

**Report to the Board of the Care Quality Commission (“CQC”) on how CQC dealt with concerns raised by Barry Stanley–Wilkinson in relation to the regulation of Whorlton Hall Hospital and to make recommendations**

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**Glossary of some Care Quality Commission acronyms used in this report**

KLOEs	Key Lines of Enquiry
PIR	Provider Information Request
NPA	National Professional Adviser
SPA	Specialist Professional Adviser
NQAG	National Quality Assurance Group
SQAG	Subsidiary Quality Assurance Group
MHAR	Mental Health Act Review(er)

## Foreword



Picture: Sarah Caldecott

“It was the programme that shocked the nation.”<sup>1</sup>

“The use of language and comments that had been recorded within daily care records and incident reports showed a lack of respect and understanding of the needs of individuals and indicated that staff had a controlling approach to managing people.”<sup>2</sup>

“In 1851, the American physician and philanthropist Samuel Gridley Howe wrote about the “evils” of institutional care. He wrote, “all such institutions are unnatural, undesirable and very liable to abuse.””<sup>3</sup>

I include these quotations to remind us all that concerns about the regulation of independent mental health hospitals like Whorlton Hall (the subject of this review) are not novel. Indeed, without reference to the citations below it would be understandable if readers assumed that all three refer to Whorlton Hall in 2019 after the BBC Panorama programme rather than to Winterbourne View in 2011 after that earlier Panorama programme.

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<sup>1</sup> Winterbourne View: Abuse footage shocked nation: By Rebecca Café: BBC News 26 October 2012  
<https://www.bbc.co.uk/news/uk-england-bristol-20084254>

<sup>2</sup> CQC: Review of Compliance: Castlebeck Care Teesdale Ltd. – Winterbourne View July 2011 publication date  
[https://www.cqc.org.uk/sites/default/files/documents/1-116865865\\_castlebeck\\_care\\_teesdale\\_ltd\\_1-138702193\\_winterbourne\\_view\\_roc\\_20110517\\_201107183026.pdf](https://www.cqc.org.uk/sites/default/files/documents/1-116865865_castlebeck_care_teesdale_ltd_1-138702193_winterbourne_view_roc_20110517_201107183026.pdf)

<sup>3</sup> extract from the quotation in the foreword by Sir Stephen Bubb to “Winterbourne View – Time for change: Transforming the commissioning of services for people with learning disabilities and/or autism” commissioned by NHS England, published 2014

## Chapter 1

### Summary

- 1.1 On 3 May 2019, the Care Quality Commission (CQC) received correspondence from BBC's Panorama programme outlining research they had conducted into concerns about the management of, and staff culture at, Whorlton Hall, an independent hospital for adults with a learning disability based in County Durham.
- 1.2 The programme, broadcast on BBC at 9pm on Wednesday 22 May 2019, revealed shocking evidence, from hidden cameras and microphones, of staff abusing patients.
- 1.3 On that day Dr. Paul Lelliott (then Deputy Chief Inspector of Hospitals Directorate and Lead on Mental Health) issued a statement on behalf of the CQC which stated, among other matters:

"When we last inspected Whorlton Hall in March 2018, we did so as a result of whistleblowing concerns. Our inspectors identified concerns around staffing; staff sometimes worked 24-hour shifts, agency staff were not receiving appropriate training, and not all staff were receiving individual supervision. We found the provider in breach of regulations and told them to address these issues.

It is clear now that we missed what was really going on at Whorlton Hall, and we are sorry. The patients we spoke to during this inspection told us they felt safe and had not experienced aggression towards them. We also spoke to health care professionals who had formal caring roles for patients at the hospital, but who were independent to the hospital; they did not raise any concerns. This illustrates how difficult it is to get under the skin of this type of 'closed culture' where people are placed for long periods of time in care settings far away from their communities, weakening their support networks and making it more difficult for their families to visit them and to spot problems. When you add staff who are deliberately concealing abusive behaviour, it has the potential to create a toxic environment.

We will urgently explore ways in which we can better assess the experience of care of people who may have impaired capacity, or even be fearful to talk

about how they are being treated because of the way that staff have behaved towards them. We must do all we can to lift this cloak of secrecy. We will also be reviewing what we could have done differently or better that would have meant we were able to identify and stop this abuse more quickly.....  
We are sorry that we did not identify the abusive practices at Whorlton Hall – but we do act on concerns from members of the public every day. Over the past three years, we have placed seven hospitals for people with a learning disability and/or autism into special measures, leading to closure in three cases."

- 1.4 On 23 May 2019, Mr. Barry Stanley–Wilkinson contacted the Chief Executive of CQC, Ian Trenholm by e–mail stating, among other matters: "When I worked at CQC I was the inspector responsible for Whorlton Hall, I carried out its inspection [in 2015] and raised significant concerns about the place and the care and treatment of people. So much so I had no alternative but to whistleblow as the report I had written was hidden and not published by senior managers in CQC. This hospital was the fundamental reason that lead [sic] to my departure in 2016 so I hope you can appreciate my absolute disgust that action was never taken when I raised such serious concerns. The whistleblowing investigation was completed by [AA] and recommendations were made and one of those being the report being published. It never was. CQC stated in its "good" report<sup>4</sup> that an inspection had been carried out but there was not sufficient evidence to publish the report. This report had been written by [BB] and ... [BB] was told by senior managers [they] had to rate the hospital as good. I suggest you ask [BB] as [BB] was bullied into this. I know because [BB] told me directly."
- 1.5 Mr Stanley–Wilkinson made other public pronouncements and provided evidence to the UK Parliament's Joint Committee on Human Rights<sup>5</sup> as part of their inquiry into the detention of children and young people with learning disabilities and/or autism (HC 1861). Ian Trenholm and Dr. Paul Lelliott provided oral evidence to that inquiry<sup>6</sup>

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<sup>4</sup> Inspection carried out on 3 and 4 March 2016. Report published on 17 June 2016.  
[https://www.cqc.org.uk/sites/default/files/new\\_reports/AAAF5065.pdf](https://www.cqc.org.uk/sites/default/files/new_reports/AAAF5065.pdf)

<sup>5</sup> Email correspondence from Mr Stanley Wilkinson to HR and Senior Management at the CQC explaining his decision to resign: <https://www.parliament.uk/documents/joint-committees/human-rights/correspondence/stanley-wilkinson-resign.pdf>

<sup>6</sup> <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/the-detention-of-young-people-with-learning-disabilities-and-autism/oral/103107.html>

- 1.6 On 31 May 2019 CQC announced that it had commissioned this independent review into how the Commission had dealt with concerns raised by Mr. Stanley-Wilkinson in relation to the regulation of Whorlton Hall. The review, it was stated, would focus in particular on concerns raised about the draft report prepared in 2015, and how they were addressed through CQC's internal processes and to make recommendations. (My terms of reference are in Annex 1 to this report)
- 1.7 I have examined a very substantial documentary record obtained from CQC's own electronic and hard-copy recording and storage systems, and from other sources, including from those who directly participated in the inspections of Whorlton Hall or who had provided whistleblowing material about what was happening at Whorlton Hall.<sup>7</sup>
- 1.8 I have conducted over 27 hours of transcribed interviews covering 17 individuals (some more than once) and a further 6 who were interviewed by telephone. These comprise CQC staff involved in the two inspections in 2015 and 2016; inspectors; middle and senior managers of CQC responsible for the policies and processes which applied at the time; legal and policy advisers; external specialists contracted by CQC to provide expert input into the inspections; whistleblowers and others who notified CQC of their concerns; the internal reviewer of whistleblowing and the current CQC "Speak Up guardian". I am grateful for the almost universally frank, open, constructive and helpful approach of those I have arranged to interview. This has been a difficult time for them all and the existence of my review has had an effect on the operations of the Hospitals Directorate of CQC and possibly the wider CQC staff which I recognise and acknowledge.

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<sup>7</sup> CQC's Customer Relationship Management (CRM) system is the main system used by CQC to record regulatory matters and interactions with providers and others. CRM was searched to identify any records held there of relevance to the review. Searches have also been conducted of saved records stored in folders in CQC's other main records system drive. Where CQC staff with involvement in the case had subsequently left the organisation, attempts were made to restore those records. In many cases however, email accounts and record drives of other relevant former employees were not recoverable due to the time elapsed since they left CQC. Manual searches for paper records were carried out in CQC's Newcastle, Leeds and Preston offices. CQC employees with direct links to the regulation of Whorlton Hall searched for emails and records on other drives. All CQC colleagues were asked, via internal bulletins, to check for and report any potentially relevant documents and records that they held (Annex 2 to this report is an example of one of these). Further searches were conducted, and further documents provided, where I requested them. These have included relevant policies and guidance in place at the time of the events under review.

- 1.9 I have been acutely aware of the on-going criminal investigations arising from the material exposed by the BBC and so have limited my inquiries to those listed above (therefore excluding staff and management from Whorlton Hall Hospital and the operator, Danshell – now Cygnet) in order to avoid any possible interference with the criminal justice process.
- 1.10 I have also liaised with Professor Glynis Murphy, the clinical psychologist who, on 19 June 2019, was commissioned by CQC to undertake the wider independent review of its regulation of Whorlton Hall between 2015 and 2019 and to make recommendations for how CQC’s regulation of similar services can be improved, in the context of a raised level of risk of abuse and harm. The material which underpins this report will be available to her for use in her review.
- 1.11 I make 4 general observations.
- 1.12 **First**, it is worth remembering the government’s (Department of Health) response in 2012 to the Winterbourne View hospital scandal. The summary response<sup>8</sup> is Annex 1 to this report but the following extracts appear to me to be particularly apposite to the wider context of my review:
- Patients stayed at Winterbourne View for too long and were too far from home.
  - There was an extremely high rate of ‘physical intervention’.
  - Multiple agencies failed to pick up on key warning signs – which could and should have raised the alarm.
  - There was clear management failure at the hospital.
  - A ‘closed and punitive’ culture had developed.
- 1.13 The summary response continues, to record that “The Review also exposed wider concerns about how people with learning disabilities or autism and with a mental health condition or challenging behaviours were being treated in England:”

**Inappropriate placements** – too many people are being placed inappropriately

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<sup>8</sup> Winterbourne View Summary of the Government Response 2012  
[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/213221/4-page-summary.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/213221/4-page-summary.pdf)

in hospitals for assessment and treatment, and staying there for long periods.

**Inappropriate care models** – too few people are experiencing personalised care that allows them to be in easy reach of their families, or their local services.

**Poor care standards** – there are too many examples of poor quality care, and too much reliance on physical restraint.

- 1.14 Whilst I am not suggesting that all of these apply to the same extent and degree in Whorlton Hall as they did in relation to Winterbourne View, it has become clear in the course of my, admittedly more narrowly focussed, review that these responses could just as well be made now, in 2020, to the material and evidence uncovered in respect of the placement, care and treatment of patients at Whorlton Hall as they were in 2012 at Winterbourne View. It must be deeply concerning to all of us that this is the case.
- 1.15 **Second**, Whorlton Hall Hospital had been inspected in August 2015 by a CQC inspector-led team but that inspection and draft report indicating concerns about the care provided to patients, with a proposed rating of “Requires Improvement”, was not published. Instead a decision was taken to carry out another CQC inspector-led team inspection in 2016 with this explanation given for the absence of a report from the 2015 inspection: “The hospital was visited in August 2015 as part of the comprehensive inspection programme. There was concern about the August 2015 inspection and not enough evidence was gathered. It was therefore agreed to repeat the inspection. This report covers both the main findings of the August 2015 inspection and the inspection undertaken in March 2016.” That report concluded that the hospital service was rated as “Good”.
- 1.16 Although the internal reviewer of the whistleblowing complaint, brought by the first inspector, concluded that the decision taken at senior levels in CQC not to publish the report of the 2015 inspection was wrong and recommended that CQC publish the 2015 report, it was not published (until June 2019 in relation to an inquiry by the Joint Committee on Human Rights). But it is important to record that the 2015 inspection did not itself find, and then report, evidence of abuse of patients. It did, however, find numerous areas of serious concern and failings by the provider properly to manage the care and safety of individuals in Whorlton Hall at that time. A published

report with a “requires improvement” rating at that time would have led to closer examination of the service. This was a missed opportunity to record a poorly performing independent mental health institution which CQC as the regulator, with the information available to it, should have identified at that time.

1.17 I have concluded, as did the internal CQC reviewer of the whistleblowing complaint, that the decision not to publish was wrong and I have further concluded that this error was compounded by the failure to then publish the report as recommended by the internal reviewer. Those decisions were a missed opportunity for CQC to publicise that the care and safety of patients at Whorlton Hall were indeed, not good.

1.18 Fortunately, action to secure improvements to the care and safety of those patients did, in fact, take place in response to that unpublished inspection report since the provider responded with an Action Plan to oral feedback they received at the conclusion of that inspection.

1.19 I say this whilst also noting that all those involved in the 2015 inspection confirmed that, despite their varying degrees of concern and disquiet about the operation of the hospital at Whorlton Hall, none of them saw, concluded or reported at that time, that patients were being abused. In evidence to the Joint Committee of Human Rights, Dr. Lelliott said:

“The summary, which is the conclusion the inspection team came to about what they found and the judgments about weighing up the evidence, contains no statement that the team concluded that patients were being abused.

It is our expectation that if an inspection team believes that patients are being abused, they do not wait until they write the report; they take action immediately. Had that team concluded that abuse was happening, I would have expected them to alert the police. Safeguarding would have been informed. Following that inspection, there should have been a review meeting at which urgent enforcement action was taken to stop any abuse that was happening.

Also, on that inspection in 2015 there were a number of healthcare professionals: a psychiatrist, clinical psychologist and a nurse. If any of those



people had suspected abuse happening, their professional code of practice would have caused them to raise concerns immediately, either with us or with the police. None of those things happened.”<sup>9</sup>

- 1.20 The subsequent 2016 inspection and report did not take place until 7 months after the 2015 inspection during which time the provider had responded with improvements based on the action plan produced in response to the findings of the 2015 inspection.
- 1.21 How and why this decision not to publish the report was made, lie at the heart of this review. Despite requests for justifications and documentation I have not had explained to me, in any satisfactory and documented way, a detailed and persuasive justification for that decision not to publish. Nor have I received any clear and detailed analysis of the faults in that draft inspection report which were considered so fundamental that they justified the decision not to publish it. (see paragraphs 4.49 – 4.53 below)
- 1.22 I have interviewed whistleblowers about Whorlton Hall during the period covered by this review (2015–2016), who also reported serious safeguarding issues and risks to service users directly to CQC in 2018. Consequently, I have a similar concern about this further possible missed opportunity which appears to have presented itself in 2018, before the hospital received a “Good” rating in the 2018 Report.
- 1.23 Given that the terms of reference for this review extend only to the period 2015–2016, I have passed my concerns and the information from the whistleblowers to Professor Glynis Murphy<sup>10</sup> who is conducting the wider review, for her consideration.
- 1.24 I pause at this point to express my respect for the courage and determination of those healthcare professionals who have paid a considerable price personally and professionally for their actions in whistleblowing. It should be a source of profound regret that their concerns were validated subsequently

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<sup>9</sup> Houses of Parliament: Joint Committee on Human Rights - Oral evidence: Detention of children and young people with learning disabilities and/or autism, HC 1861 paragraph Q42  
<http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/the-detention-of-young-people-with-learning-disabilities-and-autism/oral/103107.html>

<sup>10</sup> Report to the Board of the CQC on the regulation of Whorlton Hall between 2015 and May 2019 forming a view as to whether the abuse of patients that has been identified could have been recognised earlier by the regulatory or inspection process and to make recommendations for how CQC can improve its regulation of similar services in the future. <https://www.cqc.org.uk/news/stories/update-independent-review-regulation-whorlton-hall>

by the evidence of abuse and poor care standards revealed by the BBC Panorama programme.

- 1.25 **Third**, the period immediately before and during the 2015 inspection of Whorlton Hall, the report writing and the quality assurance process, was one of considerable institutional change within CQC. Partly as a result of the government's response to the Winterbourne View scandal, the CQC changed its operating model in relation to the inspection of the services it regulates. The key changes included:

"...the introduction of Chief Inspectors; expert inspection teams; clear standards of care; better use of information to help us decide when, where and what to inspect; ratings to help people choose care; a focus on highlighting good practice; a commitment to listen better to the views and experiences of people who use services; and a determination to build a high-performing organisation that is well-run and well-led."<sup>11</sup>

- 1.26 Annex 2 to that document set out the proposed timeline for the changes to all sectors regulated by the CQC from September 2013 through to July 2015. This shows both the scale and pace of the institutional change through which CQC went in those months. Dr. Lelliott, who had been recruited as the Deputy Chief Inspector, Hospitals with lead responsibility for mental health told me that "... by August 2015 we were still in the very early days of applying the new methodology to mental health services". When he arrived at CQC in early 2014 "... we were at a fraction of our establishment in terms of our staff. We had something like twenty-two inspectors for the whole country in mental health". By Summer 2015 there had been more recruitment but the number of inspectors was, according to Dr. Lelliott "... still some considerable way short of the establishment number." In the North East region the figures I have been given varied between 2 and 6 at the relevant time, although it is clear that inspectors were working across regions (North West and North East England to cope with the demand)

- 1.27 Several of those I have interviewed, from front line through to senior management levels in the North East and North West Region have confirmed this under-resourcing for the inspection burden at the time. They described

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<sup>11</sup> CQC – A New Start - Responses to consultation on changes to the way CQC regulates, inspects and monitors care services October 2013 [https://www.cqc.org.uk/sites/default/files/documents/cqc\\_newstartresponse\\_2013\\_14\\_tagged\\_sent\\_to\\_web.pdf](https://www.cqc.org.uk/sites/default/files/documents/cqc_newstartresponse_2013_14_tagged_sent_to_web.pdf)

this period of “change management” in unfavourable terms: “....very chaotic in terms of managers...” ; “thrown in at the deep end, expected to know everything”; causing “incredible anxiety”; “we were fairly depleted of inspectors and it was almost [as if] they were appearing before our eyes..”; “running around like headless chickens trying to inspect ..... because the programme had already been agreed...”; “we were short on inspection managers so [they] were pretty pressurised.”; “We were a really small team, that’s what half the problem was. We were literally being pulled into every single inspection that was going and so we had too much going on, I think, given the level of work that we were actually expected to do.” and “The support structures were probably not, as good as they are now.”

1.28 **Fourth**, this review is concerned with events which took place primarily between 3 and 4 years ago. Inevitably this means that several key people have moved on, some have left the CQC for other employment, retirement or other ventures. It also means that individuals I have interviewed have understandably had varying amounts of recall about the matters I have questioned them about. To an extent this has been compensated by the amount of documentary material I have been provided with, from the CQC hard and electronic storage systems or obtained from additional or supplementary material supplied by individuals.

1.29 However, there have been critical gaps in both the institutional (documentary) and personal memories which have meant that in certain areas I have not been able to make a firm conclusion based on uncontested testament or documentary evidence<sup>12</sup>. I specifically identify those areas in the report and, where I have made a conclusion I set out the basis for my judgment, but in some cases I have had to leave the matter unresolved. This is both unfortunate and unhelpful. These gaps have, in part, prompted my recommendation about the data retention and document control processes and the recommendation for CQC to produce generic legal advice about the “duty to publish a report” under section 61(3) where an inspection “is carried

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<sup>12</sup> In particular:

- The missing “2 earlier versions” of the 2015 report pre-dating those which have been published, as claimed by the Inspector, which could not be found in the CQC systems but which some others I spoke to confirmed must have existed – not least because the first published version is one with tracked changes in it from a reviewer;
- Policy (and possibly) legal advice which was provided at the time the 2016 inspection report was cleared for publication concerning that decision and the way in which elements of the 2015 inspection were incorporated into that 2016 report.

out under section 60” of the Health and Social Care Act 2008.

1.30 **Fifth**, as with an earlier report for the CQC<sup>13</sup> and given my terms of reference, the focus of this investigation has been on one particular directorate (and indeed, largely, one region within that directorate) of CQC. However, some of the recommendations have a wider scope than just that region or that directorate. The CQC Executive Team and Board will wish to reflect on the extent to which they should be applied, if accepted, across the whole organisation. Furthermore, in two cases my recommendations contain (or are) in the form of a recommendation to the wider review being conducted by Professor Glynis Murphy into how to better regulate services similar to Whorlton Hall.<sup>14</sup>

1.31 **I make the following recommendations:** Under three broad headings; general, quality assurance processes, and whistleblowing processes.

#### **General**

##### **Recommendation 1: Security and availability of notes from inspections**

1.32 **CQC must ensure that secure and effective arrangements are in force for the collection and storage of physical notes and electronic records made in the course of gathering evidence at inspections.**

**These arrangements should be capable of producing both the documents/records and a reliable audit trail.**

**They need to operate both during and at the end of an individual’s employment with CQC, and must ensure that data protection requirements are fully met.**

##### **Recommendation 2: Improvements to the information provided to inspectors about services**

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<sup>13</sup> Report to the Board of the Care Quality Commission on CQC’s Regulation of 14 Colne Road Care home London N21 2JD <https://www.cqc.org.uk/news/stories/cqc-publishes-independent-investigation-its-regulation-14-colne-road>

<sup>14</sup> See footnote 10.

- 1.33 As part of the wider review being conducted by Professor Glynis Murphy and the work already underway in CQC to improve how they assess learning disability and mental health hospitals; CQC should consider what further improvements can be made to the systems that pull together information about a service.

Easy access by inspectors to all the information which CQC holds and receives about services is critical to the quality of inspections and reports.

#### CQC Quality Assurance and Complaint Processes

**Recommendation 3: Re-examination of the number and benefit of “quality assurance” processes**

- 1.34 CQC should re-examine the quality assurance processes it has designed and applied to inspections and report-writing to ensure that they are delivering cost-effective, valuable “quality assurance” at the right points in the system.
- 1.35 I recommend this review take place as part of any response to this and the wider review of regulation being conducted by Professor Murphy rather than as part of the immediate work programme of the Whorlton Hall Co-ordination group. The review should examine whether more investment earlier in the regulatory/inspection process might not be a better use of time, money and management input than the current model.

**Recommendation 4 Legal (and policy) advice about non-publication of inspection reports.**

- 1.36 CQC should urgently consider the potential benefit in producing legal advice, available across all directorates about the Commission’s duties under sections 46(1)(c) and 61(3) of the Health and Social Care Act 2008 to “publish a report”....

It should also ensure that policy advice on inspection methodology is clear and is consistent with the legislation in all respects. This also should apply across all operational directorates not just the Hospitals Directorate. The

Board of CQC may wish to consider whether there should be Board oversight of decisions not to publish.

**Recommendation 5: Investigation of provider complaints**

- 1.37 CQC should review its current approach for examining complaints from providers about inspections to ensure that lessons have been learned from the shortcomings of the Whorlton Hall complaint investigation in 2015.

**CQC Internal whistleblowing/Speak-Up process**

**Recommendation 6: Implementing the results of the 2016 investigation of the whistleblowing complaint**

- 1.38 Recognising that this will be nearly 4 years late, I nevertheless recommend that CQC formally write to Mr. Stanley-Wilkinson as recommended (and accepted by management) in relation to the second and third elements of the internal review of his whistleblowing concern:

“They should be thanked for taking the time and the energy to raise the concerns affording CQC the opportunity to look and learn from them.”

“There should be an apology that the person was not fully involved in the complaints investigation and outcome prior to the outcome letter being sent to the provider.”

**Recommendation 7: Noting the updated CQC “Speak Up” policy (September 2018) CQC should consider building more confidence in the process by ensuring wherever possible that reports of the action planned or taken are part of the feedback to the complainant.**

- 1.39 In particular, CQC should re-examine its processes for handling and implementing the results of the internal investigations to ensure that they are, in fact, carried out where accepted and that the individuals who raised the complaint are made aware of this.

## Chapter 2

### Introduction

- 2.1 Whorlton Hall, at the time covered by this review, had been registered with CQC since 3 September 2013 and had not been inspected, prior to the 2015 inspection. The hospital, originally part of the portfolio of premises operated by Castlebeck (which had operated Winterbourne View), was then operated by Danshell Group/Danshell Care Ltd. It was later acquired by Universal Health Services, Inc. through its UK subsidiary Cygnet Health Care, when it acquired the whole Danshell Group in August 2018.
- 2.2 Whorlton Hall was registered to provide treatment and care for patients over the age of 18 who had a learning disability and/or autism. It could accommodate up to 24 patients but had reduced its beds to 19. The hospital was located in the village of Whorlton, about 3 miles east of Barnard Castle, County Durham and 13.5 miles from Darlington railway station.
- 2.3 On 22 May 2019 the BBC's Panorama Programme "uncovered shocking evidence of patients with autism and learning difficulties being mocked, taunted and intimidated by abusive hospital staff.....Panorama filmed vulnerable adults being deliberately provoked by staff who then physically restrained them. The investigation comes eight years after the programme exposed the scandal of abuse at Winterbourne View, another specialist hospital."<sup>15</sup>
- 2.4 The BBC further reported<sup>16</sup> that CQC ".....went in three times – in March, April and July of last year. One of the visits lasted two days and involved a team of three after concerns were raised by a whistle-blower. The inspection found breaches of regulations in relation to staffing and good governance, but the hospital kept its good rating." And continued: " On top of the CQC visit, there were multiple visits by 10 different councils and local NHS bodies. Durham Council visited the hospital 33 times over the past year – 12 because of safeguarding concerns – with the rest largely related to the placement of new patients at the 17-bed unit. The council's corporate director of adult and health service, Jane Robinson, said: "We found no evidence suggesting issues

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<sup>15</sup> <https://www.bbc.co.uk/news/av/health-48371390/hospital-staff-abused-vulnerable-patients-in-durham-bbc-s-panorama-reveals>

<sup>16</sup> 23 May 2019 <https://www.bbc.co.uk/news/health-48388430>

of the nature shown in the programme."

- 2.5 The BBC reported that Dr. Lelliott, Deputy Chief Inspector (Hospitals) said it was "now clear we missed what was going on". "He said the regulator was sorry. He said inspectors spoke to staff and patients as well as independent people familiar with the hospital. But no concerns were raised. "This illustrates how difficult it is to get under the skin of this type of 'closed culture'," he added."
- 2.6 On 28th May 2019 Cygnet Health Care Ltd (Company number 02141256) issued a statement about Whorlton Hall:  
"We are shocked and deeply saddened by the allegations made against members of staff at Whorlton Hall, part of the Danshell Group, which Cygnet recently acquired. We take these allegations extremely seriously. We have suspended all the members of staff involved and informed all relevant authorities including the police, who have instigated an inquiry, and we are cooperating fully with their investigation. We have a zero tolerance of this behaviour at Cygnet. This appalling behaviour is entirely inconsistent with our values and high standards and we remain absolutely committed to delivering the highest quality healthcare, which our patients and residents expect and deserve. We have transferred all the patients to other services. Until the conclusion of the police investigation, we are unable to comment further with regards to Whorlton Hall. Those implicated in this programme have betrayed not only some of society's most vulnerable people but also the thousands of people at Cygnet who work daily with dedication and compassion to look after the people in their care."
- 2.7 16 staff members were suspended from work by Cygnet Health Care following the broadcast of the Panorama programme and subsequently 10 members of staff were arrested by Durham constabulary.
- 2.8 Mr. Stanley-Wilkinson, in a social media post on the day the Panorama programme was broadcast, stated: "...I was the lead inspector for that place and raised significant concerns! Internally the report was deleted and never published. I whistleblow and an internal investigation found my report should have been published and recommended so. It never was! These poor people have been let down significantly and CQC new [sic] about this because I wrote the report and raised concerns to the highest level possible and nothing was



done. A total cover up .....it was the whole reason why I left after 9 years.”

2.9 As is recorded in paragraph 1.4, Mr. Stanley–Wilkinson, the inspector on the 2015 inspection of Whorlton Hall emailed the CQC Chief Executive about his concerns raised in 2015/2016.

2.10 He subsequently gave an interview to the BBC News reported on their website as follows:

“Mr Stanley–Wilkinson says he noticed a "very poor culture" was evident when he led the 2015 inspection. He told the BBC that he had raised concerns over the "very poor culture" in a report he wrote – four years prior to the BBC investigation. He said: "I strongly believe that anybody that can understand organisational culture reading that report would agree that there was definitely warning bells there. "I was extremely upset. This should have been listened to back in 2015 and I said quite openly, when I left the organisation, that I felt it had neglected its promise to people with learning disabilities.”<sup>17</sup>

2.11 On the day following that interview Mr. Stanley–Wilkinson posted a further comment on social media stating: “CQC have said in a statement that my report contained “no concerns regarding abusive practice” This is to discredit me. This is not true the report detailed how there was seclusion taking place without any policies in place, it was written in a care plan if people raised allegations of abuse they were to be ignored, it was also written that where patients raised concerns about the attitudes and behaviours of staff they did not feel listened too [sic]. It was written an external agency also made allegations about staff attitudes and behaviours. It also included information from another Government Department that stated the place was like something from the 1990s it was so institutionalised.”

2.12 As is recorded in paragraph 1.6, I was appointed on 31 May 2019 to conduct this review of the way in which CQC dealt with his concerns in relation to the regulation of Whorlton Hall in particular during the period 2015–2016 and through the Commission’s internal grievance and “speak–up” policies.

2.13 Subsequently, before the attendance of Ian Trenholm and Dr. Paul Lelliott as witnesses before the Parliamentary Joint Committee on Human Rights on 12

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<sup>17</sup> Whorlton Hall: Former inspector says warnings were ignored: <https://www.bbc.co.uk/news/health-48416870>

June 2019, the CQC published five draft versions of the report of the 2015 inspection led by Mr. Stanley-Wilkinson on 10 June 2019. These five draft versions start with a peer-reviewed draft dated 25 November 2015 and conclude with a post-Inspection Manager-review version dated 16 December 2015. In addition the already published 2016 inspection report dated 17 June 2016 and a new document comparing the 5 versions of the draft 2015 report (undated) were also published.

2.14 No “original” draft of the 2015 report (i.e. one before the peer-review commented version) was published and none has been found in the CQC systems or in any other records. However, the inspector has stated that at least two earlier and fuller drafts existed and this has been supported by his immediate manager. Logically of course, there must have been at least one version pre-dating the peer-reviewed one.

2.15 I am also aware that criminal investigations following the Panorama programme have commenced and are continuing (see paragraph 1.9 above). I have been careful to ensure that this review does not impinge on those (for example, I have not sought to interview any of the then serving members of the Whorlton Hall staff).

## Chapter 3

### My Approach

- 3.1 I have conducted 21 interviews either in person or via Skype and a further 6 telephone interviews. These have covered both the lead inspector for the 2015 inspection, Mr. Stanley-Wilkinson and nearly everyone else involved in that inspection (10 people took part for some or all of the time); the inspector who conducted the 2016 inspection (which involved 3 people); the management line at the time, and in some cases still continuing, from the Deputy Chief Inspector of Hospitals (Dr. Lelliott) through to inspectors; legal and policy advisers at the time; and numerous other CQC officials who provided information regarding the operation of the Speak Up Policy; or who had information regarding the culture and practices of the relevant directorate at the time (and now); or who helped in the search for documents and the production of timelines of events for this and Professor Murphy's review.
- 3.2 I have been provided with the results of the extensive document searches which CQC has conducted in respect of the CQC's regulation of Whorlton Hall and other relevant independent mental health inspections which were taking place at around the same time in 2015/2016 in the North East Region. CQC management, before I was appointed, had already requested all staff to conduct searches of their electronic and hard copy records for material related to the regulation of Whorlton Hall and I have received further material directly from those I have interviewed which, in some cases, filled considerable gaps in the records which the search of the CQC systems had left.
- 3.3 It is important to note at this point that there remain four significant "gaps" in the CQC documentary record that has been recovered and produced to me:
- (a) There are no records held by CQC of the "inspector's notes" of the 2015 inspection. By this I mean the notes, either handwritten or typed, on CQC templates or freestyle, of what the inspection team found (the "evidence") during that inspection. This gap has, in part, been filled by copies of notes supplied by some of the members of the inspection team. This absence of documents in the CQC systems is possibly explained by one of the following three scenarios:
- (i) The documents were submitted by the inspector to the CQC Newcastle office at, or after, the end of his employment but then destroyed later, in

accordance with the then applied document destruction policy (destruction after 6 months)

(ii) The documents were not submitted to the CQC by the inspector at, or after, the end of his employment

(iii) The documents were submitted by the inspector to the Newcastle office at, or after, the end of his employment and were either mislaid or destroyed, not in accordance with the revised CQC document destruction policy (which provided for a longer retention policy).

I have not included a fourth possible scenario (suggested by one interviewee) that the documents never existed because that scenario is undermined by the existence of copies of notes produced by some of the members of the team together with covering e-mails to and from the inspector. I comment further on this aspect in detail below (see paragraphs 4.21– 4.26 below) and the problem it has caused this review forms part of the reasoning for recommendation 1.

(b) There is a dearth of documentary evidence (e-mails, records of meetings, records of decisions) about the senior managers' particular concerns about the quality of, and evidence for, the conclusions in the draft reports of the 2015 inspection (the 5 versions now published by CQC in June 2019);

(c) There is, similarly, very little documentary evidence (e-mails, records of meetings, records of decisions) about the decision made in late 2015 and confirmed in early 2016 not to publish that report, but instead to organise a subsequent inspection (the 2016 inspection); and

(d) There is no documentary evidence of any guidance given to the inspector who conducted the 2016 inspection about how to conduct that inspection in light of the decision made by senior managers that it would need to reflect and report upon concerns expressed in the 2015 draft report (i.e. the proposed "solution" to the "problem" of the non-publication of the 2015 draft report).

3.4 I have therefore had to rely upon both incomplete and contradictory oral testimonies from those I have interviewed to fill these gaps. Given that this review is concerned with events which took place 4 years ago it is understandable, possibly inevitable, that people, even those closely involved with the events will now only have partial memories. The consequences for this review are serious because in some areas I have not been able to come to a firm

conclusion based upon the limited or conflicting testimonies I have been presented with. I have tried to identify these uncertainties in the body of this report where they have had an impact.

- 3.5 This report focuses on what happened in 2015 and 2016. Following the Panorama programme, CQC immediately commenced work internally to examine not only what went wrong in terms of their own operations but also what changes needed to be made for future inspection and regulation of this sector.
- 3.6 I have therefore, been made aware of the work of the Whorlton Hall Co-ordination Group within CQC whose aim is to co-ordinate work across CQC to improve the regulation of services similar to Whorlton Hall in future. The Group is overseeing immediate, medium and long term work-streams which include: improvement of intelligence monitoring capability (warning signs) for high risk services, ratings methodology, strengthening external engagement with others providing safeguards (eg advocates, commissioners, regular visitors to services such as GPs) and, in the longer term, Phase 2 of the thematic programme which will be looking at practice in restricted and closed institutions. The Group reports to the Chief Inspector of Hospitals who, in turn, reports to the CQC Executive Team and Board. It is possible that some or all of my recommendations will be reflected in work of this Group either now or in the future. That is for CQC to decide.
- 3.7 It is important to emphasise that my review has not been conducted as a disciplinary investigation. My focus has been instead on that part of my terms of reference about “....making recommendations to the CQC Board in relation to any areas for change, improvement or development identified in the course of the investigation.” I have also sought, where possible, to address the request for recommendations in particular, about “....how concerns or disagreements that arise during the inspection or report-writing stage are managed within CQC’s regulatory decision making processes, and where they are handled within internal grievance and “speak up” policies.”
- 3.8 In the next 3 chapters, I have summarised, in narrative form, what happened in 2015–2016 in respect of the regulation of Whorlton Hall. First, in Chapter 4, the inspection led by Mr. Stanley-Wilkinson and the then unpublished draft reports: Second, in Chapter 5, the inspection and published report in 2016: Third, in Chapter 6, I deal with the grievance or whistleblowing process which Mr.

Stanley–Wilkinson pursued shortly before and after his resignation as an inspector in CQC. These are not strictly chronologically separate because some of the later narratives overlap in time with the earlier ones but I hope that separating out the three strands makes the analysis of these events and my terms of reference easier to comprehend.

- 3.9 I have drawn these summary timelines principally from the documentary evidence that has been provided to me by CQC and from documents I have received from those I interviewed. In some areas, where the documentary record is partial or missing, it has been necessary to amplify this with material from the interviews I conducted.

## Chapter 4

### Narrative: The 2015 Inspection of Whorlton Hall

4.1 **Documentary Timeline:** It is helpful to set out here the key dates and events during the period 2015–2016 from the documents I have seen relating to the 2015 inspection of Whorlton Hall (Terms of Reference paragraphs 1B & D in particular and 1A):

- 13<sup>th</sup> April 2015 – Safeguarding No.8 ENQ–21024865759 – CRM entry: Alleged physical and verbal abuse by S1 (staff) of P1 (patient). Safeguarding Local Authority and CQC notified. S1 transferred away and working under supervision during investigation
- 31<sup>st</sup> May 2015 – Inspector sends an email to set up a pre-inspection telephone call with members of the inspection team for the same day
- 16<sup>th</sup> June 2015 – Standard Provider Information Request (PIR) sent to the Danshell Group
- 17<sup>th</sup> June 2015 – e-mail from Head of Inspection to CEO of Danshell informing him of the 3 planned inspections – including Whorlton Hall on 4<sup>th</sup> August and Newbus Grange on 18<sup>th</sup> August both to be led by Barry Wilkinson. Mention is made of the changed methodology of inspections and the need for a presentation from the team/registered manager “to give an overview of the service, notable practice and areas of concern”.
- 9<sup>th</sup> July 2015 – PIR returned to CQC
- 20<sup>th</sup> July 2015 – Hospital Overview from PIR information uploaded
- 24<sup>th</sup> July 2015 – CQC Share Your Experience web-form recording a 2 day visit from NHS England’s Improving Lives Team<sup>18</sup>: “Whilst undertaking the review we expressed concerns over the use of Nurse Holding Powers as defined by the Mental Health Act which we felt were being over used and inappropriately used. The review team also felt that documentation and record keeping in general was of a poor quality. The team observed poor interactions with patients and a complete lack of professionals on site to

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<sup>18</sup> The Improving Lives Team was established by NHS England to re-review everyone who had been a patient at Winterbourne View. The team consisted of clinicians with expertise in learning disability and “experts by experience”. It was led by a Consultant Nurse. Those reviews were completed by June 2014. However, by “early 2014, it became clear that the ambition to “...support everyone inappropriately placed in hospital to move to community-based support as quickly as possible, and no later than 1 June 2014:” was much more complex than first thought and could not be met.” So Review teams continued to track patients in hospitals such as Whorlton Hall. See: <https://www.england.nhs.uk/wp-content/uploads/2014/10/item8-board-1114.pdf>

oversee day to day nursing care. There appeared to be a[n] attitude reminiscent of long term institutional care as provided prior to NHS Campus closure of the 1990s. The review team saw evidence of staff initially sat outside and at least one patient left indoors on her own, monitored via a bedroom alarm system. When questioned it transpired this lady usually had 2:1 staff supervision which correspond to the 2 staff we witnessed running in to the building as the alarm was clearly triggered. The senior nurse/ward manager was reportedly soon to be retiring and didn't seem overly motivated or concerned by the practice witnessed. We were mindful that since Danshell has taken over the running of this hospital CQC have not been and inspected the service. We felt that this alert was needed to timetable such an inspection." The notification continues "My concerns are urgent and people's safety may be at risk." And under the heading "The good things about this service are..." the NHS team noted that "Some of the staff were committed to trying to provide good quality care but there was little to lighten our feelings of concern."

- 31<sup>st</sup> July – email from manager of Whorlton Hall with presentation slides and some information about speaking to relatives.
- 4<sup>th</sup> August – emails from Alison Mitchell with documents to support the inspection.
- 4<sup>th</sup>, 5<sup>th</sup>, 6<sup>th</sup> August 2015 – Inspection of Whorlton Hall Hospital (the 2015 inspection) covering Tuesday, Wednesday and Thursday with a night visit on Wednesday night. Lead by Mr. Stanley-Wilkinson with two inspectors (in training/observing), one inspection manager – present as a mental health nurse specialism, one psychiatrist (NPA), one psychologist (SPA), one occupational therapist (SPA), one pharmacist and one Expert-by-Experience & carer.
- 8<sup>th</sup> August – email from Whorlton Hall Manager with Observation Policy. And promising that completed action plan will be sent on 10 August
- 11<sup>th</sup> August 2015 – Management Review Meeting (MRM) Mr. Stanley-Wilkinson, Inspection Manager and Legal Adviser – Preliminary Rating – Requires Improvement for each key question
- 21<sup>st</sup> August 2015 – e-mail from the Chief Executive of Danshell Group complaining about the 2015 inspection of Whorlton Hall and requesting a meeting with the Inspection Manager (NB complaint raises no issues about the matters apparently raised in the feedback at the end of the



inspection which were later responded to in a comprehensive 13 page action plan (see 25 November entry))

- 21<sup>st</sup> August 2015 – e-mail from Mr. Stanley-Wilkinson to the SPAs on the inspection requesting their notes and noting that other inspection colleagues had “carried out a couple of visits to other services of Danshell and are not sharing our concerns ....The provider has requested to meet with us but my concern is that as an organisation we are not taking a consistent view and the risks this poses.”
- 22<sup>nd</sup> October 2015 – e-mail from Mr. Stanley-Wilkinson to Inspection Manager expressing intention to terminate employment with CQC citing, among other things, since December 2014 “...it has been difficult over this year with lack of managers and inspectors which has put a huge amount of pressure on those that have been here.” Subsequently withdrawn following meeting with line manager and Head of Service.
- 2<sup>nd</sup> November – draft response to complaint from Danshell Chief Executive prepared by Inspection Manager with comments from Head of Inspection
- 10<sup>th</sup> November 2015 CQC letter to the Chief Executive of Danshell responding to his complaints from 21<sup>st</sup> August 2015.<sup>19</sup>
- 23<sup>rd</sup> November 2015 – e-mail from Mr. Stanley-Wilkinson to former manager (responsible for the response to the complaint from Danshell), noting that current manager had gone “through the complaint and response” with him. Notes his disappointment with parts of the response, that “there is something very dishonest and untrue about what they have said. I would have liked to have been able to have seen this response prior to it going, as that way I would have been able to have at least expressed my view.”
- 24<sup>th</sup> November 2015 – Unannounced Mental Health Act 1983 ( MHA ) Monitoring visit of Whorlton Hall – Domains 1 & 3 not inspected and 2 of 8 elements in Domain 2 not inspected. Many positive comments but required an action plan to be submitted to CQC by 30 December 2015 as to “How the company will ensure its staff comply with paragraph 25.67 of the Code of Practice.” (Clinician in charge of treatment should record their actions in providing patients with (or withholding) the reasons supplied by a Second Opinion Appointed Doctor) but also raising

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<sup>19</sup> Now published by JCHR: <https://www.parliament.uk/documents/joint-committees/human-rights/correspondence/whorlton-hall-complaint.pdf>

concerns about the omission of common ligature points in door frames from the risk assessed list of ligature points.

- 25<sup>th</sup> November 2015 – e-mail from the Registered Manager of Whorlton Hall to Mr. Stanley-Wilkinson attaching an “internal action plan we have been working on in response to the feedback provided at the inspection on the 4–6<sup>th</sup> August 2015” (detailing responses to 17 Safe issues, 13 Effectiveness issues, 5 Responsiveness issues) (The “Action Plan”)
- 25<sup>th</sup> November 2015 – e-mail from registered manager with details of 6 safeguarding allegations from 2 August 2014 to 7 July 2015 (5 not upheld and 1 related to a previous placement not WH)
- Before 25<sup>th</sup> November 2015 – one (or two) initial drafts of the report are produced.

*(5 drafts of the report of the 2015 inspection † are available<sup>20</sup>)*

- 25<sup>th</sup> November 2015 – Peer Review version of draft report<sup>†</sup>
- 3<sup>rd</sup> December 2015 – E-mail from Mr. Stanley-Wilkinson to two heads of service who had chaired an SQAG meeting, the day before on the draft report for Waterloo Manor hospital complaining about the treatment he received in the meeting
- 4<sup>th</sup> December 2015 – Draft report sent to report-writing coaches<sup>†</sup>
- 8<sup>th</sup> December 2015 – MHA Monitoring visit report published with One Domain 2 matter requiring action: “That the responsible clinicians had not recorded the feedback they had provided the patient following the visit by the second opinion appointed doctor (SOAD).”
- 10<sup>th</sup> December 2015 – Draft report post report writing coaches review<sup>†</sup>
- 14<sup>th</sup> December 2015 – Mr. Stanley-Wilkinson begins a 4 week period of sickness absence from work citing (in an e-mail to his line manager) among other things, “issues with work”. It also states “I have finished all the changes to the Whorlton Hall report so will be ready for you to Inspection Manager review. .... [“X”][another inspector who had been on the inspection] will be able to help with any changes.”
- 14<sup>th</sup> December 2015 – Draft report ready for Inspection Manager review<sup>†</sup>
- 16<sup>th</sup> December 2015 – Draft report containing details of 6 breaches of regulations post Inspection Manager review<sup>†</sup>
- 21<sup>st</sup> December – Inspection manager visits Chief Executive of Danshell at Whorlton Hall. Noting in the e-mail below the “significant amount of work since the inspection and are reviewing the action plan again and

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<sup>20</sup> The dates <sup>†</sup> and copies are taken from the versions published on the CQC website on 10 June 2019

<https://www.cqc.org.uk/news/stories/cqc-shares-previously-unpublished-findings-2015-inspection-whorlton-hall>

sending this on to me. They are clearly still “bitter” about Barry’s inspection and the waves that continue to flow from it.”

- 22<sup>nd</sup> December 2015 – e-mail from Inspection Manager to Head of Hospitals Inspection NE with concerns about draft report “...the report needs so much work and has so many unanswered questions I don’t think we can put anything together.....my thoughts are to forget a report and re-inspect in the new year with a fresh team – but not sure of our reporting responsibilities following an inspection. Just to add insult to injury there was a MHAR there on the 24 Nov who contradicted some of the things.....outlined as poor practice– the MHAR cited them as good! (he obviously wasn’t aware of the recent inspection).”
- 29<sup>th</sup> December 2015 – Provider Action Statement in response to MHA Monitoring visit report submitted to CQC by Whorlton Hall provider containing response to the single action required and the concerns about the ligature points in door frames.
- 6<sup>th</sup> January 2016 – e-mail from Head of Inspection to Inspection Manager in reply to 22 December e-mail: “I have now read it [the report] and like you I tried to complete this and then realised it needs starting again! Not sure that the MHAR got it wrong – I am not convinced Barry knows what he is talking about.... Speak Thursday!”
- 7<sup>th</sup> January 2016 – letter from Danshell’s Group Operations Director to Head of Inspection complaining about the failure to receive the final report of inspection in relation to Waterloo Manor Hospital, Leeds which had been inspected in February 2015 and rated “inadequate” in all 5 areas and had then been re-inspected on 19–21 August 2015 to check that improvements required had been made. Seeking a definite date for submission of the draft report for their consideration.
- 15<sup>th</sup> January 2016 – Mr. Stanley-Wilkinson tenders his resignation
- 4<sup>th</sup> February 2016 – e-mail from Director of HR to Mr. Stanley-Wilkinson discussing arrangements for his leaving CQC and listing “outstanding tasks” identified by Dr. Lelliott to be completed and concluding “Once these tasks are completed satisfactorily, we can make arrangements for you to drop off your warrant card, laptop, blackberry etc.”
- 12<sup>th</sup> February 2016 – e-mail from Head of Inspection to Dr. Lelliott about the draft Whorlton Hall Report: “ As discussed. The above report is one where the IM has tried to suggest amendments. The original and the emails and notes from the NPA and SPA can be found [here](#) [active hyper link]”

- 19<sup>th</sup> February 2016 – notes of interview from Head of Service and CQC internal investigation into whistleblowing complaint (see paragraph 6.1 below) stating: “The available draft report was not well crafted: it had contradictory and conflicting evidence, and as the gap between the inspection and likely publication of the report was ever widening, a decision was taken not to publish the report. It is accepted by the head of service, who fully owns the decision that this should have been discussed and agreed with the DCI. *However, a mitigation the head of service has agreed with the provider is for an inspection to take place and is working with the provider to make this happen.*” (Emphasis added)
- 22<sup>nd</sup> February 2016 – e-mail from Dr. Lelliott (DCI) in reply to Head of Inspection. “Hmm. And did a team of nine people really spend three days at a hospital with 19 patients [sic] and, during that time, only talk with four patients, 15 staff and look at seven prescription charts?”
- 4<sup>th</sup> April 2016 10.23am – e-mail from Mr. Stanley-Wilkinson to CQC investigator: “Also I have some inspection notes. Can you advise “XX” I will drop them into the Newcastle office tomorrow”

4.2 **Context of the inspection – methodology changes in CQC:** I heard substantial evidence from multiple sources that the period covered by this timeline and indeed extending into the next was one of considerable churn and change as the new inspection and reporting methodology was being developed and rolled out across the inspections of different types of services (NHS Trusts first and then eventually independent hospitals) across the whole country.

4.3 In the North East region of the directorate this meant that at the start of the period there were very few inspectors and inspection managers to carry out both the NHS hospital inspections which were on their portfolios but also then adding in a programme of inspections for the private/independent hospitals like Whorlton Hall simply added to this workload. It appears that recruitment into the North East Mental Health team both of inspectors and inspection managers was still significantly under target at the time of the first Whorlton Hall inspection.

4.4 The inspection of Whorlton Hall was one of the first inspections of independent mental health hospitals. Planning of these early inspections was not as they are planned and programmed now. There was a draft “end-to-end process” document (dated April 2015) which I have seen but from interviews I

was told that this was not strictly followed in those early days. It also seems likely that allocations of hospitals and indeed inspections to individual inspectors was not always as programmed in advance as they are now. I was told by a number of people of late changes and allocations to whoever was available at the time. As another inspector commented: "... at that point in 2015, inspection planning was almost in development with all the changes to methodology, so, there wasn't the kind of formal inspection plans that we have doing for the last couple of years."

- 4.5 Unfortunately, one of the disadvantages of the lack of reliable documentary evidence at this distance from 2014/2015 is that I cannot be certain of exactly when Whorlton Hall was assigned to Mr Stanley–Wilkinson. I have seen a copy of a document entitled "MH North NHS IH Schedule 2015–6 and up to Q2 2016" which appears to have been created on 22 April 2015 and which allocates Whorlton Hall for inspection in August 2015 to Mr. Stanley–Wilkinson and another inspector. However, the document may not be accurate in terms of what actually happened during that period or it was not updated to reflect later–made changes; for example, it assigns another hospital to him for inspection which was in fact carried out by another inspector. Furthermore, there is evidence that the "notifications" (alerts from safeguarding authorities and other external sources) were not transferred to him until much nearer the date of/during the inspection in August 2015. Normally notifications would be assigned to the inspector with the relationship manager role for that hospital rather than being left with the inspection manager or a previously allocated inspector.
- 4.6 As one of those I interviewed, who was then at middle management level, said: "I think back then, things were quite primitive and I think everyone would agree, we had just started–out inspecting these independent health settings ..... and while we had some methodology in place, I think the surrounding governance perhaps within our Directorate wasn't quite as robust as perhaps it is now..." and "...for a long while there we were [doing] back to back inspections."
- 4.7 **The Waterloo Manor Inspections February & August 2015:** The inspection scheduling document also lists another hospital, called Waterloo Manor, for inspection in Quarter 2 of 2016 although that hospital was also assigned to

Mr. Stanley–Wilkinson for inspection on 19, 20 and 21 August 2015<sup>21</sup> and this is not recorded on the schedule. This allocation, of another 3 day inspection 8 working days after the end of the previous 3 day inspection of Whorlton Hall has been described by one senior manager in this way: “They are quite big inspections to have one after another.” This is particularly the case when the nature and background of that second inspection is considered.

4.8 The August inspection of Waterloo Manor was a “focussed re–inspection” following an earlier inspection (11–12 & 19–20 February 2015)<sup>22</sup> the report of which (published 2 days before the August re–inspection) had rated the hospital as “Inadequate”. This had generated enforcement action in the form of four warning notices, informing the service that they must meet the required standards by 9 July 2015). It had also generated one requirement notice in relation to safeguarding patients from abuse (see pages 25 to 27 of that report).

4.9 That report of the February inspection, involving Mr. Stanley–Wilkinson, is worth noting because it clearly identifies abuse of patients and generated enforcement action immediately. This contrasts starkly with the conclusions and enforcement actions listed in either the 2015 or 2016 inspection reports of Whorlton Hall. If abuse had been detected and reported in either of those inspections a report containing warning and requirement notices like the Waterloo Manor one would have been expected, for example: “The service MUST ensure that patients are protected from the risk of abuse or possible harm by ensuring that there is an open and transparent culture within the hospital and the wider organisation to allow and encourage staff and patients to discuss concerns openly without fear of victimisation, bullying or harassment.” in the body of the report’s findings. A reference such as: “Regulation 13 HSCA (RA) Regulations 2014: Safeguarding service users from abuse and improper treatment. ... Practical steps had not been taken to prevent the risk of abuse to patients.” in the enforcement section (requirement notices) would also have been expected.

4.10 As noted in paragraph 4.8 above, the publication of this comprehensive report of the February inspection occurred only two days before the focussed re–inspection in August commenced. There is contested testimony as to whether

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<sup>21</sup> Published on CQC’s website on 3 March 2016; [https://www.cqc.org.uk/sites/default/files/new\\_reports/AAAE1298.pdf](https://www.cqc.org.uk/sites/default/files/new_reports/AAAE1298.pdf)

<sup>22</sup> Published on CQC’s website on 17 August 2015; [https://www.cqc.org.uk/sites/default/files/new\\_reports/AAAD5077.pdf](https://www.cqc.org.uk/sites/default/files/new_reports/AAAD5077.pdf)

Mr. Stanley–Wilkinson was the second (not lead) inspector on the February inspection with the lead being taken by another inspector, at the time temporarily on promotion to inspection manager. Assuming this testimony to be correct, this would have meant that the inspection manager lead would have been responsible for producing the report and the enforcement notices. I am relatively confident from the evidence I have received that Mr. Stanley–Wilkinson was asked quite late in the process to take over writing, or substantially completing the report and the enforcement notices, which had previously been the responsibility of the inspection manager who had led that inspection.

4.11 Then the focussed re–inspection of Waterloo Manor took place, leading to the more positive report finally published in March 2016<sup>23</sup>. This report and the style, conduct and effect of the quality assurance process applied to it was raised in Mr. Stanley–Wilkinson’s whistleblowing complaint so I will return to that aspect later (in Chapter 6). For the purposes of this part of the narrative it is enough simply to note that this re–inspection was of a service where abuse had been found and clearly reported upon. I record also, that the scheduling of this inspection was very shortly after the 2015 Whorlton Hall inspection and that delays which occurred in producing this report and the quality assurance processes for it, added further workload pressures on the inspector.

4.12 **Organisation of the Whorlton Hall inspection in August 2015:** Criticism was made of the size of the inspection team given the number of patients in Whorlton Hall both by the provider, Danshell, in their complaint and by senior CQC managers when considering the draft inspection report. Whorlton Hall had originally been registered for 24 patients, then reduced to 19. The Provider Information Report stated, on page 23, “reported figures for bed occupancy at 50%, for the six month period (24 December 2014–24 June 2015)” indicating a total occupancy of 9 or 10. And on page 33 in the tabular format of the provider’s Risk Register for Quarter 2 of 2015 it records against the second highest risk “Reduction in occupancy due to pending discharge and no referrals in pipeline” ..... “occupancy currently at 11 which is two above budget. 5 discharges pending two of which will take place by the end June 2015.”

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<sup>23</sup> “We were satisfied that the requirements set out in our warning notices had been met and that the service was improving its systems for identifying and preventing concerns of abuse.” See Footnote 21 - page 2.

4.13 By the time the inspection took place in August, bed occupancy had declined to 7 patients. The inspection team totalled 10 however, this bald figure is misleading. The team comprised the following with details of the days they were on site:

1. CQC lead inspector – Mr. Stanley–Wilkinson (Three Days)
2. National Professional Adviser – Psychology (Three Days)
3. Specialist Professional Adviser – Psychiatry (Three Days)
4. Specialist Professional Adviser – Occupational Therapy (One day)
5. Learning Disability Nurse Specialist (a CQC Inspection Manager) (Two days)
6. An Expert by Experience (Three Days) and
7. their carer (Three Days)
8. Specialist Professional Adviser – Pharmacy (One day)
9. A trainee inspector (One day)
10. A trainee inspector (One day)

4.14 So, a number of the team were not there for the whole inspection (in fact the core team was 5 or 6). All those interviewed said that they were not aware before arriving at the hospital that the occupancy rate at the hospital was only 7. It was thought that occupancy was 19 since that was the figure given to the inspector in a phone conversation with a senior Danshell manager when discussing arrangements for the inspection. The inspector and others interviewed have also forcefully made the point that they did not walk around the hospital *en bloc* since they each had specific tasks and specific people to interview. They worked individually or, at most, had a trainee or the Expert by Experience (with carer) with them when interviewing a patient or staff member. The trainees were there on different days. Others came for their specific inspection role and left. One of those on the inspection commented that “... there’s something slightly disingenuous about that [the size of the team] as a complaint when the opening presentation that we had was done in a kind of lecture theatre style with a considerable number of people from Danshell management and others.”

4.15 I return to this issue when considering the handling of the complaint made by the provider. It is worth noting however, that this complaint was made *after* the inspection had concluded (and after negative feedback had been provided to the management on the Friday). Had there been serious concerns about the welfare of the patients arising from a large inspection team being in the



hospital one might have expected it to be raised with the inspector or his manager at the start of the inspection when senior Danshell managers had been on site for the presentation. It is also clear that the inspector made arrangements to ensure that the trainees he had been assigned were then on site only one day rather than both days, and made further efforts with the local manager of the hospital to ensure that there was no undue disturbance from the presence of the inspection team.

**4.16 What the inspection team observed on the inspection (4–6 August):** All those interviewed who took part in the inspection confirmed the general view, which comes through the now-published drafts of the report, that there were significant concerns about this hospital in terms of the therapeutic outcomes for and care of the patients. It is also clear from the documents and from speaking to those involved that the immediate physical environment and the corporate presentation (requested by CQC) both had immediate negative effects:

- i. The environment: As one of those on the inspection said to me “ I don’t think it started off on the best footing because as we arrived there was a huge skip outside with broken glass and there was wood and nails and plaster...As we approached the building, the main door was on that side and obviously shut and there was a door there, sort of in front of the skip – open, wide open and we had a discussion about whether [Mr Stanley–Wilkinson] should go in and see where the door went to.” The first version of the report published by CQC (with peer-review comments) records this issue on page 13.

Another member of the team who went on the escorted tour of the building and gardens also confirms that “...we went outside and it looked beautiful, there was a rolling lawn and we walked down the path to the side and it was really dangerous. There was broken glass, there were broken greenhouses, there were things you could stand on and climb over the fence, so we immediately said we thought this was dangerous and we told Barry and he dealt with it immediately.”

It is worth recording, as the first published draft records at page 13, that “Five of the seven patients had a history of assaulting others, which also included

using objects as weapons.”<sup>24</sup>

- ii. The presentation by Danshell management: The inspection notes from a clinical member of the team record that: “The presentation given by the Service Manager.... was primarily a corporate view of the Danshell Group. It made reference to a model of care called PATHS which appears to be unique to the Danshell Group .....There was a lack of clarity however how this related to the role of Whorlton Hall as a hospital. Staff were unable to give an adequate explanation of how Appreciative Inquiry [the A in PATHS], for example, related to care and treatment or clinical outcomes (and the knowledge of appreciative inquiry as a methodology appeared to be superficial)”.

A particular concern of many was the way in which the provider had sought (unsatisfactorily) to involve patients in the presentation: Again, from the same clinical member’s notes: “...one patient was given a script to read when his reading skills were clearly very limited as was his communication in general. This resulted in a humiliating exercise that was embarrassing for all concerned – staff did not demonstrate any skills to be able to turn this around with a knowledge of how to engage the person in conversation or how to work alongside him.”

- iii. Concerns about the therapeutic role of the hospital: Despite the absence of the inspector’s notes and the other notes from some of those on the inspection, there appears to be sufficient evidence in the notes which have been retrieved, to justify the negative conclusions in the draft report in relation to the Caring, Effective and Responsive domains. One example, of many taken from the review of clinical records, in relation to the care of one individual who had significant behavioural impairment requiring attention or treatment, may assist in supporting this conclusion: “Despite previously identified communication issues and the use of Makaton<sup>25</sup>, Talking Mats<sup>26</sup> etc [at the patient’s previous hospital] – the “one–page profile” in the section on

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<sup>24</sup> I was informed by those who had worked at the hospital at the time that the reason for the skip and the broken glass was because the staff were clearing the broken down greenhouses and removing the danger so that that area of garden could be used to grow plants and vegetables and that the patients could take part in the activity. Laudable though this was an aim it does not remove the nature of the physical risks observed on the inspection

<sup>25</sup> “In Makaton signs are used, with speech, in spoken word order. This helps provide extra clues about what someone is saying. Using signs can help people who have no speech or whose speech is unclear. Using symbols can help people who have limited speech and those who cannot, or prefer not to sign.” <https://www.makaton.org/aboutMakaton>

<sup>26</sup> “Talking Mats communication symbols tool is .... designed by Speech and Language Therapists. It uses unique, specially designed picture communication symbols .... and is used by clinical practitioners, carers and support workers.” <https://www.talkingmats.com/about-talking-mats>

“How to Support ‘A’” makes no reference to this other than ‘explaining things slowly in simple terms’ ... a document labelled as Communication Passport states that ‘A’ is ‘familiar with talking mats’ and he will use these to express preferences, feelings, favoured activities.’... there was no evidence of these being used as stated. .... There is minimal emphasis on communication and no continuation/development of the work done at [previous hospital]. There is little routine use, if any, of the communication skills ‘A’ possessed.”

- iv. The use of the low stimulus room (Room 10): In the first draft of the report which has been published (with peer-review changes) the following is stated about this room: “Staff told us that the service did not have a seclusion room and this was something the service did not do. A designated room referred to as “room 10” which was presented to us as a low stimulus room. Patients were escorted to the room by staff and held in restraint on occasion unable to leave should they be in distress. The Mental Health Act Code of Practice defines seclusion as: “The supervised confinement of a patient in a room, which may be locked. Its sole aim is to contain severely disturbed behaviour which is likely to cause harm to others.”” And “We looked at eight incident records where the use of the room had been used and brought our concerns to the attention of managers in that there was no policy or guidance in place for the use of the room and equally no appropriate safeguards to ensure the room was used for its intended use.”

4.17 Another of the specialist clinicians on the inspection concluded that this hospital was at the poor end of the scale in delivering therapeutic activity. Their concern was that there was no evidence of how the patients were being given the necessary skills to ‘move on’. In their notes of the inspection they recorded: “There is also a lack of therapeutic intervention to support and train clients in the areas of need.” ... “It was not clear how the Whorlton Hall model or the staff delivered that. Also, if the individual aspects of the people being cared for are not understood then how would staff go about “moving them on”?”. Their notes of the inspection also recorded: “Poor understanding of [the] link between communication or inability to communicate and behaviour. ....Lack of evidence of supporting people’s progress through [assessment] , definition of priorities, goal setting, intervention and review of goals (outcomes) then modifying plans accordingly.”

4.18 As regards risk management, another member of the team recollected; "... looking at care plans..... and there was somebody who ... was a sex offender and there was supposed to be a risk assessment and ... they were supposed to inform MAPPA but did not do so until we pointed it out. They did it as soon as we pointed out that he wasn't there [in the hospital] so it was then logged. So there were lots of problems with the service."

4.19 **The night visit:** It is important to note (not least because this was not done during the 2016 inspection) that there was a night visit on the 2015 inspection. Concerns which had arisen during the day inspection, for example, about the lack of lines of sight for the staff to monitor the patients prompted the inspector to conduct a visit to speak to the night staff. Unusually, given the presence of several CQC officials and commissioned specialists, he took with him the person who was on the inspection solely as the carer for the Expert by Experience. It appears that he may have asked the team for a volunteer (although some of the others on the inspection do not recollect that) since the visit was going to be after midnight. Clearly, it was sensible to go accompanied by someone else so that anything identified could be corroborated, but the decision to take the carer caused concern later with CQC senior managers when reviewing the details of the inspection.

4.20 For the purposes of this review it is sufficient to record that the night visit produced more negative results. It was reported by the inspector that all the night staff were seated together eating a meal when he arrived with no-one monitoring the patients other than by relying on door alarms. This claim was contested in the complaint from Danshell (see paragraphs 4.29–4.35 below) and so having another person with the inspector became rather more important. In the end it appears that Danshell management accepted the assertion since it featured in their remedial action plan. The night staff were also questioned about seclusion issues, training and what therapeutic treatment the patients were receiving and the recorded results were not good. These concerns prompted the inspector to speak to the hospital manager the following day, possibly adding further to the pressure that she felt from the earlier issues with the open skip and broken glass.

4.21 **Documentary material and interviews:** I have set out in summary form in these paragraphs details from the notes which have become available. Where there is no documentary record I have referred to material from the interviews with

those on the inspection. These support the conclusions in the draft reports of the 2015 inspection that led to the proposed “Requires Improvement” rating. Indeed, as one of the CQC members of the inspection team (not the inspector himself) put it “I might have rated them ‘inadequate’ myself.... I think we had conversations about ‘requires improvement’ or ‘inadequate’. I think in some ways – if I’d been rating it, it might have been worse.”. I have not set out in detail the findings of the inspection as reported in the now published versions of the draft report since they are now publicly available.

**4.22 Management Review Meeting(s):** There is contradictory testimony and evidence about a Management Review Meeting (MRM) taking place between the inspector and his inspection manager during the course of the inspection. Some of those on the inspection team recall him making and taking phone calls during the inspection but cannot confirm that an MRM took place. He asserts that on the first day of the inspection he received a call alerting him to the fact that a set of “notifications” recorded on the CQC system (CRM) had been signed over to him to deal with during the inspection. Records from that system clearly indicate that the relationship manager for Whorlton Hall (and therefore the recipient of notifications through the CRM system) was listed as his inspection manager from 6<sup>th</sup> February 2015 until 7<sup>th</sup> August 2015 when it is changed to Mr. Wilkinson (as he then was). The inspector is equally firm that he then drove away from the hospital in order to obtain an internet connection to download the notifications. These included the notification from the NHS Improving Lives Team. He stated: “...when I saw the notification that had come through from NHS England transforming lives team and the notification ... listed a whole series of concerns that they’d had about the place and I think the key point from that is I spoke to the guy that had actually sent through the notification, the next day. I called him and all of the issues they had found themselves were a mirror image of what we were saying in terms of; patients locked behind doors without staff supervision; lack of staff knowledge and understanding of how to work with these individuals; lack of discharge planning. All of these issues were being raised, were a mirror image of what we had been saying.”

**4.23** The inspector also states that he telephoned his manager the next day (Thursday 6<sup>th</sup> August 2015) to discuss the notifications and the confirmation of the concerns expressed by NHS England by the inspection team. His manager has no recollection of this telephone call/possible MRM taking place;

“I certainly don’t have a recollection of doing an MRM whilst we were there or him ringing me for advice or anything while he was on site..... I don’t know what sort of MRM it could have been, because I think with the scheme of delegation I would have had to have been there. At least dialled in and I didn’t, and I can say that for definite.” Mr. Stanley–Wilkinson says he was told to continue gathering evidence for the report and it was this conversation that prompted him to arrange the night visit.

4.24 The only document relating to any MRM is one dated Tuesday 11<sup>th</sup> August 2015, after the inspection had concluded on the preceding Friday when feedback had been given to Danshell management at Whorlton Hall. It is not a full or completed record of the MRM since only pages 1 to 5 are complete. These record the provider details, the location details, the date of the MRM and the name of the lead inspector. Two pages under the heading “Brief overview and initial analysis” then contain considerable details about what the inspection team had found in fairly trenchantly negative terms tied to suggested breaches of regulations, for example: “There were no therapeutic treatments or programmes taking place to support people in a meaningful way to ensure positive outcomes that could be effectively assessed. **Reg 9**”. In passing it is worth noting that there are no allegations of abuse but this was recorded: “**Restraint** – was used regularly but there was an overall lack of debrief after incidents. Which meant staff were not learning from incidents.” Details of those attending are then given, including Mr. Stanley–Wilkinson, his manager and a principal legal adviser. However, the section headed “Decision Details” (pages 6 to 11) of the template document is empty apart from a list of 4 applicable regulations (9, 11, 12, 17) which might be considered as relevant or breached.

4.25 **Feedback at the end of the inspection:** It is clear that the inspector, accompanied by (at least two other) members of the team provided feedback to the manager of Whorlton Hall and senior Danshell managers at the conclusion of the inspection. This appears to have been given on the Friday morning (7<sup>th</sup> August 2015). Again, there is an absence of any notes or records of this session in the CQC records but the recollection of those in the CQC team who attended is fairly consistent. Mr. Stanley–Wilkinson recalls that: “I was really clear around all of the serious concerns that we had about that place. Then I told them specifically that there would be more than likely some enforcement action that we would be taking against them as a provider.” One

of the others attending the session recollected; "... a level of tension in the room and that the meeting was uncomfortable at times when the management 'pushed back' or responded to criticisms." The other concluded that "... there are ways that you can be critical of people and you can give your criticism or your judgement or your evaluation in all sorts of ways ... you need to be quite careful in how you do that and I'm not sure that feedback session was as well controlled as it could have been..."

4.26 The absence of documents about this feedback session is, to a significant extent, ameliorated by the terms and details contained in the Whorlton Hall Action plan (see paragraph 4.36 below) which confirm the range of matters which were reported upon to the management at the feedback session.

4.27 **Was abuse found by the 2015 inspection?:** It is important to record here that none of the 35 actions in the Action Plan response from Danshell seek to address any concern raised by the inspection about "patient abuse". This confirms that this was not an issue which had been raised by the inspection team at the feedback session. A number of those in the inspection team have also re-confirmed this. "I have to say we didn't see anything that made us think they were abusing people." "My recollection is not of witnessing anything that I would have called directly abusive." "I have spent a lot of time reflecting on 2015 ... and trying to bring back conversations and I have satisfied myself that there was no mention at that point to me or any indication or suggestion that patients were being mistreated. There just wasn't..."

4.28 Mr. Stanley-Wilkinson has also confirmed this: "... I never said that we saw abuse in the service. All I've ever said [is] that there was a report that was written in 2015 and that wasn't published, and the content of that report was worrying. I couldn't say that people were being abused because we didn't see it, but what I can say is that there was extremely poor care practices and that's all I ever said about it."

4.29 **The complaint from the Danshell CEO:** Chronologically, it makes sense to consider now the complaint raised by the provider, Danshell Group after the inspection had concluded<sup>27</sup>. It is clear that the manager and senior management of Danshell Group were aware that the inspection was not going

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<sup>27</sup> Details of the complaint are set out in the letter of response from CQC sent on 10 November published by the JCHR at <https://www.parliament.uk/documents/joint-committees/human-rights/correspondence/whorlton-hall-complaint.pdf>

well, from their point of view: First, there was the problem of the open skip and open door, before the inspection had even begun. Then the presentation which the inspection team felt focussed not on Whorlton Hall treatment and care but on Danshell's corporate approach generally, and used a patient who struggled to read the script he had been given. Then there was the external inspection which revealed the broken glass and greenhouses. There was discomfort apparently about the Occupational Therapist SPA interviewing the 2 Activity Co-ordinators who, when finally interviewed together, were reported to be not very forthcoming in providing answers. Finally, there was concern about the questioning of the capacity assessment forms all being signed on the same day (30<sup>th</sup> July). This, in the words of one on the inspection team "...clearly upset people ....raising questions of how could someone have legitimately signed their understanding of all these plans on one day and does the documentation actually reflect the reality of clinical practice which led to some doubts about 'are we experiencing [a] current, balanced view of the world that it smells of fresh paint'."

4.30 It was clear to those on the inspection that the local management of Whorlton Hall and possibly the senior Danshell Group managers who had been present at the presentation were not happy with what was being questioned and, it would seem from their subsequent complaint, the way in which some aspects were being questioned.

4.31 In the course of the inspection the inspector made, or took, a phone call with another inspector leading an inspection of another Danshell facility where they were not finding the same issues as the Whorlton Hall team. In this telephone call Mr. Stanley-Wilkinson was quite clear that the other inspection team needed to look harder because the risk assessment tool was the same and; "... whether or not the 'formulation' is in line with an evidence-based tool". This formed part of the complaint from Danshell that he had sought improperly to influence another inspection.

4.32 On 21<sup>st</sup> August (two weeks after the inspection), the Chief Executive of Danshell e-mailed Mr. Stanley-Wilkinson's manager in the following terms: "I am writing to request an urgent meeting with yourself to discuss the inspection that recently took place at Whorlton Hall. We are also concerned that the lead inspector that undertook the inspection at Whorlton Hall tried to influence the inspection that took place at Chesterholme this week and we



don't think that this was in the spirit of information sharing but to support the inspection he led at Whorlton Hall which we feel was disproportionate and the feedback inconsistent with feedback we have received elsewhere." His e-mail continued then to list in more detail points which related to these concerns: The number of people in the inspection team compared with the number of patients; an assertion that because the service had not been inspected since September 2012 this was evidence that Whorlton Hall was considered "as a low risk service"; the absence of any whistleblowing information and only 8 incidents (safeguarding) and 4 relating to police involvement in 18 months. Comparisons were made with inspections of other recently inspected Danshell services with more patients where the inspection teams numbered 5 over one or two days.

4.33 The complaint also concluded that he was "confident that staff at the service felt undue pressure during these three days given the disproportionate size of the inspection team and as a result did not perform to the standards we know they are capable of." Specific concerns were raised about; the alleged "unprofessional language to describe the service as 'a cross between Butlins and a Spa'"; an allegation that a team member acting in a prejudicial manner during the inspection by stating; "... they didn't need to discuss with staff what was in care files as they already knew what they would find."; whether comments that the Danshell Risk Assessment tool being "not fit for purpose" were balanced or evidenced based. In respect of this last element the Chief Executive made direct reference to not having yet seen the; "triangulated evidence which confirms that the risk assessment tool is in fact not fit for purpose" and expressed the view that this comment "appears at this stage to be nothing more than a personal opinion, of which we have yet had chance to challenge."

4.34 The e-mail also raised the concern Mr. Stanley-Wilkinson; "apparently had a conversation with the inspectors on day two of the inspection, we know that this took place as part of the call was overheard. Again negative comments were overheard regarding the risk assessment tool. If this did take place then the concern is that the inspector for Whorlton was prejudicing the Chesterholme inspection based on a personal opinion and on a view of which we have had no opportunity to respond. I am concerned that this hearsay evidence may have influenced the inspection team in that the inspectors were considering information from another service rather than making judgements

based on the evidence they found on the day. This would indicate a lack of impartiality on the part of the inspectors and appears to lack transparency around their sources of intelligence.”

4.35 The complaint concludes with a further concern about the future: “We must now be concerned regarding the consistency of inspectors in the North East area, given that following the feedback from the Registered Manager there appeared to be no mention of the risk assessment tool prior to this conversation.” The Chief Executive then also raises a concern that a planned inspection scheduled to be conducted by the same inspector, of another Danshell service, Newbus Grange “ has already been prejudged by the inspector and I question whether this forthcoming inspection will be based on evidence available on the day, consistent with other inspections, impartial and fair.”

4.36 **The Danshell–provided Whorlton Hall Action Plan:** Interestingly, the complaint makes no reference to the detailed feedback which the Danshell management and Whorlton Hall local management received. As a response to the feedback given to the Danshell management at the end of the inspection on the Friday by Mr. Stanley–Wilkinson and others accompanying him, the provider took remedial action straight away (dealing with skip and broken glass issue) and produced a detailed action plan to address the points raised with them.

4.37 The version of the action plan I have seen is entitled “Whorlton Hall CQC Action Plan – Version 6 SMT Review 11.11.15” and was submitted by the Danshell Group registered manager to Mr. Stanley Wilkinson on 25 November 2015. It is highly likely (given the version number on this one) that there were earlier iterations of this plan. This twelve page spreadsheet sets out very clearly against each of the Domains (listed as “Safe, Effectiveness, and Responsiveness”) the very detailed remedial action required to deal with the issue which the inspection had found and reported back upon, whose responsibility this was and time scales for completion (ranging from the dates of the inspection through to 31 December 2015 with continuing monitoring in certain cases). The final column is a “RAG rating” of progress against those timescales one of which are Red. There are 17 “Safe” actions, 13 “Effectiveness” actions and 5 “Responsiveness” actions set out. All of these can be related back to the contents of the draft report of the 2015 inspection. So, it would appear that the provider had, despite the complaint made after the

inspection, “accepted” the criticisms of the service and implemented a detailed remedial action plan.

- 4.38 **CQC’s response to the complaint from Danshell:**<sup>28</sup> The complaint lodged by the CEO of Danshell was investigated by the inspector’s then direct line–manager. It also featured in the whistleblowing complaint with Mr. Stanley–Wilkinson asserting: “Complaints being handled completely inappropriately. This again relates to Whorlton Hall. A complaint was made I was never interviewed other than a 5 minute conversation. I was never shown a copy of the complaint. I have serious concerns regarding how this was responded to as much of it is lies or a fabrication of the truth.”
- 4.39 I was told that the inspection manager shared it with their manager, the Head of Inspection. From this the inspection manager recalls being asked “ ... to do a little fact–finding and provide a response to the Provider.” In terms of follow–up with the CEO of Danshell, this involved “... probably a couple of phone calls... just to reassure him that I had got his email and was dealing with it.” Interestingly, it was only upon receipt of the complaint, raising as it did, the size of the inspection team) that the line manager first became aware of this.
- 4.40 I was not provided with any formal records of this investigation from within the CQC records or electronic systems but the inspection manager provided copies of 3 sets of handwritten notes taken when interviewing those persons who were interviewed. 2 of these are dated and record a telephone interview with one of the trainee inspectors who was on the inspection on 26<sup>th</sup> August 2015 and another with the NPA Psychiatrist dated 29<sup>th</sup> September 2015. The note of the conversation with Mr. Stanley–Wilkinson is unfortunately not dated but clearly indicates that the points made in the complaint were put to the inspector, and equally clearly contains his responses, refutations and explanations. Similarly the notes from the other two members of the inspection team are clear that they do not support the complaints (except in respect of the use of the word “garbage” – which was thought to have been made by the Expert with Experience of Learning Disabilities). The short note of the telephone call with the Chief Executive of Danshell (timed at 16.45 but not dated) mostly contains confirmation of the allegations made in the original

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<sup>28</sup> CQC Response published by JCHR <https://www.parliament.uk/documents/joint-committees/human-rights/correspondence/whorlton-hall-complaint.pdf>

complaint, including the assertion by him that only 3 of the night staff had been in the dining room during the night inspection and that the hospital manager had wanted to resign after the inspection.

4.41 A draft response was sent to the Head of Inspection on 2 November by the inspection manager (who at that point was no longer Mr. Stanley–Wilkinson’s line manager but who completed the work on this complaint). This was returned with some suggested changes, mostly pointing to unanswered elements of the complaint but a couple of them were to add further apologies. The draft response was not discussed or shown to Mr. Stanley–Wilkinson for comment before it was sent. I comment on the approach to investigating this complaint, the outcome and the possible effect it had on decision–making in relation to the report of the inspection in Chapter 7. Here, it is sufficient to record that the response which issued on 10<sup>th</sup> November, does not reflect fully the strength of the refutations and responses contained in the notes from the conversations with the 3 members of the inspection team. There is no explanation for this in the documents I have seen.

4.42 Mr. Stanley–Wilkinson sent an e–mail to his former inspection manager (who had carried out the investigation and signed the response letter) on 23<sup>rd</sup> November 2015 recording a 1–to–1 meeting with his then manager the preceding Friday (20<sup>th</sup> November); “...who went through the complaint and response with me. Not sure really what else there is to add. I am disappointed with parts of the response as I don’t think it reflects the issues at all and there is something very dishonest and untrue about what they have said. I would have liked to have been able to have seen this response prior to it going, as that way, I would have been able to have at least expressed my view.” He then records that the draft report of the August inspection is with the peer reviewer (1<sup>st</sup> published version) and will be returned the next day (24<sup>th</sup> November) and it would then be sent to the report writing coaches (2<sup>nd</sup> published version).

4.43 **CQC Review processes and the decision not to publish:** During this period (Autumn 2015) concern had been expressed by the Deputy Chief Inspector about the delays which had occurred in producing reports for publication, from the North East Directorate. This resulted in a “sweep” of all outstanding reports which included Whorlton Hall. This has been described as the point at which inspectors were told by senior management to complete all outstanding reports very quickly. The draft report for Whorlton Hall was then considered by

the inspection manager and head of inspection as not fit for purpose and additional evidence was not forthcoming from the inspector's notes (following requests for this). It was also considered that the significant time which had expired from the date of the inspection ruled out a return visit to seek further supporting evidence for what was contained in the draft report.

4.44 It appears that in this case that the CQC's internal quality assurance processes, from the inspection manager's review in mid-December – through the Head of Inspection's review in late December – to the Deputy Chief Inspector's comments in February 2016, all seem to confirm an early (and poorly-reasoned) conclusion that the report was not of publishable quality. On that point at least, since 5 drafts have since been published on the CQC website, people can now draw their own conclusions (albeit with the benefit of hindsight). Clearly there are issues with the quality of the drafting and the use of the CQC "house style", with both spelling and textual improvements called for (and in some cases achieved through peer review and the coach's revision of the summary). There is evident frustration from the managers at the apparent difficulty of obtaining corroborated additional evidence in the form of the inspector's notes to justify the conclusions in those drafts of the report. However, it is not clear from the documents made available to me, what specific efforts were made in this respect to obtain and inspect the inspector's notes *at that time* while Mr. Stanley-Wilkinson was still employed by CQC. Indeed all the e-mail efforts to secure the copies of the inspection notes that I have seen appear to date from after he tendered his resignation in January 2016, rather than earlier during the quality assurance process.

4.45 What is not in dispute however is the content of the notes which *did* (and still do) exist and which were available at the time. It appears clear that, like me, all three management levels must have had access to the 3 reports from two of the SPAs and the NPA. This is evident from the Head of Inspection's email of 16<sup>th</sup> February 2016 to the Deputy Chief Inspector which states "... and notes from the NPA and SPA can be found [here](#) [active hyper link]". I was told in response to questions about those records which were available: "I know we have some very eminent SPAs who were on that inspection but we just didn't appear to have the evidence to support it and in all honestly, the quality of the report was pretty shocking compared to the reports we're used to publishing." And " We had bits and pieces which were typed notes from specialist advisers

but not the body of evidence [from the inspection]”.

- 4.46 What is not evident is any formal, documented or even e-mailed request before the SQAG or NQAG meetings for copies of that “body of evidence” (the bulk of the inspection notes). This should have included also the notes of the additional SPA – who checked the pharmaceutical aspects of Whorlton Hall. I have seen no documentary record that those notes which were available (those from 2 of the SPAs and the NPA) were indeed examined at the time, by those who took the decision not to publish the report but instead, to incorporate it by reference in the later report. As I note above, there is much documentation available from management and Human Resources colleagues, chasing these and other inspection notes at/after the inspector’s resignation and subsequent departure from CQC, a month or so later, but none from this time.
- 4.47 Indeed, this is puzzling given that the action plan (supplied by the Danshell manager of Whorlton Hall in response to the feedback which was given by the inspector at the time of the inspection) contained very significant details to support the deficiencies identified in the draft report. In effect, the action plan appears in large part to be a mirror reflection of what had been found on the inspection and was recorded in the draft report. This action plan was known about by the management levels in CQC. Indeed the 22nd December e-mail recording a meeting the day before between the CQC manager with the Chief Executive of the Danshell Group at Whorlton Hall, states that the provider had carried out “a significant amount of work since the inspection and are reviewing the action plan *again* (emphasis added) and sending this on to me.” Despite this other “evidence” of deficiencies, it was decided late in December 2015 and again in effect, in January and February 2016, that the correct course of action was to proceed with the re-inspection which took place in March 2016 with a different inspector and smaller team and not to seek to make the 2015 report of publishable quality, or indeed simply to publish at the same time as the 2016 report was published.
- 4.48 After the 5<sup>th</sup> draft had been through the new inspection manager’s review, (which was one of the first he had ever conducted), he concluded that “...the report needs so much work and has so many unanswered questions I don’t think we can put anything together.....*my thoughts are to forget a report and re-inspect in the new year with a fresh team – but not sure of our reporting responsibilities following an inspection.*” (Emphasis added). Added, by way of

further justification is this comment: “Just to add insult to injury there was a MHAR [ Mental Health Act Reviewer] there on the 24 Nov who contradicted some of the things.....outlined as poor practice– the MHAR cited them as good! (he obviously wasn’t aware of the recent inspection). having so many unanswered questions I don’t think we can put anything together...”. The communications I have seen do not indicate clearly which conclusions in the MHAR’s report are those for which the managers had been unable to secure corroborating or “triangulating” evidence.

- 4.49 The decision not to publish the draft report appears to have been made, in essence, by the Head of Inspection in late December: “I made the decision that actually we [had] got to the point where we had gone well over 3 months since the inspection and what we needed to do was get a team in there because we knew that we had got an action plan..... and I thought, I need to speak to [Dr. Lelliott, the DCI] about this. .... I had absolutely made the decision and the key points from the report that were concerning needed to go through into the next report. We’d already set up an inspection at the time because to set up a comprehensive inspection, you had to give 20 weeks’ notice and we’d done that. We’d told the provider we were coming back so they knew.”
- 4.50 This appears to be confirmed by the reply sent by email on 6th January 2016 from the Head of Inspection to the inspection manager: “I have now read it [the report] and like you I tried to complete this and then realised it needs starting again! Not sure that the MHAR got it wrong – I am not convinced Barry knows what he is talking about.... Speak Thursday!!” It is not immediately clear to me why the conclusion was made that the one day visit by the MHAR focussing on the narrower Mental Health Act specifics should be considered more “right” than the results of the 3 day long full inspection for which there were notes available, at least from two SPAs and one NPA. I comment on the relationship between regulatory inspections and MHA Reviews in Chapter 7.
- 4.51 There is no record of the conversation which may have taken place on the Thursday (7<sup>th</sup> or 14<sup>th</sup> January are immediately following dates). The next document in this train of events is an email from the Head of Inspection to the Deputy Chief Inspector on 12<sup>th</sup> February 2016 about the draft Whorlton Hall Report: “As discussed. The above report is one where the IM [inspection manager] has tried to suggest amendments. The original and the emails and notes from the NPA and SPA can be found [here](#) [active hyper link]”. There is no

documentary record of the “discussion” referred to in that e-mail but both individuals said that they would have talked about the problems with the Whorlton Hall and Waterloo Manor reports. I was told by those I interviewed from management levels that there were issues with the quality and delays in obtaining reports from Mr. Stanley–Wilkinson: I consider this also in Chapter 7.

4.52 On 22<sup>nd</sup> February 2016 the DCI, Dr. Lelliott replied: “Hmm. And did a team of nine people really spend three days at a hospital with 19 patients [sic] and, during that time, only talk with four patients, 15 staff and look at seven prescription charts?” Dr.Lelliott told the Joint Committee on Human Rights “I decided that the thing to do, because of ongoing concerns about the evidence in the 2015 report, was to ensure that the report included the findings from 2015.”<sup>29</sup>

4.53 It is necessary at this point in the report simply to record that there is very little documentation about this final decision. There are no requests for policy or legal advice *before* that decision was taken. There are no records of consideration of the inspection material (from the SPAs and NPA) that was available to support the conclusions in the report. This is important because it indicates a decision–making process which was not well–recorded, given that it appeared to be one which was not necessarily normal or within the CQC procedures applying at the time. Some of this may be attributable to the limited storage size on CQC e–mail inboxes and server capacity at the time but I am surprised that there were no more formalised records of this particular non–publication decision. I consider this poor record making/keeping further in Chapter 7.

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<sup>29</sup> Page 5 <http://data.parliament.uk/writtenevidence/committeeevidence.svc/evidencedocument/human-rights-committee/the-detention-of-young-people-with-learning-disabilities-and-autism/oral/103107.html>



## Chapter 5

### The inspection of Whorlton Hall Hospital in March 2016

5.1 I set out the key events and documents relating to the decision to carry out a further comprehensive inspection of Whorlton Hall Hospital in March 2016 and the decision that the report of that inspection would incorporate by reference certain concerns that those involved in the August 2015 inspection had about the hospital, as recorded in the draft report from that time. This was neither standard CQC policy nor, critically, did it implement the management-accepted recommendation of the internal Whistleblowing investigation, that the 2015 Report should be published (see Chapter 6 below).

- 27<sup>th</sup> January 2016 – Team Meeting Agenda – Darlington (3 inspectors present including Mr. Stanley-Wilkinson and the inspector who leads the 2016 inspection, inspection manager and one other inspector absent). Whorlton Hall still assigned to Mr. Stanley-Wilkinson, not assigned to the list of planned inspections for the subsequent lead inspector.
- 26<sup>th</sup> February 2016 – Email from lead inspector to Registered Manager of Whorlton Hall Hospital providing information concerning the planned inspection on Thursday and Friday 3<sup>rd</sup> & 4<sup>th</sup> March 2016. The inspection to comprise 2 inspectors for both days, a learning disabilities Occupational Therapist SPA for day 1 only, a Learning Disabilities Nurse SPA for day 2 only and an Inspection Manager (the one who had handled the complaint from Danshell after the 2015 inspection) for day 2 only.
- Undated (but sent before 3<sup>rd</sup> March to inspection team members) outline plan for the two day inspection allocating tasks to team members. No mention of 2015 inspection/report/issues
- 3<sup>rd</sup>–4<sup>th</sup> March 2016 – inspection of Whorlton Hall – notes from the inspectors and other team members on CQC template forms and in freehand

*(at least 8 drafts of the report of the 2016 inspection are then produced)*

- 31<sup>st</sup> March 2016 Draft report submitted for peer review (*4 comparisons made with the 2015 inspection & one reference to the Action Plan in response to that inspection's feedback*)
- 5<sup>th</sup> April 2016 Draft report returned from peer review

- 5<sup>th</sup> April 2016 Draft report after peer review changes submitted for Inspection Manager review
- 5<sup>th</sup> April 2016 Draft report returned with Inspection Manager comments (*4 further comparisons with 2015 inspection or Action Plan requested as reflected in the IM comments on the “Hospitals reporting quality passport” dated 8 April 2016*)
- 11<sup>th</sup> April 2016 Draft report ready for SQAG meeting, proposed ratings – requires improvement for safe and effective, good for caring, responsive and well-led (*now containing 6 comparisons with the 2015 inspection or Action Plan*)
- 19<sup>th</sup> April 2016 SQAG – overall comment “The two sections (safe and effective) that are ‘requires improvement’ read as ‘good’ try to move the wording around to make the issues that caused those domains to be rated RI stand out more.”
- 26<sup>th</sup> April 2016 Draft report prepared for NQAG meeting with review comments from Dr. Lelliott including “Does this report combine or cover the findings of both inspections? If so, I think we should say so. I suggest it says ‘This report covers both that inspection and the the [sic] inspection undertaken in March 2015. The rating is based on what we found in the former.”
- 20<sup>th</sup> May 2016 NQAG Meeting Record Tool recording the outcome of the NQAG meeting chaired by Dr. Lelliott with 2 voting members from Intelligence and Policy sections of CQC and 4 additional attendees including a CQC legal adviser. Details of the report reviewed and the ‘requires improvement’ rating for the effective domain was changed to good because the evidence on lack of updated policies to reflect the changed Code of Practice under the Mental Health Act 1983 were considered to be ‘Minor caveats’ and not clear enough to justify ‘RI’.

Additional note on the section headed “Introduction to the Service” states: “Provider was inspected in August, the report wasn’t published, evidence was not strong enough, it was re-inspected in March. We need to speak to Policy on how to deal with this situation. People would want to know what the current situation is. We need to say ‘this report covers both inspections but the ratings relate to March 2016. [Policy official] to confirm with colleagues – [XX] has looked at this type of methodology.’”

- 23<sup>rd</sup> May 2016 Draft Report after NQAG meeting (*now containing 17 comparisons with the 2015 inspection & Action Plan*)
- 3<sup>rd</sup> June 2016 e-mail from Director of Operations NE Danshell Group recording no comments to make in response to the Factual Accuracy draft report submitted to the provider for comment.
- 17<sup>th</sup> June 2016 Report of 2016 Inspection published on CQC website.<sup>30</sup> Overall rating 'Good' with only the Safe domain rated as 'Requires Improvement'.

(I have added, in italics, the number of references to the 2015 report in the draft 2016 report at each stage to indicate how this approach was developed during the Quality Assurance Process)

5.2 The March 2016 inspection was led by an inspector who had been an inspector-in-training at the August 2015 inspection and had attended for at least one day of that inspection, possibly two days (but their recollection is different from the recollection of others on this point which is that each of the inspectors-on-training attended only one day after it was appreciated that the size of the team over the whole inspection needed to be reduced). The inspector's background was in governance. At the time of the 2016 inspection they "didn't have a lot of experience with learning disabilities" but recollected that they would have been aware of some of the concerns from the 2015 inspection and the fact that the provider had raised a complaint.

#### **Preparation for the inspection**

- 5.3 There was no new Provider Information Request (PIR) for this inspection. Normally, I was informed, CQC inspection policy would have required a new PIR since the inspection occurred more than 6 months after the date the last PIR had been supplied (9<sup>th</sup> July 2015) since this appears to have been an announced inspection. However, the inspector recalled a data pack produced by the intelligence section (analysts) in CQC (which would normally supplement the PIR).
- 5.4 The inspection plan produced for the 2016 inspection appears to be thorough and comprehensive, assigning roles and responsibilities for checking issues to the relevant members of the team. There was no plan to conduct a night

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<sup>30</sup> Obtained from CQC website [https://www.cqc.org.uk/sites/default/files/new\\_reports/AAAF5065.pdf](https://www.cqc.org.uk/sites/default/files/new_reports/AAAF5065.pdf)

visit in contrast with the 2015 inspection which carried out a night visit to test some concerns about what supervision was occurring during the night.

- 5.5 There is no specific reference in the plan document to either the 2015 inspection or the concerns raised in that draft report but a number of matters that featured in that report were listed for inspection (eg. “Interviewing the therapy assistants to look for an understanding of individual needs.... Have they had training about how to communicate effectively?”). As regards whether a copy of the unpublished 2015 inspection report was taken on the inspection, the 2016 inspector’s recollection was “.... well whether I had it [the draft report] with me, I don’t know, but I certainly had prepared knowing I had to look at the findings from that.”

#### **What the 2016 inspection found**

- 5.6 The manager of the hospital, who it was reported by the CEO had wanted to resign following the 2015 inspection, had not done so and had indeed been responsible for the substantial action plan and its implementation, and was in post at the time of the 2016 inspection. Indeed, from other interviews I was informed that this manager had indeed made significant improvements to the running of Whorlton Hall (and had just commenced this work at the time of the 2015 inspection).
- 5.7 There are, what appears to be a complete set of the inspection notes (handwritten or typed, on the CQC inspection templates), from all members of the 2016 inspection team. These are the inspection notes, the bulk of which are missing from the CQC system for the 2015 inspection. From the 2016 ones it is clear that a number of issues which had caused concern in the 2015 inspection had been or were being addressed by the provider. For example, the staff had secured “overall compliance” with the training requirements, an issue of serious concern in the earlier inspection<sup>31</sup>.
- 5.8 Training in Makaton communication methods (a significant concern of the 2015 inspection team given the number of patients with serious communication difficulties) had started in November 2015 but was not yet complete. In the notes of an interview of a recently appointed Health Care Assistant (4 weeks in post) by the Learning Disabilities Nurse SPA he recorded

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<sup>31</sup> Although it was noted by the Lead Inspector auditing the training records that training on Safer Restrictive Practice, Care Programme Approach and antipsychotic monitoring were all below the required percentage pass-mark.

that “for those people with limited verbal communication skills [staff] show them pictures of activities and this helps them decide what they want to do..... He described using talking mats as an aid to communication, reporting that an individual who went horse riding indicated he did not like horse riding but wanted to do photography.”

- 5.9 The inspector confirmed this improvement in training from the 2015 inspection; “... they showed us talking mats and they showed us records of people going on Makaton training. They didn’t think they’d solved it but were working towards really improving that. They used pictures, large print. I think that for each person, they had a solution. I don’t think that there were any patients that we felt ‘no-one can communicate with them’. They had a solution in place for each person.”
- 5.10 Some of the notes of interviews with staff raised concerns for the interviewer. For example, an interview with a support worker who had been employed full time for 24 years who answered the question about awareness of any bullying in the negative; “never known there to be bullying” also reported that incidents were; “never reported” but that he would be; “informed in handover of any incident” and; “had not been involved in an incident for a long time but will have a debrief if needed – can’t think of a time there was one.” In total the notes of his interview contain 8 question marks as his replies to specific questions such as those relating to “Good practice in applying the Mental Care Act”.
- 5.11 Other staff interviews provided better and more complete answers but even these contained worrying confirmations of what had been noted in the 2015 inspection. For example, a similarly long serving member of staff, an Activity co-ordinator with 25 years at Whorlton Hall listed understaffing as a problem when asked what problems there were; “Should be enough staff to run the shift and lots of agency staff [used]. Activities should not be cancelled. [There] should be supernumerary [staff].”
- 5.12 In the notes there appears to have been no specific follow-up questions in relation to the use, or inspection, of “Room 10” (the low stimulation/ seclusion room) which had caused concern to the 2015 inspection team and which featured in the draft report and Mr. Stanley-Wilkinson’s social media posts in 2019. The 2016 report simply notes that: “The hospital did not have

a seclusion room. Following discussions with staff and review of care records we were satisfied that seclusion was not taking place in any other rooms.” (p.10). It is perhaps surprising that, in relation to an issue which caused such significant concern about patient safety and welfare in the 2015 inspection, there is no direct reference in the report to the “seclusion” concerns from the inspection in 2015 either in the original draft or in any of the subsequent revisions which sought to increase the cross references to the 2015 inspection findings.

- 5.13 The inspector’s notes of the feedback given to the provider at the end of the inspection lists the following under the heading “Issues”: “Emergency Kit; Medicines issue; information on New Code of Practice – so we’ll be looking at that.”
- 5.14 Under the heading “Positive” it records the following: “We’ve been very well received. We can see that you’ve had a programme of improvement over the past six months; You’ve been very transparent where your challenges still are and I think you’ve done well to show us the good work, the good care and treatment you deliver...”.
- 5.15 Included in the notes is a copy of the November 2015 Mental Capacity Act 1983 inspection visit report and Danshell’s action plan in response to remedy the one specific defect identified and to respond to a further negative comment (see paragraph 4.1 – 24<sup>th</sup> November 2015 reference above).

#### **Drafting of the report and quality assurance processes**

- 5.16 As the chronology in paragraph 5.1 above indicates a number of drafts of this report were then produced and reviewed through the CQC quality assurance processes from 31<sup>st</sup> March (peer review) through to the 11<sup>th</sup> April 2016 version prepared for the Subsidiary Quality Assurance Group meeting on 19<sup>th</sup> April 2015. At this point the comparisons with the 2015 inspection’s findings and Action Plan submitted by Danshell in response to the feedback from that inspection have increased from 4 to 6. There is no direct reference in the report into the fact that there had been a previous inspection which had not been reported upon.
- 5.17 This picture is not, in itself, surprising or sinister given that, beyond having a copy of the 2015 draft report and the provider’s Action Plan, the inspector

could not recall having any specific guidance from their manager about this aspect: “I don’t think I did have any guidance, not that I recall ... the way the inspection lead worked was to highlight any areas of concern to focus on. So, the areas that Barry highlighted, such as the environment, would definitely have been looked at.” What is perhaps surprising is that so few direct cross-references to the 2015 inspection/draft report were made in these drafts of the 2016 report.

- 5.18 There is no mention in the notes of the SQAG meeting of the fact that this inspection was a “quick” response to the perceived inadequacies of the August 2015 inspection and lateness of the report. Nor is there a record of this approach having been agreed with the provider by the Head of Service.
- 5.19 It appears that it is not until the draft report reached the most senior management level in the form of the National Quality Assurance Group (NQAG) that significant efforts are made to contrast the findings of this inspection with what had been seen on the 2015 inspection. In the draft prepared for NQAG dated 26<sup>th</sup> April 2016 the Deputy Chief Inspector points out for the first time that the sole reference in the “Summary of this inspection: Background” which read “The hospital was visited in August 2015 as part of the comprehensive inspection programme” begs the question of whether the 2015 inspection’s findings have been combined or covered. I note in passing that this commentary on the draft 2016 report occurred some 3 weeks after the report of the internal reviewer of Mr. Stanley–Wilkinson’s whistleblowing complaint had recommended that the 2015 draft report should have been published, a recommendation which had also been accepted by the Deputy Chief Inspector.
- 5.20 The NQAG meeting took place on 20<sup>th</sup> May 2015 and there is a record of that meeting (see paragraph 5.1: 20<sup>th</sup> November 2015 entry). Aside from the issue about the incorporation by reference of the 2015 inspection, the group “challenged/discussed” the negative comments and concerns in the report about the adherence of Whorlton Hall to the requirements of the Mental Health Act 1983 which were in the following form: “Several of the policies had not yet been ratified which meant that staff did not have up to date guidance to support them in meeting the requirements of the new code of practice. Although we did not see any evidence that the principles and guidance of the code were not being implemented, we were concerned at the lack of progress

with regards to updating policies.”<sup>32</sup> Interestingly the double negative in the final sentence survived the NQAG process despite a comment from Dr.Lelliott in the version he reviewed before the NQAG meeting “This is a double negative – what evidence might we have seen?” Instead it appears that the inspector had removed the following sentence which read “ We were also concerned that no other actions were evident to ensure changes to practice as embodied in the code had taken place” in relation to which Dr.Lelliott’s comment had been “such as?”.

- 5.21 The notes of the NQAG meeting record under the heading “Challenge/Discussion” at this point: “P.18 (Adherence to the MHA Act [sic]) double negative although we did not see any evidence....policies had not yet been ratified is this sufficient for RI? Which policies had not been ratified? What actions had not taken place?”
- 5.22 The reason for examining these “challenges” in some detail in this narrative part of the report is because:-
- (a) it provides an insight into the way in which the NQAG system then operated, and also because,
  - (b) as a consequence of those challenges/discussion, the “Action” column records the decision of NQAG to alter the rating for the “Effectiveness” domain: “Change to Good”. This also had the effect under the CQC’s ratings policy<sup>33</sup> of changing the overall rating for Whorlton Hall in the 2016 Report to “Good” rather than “Requires Improvement”.
- 5.23 As regards the incorporation by reference of the 2015 inspection and draft report’s findings the NQAG Meeting Record Tool records that “Provider was inspected in August, the report wasn’t published, evidence was not strong enough, it was re-inspected in March. We need to speak to Policy on how to deal with this situation. People would want to know what the current situation is. We need to say ‘this report covers both inspections but the ratings relate to March 2016’. [AB – the voting member of NQAG from Policy Team] to confirm with colleagues – [CD] has looked at this type of methodology.” (emphasis in original text)

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<sup>32</sup> p.9 2016 report published on CQC website here: [https://www.cqc.org.uk/sites/default/files/new\\_reports/AAAF5065.pdf](https://www.cqc.org.uk/sites/default/files/new_reports/AAAF5065.pdf)

<sup>33</sup> CQC rating policy requires 2 of the 5 domains to be in the lower category for the overall rating to be that category



- 5.24 In passing, it is interesting to note that no reference is made in the NQAG Meeting Record Tool to the recommendation from the internal reviewer of the whistleblowing complaint, accepted on 3<sup>rd</sup> March 2016, that the 2015 Report should be published, nor to the Initial Management Response also produced on 3<sup>rd</sup> March 2016 which confirms that this will be done. I consider this further in Chapter 7.
- 5.25 I have spent some considerable time during the course of my review (as have those assisting me with the documentation searches), trying to ascertain the details of the advice that “AB” (a voting member of NQAG) was tasked with obtaining from “CD” in the policy team and also any legal advice which the Legal Adviser (“LA” – a non-voting member of the NQAG) or another CQC lawyer might have given in respect of this issue. No documents have been retrieved recording either policy or legal advice in this case. This, in itself, is neither surprising nor sinister because, at the time, CQC had limited capacity on e-mail storage and therefore many e-mails that were not otherwise stored as records, have been lost. Equally it appears that some legal advice was provided orally at NQAG meetings but the legal adviser (“LA”) attending this NQAG could not recall any details.
- 5.26 Dr. Lelliott’s view however, was that: “ ‘LA’ would have been present and as our legal adviser ... would have supported that by being present at the meeting. If [LA had] demurred, we would have made a note of that...” and “That is circumstantial evidence that ‘LA’ would have been party to the decision in that we were going to wrap the 2015 inspection into the 2016 report.” Given that non-publication of a report was (and is) both unusual and rare, I am surprised that there is no more formalised legal advice recorded and that senior management saw no need to obtain formal written legal advice. This is particularly so given that the 2016 Report was producing a rating significantly better than that in the draft 2015 Report and that the internal review into the whistleblowing complaint had already reported at this stage and recommended publication of the 2015 inspection report with its “needs improvement” rating.
- 5.27 As regards the supply of policy advice from the policy adviser after the meeting ‘CD’ told me that, understandably given the time which has elapsed, they could not remember the details of this particular NQAG issue but confirmed that there would not be general/generic policy advice on this

matter as it would occur very rarely. Policy advice had been given in the past that this could be done, in accordance with the inspection methodology then applied, with the previous evidence (i.e. the 2015 inspection results) being given an appropriate weighting in relation to the later (more recent) inspection evidence.

- 5.28 Whether the addition of a further 11 references to the 2015 findings (in the post-NQAG version; see paragraph 5.1: 23<sup>rd</sup> May 2016 reference above) were, in effect, giving; “an appropriate weighting in relation to the later (more recent) inspection evidence” is a matter of judgment. I am not convinced that it was, given that most comparison references were added during the quality assurance process not during the actual inspection conclude on the process adopted and the apparent absence of documented legal and policy advice further in Chapter 7 together with recommendations.

#### **The published 2016 inspection report**

- 5.29 The post-NQAG report was published on 17<sup>th</sup> June 2016, after Danshell, on 3<sup>rd</sup> June, confirmed they had no challenges following their consideration of it for “Factual Accuracy”. The overall rating was “Good” and only the Safe domain was left rated as “Requires Improvement”.
- 5.30 This was the report that people would then have read as the only published report of an inspection of Whorlton Hall at that time. This was the first report on Whorlton Hall published by the CQC. It appeared 10 months after the first inspection, 6 months after Danshell had sent an Action Plan to CQC addressing those concerns which had been fed back to them from that inspection, and 3½ months after the internal review had recommended that the 2015 Report should be published.

## Chapter 6

### Narrative: The Whistleblowing Complaint

6.1 I set out the key events and documents relevant to the way in which Mr. Stanley-Wilkinson's concerns were addressed through CQC's Whistleblowing and Speak-Up policies (Terms of Reference paragraph 1A and C in particular).

- 22<sup>nd</sup> October 2015 – Mr. Stanley-Wilkinson emails Inspection Manager tendering his resignation (withdrawn after meeting with managers)
- 3<sup>rd</sup> December 2015 – e-mail from Mr. Stanley-Wilkinson to two heads of service who had chaired an SQAG meeting, the day before, on the draft report for Waterloo Manor hospital complaining about the treatment he received in the meeting.
- 11<sup>th</sup> January 2016 – Mr. Stanley-Wilkinson returned to work from sick leave with return to work interview on 12<sup>th</sup> January 2016 with manager
- 15<sup>th</sup> January 2016 – Mr. Stanley-Wilkinson tenders his resignation (8 weeks' notice period – discussions between HR and management conclude the last working day "will probably be around 19 Feb with a/l [annual leave] being taken after...")
- 26<sup>th</sup> January 2016 – Mr. Stanley-Wilkinson lodges "Whistleblowing Concerns" citing concerns about the practice "happening within the North East Mental Health directorate team.....we work in a bullying, hostile environment.....the culture is only what can be described as toxic..."<sup>34</sup> In a telephone conversation with the senior manager recipient of this notification, in response to a question about what he wanted to do now, Mr. Stanley-Wilkinson stated "I felt I wanted to leave as I didn't think there was any other option for me, as I was raising concerns about all my senior managers and their conduct"
- 27<sup>th</sup> January – email from Dr. Lelliott to recipient of complaint recording that he (PL) has spoken to HR Director and agreed to find a Head of Inspection from Adult Social Care Directorate to investigate.
- 3<sup>rd</sup> February 2016 a Deputy Chief Inspector from a different directorate is appointed to conduct the investigation of the Whistleblowing

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<sup>34</sup> A slightly redacted copy was published by the JCHR here: <https://www.parliament.uk/documents/joint-committees/human-rights/correspondence/stanley-wilkinson-resign.pdf>

Concerns in accordance with CQC's then applicable Whistleblowing policy<sup>35</sup>, later the, then still draft, Speak-Up Policy<sup>36</sup>.

- 8<sup>th</sup> February investigator contacts Mr. Stanley-Wilkinson by email. Explains process. No need to meet at this time. Follows up 11<sup>th</sup> February to ask whether BSW received the email. Further exchange between them on 11<sup>th</sup> February.
- 16<sup>th</sup> February investigator writes to Mr. Stanley-Wilkinson with summary of concerns.
- 19<sup>th</sup> February Mr. Stanley-Wilkinson responds to confirm they are accurate.
- 19<sup>th</sup> February – Head of Service responds to investigator with tracked changes to notes of their interview on 11<sup>th</sup> February 2016 "... surprised and concerned at the assertion that there was a toxic culture ... not supported by the recent staff survey findings of the relationship [management] and others had in the region." "There was an acknowledgement that in the past the team was significantly depleted ... issues were around the stresses of work rather than culture and conduct of managers."
- 26<sup>th</sup> February Investigator sends the draft report to HR Director for comment.
- 2<sup>nd</sup> March 2016 e-mail correspondence between the investigator and Dr. Lelliott among other things concerning which of them would provide feedback on the outcome of the investigation to Mr. Stanley-Wilkinson (it was concluded that it would be the investigator). As regards the recommended actions Dr. Lelliott notes: "I will take a few days to consider how to respond to the report – in terms of what action to take to address some of the shortcomings you have highlighted and to share the learning more widely."
- 3<sup>rd</sup> March 2016 the Whistleblowing/Speak up investigation is completed and a report is submitted to Dr. Lelliott and copied to HR Director: "Please find attached the final report..... [HR Director] advises that it is for you to consider the report and the recommendations. I am due to speak with the person raising concerns at the start of April, he is ok with this. It may be before I speak with him we have an opportunity to consider if you want me to report back on the management response, or

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<sup>35</sup> Amended and agreed by the Board 18 July 2012 updated 4 August 2014 V2

<sup>36</sup> February 2016 version not yet approved by the Board. Now Version 3.2 (Final) September 2018 on CQC Intranet under Working for CQC/Policies

whether you would like to manage this in another way.” The report concludes:

“The following recommendations are made to be considered by the deputy chief inspector responsible for the North East Mental Health Inspection team:

- The person raising the concerns should be given an overview of the findings of this investigation.
- They should be thanked for taking the time and the energy to raise the concerns affording CQC the opportunity to look and learn from them.
- There should be an apology that the person was not fully involved in the complaints investigation and outcome prior to the outcome letter being sent to the provider.
- Confirm that the decision not to publish the report was not in line with policy, and accept that this ran the risk of exposing those using the service to risk of potential harm.
- Confirm that the decision has been taken to publish the report.

It is recognised that the policy and methodology within the mental health inspection teams has developed, with improved “practice wisdom” and emerging policy as inspection activity increases. “The mental health inspection team should consider using the Whorlton Hall Hospital and the Waterloo Manor Hospital inspections as a learning opportunity and to identify whether the issues raised would now be addressed in light of current methodology and practice.”

3<sup>rd</sup> March 2016 Dr. Lelliott responded: “Thank you once again for this very prompt and thorough review... I will share this with [the Chief Inspector]. I attach a copy of my initial management plan – which I will discuss with [the Chief Inspector]. As you can see I propose writing to the person who raised these concerns after you have had the opportunity to talk with them.”

- 3<sup>rd</sup> March 2016 – Document attached to the email above entitled “Initial management response” provides the following details:

- ♦ Actions proposed in relation to the first three recommendations are: “[The investigator] has arranged to speak with the person in early April. I

would propose to follow this up with a letter from me after [the investigator] has talked to the person.”

♦ As regards the two recommendations about the non-publication of the 2015 inspection report the recommendations are: “This has been confirmed and acknowledged by the head of inspection NE”.

♦ As regards the final recommendation that the mental health inspection team should consider using the Whortlon Hall and Waterloo Manor hospital inspections as a learning opportunity the recommendation reads as follows: “We will certainly do this. As well as discussing the recommendations with the head of inspection NE, and sharing the lessons with the wider MH heads of inspection group, the specific actions are:

i.) To reinforce the message that inspection teams should decide well in advance of the site visit for a focussed re-inspection which KLOEs will be assessed and which, if any, ratings will be reviewed as a result of the inspection.

ii.) To revisit guidance about the minimum amount of assessment activity that must be undertaken to result in a review of the rating following a focussed reinspection of a service that has been rated previously. This has already been identified as a necessary task and is already under way.”

- 3<sup>rd</sup> March 2016 – email correspondence between the CQC investigator and Mr. Stanley-Wilkinson to arrange a meeting to give feedback on the outcome. Postponed by agreement of both until 4 April by telephone.<sup>37</sup>
- 4<sup>th</sup> April 2016 – 10.23am e-mail from Mr. Stanley-Wilkinson to CQC investigator cancelling 11am phone call and suggesting anytime from 11 April onwards.<sup>38</sup>
- 6<sup>th</sup> April 2016 – e-mail from the CQC investigator to Mr. Stanley-Wilkinson providing the feedback on the results of his investigation.<sup>39</sup> This records the following: “The investigation made a number of recommendations based on my findings and Paul Lelliott, on behalf of the directorate, and in agreement with [the Chief Inspector of Hospitals], *accepted the recommendations and has already acted on them. This includes some immediate action, for example to publish the Whorlton*

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<sup>37</sup> This is set out in (slightly redacted form) in evidence published by the JCHR at <https://www.parliament.uk/documents/joint-committees/human-rights/correspondence/stanley-wilkinson-resign.pdf>

<sup>38</sup> See footnote 35 above

<sup>39</sup> See footnote 35 above

*Hall Hospital report, although this had already been picked up before the publication of my findings.” (Emphasis added);*

“Paul and his team are also using the recommendations to secure long term learning and improvement and this includes reinforcing the message *around detailed planning in advance of the site visit for a focussed re-inspection – which KLOEs will be assessed and which, if any, ratings will be reviewed as a result of the inspection.*” (Emphasis added)

- Reports and data from the CQC Staff Surveys for 2014, 2015 and 2016 supplied to me in the course of my review. (The 2014 survey was used and referred to by the CQC internal investigator since the 2015 one had not been concluded at that point).

6.2 Although the Whistleblowing complaint in this case occurred in January 2016 after Mr. Stanley-Wilkinson had tendered his resignation but before he left CQC’s employment, it is helpful, in order to set it in context, to consider an earlier attempt to resign (by e-mail) on 22<sup>nd</sup> October 2015. This email was addressed to his then current line-manager with copies to his incoming line-manager and the head of service (North East). It set out in some detail, from his perspective, how his career within the CQC (and one of its predecessors CSCI) from April 2007 had progressed and how there had been little “career development” or “career pathway” over this time. In terms of his then current role he states: “I was relieved [sic] to be working within the hospital team as of December 2014. I know it has been difficult over this year with lack of managers and inspectors which has put a huge amount of pressure on those that have been there. ... although I thoroughly love the team and my managers I do however feel very let down by the organisation. I still have no career pathway, I have had no supervision... I feel all the positive energy I had for working for CQC has been taken from me through pure mental exhaustion.” He concluded the resignation email by informing the recipients that he had “... been offered a quality assurance managers job for [XXXX – a CQC registered provider].” At a meeting with his line manager and Head of Service the next day he was asked to reconsider the withdrawal of the resignation. It appears that there was recognition that he had not received the full support and supervision he should have had, including matters relating to health issues and the absence of an adoption plan. Based on reassurances from his managers that appropriate plans for supervision and support would be put in place he withdrew his resignation.

It is Mr. Stanley–Wilkinson’s contention that the promised support and supervision never happened. From the documentation I have seen, it certainly seems to be the case that there are no supervision records at all other than the one on 12<sup>th</sup> January 2016. Nor has any documented adoption plan been produced, although managers stated that support was provided.

- 6.3 I record this email and commentary both for the indication of concerns it expressed and also because it was sent some two months after the inspections of both Whorlton Hall and Waterloo Manor but no mention is made of them. Mr. Stanley–Wilkinson resigned later, on 15<sup>th</sup> January 2016, after returning from a 4 week period of sick leave.
- 6.4 As the timeline above indicates, Mr. Stanley–Wilkinson made his whistleblowing concern to a senior manager in CQC (not in the line management of his Directorate) on 26<sup>th</sup> January 2016. There was then a reply from that senior manager to Mr. Stanley –Wilkinson about “..what might happen next...” and recording that he had agreed that his concerns could be shared with the then Chief Executive (who, along with the Director of HR, had been copied into the initial whistleblowing email), the Director of Hospitals and Dr. Lelliott. Further emails between the senior manager and Dr. Lelliott were exchanged on 27<sup>th</sup> January who then commissioned, on 2<sup>nd</sup> or 3<sup>rd</sup> February 2016, an internal investigation headed by a Deputy Chief Inspector from the Adult Social Care Directorate (“the investigator”) to investigate.
- 6.5 The investigator sought advice from HR Directorate on 5<sup>th</sup> February 2016 about the correct policy to apply: “I understand that we are in the process of finalising our new policy, but it is not as yet signed off – as discussed ... for good governance I should be guided in the investigation by the existing [Whistleblowing] policy but of course take into account the principles of the new [Speak Up] one.” He also indicates that with the several documents which had been supplied with the whistleblowing email; “There is much information for me to study, but on the first skim read I do not think that I need to interview the whistle–blower further at this stage, although accept that I may need to later.”



6.6 On 16<sup>th</sup> February the investigator emailed Mr. Stanley–Wilkinson with his condensed version of his concerns recognising that it was stressful to raise the concerns and not wanting to add to this stress:

- “Bullying, hostile environment within the North East Mental Health team, including a failure by managers to support colleagues leaving them feeling personally bullied and for staff to leave.
- [details omitted as outside my terms of reference – relating to the inspection of an NHS Trust]
- [details omitted as outside my terms of reference – relating to the re-inspection of Waterloo Manor Hospital]
- Failure to publish the inspection report of **Whorlton Hall Hospital** which in the inspector’s views identified significant findings that compromised the safety, care and welfare of patients.
- Failure to handle complaints appropriately as evidenced by the response to the complaint made by the provider of **Whorlton Hall.**”

6.7 This was agreed as a summary of his concerns by Mr. Stanley–Wilkinson on 19<sup>th</sup> February 2016. I have excluded from this review, the two specific areas of the whistleblowing complaint related to different regulated services, but have included the overall complaint about bullying and toxic environment as this extended to all 3 specific cases and generally.

6.8 Most of the requirements under what was paragraph 5.7 of the old policy (and paragraph 5.5 of the new one)<sup>40</sup> were met through an exchange of emails with Mr. Stanley–Wilkinson although there is not a single document that does this. The investigator then proceeded to interview key people in relation to these complaints including junior and senior managers and another inspector. He also had access to the data produced by the 2015 Staff Survey for the Hospitals Directorate and the Mental Health North East part of that Directorate when considering the complaint. This had been referred to by the Head of Inspection when interviewed.

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<sup>40</sup> “Usually, within 10 working days of a concern being raised, the person investigating the concern will write to you:

- acknowledging that the concern has been received;
- indicating how the Commission proposes to deal with the matter;
- giving an estimate of how long it will take to provide a response
- saying whether any initial enquiries have been made;
- supplying information on support available to you; and
- saying whether further investigations will take place and if not, why not”

- 6.9 The survey recorded figures of only 9% positive responses (and 91% negative) to the question 77: "I have experienced harassment, bullying or abuse at work from other CQC staff in last 12 months". This figure was less than the overall figure for CQC that year (11%) and only marginally more than the hospitals directorate generally (8%), not statistically significant.
- 6.10 The investigator concluded his "Confidential Report [into the concerns raised by an employee of the Care Quality Commission in respect of the North East Mental Health Inspection Team] on 3<sup>rd</sup> March 2016. In the summary of findings he concluded as regards the first concern" It is not possible in the time or with the resources available to investigate the allegation that there is a toxic culture in the North East Mental Health Inspection Team. .... The findings of the staff survey for the ... team were generally positive, with positive results for staff engagement and staff satisfaction, while the outcomes around managers are variable ... and should be set in the context of high level of vacancy." He makes specific reference to the bullying figures quoted above (paragraph 6.9).
- 6.11 The summary continues "In considering the concerns which have been raised, it is clear that errors were made and these are drawn out in the report. However, there is no evidence or suggestion that there was any attempt to disregard concerns. When concerns were raised they were listened to, acted upon and decisions made in response. The rationale for the course of action was shared with the person raising the concerns; what is less clear is the extent to which the person agreed with or accepted the decision which was taken."
- 6.12 As regards the specific concern about the failure to publish the report on the 2015 inspection of Whorlton Hall, the investigator considers the issue of the size of the inspection team, recording the difference of opinion about this and the impact this had on the hospital provider at the time. He also notes that some of the team felt they were "rattling around" and that the planning, set-up and execution of the inspection was poorly managed but continues: "Regardless of this, the main thrust of the concern is whether CQC failed to publish the inspection report, and it is an irrefutable fact that, at the time of this investigation, the report has not been published. However, it is understood that this decision has been reviewed and a report

will be made available and published.”

- 6.13 In his report, the investigator concludes, in respect of this element of Mr. Stanley–Wilkinson’s complaint: “It is clear that there were identified risks to the people using this service, and these had been included in the draft report. In reading the draft there are perhaps issues with the balance of the report but overall it articulates the risks. Following the decision not to publish the report an inspection should have been scheduled immediately, or at least the most concerning issues shared with the provider. While there is no evidence to support that this approach is symptomatic of the North East Mental Health inspection team it has exposed people using the service and the CQC to risk. One of the greatest risks to CQC is the “time between knowing and doing” and the time lag in this case is simply too great.”
- 6.14 He further concludes: “It was clear the manager was grappling with a poor quality report, an inspection which was not balanced, a provider who was dissatisfied with the inspection and a genuine attempt to protect the credibility of CQC. It is understood that the decision has been reviewed and the report will be published.” (emphasis added)
- 6.15 As regards the element of the complaint which related to the failure to handle complaints appropriately as evidenced by the response to the complaint made by Danshell in respect of the 2015 inspection the investigator noted that: “... in line with good practice, the manager spoke with the author of the complaint in an attempt to get to the ‘nub’ of the issue. What this contact provided was a much more personalised complaint about the conduct and behaviour of two members of the inspection team.”
- 6.16 His report is critical of the conduct of the investigation of the provider’s complaint: “It is clear that the level of engagement by the manager with those involved in the inspection, and in particular the lead inspector, was not as good as it should have been. There were pressures in dealing with the complaint, including our own timeframes for doing so, along with the availability of key personnel. While the investigating officer cites these as pressures they nonetheless accept that fuller engagement should have taken place.”

- 6.17 However, the investigator considers that; "... it is clear from discussions [that he had], that the receipt of the complaint did not influence the decision to withhold the publication of the report." Finally, he concludes: "It is clear the person leading the investigation was not as fully engaged with the investigation of the complaints as they should have been, but there is no evidence this was borne of any ill intent. While there are some explanations as to why fuller engagement was not in place, the outcome was that the colleague felt "done to, not done with"."
- 6.18 In the overall conclusion the investigator, while noting that the colleague raising the concerns; "... found the final period of working for CQC difficult and stressful" concluded that: "I am unable to find evidence to support the suggestion that there is a culture in which the managers in the North East Mental Health Inspection Team are working outside the agreed policies of the CQC."
- 6.19 The report also makes conclusions about the stress and pressure that Mr. Stanley-Wilkinson was suffering at the time and the actions CQC management had taken to assist and also concludes that; "... there is no evidence to suggest that there was ill intent by any managers, but [it] was simply a way to manage a situation when concerns about the evidential basis of a report is questioned." He also notes that "some tension and uncertainty" had been created "while policy and methodology are developed in practice and therefore subject to change" in relation to the new team-based inspection method which required evidence to be "corroborated across teams".
- 6.20 The report then concludes with the recommendations, expressed as being "...made to be considered by the deputy chief inspector responsible for the North East Mental Health Inspection team" (emphasis added) as set out above (in paragraph 6.1; 3<sup>rd</sup> March 2016 entry). The words underlined possibly introduced an element of uncertainty about the nature or force of those recommendations. However, this uncertainty is significantly reduced by the clarity of the "initial action plan" with which Dr. Lelliott responded. This accepted all the recommendations and made very clear and firm commitments as to the subsequent action.

- 6.21 The investigator was then on holiday for the rest of March and, as the exchange of emails (published by the JCHR on the Parliament website) shows, he was then able to provide a summary of the outcome of the investigation and an indication of the management response in relation to the Whorlton Hall report publication issue which Mr. Stanley–Wilkinson had raised.
- 6.22 I have seen no further documents from CQC concerning the implementation of the “initial management response”. As I have noted before there is no reference to it at the SQAG meeting on 11<sup>th</sup> April 2016 for the 2016 inspection draft report, nor at the NQAG meeting on 20<sup>th</sup> May 2016 for which, the Head of Inspection (who had received a copy of the draft investigation report) and the Deputy Chief Inspector (who had both received the final investigation report and had responded with the action plan) were the respective chairs.
- 6.23 Indeed, I have seen no further correspondence or meeting notes to indicate whether, or to what extent, the initial management plan became a “final” plan and was then communicated to those who were to implement it. It may well be, for example, that there is, or was, documentation about the wider lessons to be learned from the Waterloo Manor and Whorlton Hall inspections (the final recommendation of the report) but I have not seen any evidence. It seems unlikely, given the responses made more recently by CQC following the 2019 revelations, that there is any evidence of implementation.
- 6.24 Finally, in relation to the narrative about the handling of the whistleblowing complaint, it should be noted that, contrary to the words of the initial management action plan in which Dr. Lelliott said;” I would propose to follow this up with a letter from me after [the investigator] has talked to the person.” no letter was ever sent from CQC management after the investigator had sent his summary email on 6<sup>th</sup> April 2016, to Mr. Stanley–Wilkinson.

## Chapter 7

### Analysis and Recommendations

- 7.1 In this Chapter I make a series of recommendations. Underneath each one I have set out my analysis of the relevant material from the narrative chapters which precede this chapter, together with other evidence I have obtained from interviews. Before this however, I wish to issue three warnings (or *caveats*) to the following analysis and conclusions.
- 7.2 The **first warning** is that I have had the benefit of hindsight: Not the “complete” hindsight I had hoped for since, there are significant gaps in the documentary and electronic records for the period 2015–2016; faulty or forgotten memories of the events themselves; and a range of interviewees which, despite being extensive, was not a complete ‘cast list’ of those involved in the events at the time. However, even with these restrictions, it is relevant to remember that I have written this report with the advantage of considerable hindsight and without the sort of pressures which were present at the time on those working in the hospitals directorate of CQC.
- 7.3 The **second warning** is to be aware of the organisational, legislative and regulatory context of the August 2015 and March 2016 inspections of Whorlton Hall Hospital (and the later whistleblowing complaint brought by the lead inspector of the 2015 inspection). To understand this context I consider it sufficient to rely upon the two relatively lengthy excerpts from CQC’s website from 2014 and 2015 I set out immediately below. They succinctly capture the nature and scale of the change programme and some of its consequences at that time.
- 7.4 The then chair of CQC said, in a media release for the annual report, in July 2014: "In 2013/14, we completely changed CQC’s leadership team, its organisation and governance, and began to develop a fundamentally different approach to risk monitoring, inspection and regulation. The next year is another significant moment for the organisation as we move from development to implementation of our new model. We are at the beginning of a long journey to excellence. We are heading in the right direction but it will take time to build and entrench an effective new approach to regulating health and adult social care. We are clear that our priority is the safety and quality of care that people receive and we believe that greater transparency

will help to drive improvements in standards. We are making progress and we are confident that, increasingly, those who need health and care services will be able to rely on our judgements, be informed by our ratings, be protected from inadequate care and benefit from a health and social care service that is continuously improving."<sup>41</sup>

- 7.5 CQC recorded that April 2015 brought “significant changes” to how they regulated 49,500 health and adult social care providers and services across the country. Providers would be required by legislation to follow new regulations called the 'fundamental standards', and new requirements for providers on being open about mistakes under the new 'duty of candour' and on securing that directors are 'fit and proper'. The regulations also included a new requirement for providers to prominently display their CQC ratings (Outstanding, Good, Requires Improvement or Inadequate) on their websites, premises, public entrances and waiting areas. The statement continued: “As the quality regulator, we’ll be responsible for making sure providers meet these requirements, and we’ll do this by continuing to carry out our new and better approach to inspections. These are expert-led and based on what matters most to people who use services – are they safe, caring, effective, responsive to people’s needs and well-led. ... While we’ve been inspecting the NHS, adult social care, and primary medical services using our new approach for some time, this April will see the formal roll-out of our new inspections for ... independent healthcare ....”

“When we find that people are not receiving – or are at risk of not receiving – the high standard of care that we expect and that they deserve, we will hold providers to account to make the required improvements. This will set a limited period for the provider to make the necessary improvements or to be prevented from providing the service anymore.”

“We are clear on our purpose, which is to make sure people receive safe, high-quality, effective and compassionate care and we encourage services to improve.”<sup>42</sup>

- 7.6 There had been senior recognition of the significant pressures that this necessary but substantial change to the way in which CQC regulated services

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<sup>41</sup> A year of learning and improvement for CQC: <https://www.cqc.org.uk/news/releases/year-learning-improvement-cqc>

<sup>42</sup> New regulations and responsibilities for CQC: <https://www.cqc.org.uk/news/stories/new-regulations-responsibilities-cqc>

had caused for those working at the front line of inspection. In July 2014 when the CQC's original inspection plan for 2014–15 had to be recalibrated following the failure to recruit and train sufficient numbers of inspectors in time, the then Chief Executive said that it had been “recalibrated” because “we have not recruited the numbers of staff during the early parts of this year we anticipated”.<sup>43</sup> In the same article it was reported that he had said that the decision to scale back inspections in the second half of that year was also a response to staff concerns about their workloads. “Mr Behan said some inspection teams had between two and four vacancies out of a full complement of eight. “Are we doing this to react to what our teams were telling us about the volume of work? Yes,” he said. “It’s not reasonable for me to expect them to operate as if they were fully staffed.”<sup>44</sup>

- 7.7 From the staffing details I have seen and from the interviews I have conducted with managers at all levels and inspectors, it seems that recruitment and staffing levels for inspectors and inspection managers were still significantly below their full level at the point when inspection (rather than more passive monitoring) of independent hospitals was activated in the North East Mental Health Directorate. As one manager recalled: “So 2015 is when we actually started to really develop [the inspection] teams, although we were still very much, ‘small’ in number ... and we also introduced independent health care inspection ... Whorlton Hall, I think was one of the first inspections under the new regime for an independent hospital in [the NE Region]. ” and another noted that: “I was looking after three teams [from the north to the south of the region] at that time....”
- 7.8 The **third warning** I must issue is that I have tried, so far as is possible within the conflicting forces of protecting personal data and being open about what I have found in the course of this review, to produce a full narrative of events. Inevitably however, there are some personal details relating to individuals that I have not included. There will always be differences of opinion between managers and managed staff about their respective competencies, approach and support. Occasionally prejudicial comments and negative judgments from both sides, (sometimes without directly verifiable

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<sup>43</sup> See Interview with CQC Chief Executive in Health Services Journal 30 July 2014: <https://web.archive.org/web/20160807064555/http://www.hsj.co.uk/home/cqc-to-slow-inspections-amid-staff-pressures/5073416.fullarticle>

<sup>44</sup> See footnote 43 above



evidence) were made. I have sought to avoid including any judgements about individuals and their motivations in the narrative (or this analysis) other than those which are both verified and necessary to justify a conclusion or support a recommendation.

### **Recommendation 1: Security and availability of notes from inspections**

- 7.9 CQC must ensure that secure and effective arrangements are in force for the collection and storage of physical notes and electronic records made in the course of gathering evidence at inspections.**

**These arrangements should be capable of producing both the documents/records and a reliable audit trail.**

**These arrangements need to operate both during and at the end of an individual's employment with CQC, and must ensure that data protection requirements are fully met.**

- 7.10 A crucial example of the problem this recommendation seeks to address was the problem of the missing "Inspector's notes" from the 2015 inspection. It is very clear that a driving reason behind the CQC management's concerns about the sufficiency of the evidence to support the draft report was that it appears that they could not obtain clear answers from the inspector nor evidence from the notes, nor the notes themselves (although the effort to secure these appears to have taken place mostly after the decision not to publish).**
- 7.11 Again, from the management perspective there were significant difficulties both with this inspection and with the focussed re-inspection of Waterloo Manor hospital which followed it, in terms of timeliness, quality of report-drafting and evidential support for the conclusions. Unsurprisingly, the inspector disputed, and continues to dispute these claims. There was a clear difference of opinion about the ability of CQC at that time to change the ratings for a service following a focussed re-inspection which had not examined all the KLOEs. In that case it was felt by the inspector and others that the improvements made by the provider, following the earlier inspection**

and enforcement action justified a re-rating to “Requires Improvement” from “Inadequate”. The notes from this inspection have also not been found in the CQC system.

- 7.12 In large part these difficulties in 2015–2016 can be attributed to the pressures at the time. These arose from the need to inspect a large number of independent hospitals in a relatively short period of time with insufficient numbers of experienced inspectors and junior managers while changes were being made to the new methodology and variable amounts of support were available to those in need of it.
- 7.13 However, for whatever reason (which remains unknown), the bulk of the notes of the 2015 Whorlton Hall inspection has never been found despite several written requests for their delivery and pursuit of them in the weeks after Mr. Stanley–Wilkinson left the CQC’s employment. Equally the former inspector has asserted (and there is some implied support for this assertion from emails at the time) that the notes were handed in to CQC at or about the same time as his laptop and other equipment were delivered to the Newcastle office on 5<sup>th</sup> April.<sup>45</sup> He is equally firm that no manager asked to see the inspection notes during the quality assurance processes which the draft 2015 report went through and that two earlier versions of the report (before those now published) were stored in the CQC electronic system. There is clear support for this claim in that there simply must have been at least one “initial draft” before the first one found in the CQC systems which is a version with peer reviewer comments tracked into it. His assertion is however, that the earlier drafts were lengthier and contained more detail about the findings but he had been told that they were too long and not the correct style. The absence of any documentary records and the conflicting testimony of those I interviewed means this is an issue I have not been able to conclusively determine. It emphasises the need for better and secure document and electronic record-keeping.
- 7.14 In this respect, I am aware that CQC has carried out a “sweep” of inspection documents in the course of this year to encourage inspectors to send in to CQC offices, old inspection documents that they have been holding at home

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<sup>45</sup> email 4<sup>th</sup> April from Mr. Stanley-Wilkinson to the internal investigator contains the following additional comment “Also I have some inspection notes still. Can you advise xxx I will drop them into the Newcastle office tomorrow.” Redacted copy published by JCHR on Parliament website: <https://www.parliament.uk/documents/joint-committees/human-rights/correspondence/stanley-wilkinson-resign.pdf>

(since most CQC inspectors are home-based workers). This has produced a significant amount of older and more recent inspection documents for scanning into the CQC record-keeping system.

7.15 I have seen multiple references to document handling, data security and confidentiality on the CQC intranet, in training materials and in their Code of Practice on Confidential Personal Information. For example, here is an extract from the intranet page entitled “Information security and why it’s important to CQC”:

“One of these principles (principle 7) requires that security is in place during the collection, use and storage of personal data. This principle has led to the requirement that all personal or sensitive data defined in the act must be encrypted when transmitted or transported outside of CQC, i.e. laptops, USB devices, optical media.

Paper based information that fits into this category obviously cannot be encrypted, but the act requires that mitigating controls are in place, e.g. locked briefcase, out of view of the public, vigilance that it is always in your possession or appropriately protected and only carrying the minimum required, not carrying it unless it is absolutely necessary.”

7.16 Given a widely dispersed inspectorate and manager workforce with substantial amounts of homeworking this is both a significant burden and a very significant responsibility. I have assumed that practices now, when an inspector leaves CQC’s employment, are much more standardised and rigorous than appeared to have been the case in respect of some of those I interviewed who left CQC at the time or shortly after the 2015–2016 period covered by this review. One manager described driving to collect the departing inspector’s “printer, laptop, docking station, screen ... the other bits that go with it. All the IT equipment I would bring back here [a CQC Office]” and “ I think inspectors have the option of dropping their equipment off at [any] office but managers still have to sign off to say ... that’s been done.”

7.17 However, many of those I spoke to about the processes on departure were rather vague about whether the paper records were separately signed off. I was told by a senior manager that there is no checklist for ensuring that all outstanding notes and other documents which a former employee should not be retaining have been handed in. Had this been a requirement in 2016 when

Mr. Stanley–Wilkinson left it might have at least been possible to confirm whether or not the notes from the 2015 inspection had been handed into CQC Newcastle business support team on or around 5<sup>th</sup> April 2015 as claimed.

**Recommendation 2: Improvements to the information provided to inspectors about services.**

**As part of the wider review being conducted by Professor Glynis Murphy and the work already underway in CQC to improve how they assess learning disability and mental health hospitals, CQC should consider what further improvements can be made to the systems that pull together information about a service.**

**Easy access by inspectors to all the information which CQC holds and receives about services is critical to the quality of inspections and reports.**

7.18 I am aware of both the parallel and wider review that was commissioned by the CQC after the Panorama programme and the immediate work being taken forward within CQ by the Whorlton Hall Co–ordination Group. Professor Murphy’s review “will make recommendations for how CQC’s regulation of similar services can be improved, in the context of a raised level of risk of abuse and harm.”<sup>46</sup> The immediate focus of the CQC’s internal group is to: “Begin the review and revision to specific regulation and monitoring methodology to support inspection teams. This includes ... focused and reactive well–led inspection methods ... Improving our intelligence monitoring capability (warning signs) for high–risk services types ... use of experts (professional and expert by experience) in policy, training and inspections ....”

7.19 It is clear, from the papers that I have seen in respect of both the 2015 and 2016 inspections, and from conversations with inspectors now, that improvements to the way in which information about services, supplied to CQC, is analysed (“intelligence monitoring capability”) and made available to

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<sup>46</sup> Update on independent review into regulation of Whorlton Hall: 19 June 2019  
<https://www.cqc.org.uk/news/stories/update-independent-review-regulation-whorlton-hall>

inspectors would be a significant benefit.

7.20 One of the issues that arose in the 2015 inspection related to the notifications which Mr Stanley–Wilkinson asserts were transferred to him by his inspection manager during the course of the inspection (and for which there is supporting evidence from both the CQC CRM system and the person at NHS England who spoke to the inspector about his notification). I have been told that the systems for assigning responsibility for considering notifications in relation to particular services are more structured now than they were in the early days of the new inspection methodology as applied to the independent healthcare sector in 2015. However, the processes are still, in my view, less than optimal for ensuring that serious and significant concerns such as the one raised by NHS England Improving Lives Team in this case are addressed sufficiently rapidly. Equally, the recording of conclusions following the receipt of these notifications and consequent audit trail was less than clear on the basis of the documentation provided to me for this review.

7.21 Second, despite a plethora of guidance and requirements for the writing of reports there appears to have been no guidance on how to inspect the type of institution that Whorlton Hall was. In the light of the BBC Panorama television programme, Dr. Lelliott produced “a paper<sup>47</sup> to support colleagues’ thinking about the risk factors for an institution providing services for people with a learning disability of autism at risk of developing “a closed and punitive culture:

**People stay for months or years and are highly dependent on staff to meet their basic needs.....**

**The staff group has a particular set of characteristics – including....high staff turnover; perhaps in the context of a core of longstanding staff, ... high use of agency or bank staff...**

**There is a lack of meaningful external scrutiny:** the service is isolated geographically and in organisational terms – the staff group are not exposed regularly to a wider, healthy culture. ... People living there are a long way from home.”

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<sup>47</sup> “Improving our assessment of the culture in services for people with a learning disability or autism”. Version seen dated 15 July 2019 produced for the Adult Social Care Directorate. Sometimes described as a “discussion guide”.

- 7.22 The paper then proceeds to list a number of warning signs in an institution with one or more of the characteristics listed above. These “include:
1. Whistleblowing notifications (or reports/complaints by people who use the service, carers or others who have visited) that state that; there is an unhealthy culture within the staff team....
  2. Safeguarding, incidents, complaints or other notifications; any form of inappropriate behaviour by staff towards people living in the service.....
  3. High or increasing use of restraint, seclusion or segregation ....
  4. A service providing care for people in some form of isolation from others ...
  5. Evidence of instability within the staff group – high turnover of staff, staff suspensions or dismissals, changes in management (including of the registered manager).”
- 7.23 This paper has now been converted into 29 pages of formalised guidance<sup>48</sup> including a flow diagram, published in October 2019 and valid until April 2020. Given the apparently expressed preference<sup>49</sup> for the results of the MHA Review that was conducted in November 2015 over the August 2015 draft inspection report findings, it is helpful that this new guidance applies equally to CQC inspectors and independent Mental Health Act reviewers.
- 7.24 I note that a number of the issues which this guidance highlights were raised in the 2015 draft inspection report; raised in the significant notification from the NHS England Improving Lives Team or; were recorded in the notes of the NPA and SPAs. All of this information was available within CQC and yet was not referred to by those carrying out the quality assurance processes (SQAG and NQAG). As a non-clinician, I am left with the uncomfortable conclusion that had this guidance been created earlier (after Winterbourne View for example) the opportunity to take regulatory action in relation to Whorlton Hall in 2015/2016 might not have been missed.

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<sup>48</sup> “Identifying and responding to closed cultures – Supporting information for CQC staff” Valid until April 2020. “Inspectors, Mental Health Act reviewers and other colleagues have been involved in developing the information which is relevant for anyone involved in regulating services – including Mental Health Act reviewers, inspection managers and heads of inspection, as well as inspectors.”

<sup>49</sup> See paragraphs 4.48 and 4.50 above.

### **Recommendation 3: CQC's Quality Assurance Processes for reports.**

**CQC should re-examine the quality assurance processes it has designed and applied to inspections and report-writing to ensure that they are delivering cost-effective, valuable "quality assurance" at the right points in the system.**

**I recommend this review take place as part of any response to this and the wider review of regulation being conducted by Professor Murphy rather than as part of the immediate work programme of the Whorlton Hall Co-ordination group. The review should examine whether more investment earlier in the regulatory/inspection process might not be a better use of time, money and management input than the current model which seems heavily focussed at the end of the process.**

- 7.25 The background to this recommendation comes from paragraphs 4.43 to 4.53 in the narrative about the 2015 inspection and paragraphs 5.16 to 5.28 for the 2016 inspection. It is to be expected that published reports will, to a certain extent, go through a number of drafts. In the CQC system in 2015/2016, it is not so much the number of drafts which is remarkable. Rather it is the timing, purpose and effect of each stage; the amount and detail of the knowledge or information available to the actors at each stage; and the costs to the organisation in terms of the quality "added" that is worthy of re-examination.
- 7.26 I am aware of the changes which have been made since 2015/2016 to the numbers of stages and names of the processes which now apply but it is worth considering the stages as they applied to the 2015 draft report and the 2016 report. It will be for Professor Murphy's wider review, which is examining regulation to the current date, to consider whether the processes now truly add value at the right points in the process with the right amount of information available to those involved. My own observation is that I was not persuaded that the SQAG and NQAG processes met that test.
- 7.27 In 2015/2016 the draft reports went through the following formal stages:
- Initial draft produced following inspection based upon notes of evidence obtained on the inspection and details from CQC systems (including more general national and regional guidance about particular issues –

although this was in development in respect of the independent sector at the stage of the 2015 and 2016 inspections)

- Peer review (in the case of the 2015 report – by a member of the inspection team)
- Report writing coaches – (this was not sought for every report and in the case of the 2015 draft only the summary section was commented on in detail as a guide)
- Line manager review (again reflecting national and regional guidance about particular issues)
- Subsidiary Quality Assurance Group examination
- National Quality Assurance Group examination
- And, in some cases, it appears that there was the possibility of re-submission to the SQAG or NQAG if substantial changes were required.

7.28 I have had the benefit of attending a telephone conference call-enabled SQAG “meeting”. This was considering draft reports from another region and involved a chair and members who had no involvement with the subject matter of this review. The process is time-consuming and involves significant input from senior management levels within the Hospitals Directorate since it is chaired by a Head of Hospitals Inspection (the management level directly below Deputy Chief Inspector level). It also requires attendance by an Inspection Manager and an Inspector unrelated to the reports under examination, plus a trainee Inspector as note-taker (and with others as required and pre-arranged). The inspector whose report is being “quality assured” also attends.

7.29 The process, which has evolved since the 2015–2016 period, still takes place after the Inspector’s report has been through a peer review stage (now made optional) and review by the line managing Inspection Manager. From August 2019 reports are now allocated to any SQAG – so no longer the specific SQAG of the region where the inspector works. This has been done to help reduce the “regional differences” in issues covered in similar reports across the country. Following the SQAG there may now be a further Management Review Meeting with further information required for the report to pass this stage. The report may then be re-submitted to the Head of Inspection and the panel which considered it – by e-mail, before being signed off.



7.30 The SQAG I witnessed involved none of the behaviours which were complained of by Mr. Stanley-Wilkinson in his e-mail of 3<sup>rd</sup> December 2015 in relation to the treatment of his draft report on Waterloo Manor, which also featured in his whistleblowing complaint after his resignation: “Staff feeling bullied and leaving as a consequence. It’s not for me to raise concerns for other people but this seriously needs looked into. I have attached a copy of an e-mail I sent following an SQAG to give an example of how I was left feeling.” Whilst not all those inspectors and former inspectors I spoke to about SQAGs conducted in 2015/2016 shared these views about the nature of the process, many of them did. As one former inspector recalled: “It wasn’t a very pleasant process to go through, the SQAGs ... it always feels uncomfortable... they were always done over Skype [non-video] like they are now and I think something like that, to discuss a report/investigation should be face to face because it feels very critical ... people are unpicking [the report], you are on the spot, trying to get your point across, trying to recall every bit really to explain your findings. Just not a very pleasant experience .... Very challenging, and again if you’re in the room with people it wouldn’t have felt so challenging, or at least where you can see people.”

7.31 Another inspector recalled that after the period covered by this review (2015/2016); “there was, I should say that there was ... a piece of work, I think it was a couple years ago about the SQAG process because a number of inspectors had flagged up that they had found that a difficult process ... I think it had come out of the staff survey, I can’t remember because I believe there was maybe a little working group or there was some work done around improving the SQAG process and making sure that its purpose was supportive. I think that was in response to some inspectors that [were] struggling with that challenging discussion. There was also some work done by the report writing coaches about how to peer review a report, things like not writing in red, not being really short in your questions and trying to make sure that peer review was supportive. So, there was acknowledgement that your work is scrutinised to such a degree that it’s quite a difficult process for people and they were trying to make improvements and changes so that the process was better.”

7.32 These comments tend to support the essence of the complaint made by Mr. Stanley-Wilkinson about the operation of the SQAG process in the North East region during the period of this review. However, it must also be recorded

that other inspectors did not identify their experience of SQAG examination as oppressive or bullying.

- 7.33 Another aspect which has changed is that those taking part in SQAGs now have access to the evidence notes stored in the central CQC system so, if they have serious concerns about the quality of the evidence to support judgments being made in draft reports, they can check for themselves. However, the pressures on their time in simply preparing for the SQAG with the number of reports to be read probably means that this does not happen frequently. It is, however, a notable improvement to the system in 2015/2016 where, in effect, the only person in the virtual meeting room who had access to the evidence base for the report was the inspector “defending” their report. It is this aspect of the “quality assurance” model which CQC has developed which causes me the greatest concern. It seems that a great deal of investment is being inserted into the process very late on (i.e. immediately before publication) where very few members involved have any direct real knowledge of the underpinning evidence in the report under consideration.
- 7.34 It is not within the scope of this review to examine this issue in detail. Suffice to say that while I appreciate some of the benefits which the SQAG/NQAG processes bring (better cross-regional/possibly national consistency of standards; possible identification of trends across a single provider/type of service; senior sign-off for the top and bottom ratings) I am left with two concerns. One of these was well expressed by a senior CQC manager that “these type of processes have been developed and added-to, often in response to external challenges to our reports”. Consequently the system has become process heavy or as they put it simply “CQC loves developing processes!”. The second is my concern that the significant investment of resources (staff time and costs) in this late-stage “challenge” process might be better directed earlier (i.e. investment at the front end of the process with inspectors and inspection manager review). Maintenance of a lighter but equally, if not more, effective nationwide-standardised assurance process, later in the system might then be possible.

- 7.35 **Recommendation 4: Legal advice (and possibly a policy) about non-publication of inspection reports.**

**CQC should urgently consider the potential benefit in producing legal advice, available across all Directorates about the Commission’s duties under section 46(1)(c) and 61(3) of the Health and Social Care Act 2008 to “publish a report”....**

**It should also ensure that policy advice on inspection methodology is clear and is consistent with the legislation in all respects. This also should apply across all operational directorates not just the Hospitals Directorate. The Board of CQC may wish to consider whether there should be Board oversight of decisions not to publish.**

- 7.36 Had the final draft report of the 2015 inspection not already been published by CQC (on 10<sup>th</sup> June 2019 in advance of an appearance by the Chief Executive and Dr. Lelliott before Parliament’s Joint Committee on Human Rights) this recommendation would have read “CQC should publish the (final draft) Report of the 2015 Inspection of Whorlton Hall”. This was not a difficult conclusion to reach since the CQC’s own internal review had recommended this back in March 2016 and it had apparently been accepted by CQC senior management then.
- 7.37 Given those circumstances, I was not persuaded by the contention that the existence of the 2016 inspection taking place at Whorlton Hall in the same month as the internal report and action plan were produced, meant that the better solution was to make 17 references to the 2015 inspection findings and the provider’s action plan in the published report of the 2016 inspection, in June 2016.
- 7.38 As the internal review concluded: “While there is no evidence to support that this approach is symptomatic of the North East Mental Health inspection team it has exposed people using the service and the CQC to risk. One of the greatest risks to CQC is the “time between knowing and doing” and the time lag in this case is simply too great.”
- 7.39 My efforts to obtain copies or details of any legal advice given to, and the policy advice sought after, the NQAG meeting on the 2016 inspection were

inconclusive. In the absence of any hard documentary evidence, this depended upon conversations with former members of CQC staff who understandably had no documents and only incomplete memories of the particular issue some 3 years on. I was told by another manager that legal advice had been given, to the Adult Social Care Directorate in a similar case, that the earlier report should be published even if the second report was then published shortly after.

7.40 I have also seen a sample of different legal advices to different inspectors and managers across the CQC in the 2015–2017 period, in relation to specific issues around the possible non-publication of a report. Almost all of these advised clearly against such a course of action. I am also aware of the MSI case where the publication of several reports of individual inspection reports which had taken place between April and August 2016 was delayed by a subsequent decision to conduct a “provider level responsive inspection” in response to identified concerns. “During the quality assurance of the reports of the registered location it became clear that whilst the inspections identified a number of positive factors they also identified some concerns linked to the provider’s governance arrangements.”<sup>50</sup> “It was decided that the individual location reports would be held back until all reports were ready and could be published together.”<sup>51</sup> They were then published together in December 2016. This, of course, was an option for the 2 Whorlton Hall inspections reports – which could both have been published in 2016 – either together or in sequence.

7.41 There will be exceptional cases of course where non-publication (or even just delayed publication) would be justified and lawful, but I have seen none of those exceptional characteristics in the draft Whorlton Hall 2015 report (now published). Indeed, the existence of the detailed action plan from the provider, the notes from 2 SPAs and the NPA which were retrieved from the CQC system and the ability of managers to speak to all those beyond the inspector who had been on the inspection meant that this was not such an “exception” to the duty to publish. As one senior and experienced regulatory manager said to me “... it’s always been the rule – ‘you step over the

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<sup>50</sup> See CQC website at: [https://www.cqc.org.uk/sites/default/files/new\\_reports/AAAF9029.pdf](https://www.cqc.org.uk/sites/default/files/new_reports/AAAF9029.pdf) p.2, column 1

<sup>51</sup> See CQC website at: <https://www.cqc.org.uk/news/releases/cqc-inspections-uncover-concerns-marie-stopes-international-clinics-so-specific>

threshold, you publish the report'....”

- 7.42 I was also informed by another Head of Inspection that CQC does not have a policy or process for this in the way that they thought other regulators have (e.g. Ofsted). I was told of examples where reports had not been published, or very substantially delayed: “Although it is very rare, several colleagues had experiences of this – reports overlooked or where the evidence was poor. The advice we always get from our legal team is that all reports must be published. Two colleagues had experiences of re-inspecting and then publishing the first report on one day and the new inspection report the following day. Others, including an NHS inspection, had taken the decision not to publish and had effectively run the whole process again.”
- 7.43 I was informed that there is a recognition that this is a gap in CQC’s policy and processes. I was informed that the response has been for a Head of Inspection in a corporate role to be tasked with “an action to ... get on and design and introduce a process for these rare situations.” I was told that this is to address both the absence of a policy and also the different regional approaches which have developed across the Hospitals Directorate.
- 7.44 I have serious concerns about this response. It is important to record that policy advice about how the approach fitted with the inspection methodology, rather than specific legal advice, was sought following the NQAG meeting into the 2016 report. This seems to me to be the wrong way round. Legal advice about the position of the Commission in not discharging its statutory duty under the Act was critical. For this reason it is essential that those responsible for developing “a policy” to fill this “gap” are first aware of the legal requirements and limits within which any such new “policy on publication” must sit.
- 7.45 Given the critical role that publication of what has been found on an inspection plays in protecting individuals from risk there may be considerable benefit in having readily accessible general legal *guidance* about the “duty to publish” (under s.46 and s.63(1) of the 2008 Act) available across the whole of CQC’s regulatory directorates. This legal guidance could take into account any potentially countervailing obligations, for example, “the need to ensure that action by the Commission ... is proportionate to the risks against which it would afford safeguards ...” (under s.4(1)(e) of the

2008 Act). It could also be set within some typical scenarios which have been revealed from the individual cases on which individual legal opinions have been sought to which I have referred above.

- 7.46 Clearly, this will never remove the need for specific legal *advice* in particular circumstances but the existence of such a general “line to take” might have focussed minds in 2015 when faced with the decision whether or not to make further efforts to improve the quality of the draft report rather than deciding simply not to publish it and instead to make a number of references to the findings in a later published report.
- 7.47 Furthermore, given the significance of non-publication, I consider that there is a case for Board oversight of decisions not to publish reports. This might alternatively be delegated to the Chair with details reported to the next Board meeting if timeliness became an issue. This would further strengthen the record-keeping which was noticeably absent in this case.

#### **Recommendation 5: Investigation of provider complaints**

**CQC should review its current approach for examining complaints to ensure that lessons have been learned from the shortcomings of the Whorlton Hall complaint handling in 2015.**

- 7.48 The complaint from the Danshell Chief Executive about the 2015 inspection came direct to the immediate line manager of the inspector, on 21<sup>st</sup> August 2015 who referred it to the head of service for guidance and was instructed to carry out some fact-finding and to provide a response to the provider. The details of the process, as far as the available records and individuals’ recollections provided, are set out in paragraphs 4.38 – 4.42 above. From that narrative and from the conclusions of the internal review it is clear that there were a number of issues with the process:
- The complaint investigation process took too long (from 21<sup>st</sup> August until 10<sup>th</sup> November 2015). However, given the staffing and inspection programme context at the time this was clearly an additional task assigned to an already very heavily loaded local manager.

- There appeared to have been no set procedure for the investigation of provider complaints, or at least none that was referred to, and little evident guidance from senior management.
- The selection of participants on the inspection to be interviewed was understandable but far from comprehensive nor, it turned out, particularly useful in dealing with the details of the complaint.
- The decision not to discuss or even show the draft response to the inspector was strange (and subsequently formed part of the grievance/whistleblowing complaint).

7.49 I am aware that CQC has developed a number of processes tailored to deal with different “complaints” (in the widest sense of the word). I summarise these below.

### **Complaints generally**

7.50 Changes have been introduced since the Danshell complaint was investigated in 2015. Complaints are now sent to the National Complaints Team which identifies the issues and tell the complainant how CQC proposes to handle the complaint. There are two avenues: either the first line resolution process where the complainant is told in 7 working days the action that will be taken “to consider the issues”; or, where an investigation is needed, a date for response is proposed (“usually within 30 working days”) and agreed with the complainant. This is a considerable improvement on the time taken in respect of the Whorlton Hall complaint. The complaint is investigated by someone not connected to the issues and the process is overseen by the National Complaints Team. A report is then sent to the complainant providing details of the findings and as appropriate what action has been taken or is planned to rectify the issue.

### **Complaints about ratings**

7.51 Complaints about inspection/ratings follow a separate formal review process<sup>52</sup> which explains that: “The only grounds (reasons) for requesting a rating review are that we have failed to follow our process for making ratings decisions. A rating review does not involve reconsidering the evidence and ratings awarded, unless there has been a defect in the process.” And a provider “... cannot ask for a review of ratings on the basis that you disagree with our judgments.”

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<sup>52</sup> See CQC website at: <https://www.cqc.org.uk/guidance-providers/ratings/requesting-review-one-or-more-cqc-ratings>

### **Factual Accuracy checks**

- 7.52 Although not perhaps technically considered to be “a complaint” it is worth remembering that draft inspection reports are submitted to providers before publication for “FAC” checks.<sup>53</sup> Again there is a very precise process specified for this to take place and clear limitations about the breadth of the challenges which can be made. It seems clear that some elements of the Danshell complaint might have been more properly dealt with under Factual Accuracy checking, had the draft 2015 report reached that stage (e.g. the challenge about the number of night staff – only 3 or all of them – eating dinner rather than observing the patients during the night visit).
- 7.53 It is beyond the scope of this review to examine these separate complaint processes. This recommendation is simply precautionary in nature; to ensure that, especially in relation to the general complaint process (paragraph 7.50), lessons learned from the 2015 investigation have been fully reflected in the current processes.

### **CQC Internal whistleblowing process**

**Recommendation 6: Recognising that this will be some 3½ years late I recommend that CQC formally write to Mr. Stanley–Wilkinson as recommended (and accepted by management) in relation to the second and third elements of the internal review of his whistleblowing concern:**

**“ They should be thanked for taking the time and the energy to raise the concerns affording CQC the opportunity to look and learn from them [and] There should be an apology that the person was not fully involved in the complaints investigation and outcome prior to the outcome letter being sent to the provider.”**

- 7.54 It is important here to re–state the terms of reference in relation to this particular issue: “To review and report to the Care Quality Commission (“CQC”) Board on how CQC dealt with concerns raised by Barry Stanley–

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<sup>53</sup> See CQC website at: <https://www.cqc.org.uk/guidance-providers/how-we-inspect-regulate/factual-accuracy-check-how-respond>



Wilkinson in relation to the regulation of Whorlton Hall; including in particular establishing ... How his concerns were addressed through CQC's internal grievance and "speak up" policies." It is not therefore the purpose of this review to conduct an inquiry into allegations of bullying or a toxic environment in the Hospitals Directorate, Mental Health North East Region in 2015–2016 (or indeed any other time) as alleged in the original complaint. My focus has been on how CQC investigated those concerns and allegations at the time, how it went about assessing and examining them and with what results. In the course of that review I have however, taken evidence from both the inspector, his colleagues and former colleagues, his managers and the independent internal investigator.

7.55 From the narrative I have set out in chapter 6, my conclusions on this aspect of the review can be relatively simply stated:

(a) The process applied to the investigation of Mr. Stanley–Wilkinson's complaint under the then applicable policies (existing, in force and new, awaiting Board approval) was good.

(b) The independent internal investigation, with two exceptions, met the "Good Practice" set out in Sir Robert Francis's 2014 Report "Freedom to speak up"<sup>54</sup>. It was very well organised and delivered without delay. The investigator displayed considerable sensitivity and humanity in dealing with the complainant and (from the documents I have seen) those whose conduct was questioned and produced a well–reasoned report.

The exceptions are first, that the individual selected for the role had a limited amount of time remaining as an employee of CQC and this time pressure may have influenced the decision (made early on) not to interview Mr. Stanley–Wilkinson (noting that this was agreed to by him). Second, that time deadline may also have limited the extent to which the allegations of "a bullying and toxic environment" were investigated. There was, in my view, an undue reliance placed on the results of the single bullying and harassment question in the 2015 staff survey rather than considering other indicators in the survey and conducting wider interviews with colleagues and others who had also left that directorate either on transfer to another part of

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<sup>54</sup> At page 130: [https://webarchive.nationalarchives.gov.uk/20150218150953/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU\\_web.pdf](https://webarchive.nationalarchives.gov.uk/20150218150953/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf)

CQC or completely. This perhaps provided an unjustified level of comfort in this aspect not least because the 2015 survey results were all significantly better than the very low level recorded in the 2014 survey when CQC had experienced considerable criticism. Interestingly, answers in the later staff surveys in 2016 and 2017 (obviously beyond the timeline of the internal review) reveal statistically significant indicators of concern with management.<sup>55</sup>

(c) The management response to the investigator's report, whilst good on paper, was almost completely defective in practice.

7.56 Sir Robert Francis noted in his report<sup>56</sup>: "One of the strongest messages from both individuals and organisations was that feedback after raising a concern is vital for both individuals and other staff in organisations. This should include *evidence of action being taken as a result of a concern or reasons if not* (emphasis added). Without feedback staff are unlikely to see the point of raising concerns in the future, there may be suspicion about action or inaction, and there will be lost opportunities for wider learning."

7.57 Although the complainant received summary feedback from the investigator the management action plan never delivered the "evidence of action" which it proposed. It may be considered to be of limited value now, nearly 4 years after the complaint was made, but at the very least I recommend that CQC write to the complainant as proposed in that original management action plan.

**Recommendation 7: Noting the updated CQC "Speak Up" policy (September 2018) CQC should consider building more confidence in the process by ensuring wherever possible that reports of the action planned or taken are part of the feedback to the complainant.**

7.58 Finally, during the course of my investigations for this review, I was made aware of the updated CQC Freedom to Speak Up policy (Version 3.2 –

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<sup>55</sup> For example - the 2016 staff survey records only 57% positive response in NE Mental Health Region to the statement "Senior leaders in CQC in my part of the organisation (Director and "Heads of") provide clear direction and leadership 19 points below Hospitals Directorate and 16 points below CQC overall. And for the statement "Overall I have confidence in the decisions made by Leaders in my part of the organisation" the result was 50%, 21 points below Hospitals Directorate and 20 points below CQC overall.

<sup>56</sup> See Footnote 54 above; at page 127, paragraph 6.4.21

September 2018). I have also had the advantage of discussing the past and current practice with the CQC Speak Up Guardian. It is encouraging that the policy now makes clear that “Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others)...”.

7.59 Where I think there might still be room for improved clarity in the policy, given the experience of this (admittedly) single and now dated case, is in relation to action taken as a result of an investigation. The current policy states: “Where [the investigation] identifies improvements that can be made, we will track them to ensure the necessary changes are made, and are working effectively.”

7.60 For this to be a truly transparent process I would recommend that those actions and changes are not only “tracked” by management but also reported back to the complainant(s) when they happen (where possible). From the discussions I have had during the course of this review, this lack of confidence in “actual change happening” following a complaint was referred to most frequently by individuals when asked why they had not pursued the “Speak Up” route.

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## **Acknowledgements**

I have been helped by many staff, former staff and contractors to CQC in the course of this review. I am also most grateful to those former Whorlton Hall staff who whistle-blew and those who visited from NHS England and raised concerns, for their assistance in understanding the material I have reviewed. Finally, my particular thanks go to Simon Richardson who provided such thorough and effective documentary searches and support, and to Natalie Adefowokan for all the logistic and organisational assistance she supplied to this review.

## **End Note**

I regret that this report is being published only now, in January 2020. Delays in securing interviews with key individuals during the summer holiday months of July and August and then suspension of publication of the report during the pre-Election period at the end of 2019 have postponed its presentation to the CQC Board until now.

David Noble QSO

January 2020

## **Annex 1 – Terms of Reference for review of how CQC dealt with concerns raised by Barry Stanley–Wilkinson**

1. To review and report to the Care Quality Commission (“CQC”) Board on how CQC dealt with concerns raised by Barry Stanley–Wilkinson in relation to the regulation of Whorlton Hall; including in particular establishing –

A. What concerns of abuse or harm at Whorlton Hall were raised by him in 2015, and how these were shared with CQC colleagues;

B. What happened in connection with the 2015 draft inspection report, and to concerns raised by Barry Stanley Wilkinson about Whorlton Hall and the draft report;

C. How his concerns were addressed through CQC’s internal grievance and “speak up” policies;

D. What impact decisions made in relation to the draft inspection report had on the subsequent 2016 inspection and report.

2. To make recommendations to the CQC Board in relation to any areas for change, improvement or development identified in the course of the investigation including, in particular, how concerns or disagreements that arise during the inspection or report writing stage are managed within CQC’s regulatory decision making processes, and where they are handled within internal grievance and “speak up” policies

The report is to be presented to the CQC Board for publication and completed as soon as practicable.

Annex 2 – Call for documents (taken from the CQC Intranet) – see footnote 7 above

## **Do you have information relating to Whorlton Hall?**

**07/06/2019**

As you will be aware the CQC has commissioned an independent review into our regulatory actions relating to Whorlton Hall from the start of 2015 to May 2019.

**As part of this an internal team has been established to collect, collate and summarise all the documentary evidence during that period. This will enable us to ensure we have all the facts and ensure conclusions and recommendations for improvement are based on these.**

Whilst there are many documents we can obtain from CRM, Y Drive etc., we need to be sure we have had the opportunity to review everything so we are asking all colleagues to review their personal drives, emails and desktops as well as any paper records they have that may relate to this location during this period.

I want to emphasise that this review is about our systems and processes and how they support us to do our jobs. It is not about judgements on what documents colleagues may or may not have kept. Hopefully everyone will have seen [Ian Trenholm's message](#) setting out clearly that the review is about learning.

Our ask is for everyone to review any documentation they have in any form that relates to Whorlton Hall and contact the team at [@cqc.org.uk](mailto:@cqc.org.uk) and we will advise you what to do next.

**There is a tight turnaround for this so it would be helpful to have any documents by close of play on Monday 17 June 2019.**