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Rt. Hon Harriet Harman MP
Chair, Join Committee on Human Rights
House of Commons
London
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By email: harriet.harman.mp@parliament.uk

10 June 2019

Dear Ms Harman,

I am writing to you in response to your request for a copy of the draft report of the inspection undertaken in August 2015 which was led by Barry Stanley-Wilkinson.

As you will be aware we have commissioned David Noble QSO to undertake an independent review into how we dealt with concerns raised by Barry Stanley-Wilkinson in relation to the regulation of Whorlton Hall.

This review will focus on concerns raised about the draft report prepared in 2015, and how they were addressed through our internal processes. It will be for the independent reviewer to report on the handling of our draft reports and it is important not to pre-empt their findings. However, we are keen to co-operate with the Committee to the fullest extent and the enclosed documents are shared in this context.

The following are enclosed to assist the Committee:

- All the versions of the findings of the 2015 inspection we have identified thus far including comments captured during the quality assurance process;
- A table which draws out key changes in the documents above;
- The published 2016 report, which states “this report covers both the main findings of the August 2015 inspection and the inspection undertaken in March 2016”.

It may help to provide a short explanation of the standard steps that are taken before an inspection report is published, since our reports go through a sequence of iterations before publication to ensure they are as robust as possible.

Following a CQC inspection, the lead inspector is responsible for collating evidence in order to draft the report. Our hospital inspection reports go through a series of quality assurance processes that include, peer review; management review; a national quality assurance group, and a factual accuracy check with the provider. This process has been developed to ensure CQC’s reports are of a consistent standard, proportionate and evidence-based.

If an inspection finds evidence of abusive practices, the lead inspector would be expected to take immediate action to protect people. Depending on the nature and severity of the issues identified, these actions could include notifying the police, making a safeguarding referral, or taking urgent enforcement action. From the evidence we have seen so far, it appears that none of these actions were taken following the August 2015 inspection of Whorlton Hall.

In the case of Whorlton Hall, as I have explained, we are still conducting searches for all potentially relevant records, and we do not yet have a complete picture. I understand, however, that those identified to date indicate that in the case of the 2015 inspection of Whorlton Hall, concerns that there was insufficient evidence gathered arose during the application of this review process. Subsequently a decision was taken to reinspect the service in March 2016, and an inspection report was published in June 2016, which references evidence gathered during the 2015 inspection. The independent reviewer will be undertaking a detailed investigation of the process that led to this decision, taking full account of the concerns raised by Barry Stanley-Wilkinson both at the time, and following the Panorama programme about the handling of the report.

We will action the findings of the independent reviews and are committed to learning from all aspects of our regulation of Whorlton Hall including the concerns raised by Barry Stanley-Wilkinson. The full terms of reference for both independent reviews will be published on our website shortly, and the findings of the reviews will be presented at CQC's public board meetings.

It is clear that we missed what was really going on at Whorlton Hall, and we are sorry. I know that each and every colleague here who watched Panorama was appalled by the images of abuse and we are committed to making all the changes we need to in order to protect people.

We have been carrying out unannounced inspections of a number of services for people with a learning disability and/or autism operated by Cygnet (OE) Limited. We are also undertaking a review of all locations operated by this provider looking across safeguarding, whistleblowing, incident reports and complaints to explore whether there are any areas of concern.

The interim report on our review of Restraint, Segregation and Seclusion made five recommendations:

- Over the next 12 months, there should be an independent and an in-depth review of the care provided to, and the discharge plan for, each person who is in segregation on a ward for children and young people or on a ward for people with a learning disability and/or autism. Those undertaking these reviews should have the necessary experience and might include people with lived experience and/or advocates.
- An expert group, that includes clinicians, people with lived experience and academics, should be convened to consider what would be the key features of a better system of care for this specific group of people (that is those with a learning disability whose behaviour is so challenging that they are, or are at risk of, being cared for in segregation). This group should include experts from other countries that have a better and/or different approach to the care for people with complex problems and behaviours that challenge.

- Urgent consideration should be given to how the system of safeguards can be strengthened, including the role of advocates and commissioners, and what additional safeguards might be needed to better identify closed and punitive cultures of care, or hospitals in which such a culture might develop.
- All parties involved in providing, commissioning or assuring the quality of care of people in segregation, or people at risk of being segregated, should explicitly consider the implications for the person's human rights. This is likely to lead to both better care and better outcomes from care.
- Informed by these interim findings, and the future work of the review, CQC should review and revise its approach to regulating and monitoring hospitals that use segregation.

The events featured in the Panorama programme further underlined the significance of these issues. Dr Lelliott and I look forward to speaking to your committee and exploring the challenges of these closed environments, particularly from a Human Rights perspective.

Please don't hesitate to get in touch if we can be of further assistance.

Yours sincerely,

Ian Trenholm
Chief Executive

Documents enclosed:

- 20151125 Draft NOT FOR PUBLICATION - Peer review of draft report.pdf
- 20151204 Draft NOT FOR PUBLICATION - Draft sent to report writing coaches.pdf
- 20151210 Draft NOT FOR PUBLICATION - Draft report post report writing coaches review.pdf
- 20151214 Draft NOT FOR PUBLICATION - Report ready for IM review.pdf
- 20151216 Draft NOT FOR PUBLICATION - Draft report post IM review pdf
- 20160617 Published report on Whorlton Hall.pdf
- 20190610 Whorlton Hall inspection report comparison.pdf