **October 2011** was when the first of the 12 adults at risk was admitted to Long Leys Court. **October 2015** was when the remaining five adults at risk from the 12 who are the subjects of this review were moved to new placements. However, the panel also asked that Individual Management Reports include relevant analysis of the decision-making leading up to admission/discharge where this fell outside the period for the Review.

2.5 **Safeguarding Adult Review Panel**

Independent Reviewer Fran Pearson

Advisers – Lincolnshire Safeguarding Adults Board Business Manager and Legal Adviser

Agency	Services involved	IMR Author	Panel Member
Lincolnshire Partnership NHS Foundation Trust	GP, Multi-Disciplinary Team, Commissioning and Regulatory Oversight	Stephen Edgeley Independent Reviewer	Anne-Maria Newham

Lincolnshire Police	Lincs Police	Perce Bosworth	Perce Bosworth
Lincolnshire County Council	Lincolnshire Adult Care and Community Wellbeing	Elaine Grocock	Linda MacDonnell
United Lincolnshire NHS Hospital Trust	Lincoln Hospital Outpatient Services, A&E	Jenny Hinchliffe	Jenny Hinchliffe
South West Lincolnshire Clinical Commissioning Group	CCG Complex Case Team, Commissioning and Regulatory Oversight	Gail Colley-Bontoft	Pamela Palmer
East Midlands Ambulance Trust	999 Service, Patient Transport Services	Zoe Rodger-Fox	Zoe Rodger-Fox
Care Quality Commission	Commissioning and Regulatory Oversight	Did not submit an IMR	Teresa Kippax

2.6 Key Issues that form the Terms of Reference for this Safeguarding Adults Review

- Holistic practice, influence and effectiveness of the Multi-Disciplinary Team
- Commissioning and Regulatory Oversight (NHSE and Care Quality Commission as well as Clinical Commissioning Group)
- Deprivation of Liberty, Best Interests and restrictive practices
- Families, service users and Making Safeguarding Personal
- Culture, competence and attitudes towards reporting wrongdoing

Appendix 1 gives more detail on the Terms of Reference.

The purpose of this Safeguarding Adults Review, and what makes it distinct in the context of other investigations around Long Leys Court

2.7 The Care Act Statutory Guidance, s168, sets out the purpose of Safeguarding Adults Reviews in relation to other processes.

> SARs should seek to determine what the relevant agencies and individuals involved in this case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation such as CQC [Care Quality Commission] and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

2.8 In the case of Long Leys Court, police investigations did not result in criminal proceedings; disciplinary cases were concluded before the Safeguarding Adults Review began. The Coroner's Inquest for the resident who sadly died, concluded that this resident had died from Bronchopneumonia and Frailty. LPFT had also commissioned an independent review of Long Leys Court and shared the findings with partner agencies and commissioners. All actions for this were complete at the time of commencing the review. As a result, there were no outstanding processes to constrain or delay the Review.

2.9 Terms of Reference for this Safeguarding Adults Review were agreed on 1st February 2018. The aim of the Review was to analyse five key areas and provide assurance to the Safeguarding Adults Board. These five areas were identified by the Serious Incident Review Group and panel members for this Safeguarding Adults Review. A substantial amount of work had taken place since 2015 in trying to establish the extent and nature of abuse and neglect at Long Leys Court, making sure the adults were safe, and in setting up new governance arrangements. As a result, by the time it came to agreeing terms of Reference, these key areas had been extensively discussed and addressed. However, the Lincolnshire adult safeguarding system did not keep the adults at Long Leys Court safe, and the starting point for this review was to step back and reflect why this was so, and then to make recommendations as to how the Safeguarding Adults Board could promote a safer system in the future.

3 The adults at the centre of this Review

3.1 In order to try and paint a picture of the group of adults for the reader of this report, but preserve anonymity where necessary, this section is purposely brief. Analysis draws on interviews carried out by the Independent Reviewer.

3.2 The twelve adults were all from Lincolnshire, and they were all White UK residents in line with the demographics of the county, where 5% of residents are non-White (LSAB 2018). Seven were men and five were women. Their age span on discharge was 20 to 69 years old.

Involving those families and adults in this review

3.3 The Care Act Statutory Guidance sets out clear expectations about how Safeguarding Adults Boards should involve families in Safeguarding Adults Reviews:

- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively

3.4 Since the events of 2015 at Long Leys Court, families have been involved in a number of ways. This has including meetings and briefings about the closure, and face to face meetings with some of the families by the Director of Nursing at Lincolnshire Partnership NHS Foundation Trust. Where there have been criminal investigations around some of the adults in this case, Lincolnshire Police investigating officers have interviewed and subsequently updated families.

3.5 The panel for this review recognised that some families, with the passing of time, may wish to put events at Long Leys Court behind them. Equally, others take a continuing interest in the outcome of this Safeguarding Adults Review and want to contribute. As a result, five families contributed to this report. Three had face-to-face meetings, and two spoke on the telephone. One of the adults in this case was part of a face-to-face meeting. Those interviewed were clear that they were doing this because they wanted to reduce the chances of what happened to their loved ones happening to someone else. It is a huge 'ask' of these residents to go over, yet again, very painful events. The panel would like to thank them for this and assure them that this report is more robust and credible for their input.

Families then had a chance to comment on a draft of the report and suggested some helpful changes ahead of this final version.

The views of the families and service users

3.6 The analysis in each of the Five Key areas uses relevant comments and opinions from the families to try and answer the question of how and why the scale of abuse and neglect at Long Leys Court could have come about and what can be done to try and prevent any aspects of what happened there ever recurring.

Additionally though, families made comments that do not necessarily fit neatly into the analysis of the Five Key Areas, and these are presented separately in this section.

3.7 First of all, without minimising the abuse and neglect that the number of 39 very vulnerable adults are now known to have experienced at Long Leys Court, the setting was also seen as positive by two out of the five families who contributed to this review. One family member gave an account of their anger at being told very suddenly in May 2015 that the unit was closing. This person initially fought the closure but on reflection, once they were made aware of the scale and type of incidents there, began to understand the decision despite the upheaval that the closure of Long Leys Court would bring for their family member. This was felt even more strongly by another relative, who to this day, cannot understand why the unit closed. Their relative was on the receiving end of one of the incidents that met the threshold for a Safeguarding Adults Review. But this family member said "The care was really good until [another vulnerable adult admitted to the unit] attacked her. Everything was provided for her. I don't know why it closed. She's in a lovely place now – quite sorted, but these sort of places shouldn't be closed".

3.8 The other three families did not feel positive about the care their relatives received. All three talked about their concern for the noticeably increased level of medication their family members were said to need on admission to Long Leys Court. Chemical restraint - another way of naming this – is explored in Key Area Three, and that section includes family comment on medication. Two of the three said that the one and only time their family members had ever cried was in Long Leys Court. Andrew's parents, whose name we do have permission to use, said that he had been an in-patient at the unit some years before the period under review and as a result of that experience they were reluctant for him to return

at the start of 2015. On top of their concerns about the amount of medication he was said to need and its effect on him, they were overcome by his level of distress on one particular visit. Andrew clung onto a door handle and cried, as mentioned above this was not something his parents had ever seen him do, and he was by this time 33 years old. Staff at the unit persisted in recording the episode as an 'incident'. His parents felt this missed the point of Andrew's extreme distress and it was evidently painful still for them to talk about.

3.9 Strikingly uncharacteristic behaviours were described by someone else's relative. Her family member had never cried until [their] admission to Long Leys. [they] asked [their] relative to draw [their] bedroom at home. Additionally and unprecedentedly, this vulnerable adult was mute for a year.

3.10 Another family member told how his relative had been admitted 'to sort [their] sleep out, to assess [their] epilepsy and autism'. This relative found it a very hard decision to agree to this admission but concluded 'best give [his loved one] a chance'. He felt that it was the right decision in terms of getting the autism assessment. His relative had always loved baths and 'bath' was one of the few words they could say. On their return from Long Leys Court as soon as this person got into the bath 'they screamed their head off', so much so that a passer-by called the police. He wonders what happened with bathing at Long Leys Court as a result. His family member was also very aggressive on their return, which was not like them. The family member described hearing on the radio about 'the boy who drowned in the bath' [This was a reference to Connor Sparrowhawk, referred to in the national context in the table of key events – a young man who tragically drowned in the bath at a facility in the south of England and whose case gained substantial media coverage], and said 'If I heard about him before they suggested Long Leys Court, I wouldn't have sent [them].

3.11 From observing their family members' behaviour, which they know down to the last detail, relatives are consequently still left wondering and worrying what had happened to them at Long Leys Court.

4 National Policy Context

4.1 The period under review occurred during a time of unprecedented, and significantly increased, expectation about the duty of local partnerships towards adults with learning disabilities and complex health needs who were admitted to assessment and treatment

units like Long Leys Court. This section links that context to the analysis of Key Areas which follows.

4.2 This period of change and expectation began in 2011, when an undercover journalist exposed shocking abuse of adults with learning disabilities and complex health needs at Winterbourne View, a privately-run hospital in the south of England. It was an assessment and treatment centre, as was Long Leys Court. Government ministers responded to the shock that people felt, and published a series of reports and recommendations, all of which were aimed at closing or reducing to a minimum, reliance on the network of assessment and treatment centres across England. One of the findings from Winterbourne View was that the adults there had been lost from the sight of a wider range of professionals because they were 'in hospital'. **Key Area One** focuses on the concept of the Multi-disciplinary team at Long Leys Court, its culture, understanding of roles and responsibilities both within that team but also amongst the other organisations that came into the hospital setting; and then considers how this contributed to a situation where abuse and neglect occurred.

4.3 In December 2012 the Government published its initial response to Winterbourne View. Immediate inspection of similar settings offered some small comfort

> [The Care Quality Commission's] inspections of nearly 150 other hospitals and care homes have not found abuse and neglect like that at Winterbourne View. However, many of the people in Winterbourne View should not have been there in the first place, and in this regard the story is the same across England. Many people are in hospital who don't need to be there, and many stay there for far too long – sometimes for years. (DH 2012)

However, sweeping changes to existing hospital arrangements for adults with learning disabilities and complex health needs were to follow:

- all current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible, and no later than 1 June 2014;
- by April 2014 each area will have a locally agreed joint plan to ensure high quality care and support services for all children, young people and adults with learning disabilities or autism and mental health conditions or behaviour described as challenging

- as a consequence, there will be a dramatic reduction in hospital placements for this group of people and the closure of large hospitals;

In May 2019 the BBC showed footage, filmed by an undercover reporter, of recent instances of adults with learning difficulties and mental health needs being abused at Whorlton Hall in County Durham – an assessment and treatment centre run by a private company. This sparked national concern.

4.4 In the Terms of Reference for this Safeguarding Adults Review, agencies were also asked to reflect on Parity of Esteem, how the multi-disciplinary team supported this concept between 2011 and 2015, and how effectively it is implemented now. "Parity of esteem can be defined as 'Making sure that health professionals are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities, either because of their mental health problem itself or because they don't get the best care for their physical health problems' "(NHS England Everyone Counts – quoted in South West Lincolnshire Clinical Commissioning Group's Individual Management Report). The concept first appeared in a 2011 government mental health report No Health Without Mental Health. Given its origins in 2011, it is reasonable to test out whether the multi-disciplinary team at Long Leys Court began to apply it.

4.5 **Key Area Two** examines the role of regulators and commissioners - all crucial to monitoring current standards against a backdrop of such national concern, and for developing the required plan for high quality services by April 2014. The Care and Support Statutory Guidance (14.221) says that: Commissioners from the local authority, NHS and CCGs are all vital to promoting adult safeguarding. Commissioners have a responsibility to assure themselves of the quality and safety of the organisations they place contracts with and ensure that those contracts have explicit clauses that holds the providers to account for preventing and dealing promptly and appropriately with any example of abuse and neglect. At Winterbourne View and in the other Safeguarding Adults Reviews cited in this report, as well as in emerging information about Whorlton Hall, commissioners had to respond to a majority of residents from outside the local area. Theoretically the governance task at Long Leys Court should have been easier for the local partnership in Lincolnshire because only a small proportion of those admitted there were from outside the county and therefore unknown to the local multi-agency safeguarding system.

4.6 On a daily basis, the professionals working with those adults admitted to Long Leys Court operated within two legal frameworks – one of which had a much longer history – the Mental Health Act (1983 as amended 2007) – than the other – the Mental Capacity Act (2005). In March 2014, the Supreme Court ruled in the cases of P v Cheshire West and P & Q v Surrey County Council. The ruling that these individuals had been deprived of their liberty in care settings has huge implications for the health and social care sector in relation to deprivation of liberty and the application of Deprivation of Liberty Safeguards (DoLS). These safeguards ensure that people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary, and in the person's best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS (SCIE 2015). **Key Area Three** explores how the Lincolnshire multi-agency safeguarding system around Long Leys Court responded to the implications of the Supreme Court ruling. Linked to this is the provision of advocacy arising from the Care Act or the Mental Capacity Act, and **Key Area Three** asks how standards of practice measured up to the relevant expectations, and if they fell short, why this was.

4.7 In 2014, local authorities principally, but all member organisations of the Safeguarding Adults Board, were readying themselves for the implementation of the Care Act on 1st April 2015. The Act brought significant new duties of assessment; set out the legislative framework for reviews such as this one, and the function of Safeguarding Adults Boards. One of the things that the Terms of Reference for this Review asked agencies to reflect on, was what is different now. The principles of Making Safeguarding Personal are not new, but the Care Act placed them at the centre of adult safeguarding. This had implications for the way professionals in the field of learning disabilities thought about their roles around safeguarding in particular but also around care planning. **Key Area Five** examines whether the sort of principles that Lincolnshire Safeguarding Adults Board now reports as being embedded, were recognisable in 2011 – 2015 and what the remaining systems risks are to implementing them for adults with learning disabilities and complex health needs.

4.8 One of the defining features of Winterbourne View was that a culture of abuse went unchecked and as a nurse with decades of experience, Terry Bryan was appalled by the abuse he witnessed there (Guardian 2018). After his concerns were ignored by management, he raised his claims with the Care Quality Commission. In what the CQC

described as an “unforgivable error of judgement”, no action was taken. This is of particular significance for this Safeguarding Adults Review. **Key Area Four** begins from the starting point that there was a culture of bullying and harassment at Long Leys Court that made it all the more remarkable that one professional did report abuse there. Closely linked to whistleblowing is the concept of escalation. In August 2014 the Lincolnshire Safeguarding Adults Board launched a multi-agency ‘Escalation Protocol’ (LSAB:2014). Its use in the latter part of the period under review is assessed.

4.9 The result of this policy context is that by 2015 there were national frameworks setting out the standards against which partners in Lincolnshire’s adult safeguarding system should be delivering all aspects of care for this group of adults with learning disabilities and complex health needs. There were also various expectations from government about the reporting and monitoring of these. It is against these frameworks that the commissioning and delivery of services to Long Leys Court are judged in this report.

5 Table of Key Dates

May 2011	**National Context** Panorama Undercover Care: the Abuse Exposed – shows staff at Winterbourne View assessment and treatment centre mistreating and assaulting adults with learning disabilities and autism. This led to a series of government reviews and frameworks as well as a Serious Case Review by South Gloucestershire Safeguarding Adults Board. The most significant of those frameworks, referenced by Lincolnshire agencies in their Individual Management Reports, are listed separately below
26th January 2012	The Care Quality Commission publishes Review of Compliance in relation to Long Leys Court visit December 2011 “We found that Long Leys Court was meeting all the essential standards of quality and safety we reviewed but, to maintain this, we have suggested that some improvements are made”
5thSeptember 2012	Lincolnshire Strategic Safeguarding and Dignity Board discusses the necessary follow up to a regional workshop on Winterbourne View
December 2012	**National Context** The government publishes Transforming Care: A national response to

	Winterbourne View Hospital
13th February 2013	The Care Quality Commission carry out a Mental Health Act 1983 monitoring visit to Bungalows 1 & 2 (of the four bungalows that make up the assessment and treatment centre)
1st April 2013	**National Context/ local context** NHS Clinical Commissioning Groups come into force. In Lincolnshire there are four, with LLC initially monitored by West Lincolnshire CCG whilst the wider responsibility for people with learning disabilities sat with South West Lincolnshire CCG
2013	**National Context/ local context** Quality Surveillance Groups come into force including one covering Lincolnshire. Set up by the Department of Health, the QSG remit is "to bring together different parts of the health and care system to share intelligence about risks to quality"
5th June 2013	Lincolnshire Strategic Safeguarding and Dignity Board discusses Winterbourne View follow up actions for the second time
August 2013	At Long Leys Court: Care Quality Commission routine inspection to check that essential standards of quality and safety being met (of both the bungalows for adults with learning disabilities that is the focus of this review, but also other provision on the same site for adults with mental health conditions but not with learning disabilities)
27th Sept 2013	Lincolnshire Strategic Safeguarding and Dignity Board discuss Winterbourne View follow for the third and final time, passing on the task of assurance to the Learning Disabilities Board
September 2013	Care Quality Commission inspection report published of Long Leys Inspection 21 August 2013. The five standards that the CQC assessed against at that time were all judged to be "Met" (Consent to Care and Treatment; Care and Welfare of people who use services; Meeting nutritional needs; staffing; Assessing and monitoring the quality of service provision)
8th November 2013	Care Quality Commission carry out Mental Health Act 1983 monitoring visit to the other two bungalows that make up the assessment and treatment centre

March 2014	**National Context** The Supreme Court considers two cases: P v Cheshire West and P & Q v Surrey County Council. The ruling that these individuals had been deprived of their liberty in care settings has huge implications for the health and social care sector in relation to deprivation of liberty and the application of Deprivation of Liberty Safeguards (DoLS)
3rd October 2014	Care Quality Commission carry out Mental Health Act 1983 monitoring visit to Bungalows 1 & 2
November 2014	**National Context** Duty of Candour: the statutory duty was introduced for NHS bodies such as trusts and foundation trusts in England
Nov 2014	Care and Treatment Reviews were introduced and implemented within Lincolnshire / Long Leys Court
January 2015	The Government publishes Transforming Care for People with Learning Disabilities – Next Steps
February 2015	LPFT commission a first independent review of incidents at Long Leys Court
24th February 2015	Care Quality Commission carry out Mental Health Act 1983 monitoring visit to the other two bungalows that make up the assessment and treatment centre
1st April 2015	**National Context** The Care Act 2014 comes into force
1st April 2015	Duty of candour extended to cover all other care providers registered with the Care Quality Commission
1st April 2015	Care Quality Commission's inspection methodology changed
14th April 2015	Initial concerns presented to the NHS Clinical Commissioning Group - an allegation of abuse by an employee against a patient at Long Leys Court that occurred on 6 April 2015
16th April	Chief Commissioning Officer for Specialist Adult Services, (a joint health and local authority role) sends email to Clinical Commissioning Group asking for wider risk assessment; and to Adult Safeguarding Team asking them to support the process
17th to 20th April 2015	A series of multi-agency safeguarding actions by NHS and local authority as commissioners of the service

	The Designated Safeguarding Nurse; the Head of Adult Safeguarding; and the Head of Commissioning for Learning Disabilities and Autism, make an unannounced visit to Long Leys Court and they escalate their concerns to the relevant senior manager in their own organisations, and to NHS England. In addition, local safeguarding arrangements are implemented which respond to the range of allegations and number of individuals who may be involved. This culminates in a multi-agency strategy meeting on 20th April to review all known concerns, agree actions already taken and those still required. At this meeting the Clinical Commissioning Group query, and this remains contested, whether or not they had received all relevant safeguarding concerns, directed to the local authority, and which the local authority have subsequently assured themselves, were sent. The NHS Clinical Commissioning Group, the local authority, and Lincolnshire Partnership NHS Foundation Trust provided a joint statement to the independent reviewer. They are now able to say with confidence that things are different and all correspondence between their organisations about safeguarding concerns is logged appropriately by each of the three organisations.
1st May 2015	A Safeguarding Planning meeting involving the NHS and local authority commissioners, and LPFT as the provider, for LPFT to provide assurance on their improvement plan
15th May 2015	A further reported incident involving alleged strangulation - Information shared by ASC Safeguarding team to Designated Safeguarding Nurse for the Clinical Commissioning Groups
May 2015 throughout month	LPFT demonstrates to commissioners that NHS England has begun to carry out the required Care and Treatment Reviews for the relevant individuals at Long Leys Court
13th May 2015	The same three local commissioners who visited in April, carry out their second visit to Long Leys Court. They note 'staff and patients were without exception welcoming and friendly' during the visit. A staff member on duty talks the commissioners through a safeguarding incident she has reported

26th May 2015	Safeguarding Planning meeting - received an improvement plan that had been implemented by LPFT covering the wider safeguarding issues including safeguarding and leadership • admissions to remain suspended whilst all in-patients received a full CTR within two weeks to ensure a safe discharge and future care management • at this point it is recognised that there has been an increased knowledge about the safeguarding concerns, and positively a Protection Plan is designed to protect the patient group as a whole
29th May 2015	A safeguarding referral is made in relation to the oldest of the twelve vulnerable adults sampled for this review, in relation to neglect of his physical health care by staff at Long Leys Court
2nd June 2015	The NHS England-led Care and Treatment Review for twelve adults sampled for this review, showed that staff used chemical restraint, and raised concerns about the staff use of seclusion. This is shared with the commissioners
5th June 2015	Following an incident regarding the restraint of a patient, LPFT and the South West Lincolnshire Clinical Commissioning Group agreed to close the service to admissions on a temporary basis and arrange moves for relevant individuals to other placements. LPFT issues a media statement that Long Leys Court is to close
8th June 2015	The older resident, who was referred on 29th May with concerns in relation to physical neglect, dies in the local acute hospital
12th June 2015	Following the notifications to Lincolnshire Safeguarding Adults Board referred to in 1.2, and 1.3, the SAB Command group meets, and a police investigation begins, which takes precedence over other processes
25th June 2015	Risk summit about Long Leys Court, convened by NHS England
2nd July 2015	**National Context** NHS England publishes Safeguarding Vulnerable People in the NHS – Accountability and Assurance Framework for the most senior leaders in NHS commissioning and providing to deliver and be accountable for
July & September	Long Leys Court is discussed at the newly established Quality Surveillance Group for the region

2015	
October 2015	**National Context** NHS South Region and Oxford Safeguarding Adults Board publish their 2nd report into failings at the local assessment and treatment centre where Conor Sparrowhawk had died in 2013. This report was focused on systems leadership
October 2015	**National Context** NHS England publishes Policy and Guidance for Care and Treatment Reviews
October 2015	The last of the 12 residents included in this review was moved out
November 2015	LPFT appoint a Lead Nurse for Physical Health Care - initially funded for 18 months
January 2016	Lincolnshire Transforming Care Partnership (TCP) was established - bringing together Lincolnshire County Council and NHS Commissioners for the whole county.
June 2017	The Care Quality Commission publish their latest inspection report for LPFT. They rate it 'Good' overall and 'Good' on the judgement area of 'Safe'
6th September 2017	A second independent review commissioned (in this instance from 'Orca') by LPFT is shared. It states that a greater number of safeguarding allegations were passed on by LPFT to the local NHS commissioners than the trust's first independently commissioned report had suggested, and that the trust staff had entered four times as many incident reports on the system known as Datix, where they can log anything they consider to be an incident. The discrepancy remains unresolved, as does the contention that information was passed on. The NHS Clinical Commissioning Group, the local authority, and Lincolnshire Partnership NHS Foundation Trust provided a joint statement to the independent reviewer. They are now able to say with confidence that things are different and all correspondence between their organisations about safeguarding concerns is logged appropriately by each of the three organisations.
May 2019	**National Context** The BBC Panorama Programme exposes abuse of adults with learning

	disabilities and complex mental and physical health problems at Whorlton Hall assessment and treatment centre in the north east of England
November 2019	House of Lords select committee on Human Rights publishes critical report into the detention of young people with learning disabilities and / or autism

6 The Analysis of the five key areas

6.1 This review sets out to answer two overarching questions – the first of these questions seeks to understand how the abuse and neglect at Long Leys Court between 2011 and 2015 could have occurred, and the second question looks to the future and the idea of creating an adult safeguarding systems that is as safe as possible, thereby reducing the chances of such an event happening again.

What barriers prevented the multi-agency system from keeping adults with learning disabilities and complex health needs in a supposedly safe in-patient setting, free from abuse and ensuring they received good care and treatment?

And

How can Lincolnshire Safeguarding Adults Board promote a safeguarding system that delivers safe and person-centred care for this group of the county's residents in the future?

Key area 1
Holistic practice, influence and effectiveness of the Multi-Disciplinary Team

6.2 The vulnerable adults with a complex combination of learning difficulties and mental health problems who were admitted to Long Leys Court for in-patient treatment did not appear to be lost from the sight of the multi-agency safeguarding system because they were in hospital, in the way that the adults in the Winterbourne View Serious Case Review were said to be. As already mentioned, the majority of in-patients at Long Leys Court were Lincolnshire residents, and the twelve adults whose cases were sampled for this review were all from the county. As well as the NHS multi-disciplinary team who were the main care providers, social care professionals from the local authority went into Long Leys Court on a regular basis. Local GPs were contracted to provide additional health services, and

ambulance and police officers occasionally attended Long Leys Court in response to call-outs for their service. Advocates were commissioned to work with some of the adults there. This section focuses on the provision of care, and assessment of need, and seeks to understand why abuse and neglect could have occurred in this context.

6.3 The multi-disciplinary NHS team at Long Leys Court were responsible for providing care and medical assessment and treatment to the adults admitted there, taking on that responsibility from other organisations at the point of admission and for its duration. This team consisted of:

- Staff on the unit, employed by Lincolnshire Partnership NHS Foundation Trust, some registered nurses, the majority non-registered workers, but all trained to work in an assessment and treatment centre
- Therapy staff – for example occupational therapists and speech and language therapists employed by the trust
- Psychiatrists and psychologists, again, specialists working with this group of adults at risk

The culture and 'feel' of the NHS multi-disciplinary team at Long Leys Court is described in the Individual Management Review by Lincolnshire Partnership NHS Foundation Trust.

> "The Multi-Disciplinary Team was seen to be inadequate in a number of reviews and reports scrutinised. These reflected 'professional polarisation', meaning that each professional practitioner would rely on their own professional identity and practice with no evidence of shared practice…
>
> The medical model of leadership and practice did not reflect Royal College of Psychiatrist standards and practice guidance during 2013-2015."

6.4 Meanwhile, the local authority social care professionals were on the unit regularly and knew individual patients to varying degrees, but in fact during admission, did not have a defined role. This had implications for their interaction with the multi-disciplinary team and they did not see themselves as part of it. When an adult with social care and support needs is living in the community, the local authority holds the responsibility for assessing their social care needs and developing a care package to meet those needs. However, on admission to Long Leys Court, as an in-patient facility commissioned by the NHS Clinical Commissioning Group, this responsibility transferred to its NHS team.

6.5 Consequently, although practitioners from the local authority's Adult Care and Community Wellbeing Directorate came into Long Leys Court for the following reasons

- Admissions meetings
- Interim or Review meetings
- Care Programme Approach Meetings
- Ward rounds
- Visiting the service user,

The local authority is clear that this is as a contributor to the planning and assessment process, rather than being responsible for the end care plan and delivery of it. This meant that "the Local Authority 'could have' made a decision to close their involvement until the service user was ready for discharge" (AC&CW Individual Management Report). Looking back at the period under review, panel members reflected that a challenge then in delivering the Care Programme Approach, was regional variation in how it was delivered. With hindsight, this impacted on the perceptions of LPFT and local authority practitioners at the time. In practice, social care professionals employed by the learning disability service within the local authority, did go onto the unit for the reasons listed above. They saw this as good practice in respect of the service users they had worked with in the community. However, it had unintended consequences in terms of how influential they sometimes felt in response to the multi-disciplinary team at Long Leys Court.

6.6 Because local authority practitioners saw themselves as a "supportive element" this reportedly had the effect that they were not as professionally curious as they could have been. Paradoxically they were clear about what their role was not, in terms of the responsibility being assumed by the NHS trust staff when someone was admitted, but a lack of organisational clarity about what their role was, left them professionally unconfident and feeling peripheral. It would be applying hindsight to say that if they had felt more confident about their role on the unit they could have been more professionally curious and assertive, but it is understandable that they found it difficult to be influential given this sense of being peripheral combined with "[the] need to work within the medical model of delivery as this was the focus of their working practice". As a professional group they were clear that they would have reported wrongdoing had they seen it, but they did not observe the abuse and neglect that was taking place.

6.7 Given the professional polarisation of the multi-disciplinary team, opportunities for different professionals from the community to share perspectives on cases could be a potential way of breaking down this polarisation. Previously an element of this happened at wider learning disability case discussions. In terms of what has changed since the abuse and neglect at Long Leys Court came to light, a 'Hub' system of working for learning disability services was introduced. The AC&CW IMR points to a potential loss to the system of multi-disciplinary discussion, as under the previous system although "some practitioners indicated the meetings could become unfocused and lacked direction… they welcomed the opportunity to meet with professionals from other agencies and felt that this improved working relationships between staff"

6.8 With the closure of Long Leys Court, the assessment and treatment provision for adults with complex combinations of learning disabilities and mental health needs takes place, where possible, in the community. The number of adults in hospital settings is smaller but because there is no provision in the county, where social care professionals continue to contribute during an admission, there is now a different risk to be alert to, which is that the distances involved and travelling time make their contribution to the discussion of NHS multidisciplinary teams less likely and if they are not there, it is even harder to be of influence.

6.9 Sections 6.1 to 6.8 are intended to give the reader a sense of overlapping issues that allowed a polarised multi-disciplinary team to continue for too long, and to give the Safeguarding Adults Board some indicators to be alert to, in the sense that if they co-exist, they create the context in which abuse and neglect is more likely to happen. Another such indicator is the quality of physical health care provision. Consequently, the Terms of Reference for this Safeguarding Adults Review, asked agencies to reflect on "Parity of Esteem", and assess how the multi-disciplinary team supported this concept between 2011 and 2015, and how effectively it is implemented now. "Parity of esteem can be defined as 'Making sure that health professionals are just as focused on improving mental as physical health and that patients with mental health problems don't suffer inequalities, either because of their mental health problem itself or because they don't get the best care for their physical health problems'". (NHS England Everyone Counts – quoted in SouthWest Lincolnshire Clinical Commissioning Group's Individual Management Report).

6.10 The contract between the Clinical Commissioning Group and Lincolnshire Partnership NHS Foundation Trust in 2014-2015, therefore within the period under review, included that a minimum of 90% of all eligible rehabilitation patients were to have a physical health plan, and that all patients who had been in hospital for more than a year should have a physical health check at least annually. The evidence at the time from LPFT did not provide sufficient assurance, and the CCG pursued it. In terms of changes that were made, LPFT, as set out in the Key Dates table, appointed a Lead Nurse for Physical Healthcare. General Practitioners should have had an influential and effective role at Long Leys Court helping deliver physical healthcare, but accounts are that this did not work as a robust arrangement. There is no comparable arrangement now because service users register with a new GP if they do need to move away from their home and go into treatment and then re-register when they move back. However, there is wider applicability for GP care arrangements to nursing homes and other residential settings, to which the learning from Long Leys Court could be applied.

6.11 **In summary:** The NHS multidisciplinary team at Long Leys Court between 2011 and 2015, had a culture that was polarised, based on a medical model, and this was challenging for social care professionals, who were clear about their role in some ways but not confident about where there, essentially discretionary, support to in-patients left them in terms of influence. The lack of robust GP provision may also have removed another perspective from discussions with team members which could have lessened the polarisation described at the start of this section. However, a debate that began with Winterbourne View, and has surfaced with the 2019 case of Whorlton Hall, is that when other professionals, inspectors, and NHS commissioners go in to assessment and treatment centres where abuse and neglect is later known to have been taking place, at the time there is nothing obviously untoward to see. The multidisciplinary team factors at Long Leys Court could serve as an alert to the adult safeguarding system to be particularly curious about the implications for very vulnerable adults if these factors exist.

Key Area 2

Commissioning and Regulatory Oversight (NHS England and Care Quality Commission as well as Clinical Commissioning Group)

7.1 By early 2015, commissioners and regulators had had over two years, since the publication of Transforming Care in 2012 (DH 2012), to be clear about their responsibilities

in keeping adults in assessment and treatment centres safe and moving them to different types of provision. Transforming Care contained immediate analysis from the government about what had gone so wrong in the safeguarding system around Winterbourne View

> Events at Winterbourne View flagged the need to prioritise strengthening adult safeguarding arrangements. The Serious Case Review shows that adult safeguarding systems failed to link information. NHS South of England's review highlighted the absence of processes for commissioners to be told about safeguarding alerts and failures to follow up concerns when commissioners became aware of them. (DH 2012)

7.2 In Lincolnshire there was a complicated picture of governance - joint boards, joint agreements and joint posts which meant that as late as 2014, the risks arising from lack of process for commissioners that were referred to in the national call to action, existed in Lincolnshire. On paper, Lincolnshire had a number of different forums to monitor local arrangements. Agencies' own analysis however, is that this did not result in consistent or reliable assurance that arrangements were working. All the organisations involved in this oversight, with the exception of the Care Quality Commission, are members of the Safeguarding Adults Board. NHS England delegates its responsibilities to the local Clinical Commissioning Group and is therefore represented at the Safeguarding Adults Board. Since 2018, the board has begun to receive new and different indicators that are intended to alert the safeguarding partners to trends in the system. The final paragraphs of this section reflect on the role of the Safeguarding Adults Board in seeking assurance about adults with learning disabilities and complex health needs, but before that, the role of the NHS is set out and the factors that made this significant piece of the system ineffective, are explored.

7.3 South West Lincolnshire Clinical Commissioning Group leads in commissioning the NHS Mental Health, Learning Disability and Autism Services for the entire county and did so during the period under review. CCGs are responsible for ensuring that NHS commissioned services have effective safeguarding arrangements in place. To carry out some of this commissioning function, the CCG set up the Complex Case Team (Learning Disability), responsible for a number of the adults who are the subject of this review. This team was unclear about its responsibilities, meaning it had limited involvement with Long Leys Court and leaving the adults who this review is about without a potential check in the safety system during their in-patient admissions that the Complex Case Team could have provided.

The basis for this misunderstanding centred on joint agreements between the local authority and the CCG about commissioning and quality assuring provision for adults with learning difficulties in Lincolnshire. What this Safeguarding Adults Review found was that some professionals working with the cohort of adults placed at Long Leys Court during the period 2011 to 2015, were not clear about whether this group was 'in' or 'outside' the scope of the joint governance arrangements of the time. In fact, in-patient specialist facilities for adults with learning disabilities were not part of any joint governance and budget arrangement at that time. The Complex Case Team was only one element however in several NHS assurance mechanisms that should have come together in relation to Long Leys Court.

7.4 A crowded landscape of governance bodies that touched upon adults with learning disabilities and complex health needs was the cause of further misunderstanding. The significance of this was that it meant another part of the assurance system did not work. During the period under review, October 2011 to October 2015, the following relevant (in the sense that the Long Leys Court cohort was within their remit) arrangements concerned with quality and safety were in place in this landscape.

- The Safeguarding Adults Board (known until June 2013 as Lincolnshire Strategic Safeguarding and Dignity Board) - the aim of Lincolnshire's Safeguarding Adults Board is to ensure the effective co-ordination of services to safeguard and promote the welfare of adults, in accordance with the Care Act 2014 and Care and Support Statutory Guidance 2014.
- The Lincolnshire Health and Wellbeing Board - a forum which brings together key people from the health and care system to work together to reduce health inequalities and improve the health and wellbeing of the people of Lincolnshire
- From 2013: The Quality Surveillance Group – "Quality Surveillance Groups bring together different parts of the health and care system, to share intelligence about risks to quality" (Department of Health 2017)
- Local risk forums involving the Care Quality Commission
- The Learning Disabilities Delivery Board for Lincolnshire
- Clinical Commissioning Group contract monitoring meetings with the mental health trust

7.5 Within this landscape the most significant misconception was that the Learning Disabilities Delivery Board was able to call in assurance, including about the assessment and treatment facility at Long Leys Court. Instead its objective was to join up previously separate

health and social care systems to provide better experiences for adults with a learning disability in Lincolnshire. Over time, various posts jointly-funded with budgets from health and social care commissioners were established, but there was no shared line management of commissioning and assurance roles across the system, and this, combined with the fact that the Learning Disabilities Board was not, despite what was thought, a place that could test out the effectiveness of assurance processes, meant that the ineffectiveness of NHS commissioning was not picked up.

7.6 As soon as the Clinical Commissioning Group became aware of the scale of reported abuse and neglect at Long Leys Court, it initiated a concentrated programme of monitoring visits, multi-agency monitoring meetings and escalation up to NHS England. The volume of activity from that point on is not in doubt. The question for this is review is how the CCG did not become aware of concerns at Long Leys Court until April 2015, when neglect and abuse was taking place there during 2014 on a scale that should have been picked up. "The CCG had no previous records to demonstrate that concerns had been raised about Long Leys Court. The first notification raised to the CCG by LPFT was on 14 April 2015 of an alleged allegation of abuse by an employee against a patient at Long Leys Court that occurred on 6 April 2015". However, the notification quoted at the start of this report stated

> From 17th January 2014 to 30th August 2014 there were 4 separate incidents of abuse towards patients at Long Leys Court which resulted in the dismissal of 3 staff and 1 that resigned prior to disciplinary hearing (and then goes on to list incidents in 2015 which were more promptly notified and followed up).

7.7 One possible explanation might lie in large scale organisational restructure. Long Leys Court was explicitly mentioned in the Learning Disability Service Action plan following Winterbourne View Hospital Review (2012), a documented action plan created in October 2012 and updated in January 2013. The introductory page stated that "local discussions have also reflected on community learning disability services provided by LPFT as well as the in-patient unit, Long Leys Court as the issues raised in the reports are equally applicable to community services." Intended actions included a number which recur in this review: Safeguarding; access to advocacy services; Whistleblowing responsibilities; Deprivation of Liberties and recording of 'near misses' (all terminology quoted from LPFT 2012). An email exchange of 14 February 2013 records a member of LPFT staff sending the action plan to the

local NHS commissioning manager at the Primary Care Trust, the predecessor organisation of the Clinical Commissioning Group) saying: " [X] mentioned to me that you would like a copy of our Winterbourne Action plan, please find it attached…". Organisational restructure can be a risk to safeguarding systems and the timing of this email exchange just ahead of the transition to Clinical Commissioning Groups in 2013 may be significant. What appears more significant is that the CCG relied on Lincolnshire Partnership NHS Foundation Trust's self-reporting.

7.8 If local NHS mechanisms were not working effectively, a further check and balance might be from external 'arm's length' regulation and inspection. The Care Quality Commission inspected Long Leys Court twice during the period under review, using its current methodology of that time. In 2011 and in 2013, Care Quality Commission Inspectors concluded, that all five standards they inspected against were 'met' at Long Leys Court (the alternative judgment being that standards were 'not met'). The five standards against which Long Leys Court was measured were: Treating people with respect and involving them in their care; Providing care, treatment and support that meets people's needs; Caring for people safely and protecting from harm; Staffing; Quality and Suitability of management. The 2015 inspection methodology for hospitals was a new one, which assigned a rating of 'inadequate'; 'requires improvement'; 'good'; or 'outstanding' against five new lines of enquiry – 'Safe'; 'Effective'; 'Caring'; 'Responsive'; and 'Well Led'. Lincolnshire Partnership NHS Foundation Trust has so far been inspected twice under this 2015 methodology, by which time Long Leys Court was shut. The overall rating in 2016 was 'Requires Improvement' and in 2017 'Good', with judgements on 'Safe' improving from 'Inadequate' in 2016 to 'Good' in 2017. By 2018 and the third inspection from the Care Quality Commission, the LPFT was rated good overall and outstanding for the area of being 'well led'. Other reviews nationally have explored why it is that abusive and neglectful in-patient settings are not detected by inspection.

7.9 The CQC was not receiving reports that suggested the number or type of care delivery problems or safeguarding incidents at Long Leys Court were out of an expected range, or that they indicated a culture of abuse or neglect. The emerging information about abuse and neglect at Whorlton Hall in 2019 has resulted in a national questioning of the very nature and purpose of inspection of assessment and treatment centres. One of the issues that the CQC is reviewing extensively is how inspections of establishments where widespread abuse and neglect is subsequently found do not see signs of it. This was picked

up and pursued by the 2019 Joint Human Rights Select Committee report (HC121 2019) into the detention of young people with autism and / or learning disabilities. One of the main recommendations was that

> Substantive reform of the Care Quality Commission's approach and processes is essential. This should include unannounced inspections taking place at weekends and in the late evening, and the use, where appropriate, of covert surveillance methods to better inform inspection judgements.

That the CQC's Mental Health Act monitoring visits and inspections of Long Leys Court did not uncover any extensive lack of compliance with the Mental Health Act, and the Commission's standards of the time were found to be met during two successive care inspections there, was not unusual in terms of their inspection findings about other in-patient units where neglect or abuse was in fact happening. Because the situation with NHS oversight in Lincolnshire between 2013 and 2015 was ineffective, there was nothing in terms of volumes of reported incidents or concerns about Long Leys Court to make the CQC think their own assessment was wrong.

7.10 Finally, the remaining paragraphs in this section consider the role of the Lincolnshire Safeguarding Adults Board in the context of expectations of local safeguarding adults boards following the national outcry about Winterbourne View. Nationally, (DH 2012)

> The Department of Health has already announced its intention to put Safeguarding Adults Boards on a stronger, statutory footing, better equipped both to prevent abuse and to respond when it occurs. By strengthening the safeguarding adults boards arrangements and placing health, NHS and the police as core partners on the boards we will help ensure better accountability, information sharing and a framework for action by all partners to protect adults from abuse.

Independently chaired from when it was set up in 2010, the Safeguarding Board discussed Winterbourne View following a regional workshop in September 2012, and three times thereafter, with its oversight transferring to the Learning Disabilities Board in September 2013. It was the strategic safeguarding group of the most senior accountable officers from the NHS, police and local authority who held these discussions – Winterbourne View was not on the agenda at the wider 'operational' board. Minutes show there was considerable

discussion about where the governance should sit in the longer term. This is explored in the paragraph below.

7.11 The Safeguarding Adults Board appeared timely in asking for assurances about what has happening to adults in Lincolnshire who were considered in need of admission to assessment and treatment centres. There was then a decision clearly discussed and minuted, and for which there was a rationale, to locate system assurance with the Learning Disability Board from the end of 2013. The SAB Strategic group took items around this on the following dates:

5th September 2012

5th June 2013

27th September 2013

7.12 Members of the strategic group sought and were provided with, reports addressing the government requirement, quoted in paragraph 4.4, namely that 'all current placements will be reviewed by 1 June 2013, and everyone inappropriately in hospital will move to community-based support as quickly as possible and no later than 1st June 2014". Some of the individual adults with complex learning disabilities and mental health problems whose reviews the SAB strategic group received reports on were those who are the subject of this review.

7.13 On 27th September 2013 the SAB senior officers agreed that the Joint Commissioning Board, successor body to the Learning Disability Board, would take on the assurance task for this group of adults. The independent reviewer has been told in one interview for this review, that the Learning Disability Board lacked the ability to hold the wider system to account and that this was a weakness in the local governance arrangements. The group of adults who are the focus of this review then disappeared from the SAB agenda until 2015 when the abuse and neglect at Long Leys Court surfaced. At a panel discussion for this review, in the context of trends and themes in safeguarding referrals, it was noted that only in the first half of 2018 had LSAB begun to receive a 'dashboard' analysing trends and patterns in safeguarding referrals. Prior to that "LSAB wouldn't have been made aware of patterns… because… the Safeguarding Team [in the local authority] would have dealt with it".

7.14 **In summary:** The assurances and checks in the NHS were ineffective in protecting the adults at Long Leys Court between 2011 and 2015. Given that the majority of those adults admitted to the unit for assessment and treatment were all from Lincolnshire and in their home county, the assurance task should have been more straightforward than for parts of the country where a high proportion of local residents were either placed at a distance, or – as was the situation in Winterbourne View – where the vast majority of residents were from outside the area. This makes the shortcomings in the system even more striking. It remains unclear why, prior to 2015, 'The CCG had no previous records to demonstrate that concerns had been raised about Long Leys Court,' but the factors of the time that could have contributed are: insufficient curiosity, organizational restructure and a misplaced sense 'another part of the system' (the Learning Disability Delivery Board) was doing more in relation to Long Leys Court than it was ever intended to in its objectives. The Safeguarding Adults Board took its post-Winterbourne View governance seriously but delegated that task to the Learning Disability Delivery Board. As a result there was nowhere to test out how assurance was working and the CCG was not challenged about how it was carrying out its role. The external regulator, the Care Quality Commission, did not pick up any unusual alerts about Long Leys Court because of the combination of a culture there which did not encourage reporting and the lack of curiosity at the CCG.

Key Area 3

Deprivation of Liberty, Best Interests and restrictive practices

8.1 Three of the twelve adults who are the subjects of this Safeguarding Adults Review were admitted to Long Leys Court under the Mental Health Act, and a fourth was subsequently held under the Mental Health Act after admission as a voluntary patient. Of the twelve adults, they were variously:

- deprived of their liberty without proper authorisation;
- not always assessed in line with the Mental Capacity Act when they should have been;
- restrained including chemical restraint;
- and not always referred for advocates as required under either the Mental Health Act and the Mental Capacity Act during their admissions to Long Leys Court.

This section explores how well the balance was struck between respecting people's rights on admission to Long Leys Court whilst being able to give them treatment or assess them according to an agreed plan.

8.2 As far as the framework of the Mental Health Act was concerned, during the period under review, the Care Quality Commission carried out four Mental Health Act visits to Long Leys Court, visiting each of the four bungalows, where the adults at the centre of this review were in-patients, twice over the period February 2013 to 2015. These visits result in a report that is given to the provider but not published. The findings of those four visits were variable with a particularly positive set of comments in the first of two 2013 visits. This raised the question of whether the data in those reports could have been a valuable source of information to local commissioners. However the CQC explained the purpose of these visits as

> The unit of monitoring for the Mental Health Act is at ward level to ensure all places of detention are visited within a two-year period. This is to maximise opportunities for patients to meet with CQC. Patient interviews are the core task of the MHA reviewer. During these visits the MHA reviewer met with 13 patients. During these interviews no concerns were raised about restrictive intervention. As the reports contain very specific information regarding patient's detention it is CQC policy to not publish these reports. Should a significant safeguarding issue be found during a visit MHA Reviewers are required to make a safeguarding referral at that time. This was not required during these visits.

8.3 The Adult Care and Community Wellbeing Individual Management Report concludes:

"[T]he Mental Capacity Act should have been the primary focus for eight of the service users within this review. While MCA was followed there was no evidence of consistent, embedded practice in relation to this". The best example of good practice, prior to one individual's planned admission from home to Long Leys Court, was led by the Adult Care practitioner and included a Best Interest Meeting. Sadly, a well thought-out plan that included the intention to refer for the specifically-required type of advocacy and consideration of an entirely appropriate Court of Protection application, broke down because the individual eventually had to be admitted under the Mental Health Act.

8. 4 In March 2014, therefore in the final year under consideration in this review, the Supreme Court ruled in the cases of P v Cheshire West and P & Q v Surrey County Council, finding shortcomings in the way those two local authorities had applied Deprivation of Liberty Safeguards (DoLS). These safeguards ensure that people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary, and in the

person's best interests. Representation and the right to challenge a deprivation are other safeguards that are part of DoLS . The terms of reference for this review asked about the impact of this extremely important ruling on practice at Long Leys Court. The information from agencies suggests that "Cheshire West" could have resulted in more rigorously person-centred practice for the adults at Long Leys Court but had yet to make its impact there. Lincolnshire Partnership Foundation Trust, as the provider of care, was what DoLs assigns as the "managing" authority with responsibility to consider whether an application was required and to apply to the "supervisory body" – the local authority. Although local authority practitioners reported that their understanding of DoLs had significantly changed since the judgement, at the time under review the practice tended to assume applications had been made if needed, rather than directly considering if they needed to be made. There was no suggestion that practitioners would actively check if a DOLS application had been considered or made. In the Clinical Commissioning Group, the implications of Cheshire West were assessed and legal training sought from the local authority so that the Complex Case Team understood their role. However this was too late for the adults who were in-patients at Long Leys Court because it was August 2015. Cheshire West did not impact on practice at Long Leys.

8.5 Chemical restraint and the reasons for what is an apparent lack of challenge by professionals, in contrast to family members, is one of the most troubling aspects of this review. In one case a medication incident apparently put one adult's life at risk, as well as overuse of medication troubling that person's family for the duration of their admission to Long Leys Court.

"Quite soon they made a mess-up of her medication and rushed her to hospital. 'we thought we'd lost her at the time', a staff member said. They left something off her medication, a long list, ten regular, five [as needed]". And from the same family member: "One of her carers thought [name of a professional] was too keen on dishing out medication" (although as family members they got on 'ok' with this professional). "she had so much medication over the years" and this family member's experiences had left him with the conclusion that people of his relative's age were "used as guinea pigs" where medication was concerned.

8.6 Andrew's parents talked about the effect of the medication their son was prescribed on admission to Long Leys Court. "At one stage we thought he was dying" and they talked about the shock of seeing him shuffle, aged 33, with a way of walking that looked as if he had Parkinson's Disease. His behaviour changed and he kept grabbing people. They contrasted this with the setting that Andrew moved to when Long Leys Court closed, where

"they immediately weaned him off tablets". This had to be done gradually due to the dosage level he was on when he left Long Leys Court but they said with relief "Now he is no longer on loads of medication". Finally a third relative out of the five interviewed, also noticed different attitudes to medication when her family member was moved following the closure of Long Leys Court. "The psychiatrists are so different there, they believe that medicating people is not the way to do things".

8.7 "[Social care] practitioners viewed that amending medication including that used [as needed] was often understandable and expected when considering the circumstances of a service user entering Long Leys Court". But the IMR recognises that local authority staff were not always in possession of explicit information about this and nor did they seek it. As mentioned in the introductory section around service users and their families, three relatives very much wanted to convey their concerns about chemical restraint for this review. For their part, LPFT reviewed the use of medication for all twelve individuals that are at the centre of this review and acknowledged the instances where this had happened (these instances are expanded upon in the next paragraph). But with some of the individuals, LPFT felt assured that practice in relation to medication was proportionate and appropriate.

8.8 Care and Treatment Reviews on their inception, offered an additional layer of potential scrutiny. The Care and Treatment Review process is the quality assurance tool to enable the least restrictive environment, as close to the patients' homes / families as possible. Care and Treatment Reviews, although still discretionary, were being rolled out in Lincolnshire by the end of 2014. The assessment in the Individual Management Reports is that after they were introduced, some Care and Treatment Reviews were carried out to the expected standard. The South West Lincolnshire Clinical Commissioning Group Individual Management Report references a 2nd June 2015 review of both Care and Treatment under Transforming Care, and Care Programme Approach for a patient detained under the Mental Health Act. This showed that staff used chemical restraint inappropriately and by contrast did not use a direct observational tool which was designed to map and pre-empt behaviour that might otherwise have resulted in chemical restraint. The same Care and Treatment Review raised concerns about staff use of seclusion and the use of prone restraint, which was being used even when the Care and Treatment Review stated that it was not to be. The Lincolnshire Partnership NHS Foundation Trust confirms the documentation within the Trust of "inappropriate use of restrictive practice which includes chemical restraint, seclusion and physical restraint outside that of good practice and national standards. Five of the cases

identified [for this Safeguarding Adults Review] reflect evidence of poor practice in this context and abuse of a vulnerable adult". What this does illustrate is that when carried out to the expected standard the Care and Treatment Review was a tool that could contribute to keeping the adults who were in-patients at Long Leys Court safe.

8.9 One of the important entitlements relevant to this Key Area that the adults in Long Leys Court had, was to advocacy. In some instances. it was not always clear how advocacy referrals were progressed and why some halted although the AC&CW IMR gives examples of the advocacy contract being used appropriately.

LCC Adult Care (through their contract…) provided an IMHA for [one adult] following her being detained under the MHA and an LCC Adult Care representative attended as core panel for her Care and Treatment Reviews. A referral was also made to [the advocacy service] by LCC Adult Care for advocacy, however advocacy was not provided due to a decision by the advocate that the family were willing and able to provide appropriate support.

8.10 There is though, an instance cited, and action being taken by the local authority for assurance, about one instance where the vulnerable adult was left without an advocate:

> [A social care professional] makes a referral to advocacy for support to be offered to one adult (after initially requesting an IMCA) in relation to her move and understanding the care plan. The concerning aspect of this is that the referral is closed by [the advocacy service] without them formally advising the practitioner. This resulted in a period of time where it is believed [the adult] is receiving that additional support when she is not.

The conclusion reached in the IMR was that this instance was an isolated one in a contracting arrangement that usually worked well but with the vulnerability of this group of adults and the specific situations where practitioners were rightly identifying a need for advocacy, any occasion where they are left without support is unacceptable.

8.11 **In summary:** Application of the Mental Capacity Act, despite some good practice, was not embedded at Long Leys Court. As a new process Care and Treatment Reviews were not always carried out to the standard set in the relevant guidance. However, when one CTR was carried out to the expected standard it appeared to be a tool that could contribute to keeping the adults who were in-patients at Long Leys Court safe. Most troubling though, and in part flagged up by an effective CTR process, are the findings about restraint, particularly chemical restraint. The risks in the multi-disciplinary way of working outlined in Key Area

One, and the lack of curious challenge outlined in Key Area Two, go some way to explaining why processes were not consistently followed, and why the impact of the Cheshire West ruling was not felt at Long Leys before its closure. Combined, these factors had unacceptable consequences for the adults who were in-patients there.

Key Area 4

Culture, competence and attitudes towards reporting wrongdoing

9.1 During the period under review – 2011 to 2015, there was a confirmed culture of bullying and harassment at Long Leys Court. This suppressed effective whistleblowing and actions being taken. The same independent report for LPFT quoted in the previous sentence, provides examples of the culture within Long Leys Court at the time and sets out the actions that have since been taken, led by senior managers, to change that culture. Long Leys Court's culture at the time is not seen as representative of wider culture in Lincolnshire Partnership NHS Foundation Trust. "This was a systemic failing unique to multi agency learning disability services". What this safeguarding adults review will focus on therefore, is the combined responsibility of other relevant organisations as well as the provider of the service at Long Leys Court in contributing to the culture described above.

9.2 In the context of national scandals around the treatment of people with learning disabilities and complex health needs, the enabling of whistleblowing has been recognized as absolutely central.

A whistle blower is an individual who works for an NHS organisation and contacts an external body like NHS England with a concern about that organisation and its services. Whistleblowing does not apply to personal grievances, including employment issues, which should be dealt with through internal organisational policies. It would generally be applied to:

- Concerns about unsafe patient care;
- Poor clinical practice or other malpractice which may harm patients;
- Failure to safeguard patients;
- Maladministration of medications;
- Untrained staff;
- Unsafe working conditions
- Lack of policies;

- A bullying culture;
- Staff who are unwell or stressed and not seeking help. (NHS 2017: p5)

However whistleblowing is one aspect of wider culture and attitudes to the reporting of wrongdoing at Long Leys Court. Although police from Lincolnshire Constabulary and paramedics from East Midlands Ambulance Service attended Long Leys Court during the period under review, and some of the adults involved in this review attended the local acute hospital, it is the culture of the regulator, commissioners and the NHS organisation providing the service at Long Leys Court that are covered here, because it directly affected the lives of adults at risk who were in-patients there.

9.3 The Care Quality Commission recorded one whistleblowing report in relation to Long Leys Court, on 15th May 2014. In a telephone interview, the Commission's National Advisor, Safeguarding Children and Adults, put the view that if this Safeguarding Adults Review identifies that there were issues the Care Quality Commission was not being told about, then this constitutes learning. This whistleblowing report was followed up in line with the Commission's expected practice. Individual Management Reports suggest that across not just the Care Quality Commission, but also the local commissioner (South West Lincolnshire Clinical Commissioning Group), the other organisation whose employees were involved with some residents at Long Leys Court (the local authority), and the provider of services there – (Lincolnshire Partnership NHS Foundation Trust) there were indeed a range of issues that not everyone in that grouping of four was being told about. One source for this is the LPFT IMR, which as well as commenting that staff at Long Leys Court did not feel that the trust's whistleblowing policy of the period under review 'had any standing or value in alerting concerns', goes on to consider the issue of escalation. The 2017 Orca report for Lincolnshire Partnership NHS Foundation Trust concluded "The capturing of systemic failings and individual practice failings still remained undetected" and staff at the trust described the culture in the period covered by this Safeguarding Adults Review as "Old practice rewarded". This meant over reliance on old practice and enforcement against those who challenge led to a bullying and harassment culture. This suppressed effective whistleblowing and actions being taken.

9.4 Escalation is explored here as an indication of some of the underlying culture at the time. Both the Clinical Commissioning Group and the local authority say of professionals in the two organisations that they had no concerns at the time but would have escalated any

they had. A local authority practitioner did observe the sole incident reportedly witnessed by a professional from outside the in-patient multidisciplinary team. They raised it with unit staff at the time and with their manager, with the conclusion it was not something requiring further action. Lincolnshire Partnership NHS Foundation Trust's analysis of their historic culture during the period under review was – "There was reported evidence that staff concerns were not escalated beyond the unit management team and staff were encouraged to deter from alerting or raising concerns outside of the unit" (sic). The lack of reporting and escalation was consistent with what Lincolnshire Partnership NHS Foundation Trust's account of the culture on the unit.

9.5 Understanding why this culture developed is critical to reducing the likelihood of it developing again. From the local authority perspective, social care professionals were uncomfortable about challenging NHS colleagues: '… there was a clear differentiation between professionals' perceived ability and willingness to challenge the care and support provided by private providers, and that provided by Health Authorities in general.' What lies behind this though is an issue already identified in relation to the effectiveness of the multi-disciplinary team at Long Leys Court – the local authority professionals did not feel confident about their role and remit at the unit. This contrasted with their very clear remit in relation to private providers where they carried out annual reviews of establishments. Additionally though, local authority professionals felt better supported by their managers in asking for further assurance from private care homes than they did in asking the mental health trust for the same sort of information. They would have reported wrongdoing, but they did not have the same detail from the Long Leys Court provider – LPFT – that enabled them to escalate concerns about private providers. The system is not safe if professionals do not feel able to seek the same level of information from all providers.

9.6 This principle of all partners treated the same, underpins the local escalation protocol. Introduced by the Safeguarding Adults Board, the protocol is easy to find on the Board's website (LSAB 2014) – with the full title Escalation Protocol for Resolution of Professional Disagreement for all agencies. Complex Case Team workers interviewed for the CCG IMR, said 'they were unfamiliar with the escalation policy for practitioners to follow and as a result this was not considered to address any gaps in sharing information. Individual team members were unclear regarding the escalation and organisational governance of safeguarding, serious incidents and incidents, complaints, information governance and data flow and contractual compliance'. The Clinical Commissioning Group and the Lincolnshire

Partnership NHS Foundation Trust both include examples of the way that the escalation policy is now a routine part of training, however it is less clear to what extent there has been testing out of the confidence of professionals to use it.

9.7 One organisation that is not signed up to the Escalation Protocol is the Care Quality Commission, because the regulator is not a member of the Safeguarding Adults Board (in line with the Commission's national policy). The local authority IMR makes reference to lack of attendance by the CQC at strategy meetings around Long Leys in the summer of 2015 and the loss of a particular type of expertise from those meetings as a result, an absence which could not be escalated via the local protocol because the CQC were not signed up to it. The Care Quality Commission explained as part of this review that their remit is to regulate and CQC inspectors cannot attend all meetings they are invited to. CQC officers did attend risk meetings in June 2015 and prior to this had not been informed of concerns. From their perspective as a regulator there can be an overreliance on meetings and a reluctance for organisations to use technology to enable participation. In addition It is also important that if information is known about a service and which raises concerns about the safety of service users/patients there should not be a barrier to sharing that information outside of a formal meeting. This difference in emphasis about attendance at meetings is a useful reminder about the value of technology in enabling participation in strategic discussions about risk. The point about formal meetings is suggestive of different organisational cultures which could have an adverse impact on the safe functioning of the adult safeguarding system.

9.8 **In summary:** Professionals from the Clinical Commissioning Group and the local authority did not witness the wrongdoing at Long Leys Court. The culture inside Long Leys Court was not one that encouraged openness or reporting. The local authority account that their staff did not feel as comfortable challenging NHS colleagues as they did other providers of services for vulnerable adults may be something that the Safeguarding Board can consider as a factor that could reduce the likelihood of escalation in certain settings.

Key Area 5

Families, service users and Making Safeguarding Personal

10.1 Making Safeguarding Personal is defined as an approach to adult safeguarding that

sits firmly within the Department of Health's Care and Support Statutory Guidance, as revised in 2017. It means safeguarding adults:

- is person-led
- is outcome-focused
- engages the person and enhances involvement, choice and control
- improves quality of life, wellbeing and safety (Paragraph 14.15)[1].

Making Safeguarding Personal must not simply be seen in the context of formal safeguarding enquiries as defined in the Care Act as a Section 42 enquiry[2] but in the whole spectrum of safeguarding activity. (LGA 2017)

10.2 This section sets out to ask what a reasonable expectation of agencies' practice would have been during the period under review – 2011 to 2015, given that statutory guidance for the Care Act 2014, setting out the concept and expectations, was being consulted on during the summer of 2014 ahead of Care Act implementation on 1st April 2015. The section draws on agencies' own analysis as well as setting these against what would have been the framework or expectations at the time.

10.3 For the Clinical Commissioning Group the place that Making Safeguarding Personal might have been, according to their analysis, most evident, was in the Care and Treatment Review process. In November 2014, Care and Treatment Reviews were introduced and implemented within Lincolnshire and to Long Leys Court. The NHS Clinical Commissioning Group's comment is:

> In some of the cases, there is evidence that the voice of the patient was not heard and therefore not acted upon. Lines of enquiry that could have been pursued further with the patient were not followed. Patient voices were not being interpreted within the context of emotional/psychological and physical abuse.

10.4 For the local authority, expectations at the time would have centred around their response to safeguarding concerns that were either referred in to them or identified by professionals within the organisation. The IMR concludes that

> Where information was received by the Safeguarding Team, the principles of making safeguarding personal were reinforced, for example checking whether the service users wanted to make a police complaint and/or if family had been informed.

10.5 Practice appeared, in this respect, to measure up to expectations. However, the AC&CW IMR reflects on engagement with one person's mother, who consistently raised concerns. The framework applied in this instance is the "whole family" approach to care and assessment. Within Adult Social Care, this is set out in Quality Practice Standards. The relevant standard is described as appropriately not dictating the extent of contact or involvement of the family. This however had its implications:

> As such there appeared to be variance in the amount of communication with family members; some of this intentional and respecting the families own preference of contact. However, there was a theme of the amount of contact being influenced by how proactive the family were with contacting the practitioner.

For the Partnership Foundation Trust

10.6 Learning disability services nationally have, in theory, a substantial history of person-centred care planning and supporting and encouraging different types of advocacy for adults with learning disabilities. Some of the rationale for this and a programme setting out future improvements to further value people with learning disabilities, was set out in a 2001 government strategy of the same name (DH 2001), the starting premise for which was that people with learning disabilities often have little choice or control over many aspects of their lives. The IMR for LPFT however states that

10.7 "In the context of families and the family member in care, there was evidence in all of the 12 cases of lack of engagement, valuing and understanding the needs of their family member going into care, carers assessment and personalised care. Complaints and concern reports in 2014-15, related to all twelve cases show conflict and discord between the staff and carers. There was a reluctance to involve family members in multi professional reviews in six of the cases and two cases where parents were restricted in their contact with no foundation to this being in the interest of the patients. There was an absence, at that time of compliance with regard to Duty of Candour and non-compliance to existing Trust Policies and Procedures. Records show no evidence of changes in practice as a result of concerns raised or complaints in six of the cases identified."

For the Lincolnshire Safeguarding Adults Board

10.8 From the time the Care Act came into force on 1st April 2015, the LSAB had a three-year priority work programme around Making Safeguarding Personal with the aims of

- Multi-agency work differently and in accordance with the Care Act and Making Safeguarding Personal
- Engagement with carers and service users to identify options for participation in the Board membership and user group consultation about around the strategy
- Establish and monitor a service user experience programme

10.9 Information provided from LPFT to the review shows the Board priorities reflected in LSAB's safeguarding and mental capacity workplan for 2015/16 (section 5) "implementation of the Care Act". In 2015 LPFT and the local acute hospital trust agreed to work on this with the Director of adult social care.

Reporting on three years of progress to March 2018, the LSAB Annual Report set out a range of activities that had taken place and identified one that was yet to happen.

Work that had been completed:

- Audited all agency partners to ensure MSP is embedded within all safeguarding.
- Re-designed the concern form to ensure MSP questions are asked and acted upon.
- The board is now a member of a number of County wide groups that have service user input.
- Promote and utilise the Local Government Association suite of MSP guides for partners

And the task still under way

- A service user experience programme is still under construction and will continue to be a priority for the Board.

This outstanding strategic activity is picked up in a recommendation at the end of this report.

10.10 **In summary:** Agencies have reflected on their practice to "make safeguarding personal" during the period under review and it makes for an uncomfortable read, as

despite the fact that MSP was introduced via the Care Act, the concept was not a new one. Consequently, an approach with the same principles as Making Safeguarding Personal should have been evident throughout the 2011 to 2015 period which is under review here. Learning disability services even prior to the publication of Valuing People in 2011, had been told by service users, families, and by government that higher value had to be placed on the views and wishes of adults with learning disabilities. If there was any doubt about this in Lincolnshire, then the context of 2011 onwards following Winterbourne View, was a mandate to the whole local safeguarding system to shine a light on Long Leys Court and ask how the views and wishes of patients and families were being valued. The IMRs from the CCG and LPFT acknowledge the shortcomings in their organisations. The conclusions section below returns to the responsibility of the whole system for organisations' practice that let down the adults placed in Long Leys Court.

11 Conclusions – What barriers prevented the multi-agency system from keeping adults with learning disabilities and complex health needs in a supposedly safe in-patient setting, free from abuse and ensuring they received good care and treatment?

11.1 The Care and Support Statutory Guidance (14.168) says that Safeguarding Adults Reviews should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

11.2 That the abuse and neglect at Long Leys Court occurred in the years immediately following the national outcry over another assessment and treatment centre, Winterbourne View, is one of the most striking aspects of this case. Lincolnshire Safeguarding Adults Board's senior leaders' group was timely in asking questions about what the county response was in the light of Winterbourne View. Even more strikingly, they were given assurances about adults at risk with learning disabilities and complex mental health needs that included as part of the data, anonymised references to the twelve individuals who are the subject of this review. These assurances were given in 2013. By 2015 it was apparent that a culture of abuse and neglect had existed at Long Leys Court not only while these 2013 assurances were being given, but over the intervening period too.

11.3 In the adult safeguarding system, assurances were either not sought, or on the occasions they were given, not tested out sufficiently. It may have been that there was a

lack of tenacity and curiosity, and this is the question for Lincolnshire Safeguarding Adults Board through its various assurance mechanisms of the present, to continue asking. Symptoms of this lack of tenacity and curiosity included:

- The SAB delegated to another board the "post Winterbourne" task of monitoring progress with new care arrangements for the county's cohort of most vulnerable adults with learning disabilities and mental health needs. This board did not have the ability to insist on the required changes, and the loop of assurance back to the Lincolnshire Safeguarding Adults Board was not closed despite a discussion about how to keep a conduit open between the two bodies
- A second independent review commissioned (in this instance from "Orca") by LPFT in 2017 stated that a greater number of safeguarding allegations were passed on by LPFT to the local NHS commissioners than the trust's first independently commissioned report had suggested, and that the trust staff had entered four times as many incident reports on the system known as Datix, where they can log anything they consider to be an incident. The discrepancy remains unresolved, as does the contention that information was passed on. The Clinical Commissioning Group IMR also confirms that "The CCG had no previous records to demonstrate that concerns had been raised about Long Leys Court. The first notification raised to the CCG by LPFT was on 14 April 2015 of an alleged allegation of abuse by an employee against a patient at Long Leys Court that occurred on 6 April 2015" (also quoted in para 7.6 of this report). It is unclear though what curiosity the CCG displayed about Long Leys Court during the period when they received no concerns about provision there. The NHS Clinical Commissioning Group, the local authority, and Lincolnshire Partnership NHS Foundation Trust provided a joint statement to the independent reviewer. They are now able to say with confidence that things are different and all correspondence between their organisations about safeguarding concerns is logged appropriately by each of the three organisations.
- There were misunderstandings about the scope of a joint agreement between health and social care commissioners which could be indicative of this lack of tenacity and curiosity.

11.4 The final question in terms of barriers in the system, and the most difficult to answer, is how an adult safeguarding system might have become lacking in tenacity and curiosity around the care of one of the most vulnerable groups of adults in that system, at a time of heightened national concern about that group. Changes put in place subsequently

suggest that the systems leaders in Lincolnshire are alert to the possibility that this is something that could recur, but with the measures now in place, are demonstrating their commitment to preventing it happening ever again.

12 Recommendations for the future

How can Lincolnshire Safeguarding Adults Board promote a safeguarding system that delivers safe and person-centred care for this group of the county's residents in the future?

12. 1 Organisations provided a considerable list of actions and improvements, some of which began in response to national outcry about abuse at Winterbourne View Hospital in Gloucestershire in 2011. Other actions were in response to reported incidents and abuse and neglect at Long Leys Court, once these became known. Actions continue to be developed and implemented as part of local work to improve the experience of adults with similar levels of need and vulnerability to those who are the subject of this review. Under the heading "What's different now?", organisations were asked to include these improvements in their Individual Management Reports. These are not included here as they are constantly being updated but the recommendations below include actions for those organisations to provide relevant updates to the Lincolnshire Safeguarding Adults Board in 2020/2021.

Recommendation 1

Lincolnshire Safeguarding Adults Board to use its "Dashboard" as a tool to identify any gaps in reporting of safeguarding concerns by the organisations involved in this review in relation to adults with learning disabilities, autism and mental health diagnoses.

12.2 By the end of 2020/2021: the LSAB should use its revised dashboard and audit process to probe safeguarding concerns data for the above cohort of adults. Numbers reported by Lincolnshire Partnership NHS Foundation Trust, the NHS Clinical Commissioning Group, and the local authority should match up. This would confirm the three organisations' assessments that they now have robust systems to identify risk and to accurately log shared safeguarding information for adults with learning disabilities, autism and mental health diagnoses. This action could then be closed down.

12.3 For 2021/2022 onwards: the LSAB to make sure there are clear processes for monitoring this information and putting it on the board's assurance programme.

Recommendation 2

Lincolnshire Safeguarding Adults Board will test out how organisations hear, and act upon, the voices of adults with learning disabilities, autism and mental health diagnoses, and the voices of their family carers.

12.4 In 2020/2021 LSAB to: implement its planned updates to the Making Safeguarding Personal Programme, which will include inviting a family member involved in one of the Boards' Safeguarding Adults Reviews onto the group that oversees this work.

12.5 For 2021/2022: Twelve months after the publication of this report, LSAB to conclude the actions for this recommendation by carrying out an audit on its Making Safeguarding Personal Programme and reporting the findings.

Recommendation 3

In order to embed work on Parity of Esteem between physical and mental health, Lincolnshire Safeguarding Adults Board should use the regular reports that come to the board on the local Learning Disability Mortality Review process to drive improvements in physical health care for adults with learning disabilities, autism, mental health diagnoses and complex needs.

12.6 In 2020/2021 LSAB to take a report from the Clinical Commissioning Group - first of all comparing local findings with those outlined in the Annual Report of the national Learning Disability Mortality Review Programme, and secondly, including recommendations on how relevant information from these sad cases where adults have died, can be applied to improve the health of others in this group through preventative work.

Recommendation 4

Commissioners of all the relevant services should provide Lincolnshire Safeguarding Adults Board with assurance that contracts, policies, and the Terms of Reference for relevant governance boards, are all fit for purpose in relation to adults with learning disabilities, autism, mental health diagnoses and complex needs.

12.7 In 2020/2021 the Chair of the Mental Health, Learning Disabilities and Autism Partnership Board is to attend the LSAB and present a report confirming how the recently updated Terms of Reference for that partnership board address the governance issues

identified in this review, such as what goes through to LSAB from the partnership. The report should also include assurance on relevant policies and contracts so LSAB members can know that these explain the governance role of the Mental Health, Learning Disabilities and Autism Partnership Board. Once the report has provided the assurance, this action will be complete.

Recommendation 5

The Lincolnshire Safeguarding Adults Board to assure itself annually on the functioning of the multi-disciplinary team that supports adults with learning disabilities, autism, mental health diagnoses and complex needs living both inside and outside Lincolnshire.

12.8 In 2020/2021 this assurance to take the form of a report from the Mental Health, Learning Disabilities and Autism Partnership Board - to come to LSAB at the same time as, and linked to, the report referred to in Recommendation 4. The report should provide a commissioner-led assessment of how the system is working inside and outside the county; and of the quality of work between professionals from the local authority learning disabilities team and the Clinical Commissioning Group. It should include an assessment of how these teams make sure members of LSAB are sighted on the adequacy of protections for the group of adults that this review has been about.

12.9 For 2021/2022 onwards, this assurance could take the form of an annual report from the Mental Health, Learning Disabilities and Autism Partnership Board to LSAB and also be integrated into the LSAB annual audit programme.

Appendix 1 – Extract from Terms of Reference – Questions put to agencies

Agencies were asked to write with the overarching 'safeguarding system' question for this review in mind

The analysis should consider the events that occurred, the decisions made and the actions taken or not taken; consider not only what happened but why. It should assess actual practice against policies, guidance and legislation. Please keep in mind the overarching question that the Lincolnshire Safeguarding Adults Board wants assurance on, via this review:

> What barriers prevented the multi-agency system from keeping adults with learning disabilities and complex health needs in an in-patient setting free from abuse and ensuring they received good care and treatment?
> How can Lincolnshire Safeguarding Adults Board promote a safeguarding system that delivers safe and person-centered care for this group of the county's residents in the future?

In this section, please set out and answer the specific TOR for this review as laid out below. The specific terms of reference must be answered for the entire time periods under review, as referred to previously in the Terms of Reference. Please note, your answers should reflect changes to Policy and Procedure throughout the period.

Holistic practice, influence and effectiveness of the Multi-Disciplinary Team

- Explain and set out your agency's role and involvement in multi-agency working during the period under review
- What are the barriers to each agency being able to provide a holistic package of care or effective intervention for each individual? This includes the provision of physical health care, in line with national guidelines 'Achieving parity of esteem between mental and physical health' DoH (2013)
- How did the MDT function work then and how does it work now? Was it effective then and now?
- How influential was the professional from your agency i.e. social worker/key worker/ named worker etc. in terms of decision making and what was their role in

the Multi-Disciplinary Team? Is it different in 2018?

- What is different now?

Commissioning and Regulatory Oversight (NHSE and Care Quality Commission as well as Clinical Commissioning Group)

- What oversight did the Clinical Commissioning Group have (or should have had) over the quality of care at LPFT and was it effective? Did any factors inhibit their function and what would happen now?
- Did the timing or the quality of the Care and Treatment Reviews undertaken on the wards have a direct impact on the care received?
- What was the role of the Approved Mental Health Practitioner in this review and was that appropriate and effective?
- What expectations and standards did the NHS commissioners have in place during the period under review to create a healthy culture of support and supervision? What does this look like now?
- Did your agency share or escalate concerns? What was the outcome?
- What is different now?

Deprivation of Liberty, Best Interests and restrictive practices

- Was the MCA followed for those decisions that sat outside the MHA?
- At the time, the Cheshire West decision was impacting around the country. What was the impact in this case?
- What factors allowed the restrictive practice (including chemical restraint) by LPFT staff to occur and persist without challenge from within LPFT or from external agencies?
- Why was the role of the Independent Mental Capacity Advocate not utilised? Is the role of advocacy promoted now?
- What factors existed to allow the poor physical care of patients by LPFT staff to occur/ persist without challenge from within LPFT or from external agencies?
- Why did the unlawful detention (without regard to Deprivation of Liberty Safeguards/Mental Capacity Act Code of Practice /the Mental Health Act) of patients occur and/or persist without challenge from within LPFT or from external

agencies? How confident is the SAFEGUARDING ADULTS BOARD that this is not an ongoing issue?

- What's different now?

Families, service users and Making Safeguarding Personal

- Making Safeguarding Personal was being promoted nationally as an approach during the period under review. How much were professionals in your agency aware of MSP or applying it in any way for the service users placed at Long Leys Court?
- What type of advocacy was considered? If none, why not?
- What was the role of the family in decision making then and what would it be now? Are they seen as part of the patients' care and support and why do some relationships appear to work and others not? Are there any policies or guidance about the involvement of families?
- How were complaints or concerns about care responded to and used to review service or effect change?
- What's different now, for example Duty of Candour or equivalent?

Culture, competence and attitudes towards reporting wrongdoing

- What were the expectations at the time within your agency around raising concerns?
- How confident and comfortable did staff in your organisation feel to flag up concerns about other organisations, where they were aware of them?
- Are there features of the LLC staff cohort & working practices at that time that makes the events at LLC unique/one off or is there a wider systemic issue with regard to the level of competence of the staff?
- Did your agency share or escalate concerns? What was the outcome?
- In 2014 the Lincolnshire Safeguarding Adults Board introduced an Escalation Policy. Was there any indication that staff were aware of or used this policy?
- What's different now?

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