Identifying abusive services: Learning lessons from Winterbourne View

Dates: **Friday 15th March 2013**

Times: **9:30 – 4:30pm**

Place: **Conference Room 1, Building 2, NLBP**

Speakers: **Dr Margaret Flynn, Author of Winterbourne Serious Case Review**
Professor Hilary Brown, Chair of Barnet Safeguarding Adults Board

The recent Panorama programme exposing serious abuse at Winterbourne View secure unit for people with Learning Disabilities and the subsequent serious case review has put a spotlight on how we identify and challenge institutional abuse. This workshop will explore the findings of the review and clarify the roles and responsibilities of individuals and agencies in relation to people placed in care homes and hospitals both within Barnet and outside our authority.

Overview

- Know what is meant by the term "institutional abuse"
- Recognise the areas of work that trigger abuse
- What can a good service do to make abuse less likely?
- How staff can be helped to work positively through supervision & training
- Understand the dynamics within teams that can lead to abuse practice
- Consider the impact of policies and guidance on practice
- Consider the signs to an outsider that a service is failing its service users
- Consider whether quality assurance systems / annual reviews pick up poor practice
- Consider your role in relation to whistle blowing

Who should attend?

- Health & Social Care Commissioners
- Supply Management & staff working in contract compliance
- Review and Reassessment Teams
- Staff working in the Learning Disability Service
- Staff working in Mental Health Services
- Continuing Care Teams
- Staff working in CLCH who provide health services to Care Homes
- Care Home Provider Managers & Service Managers

To book a place:

Please e-mail: **pearl.anderson@barnet.gov.uk** with your name, team and organisation

The conference will be divided into four sessions

Session 1: Learning lessons from serious case review

An overview of what is meant by “institutional abuse” and the dynamics that contribute to it
An exploration of what went wrong at Winterbourne View drawing on lessons identified in the serious case review authored by Dr Margaret Flynn

Session 2: Building on local expertise

Knowing your way around local safeguarding arrangements including the role of commissioning and care management in monitoring placements and the responsibility of the Safeguarding Board to ensure that concerns are identified promptly and that alerts are properly followed up.

Session 3: Recognising early warning signs

Seeing early warning signs: detecting abuse and supporting potential whistle-blowers
Group exercise based on recent research

Session 4: Table discussion and panel

This session will be interactive and engage all participants in the search for understanding and ways forward. Participants will discuss the local implications of issues emerging from the conference for their organisations and in relation to their own roles, remit and staff development

Pre-reading

Participants might find it helpful to read the following papers :

Marsland, D Oakes, P. and White, C. (2007) Abuse in care? The identification of early indicators of the abuse of people with learning disabilities in residential settings Journal of Adult Protection, The, Vol. 9 Iss: 4, pp.6 – 20

Wardaugh. J. and Wilding, P. (1993) Towards an explanation of the corruption of care Critical Social Policy July 1993 vol. 13no. 37 4-31

Faulkner, A. and Sweeney, A. Prevention in adult safeguarding: A review of the literature SCIE available at

http://www.scie.org.uk/publications/reports/report41/files/report41.pdf

And to look at the Serious Case Review that can be found at
http://hosted.southglos.gov.uk/wv/report.pdf