

Winterbourne View Hospital – Statement of Intent CLDT Response Sep.2011

At the July 2011 Learning Disability Partnership Board meeting the Taking Part in the City group presented information about the Winterbourne View Hospital. That is the hospital that was featured on a Panorama show in May 2011.

The Taking Part in the City group proposed a Statement of Intent. That Statement of Intent has 8 points in it.

The CLDT has considered the Taking Part in the City group's proposed statement of intent and have some comments about four of the points. These are our responses to those four points:

The Taking Part Group suggested:

- Brighton & Hove will not send its citizens to learning disability hospitals and until all can be moved, regular reports to the Brighton & Hove Partnership Board will be given as to numbers, length of stay and plans for move on for those individuals.

CLDT Comment: Normally hospitals or Assessment & Treatment Units are only used under the provisions of the Mental Health Act when someone needs to be detained for their and/or others safety. The Mental Health Act applies to all citizens when and if their needs require, not just people with learning disabilities. 'Learning Disability Hospitals' are used for people whose needs cannot be safely met in a Mental Health Acute Hospital ward.

Anyone detained under the Mental Health Act is afforded rights of appeal and legal advocacy. All detentions under the Act can and are scrutinised by Independent Tribunals where individuals detained have legal representation.

The Taking Part Group suggested:

- Brighton & Hove will not endorse the use of physical intervention in any of the services it provides or purchases. If physical intervention is used – a full safeguarding critical incident review will take place.

CLDT Comment: Given the shocking footage of physical abuse that took place in Winterbourne View it is understandable that it might be seen desirable to ban all use of physical intervention. Such a ban however would be counter productive for a number of reasons. What

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we saw in Winterbourne View was not a set of planned, risk assessed and sanctioned physical interventions but the sadistic use of criminal violence. We should not allow ourselves to confuse the two.

“Physical intervention involves the application of the minimum degree of force needed to prevent injury..” (Department of health, 2002). This *force* can take different forms; from the more obvious physical contact through the use of when required medication to manage behaviour or the use of barriers or equipment to prevent movement. The key point is that a physical intervention should only be considered to prevent physical harm in the form of actual or potential injury. There are some key principles that apply here which are there to safeguard individuals. Whatever level of force is applied must be proportionate to the risk – i.e. the principle of *reasonable force* comes into play. By way of example, let’s look at a scenario.

You are walking with an individual who is in front of you and they start to veer towards a busy dual carriage way. The guidelines you are following make no mention of this so you call the person’s name and then in a raised voice say “STOP”, to no avail. You’ve tried everything you know to get the person’s attention so at no risk to yourself you hold the person’s shoulders strongly and against some resistance direct the person away from the traffic.

Is this a reasonable and lawful action you’ve just taken? The reasonableness of this action is that if you didn’t do it the person may now be dead, what you did was to use the least restrictive physical intervention in your repertoire based on your current level of training and you used it as a last resort to prevent a potentially fatal injury and used it for the shortest amount of time possible. In fact if you did nothing in this situation then your duty-of-care to the person to avoid acts or omissions which are likely to cause harm to another person would be called into question. However if you strongly held the shoulders of an individual who rather than walking into a road was changing the channel on the television at home then this would not be *reasonable*. This rather crass example does at least make the point that the context determines what is reasonable or not. Thankfully it is relatively rare to have to use a physical intervention in an unforeseen emergency as in the first scenario. Most agreed physical interventions are carefully planned and risk assessed because it is known that an individual may behave in a potentially injurious way if a particular context arises.

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Rather than banning the use of physical intervention, it is instead necessary to ensure that organisations are using a model of support that ensures that current national guidance is followed. The current gold standard is the BILD code of practice for the use of physical interventions (BILD, 2010). BILD provide a stringent accreditation scheme for training organisations to sign up to and be assessed against. The physical intervention package that the behaviour support team use (SCIP, soon to be PBS Sussex) is BILD accredited so is signed up and adheres to national best practice guidance. Because SCIP and PBS Sussex physical interventions do not use pain-compliance, do not restrict breathing, aim to keep the person completely still or attempt to overpower the individual who is in crisis and are also not reliant upon the strength of person using the technique means that supporters and individuals presenting challenging behaviour can be reassured that there is no parallel with the violence used at Winterbourne View.

Physical interventions are biomechanically assessed for risk during use by physiotherapists who will only sign off low risk techniques. All use of physical interventions must be recorded and the physical interventions themselves are regularly reviewed and must be part of a broader behaviour support plan that includes non-physical strategies which in turn is part of a support plan that includes mainly proactive approaches as opposed to reactive strategies.

In summary, it is the CLDT view that some people who challenge in particular times of difficulty may require a physical intervention response to avoid serious injury. So rather than banning physical interventions within organisations instead the organisations should be measured against best practice standards and be BILD accredited. For further information on this potentially emotive topic see the BILD code of practice for a coherent explanation regarding what training organisations must adhere to.

The Taking Part Group suggested:

- No Safeguarding case conferences will take longer than one month before called following a whistle blowing incident or complaint.

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CLDT Comment: Although it is always helpful to bring a safeguarding investigation to a timely conclusion that is not by itself a measure of either good practice or indeed good outcomes for an alleged victim and can be a false indication of a judicious, or indeed person centred process.

Time frames are given as a guide to help ensure that safeguarding investigations do not needlessly drift and that proper oversight is applied to the work. Investigations often involve a wide range of people who work to their own times frames, this is especially the case with the police and Crown Prosecution Service who wish to achieve the best outcome, which for them is often an investigation leading to protection and a prosecution. The CLDT works to a person centred model to ensure the best outcome for the alleged victim; this can take place in parallel to police work and is current practice. The CLDT will also bring to an end its investigation, outcome/protection planning and implementation prior to the end of police investigations where this is deemed appropriate in the alleged victims best interests; however on occasion it is simply not possible.

It is also important to understand what triggers a safeguarding investigation, neither a whistle blowing nor a complaint are in itself reason for a safeguarding investigation. Investigations are triggered where harm or significant harm has been caused or where there is the potential for significant harm. Complaints and/or whistle blowing that do not indicate these risks may be dealt with through the council's corporate complaints unit or for example via CQC and/or individual disciplinary action, whether that be local authority or non statutory services.

Levels of Response:

Here are summaries of the thresholds for investigation, determined by the seriousness of the harm or risk of harm

Level 1: a concern / allegation that 'harm' has occurred or appears to have occurred or 'potential for significant harm'.

Level 2: a concern / allegation that 'harm' has occurred or appears to have occurred or 'potential for significant harm'. There is more clarity that this is an investigation rather than an assessment or re-assessment of needs

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Levels 3: 'significant harm' has or appears to have occurred to one adult at risk

Level 4: more than one adult at risk appears to or has experienced 'harm' or 'significant harm'. This also covers where there are possible indicators of Institutional abuse

The Taking Part Group suggested:

- Training of staff must be a priority. The training must focus on preventative strategies of positive behaviour support – not reactive management techniques.

CLDT Comment: We agree that staff training is indeed a priority when supporting individuals whose behaviour can be described as challenging on difficult days. It is also agreed that Positive Behaviour Support is the most appropriate training model and that the emphasis should be on proactive rather than reactive strategies. However reactive strategies are necessary to keep a person safe during crises.

CLDT's Behaviour Support Team provides Positive Behaviour Support Training to parents, staff and carers in Brighton & Hove. We have trained more than 1,000 participants since the training was introduced. The training is over 3 modules (3 full days) and an outline of the programme is set out below

As can be seen the emphasis of the course is on proactive strategies, i.e. intervening when the challenging behaviour is *not* happening, as this is when alternative behaviours can be taught and changes to the environment made to offset the need for challenging behaviour to occur. *However* when we know that an individual can have difficult times it is imperative that planned reactive strategies are in place in order to keep the person safe, with dignity, in the here and now.

What we are saying, and is well understood in the PBS model, is that despite best attempts to prevent challenging behaviour occurring at all, it is rare for the myriad forms to be eradicated quickly so we need to recognise that people still have bad days and need to be supported through them. All the positive things that supporters can do to help an individual through challenging time is put into a behaviour support plan which includes prevention, early intervention, crisis and recovery strategies. It should be noted that punishment techniques are not used

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in the PBS model as they are unethical and have many negative side effects. As a general rule an individual's support plan should be at least 80% proactive and less than 20% reactive.

The CLDT is working with commissioning, contracts and local providers to develop an outcomes framework for organisations who provide support for individuals who can present challenging behaviour. This framework can be seen as a set of positive standards against which services can be measured to ensure best practice. The training available to staff within the organisations is one area that is required to be evidenced