Winterbourne view and baby p essay sample

Health & Medicine

In reports for both Winterbourne View and Baby P, there are serious failures from all care providers in ensuring safe and adequate care and safeguarding of the individuals involved. The serious failures and issues range from a lack of communication and reporting, to physical and mental abuse (in the case of Winterbourne View), and a lack of training and acceptance of responsibility in both cases.

Winterbourne View:

Winterbourne View, a private residential home caring for those with learning difficulties, challenging behaviour and complex needs, was closed in June 2011 after a CQC inspection found that the registered care provider, Castlebeck Care (Teesdale) Ltd had failed to ensure that people living at Winterbourne View were adequately protected from risk, including the risks of unsafe practices by its own staff. The CQC inspection began immediately after they were informed that BBC Panorama had gathered months of evidence of serious abuse. The report published on Winterbourne View showed that Castlebeck Care (Teeside) Ltd were not compliant with 10 of the essential standards which the law requires care providers to meet:

•The managers did not ensure that major incidents were reported to the Care Quality Commission as required. •Planning and delivery of care did not meet people’s individual needs. •They did not have robust systems to assess and monitor the quality of services. •They did not identify, and manage, risks relating to the health, welfare and safety of patients. •They had not responded to or considered complaints and views of people about the service. •Investigations into the conduct of staff were not robust and had not

safeguarded people. •They did not take reasonable steps to identify the possibility of abuse and prevent it before it occurred. •They did not respond appropriately to allegations of abuse. •They did not have arrangements in place to protect the people against unlawful or excessive use of restraint. •They did not operate effective recruitment procedures or take appropriate steps in relation to persons who were not fit to work in care settings. •They failed in their responsibilities to provide appropriate training and supervision to staff.

Inspectors said that staff did not appear to understand the needs of the people in their care, adults with learning disabilities, complex needs and challenging behaviour. People who had no background in care services had been recruited, references were not always checked and staff were not trained or supervised properly. Some staff were also too easily ready to use methods of restraint without considering alternatives. The report concluded that there was a systemic failure to protect people or to investigate allegations of abuse. The provider had failed in its legal duty to notify the Care Quality Commission of serious incidents including injuries to patients or occasions when they had gone missing.

Baby P:

Peter Connolly was a 17 month old British boy who died in London after suffering more than 50 injuries over an eight-month period. During the 8 months, he was repeatedly seen by Haringey Children’s services and NHS health professionals. Peter’s mother, Tracey Connelly, her boyfriend, Steven Barker, and Jason Owen (later revealed to be the brother of Barker)[5] were

all convicted of causing or allowing the death of a child. Following the conviction, three inquiries and a nationwide review of social service care were launched, and the Head of Children's Services at Haringey removed by direction of the Government Minister.

CQC's report identifies the following systemic failings:

•Poor communication between health professionals and across agencies, such as social services and the police, meant that urgent action to protect Peter was not taken. •Staff caring for Peter did not always follow child protection procedures. For example: when he was discharged from North Middlesex Hospital in April 2007, no formal discussion was held to escalate concerns, despite him being on the child protection register; •Poor recruitment practices and lack of specific training meant that some staff were inexperienced in child protection. They also did not receive appropriate training to develop this knowledge following their appointment. •Shortages in staffing at St Ann's Hospital, where Peter had his paediatric assessment, led to delays in seeing children. This included shortages in consultants, nurses and administrative staff. At the time of Peter's assessment at St Ann's Hospital on 1 August 2007, there should have been four consultants in post but there were only two. •There were failings in governance systems in three of the trusts concerned. Healthcare professionals at North Middlesex Hospital were not always clear on who was responsible for following up child protection referrals, for example they sometimes relied on social services staff to initiate communication after faxing a referral through. Staff also reported a lack of safeguarding supervision which would have helped ensure

that they were clear about their roles and responsibilities in relation to safeguarding children.

The story of Baby P is a story about the failure of basic systems. There were clear reasons to have concern for this child but the response was simply not fast enough or smart enough. The process was too slow and professionals were not armed with information that might have set alarm bells ringing. Staffing levels were not adequate and the right training was not universally in place. Social care and healthcare were not working together as they should and concerns were not properly identified, heard or acted upon.