Learning Bulletin

Safeguarding Adults Review

Long Leys Court

This bulletin is designed to share the learning from a Safeguarding Adult Review (SAR) published in December 2020, following 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 inpatients at Long Leys Court.

You can read the full SAR report and executive report here

What was the review about?

In June 2015, the Lincolnshire Safeguarding Adults Board received two notifications from Lincolnshire Partnership NHS Foundation Trust (LPFT).

The notifications identified there had been incidents of abuse towards patients at Long Leys Court and they detailed the resulting action against staff involved.

The abuse ranged from a possible case of physical neglect to the misuse of restraint and incidents of neglectful and abusive behaviour by staff towards the other patients.

A range of assurance and investigative processes were put in place including in June 2015, LPFT and NHS Lincolnshire Clinical Commissioning Group agreeing, to close Long Leys Court. The priority was to protect the adults at risk in Long Leys Court, and to establish how previous inpatients had been affected.

This is a thematic review that looked at the care provided at Long Leys Court. Any inpatient setting should be safe and free from abuse with patients receiving good care and treatment, this SAR examines what barriers prevented the multi-agency system from keeping adults with learning disabilities and complex health needs in a supposedly safe inpatient setting, free from abuse and ensuring they received good care and treatment.

The national context and its significance for this review is important. The abuse and neglect at Long Leys Court occurred in the years immediately following the national outcry due to a shocking report of abuse into Winterbourne View a privately run unit for adults with learning disabilities and complex needs. A series of Government reports and recommendations were published introducing new processes.

The review reflects many of these processes were not embedded into practice and identifies 5 Key areas for improvement.

Below are links to information and training available to practitioners.

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

Practitioners would rely on their own professional identity and practice with no evidence of shared practice. There are number of different professionals involved in the care of the service users however they worked in silos and this led to uncertainty and a lack of professional curiosity.

What needs to happen;

All practitioners to have a good understanding of Information Sharing processes.

Cont'd overleaf

2. Commissioning and Regulatory Oversight;

The external regulator, the Care Quality Commission, did not pick up any unusual alerts because of the combination of a culture which did not encourage reporting and the lack of curiosity at the Clinical Commissioning Group;

What needs to happen;

All practitioners to have a good understanding of Professional Curiosity and embed it within their practice.

3. Deprivation of Liberty, Best Interests and restrictive practices;

Adults were deprived of their liberty without proper authorisation. The Mental Capacity Act was not embedded into practice, service users were not referred for advocates as required and the new Care and Treatment Reviews were not of the standard required.

What needs to happen;

All practitioners to have a good understand the Mental Capacity Act and Deprivation of Liberties (DoLs). Care and Treatment Reviews should be carried out to a good standard.

4. Culture, competence and attitudes towards reporting wrongdoing;

There was a confirmed culture of bullying and harassment at Long Leys Court. This undermined staff's confidence and suppressed effective professional escalation of concerns and whistleblowing.

What needs to happen;

All practioners need to have a good understanding and feel supported in their responsibility to escalate concerns (Joint professional Resolution and Escalation Protocol)and to use the Whistle Blowing procedures when required.

5. Families, service users and Making Safeguarding Personal;

The voice of the service user was often lacking, there was variable communication with families, an absence of compliance with the Duty of Candour and conflict arose between staff and carers.

What needs to happen;

All Practitioners need to ensure that the voice of the individual is heard in respect of care or safety planning and Making Safeguarding Personal is a whole spectrum of safeguarding. The views and wishes of all patients and families must be at the centre of all care and treatment options. The duty of candour is a contractual duty imposed on all NHS and service providers to provide to the service user and any other relevant person all necessary support and information in the event that a reportable patient safety incident occurs.

For more information on Lincolnshire Safeguarding Policy and Procedures and free training go to Lincolnshire Safeguarding Adults Board