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10 years since Winterbourne View: a decade of human rights failures

31 May 2011: BBC Panorama exposes the systemic abuse of autistic and learning-disabled patients at Winterbourne View, a private hospital run by care company Castlebeck. Six staff members were imprisoned for crimes against the residents. Families and campaigners call for the end to institutional care for people with learning disabilities and / or autism, and campaign for people to be cared for in their own homes in the community.

October 2011: a Care Quality Commission ('CQC') inspection reveals the widespread abuse of residents with learning disabilities and autism at Veilstone and Gatooma, care homes run by Atlas Project Team in Devon. Residents were punished by the use of bare and unsanitary seclusion rooms, physical restraint and psychological abuse by staff. Twelve staff members were later convicted of criminally mistreating residents.

June 2012: the CQC publishes its national overview following inspections of learning disability services. This found that 48% of 150 inpatient services failed to meet the CQC's basic standards of care, welfare and safeguarding.

7 August 2012: the Department of Health publishes Transforming Care and its *Winterbourne View Concordat Programme of Action*. At the time of the report, 3,400 people with learning disabilities were inpatients in NHS funded facilities. Transforming Care commits that all hospital placements for people with learning disabilities and / or autism would be reviewed, and that everyone inappropriately placed in hospital would move to community support no later than 1 June 2014.

4 September 2012: South Gloucestershire's Safeguarding Adults Board publishes its Serious Case Review into Winterbourne View. It recommends greater investment in community-based care to reduce the need for inpatient admissions.

October 2013: Connor Sparrowhawk, a learning disabled and autistic teenager, dies following a seizure in a bath at an NHS assessment and treatment unit in Oxford. The jury at his inquest found that his death had been contributed to by neglect and 'serious failings' by Southern Health NHS Foundation Trust.

1 June 2014: the government fails to meet its target of moving all people with learning disabilities and / or autism inappropriately detained in hospitals to community placements.

26 November 2014: Winterbourne View 'Time for Change' report by Sir Stephen Bubb, commissioned by NHS England, is published. The report found that 2,600 people with learning disabilities and autism were still living in inpatient settings. It called for patients to be discharged to the community and for hospital admissions to be prevented, on the basis that '*a hospital is not a home'*.

30 October 2015: NHS England publishes its Building the Right Support 'national plan' to develop community services and close inpatient facilities for people with a learning disability and / or autism who display behaviour that challenges. The three-year plan commits to reducing the number of people in inpatient units by 35 – 50% by March 2019.

March 2018: the NHS England lead for Transforming Care confirms plans to decommission just over 900 inpatient beds previously used for learning disabled or autistic people during 2018 / 2019.

2 October 2018: BBC File on 4 covers the case of Bethany, an autistic teenager locked in a seclusion room at a St Andrew's Healthcare Hospital in Northampton for almost two years. Bethany later received compensation for alleged breaches of her human rights.

January 2019: the NHS Long Term Plan reduces the Transforming Care targets to moving 35% of people out of hospitals and into the community by March 2020, and 35-50% by March 2024.

22 May 2019: undercover reporters at BBC Panorama expose the abuse and mistreatment of people with learning disabilities and autism at Whorlton Hall, an NHS funded unit run by Cygnet Health Care in County Durham. The footage shows staff swearing, mocking and taunting patients, and physically restraining them. The CQC had rated Whorlton Hall as "good" for its last inspection it in 2017. At this time 2,245 people with learning disabilities or autism remained inpatients in hospitals.

1 November 2019: the Joint Committee on Human Rights publishes its report on the detention of young people with learning disabilities and / or autism. The report finds that people living in hospitals and inpatient units regularly have their human rights violated.

March 2020: the government misses its target to move 35% of learning disabled and autistic patients to community settings.

April 2020: data shows that the number of learning disabled and autistic people in inpatient units has only fallen by 15% since 2015.

September 2020: staff at Yew Trees Hospital, a private mental health hospital run by Cygnet Health Care, are caught on camera dragging, slapping and kicking a learning disabled patient. The CQC had first identified concerns about the care and treatment of patients at Yew Trees in April 2019, but the unit was not closed until September 2020.

October 2020: the Care Quality Commission publishes its review of restraint, segregation and seclusion against autistic and learning disabled people in care settings. The review highlights the inhumane and undignified treatment of patients in hospital settings and recommends that learning disabled and autistic people be supported to live in their communities.

April 2021: NHS Digital data shows that the percentage of autistic people in inpatient mental health facilities has actually increased from 38% in 2015 to 56% in 2021. The average length of stay for an autistic person in an inpatient unit is 5.6 years.

May 2021: research by Mencap and the Challenging Behaviour Foundation (CBF) shows that 2,040 people with a learning disability or autism are still locked away in mental health hospitals, referred to by the charities as 'modern day asylums'. The research found that 355 people had been held in assessment and treatment units for more than 10 years.

26 May 2021: families of Winterbourne View residents write an open letter to Prime Minister Boris Johnson to demand better care for learning disabled adults. The letter raises the failures of the government to 'transform care', instead pointing to the "succession of missed deadlines, and broken promises, 10- years of pushing-back expectations at unimaginable human cost, all too easily ignored by those with the power to effect change".

June 2021: Barbara Keeley MP states in Parliament that, a decade after Winterbourne View, it simply is not acceptable that people are still detained, when they could and should be supported in the community. She calls for the government to provide bespoke packages of care and accommodation for learning disabled and autistic people, not institutions.