# Submission to the call for inputs on violence against older persons – 2023 HRC report

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## Introduction

The abuse and neglect of older people is a common feature identified by staff in English care homes.[[1]](#footnote-1) Their prevention is purportedly assured through regulation, public law duties and criminal legal sanction. Despite the pressing human rights issues raised and the significant amount of public monies involved in brokering arrangements for older people’s care and support, the legal surveillance of this expanding milieu is clumsy and underdeveloped.

## Meeting Older People’s Care Needs – the ‘Levelling Down’ of Care for Older People in the Aftermath of Covid-19

COVID-19 presented widespread challenges to the delivery of social care for older people, leading to concerns that older adults living in care homes would be even more vulnerable to abuse or neglect. Restrictions imposed such as suspension of visits by families, professionals, and the regulator, meant an inability to effectively monitor care homes. Visitors to care homes are an important source of ‘natural surveillance’ against such institutional failings, and statistics reveal a marked decrease during the pandemic in safeguarding referrals in relation to abuse or neglect in care homes.[[2]](#footnote-2) Moreover, family members have- and continue to be – routinely denied access to their loved ones in care settings, itself a form of abuse and arguably a violation of rights guaranteed under domestic law. Evidence also shows that this enforced separation has led to significant levels of deterioration in cognition among those who have dementia living in these settings, for example.[[3]](#footnote-3) These concerns have often led families and carers struggling to continue to provide care at home rather than risk moving to a care setting.[[4]](#footnote-4) Combined, these factors have subsequently led to more complex cases of abuse and neglect being uncovered by professionals.[[5]](#footnote-5) Notwithstanding, there is some evidence of good practice which promotes better outcomes for older adults living in care homes against abuse and neglect. For example, where there are specific safeguarding teams in local authorities and where different agencies with responsibility for safeguarding (such as social work, police, fire etc) are based in the same physical location, and where there are positive existing relationships between the care providers and local safeguarding teams.[[6]](#footnote-6)

## Regulation of care provision is failing to detect and prevent abuse and neglect of older people.

Over the past forty years, the United Kingdom has experienced a shift from state provision of care to state-sanctioned provision, to manage the care of older people by a range of state, voluntary and private-sector organisations. In consequence, accountability for failures in care has in large part been diverted away from government. This is despite its significant under-resourcing of health and social care and its inadequate investment in the care workforce; both have emerged in tandem with a substantial growth of private sector, profit-driven providers. Instead, the regulators are held responsible for failing to identify and respond effectively to abuse and neglect. Many care scandals in the past 10 years have been exposed by investigative journalists rather than by the regulators through the exercise of their statutory functions.[[7]](#footnote-7) Even if a care home is identified by a regulator as providing inadequate care, there is no bar in law or policy to placing older people in such settings. The regulatory process through which a care home is de-registered can be lengthy and cumbersome and leaves older people at ongoing risk of neglect, even after harmful care has been identified and investigated.

Of concern is the ‘blanket’ use of *Do Not Attempt Cardiopulmonary Resuscitation* (DNACPR) in respect of older people in nursing homes. In its 2021 report, the Care Quality Commission (CQC) noted that the percentage of nursing home residents with a DNACPR recommendation in their medical notes increased from 74% to 92% between March and December 2020.[[8]](#footnote-8) This increased recording of DNACPR recommendations was not accompanied by safeguards, i.e. effective involvement of the person concerned in making the decision and clear evaluation of the clinical implications of resuscitation. This practice is in breach of Regulation 13 in England to protect people from abuse and neglect.[[9]](#footnote-9) Despite this widespread practice, the CQC has not reported on the range or frequency of remedial actions taken against providers.[[10]](#footnote-10)

During 2021, the CQC responded to criticisms with a shift in its methodology to a more ‘dynamic’ model of regulation, which it claims will be evidence-based and data-driven.[[11]](#footnote-11) It has committed to focus more closely on institutions with ‘closed cultures’, described as “a poor culture in a health or care service that increases the risk of harm”.[[12]](#footnote-12) We are concerned that the government’s reliance on the regulator as the organisation responsible for preventing abuse and neglect in institutional care settings in an increasingly unstable care market is erroneous and will struggle to ensure effective safeguarding of older people when instances of neglect are so widely tolerated within the sector.

## Criminal law measures are inadequate to address elder abuse and neglect.

The transition to a regulated market in care for older people has facilitated entry into the care sector of individuals who may lack the bona fides needed in terms of financial stability, health and welfare expertise and integrity. Attribution of criminal responsibility is rarely possible save in relation to very small business concerns, due to the requirement in many criminal offences of having a ‘guilty mind’. Nevertheless, the market is growing exponentially  to include  complex corporate chains and shadow- arrangements.

In the case of Operation Jasmine, 63 older people died in privately-owned care homes. Prosecutions against the owners for manslaughter or wilful neglect did not proceed as the Crown Prosecution Service formally advised that there was insufficient evidence to support a reasonable prospect of prosecution, in part because the deaths of older people were considered difficult to connect causally to the allegations of neglect. Charges for fraud and breaches of health and safety law were brought but did not proceed, resulting in an enduring sense of injustice for the families. It is almost ten years since a review of the neglect of these older people was published.[[13]](#footnote-13) It highlighted the absence of corporate social responsibility in the context of health and social care provision; endemic poor management of companies responsible for the homes; and weak corporate safeguards despite the public interest associated with the care of frail, older people. There remains a compelling case that egregious breaches of care standards should result in the disqualification of company directors, thereby giving ‘teeth’ to the corporate social responsibility provisions of the Companies Act 2006.

It is remarkable that low paid employees may be prosecuted and barred from future practice whereas owners and/or directors are typically left untouched; they may even acquire new directorships. The Law Commission has indicated that a potential option for remedying the gap in legal provision could lie in the creation of a new “failure to prevent” ill-treatment and/or neglect offence that could be targeted at care providers.[[14]](#footnote-14) This would enhance the process of establishing wrongdoing in the large and volatile market of care provision for older people. We are convinced of the need for seismic change not only because of the shortcomings of existing protective arrangements, but also because legislation frequently exhibits a symbolic as well as an instrumental function; the institutional abuse of vulnerable individuals is an all too frequent occurrence.

1. Cooper et al, “Do care homes deliver person-centred care? A cross-sectional survey of staff-reported abusive and positive behaviours towards residents from the MARQUE (Managing Agitation and Raising Quality of Life) English national care home survey” (2018) PlosONE <https://doi.org/10.1371/journal.pone.0193399>). [↑](#footnote-ref-1)
2. LGA, “COVID-19 adult safeguarding insight project: findings and discussions” (2020) available at: [www.local.gov.uk/sites/default/files/documents/25.177\_Insight%20Project\_layout\_FINAL%20WEB.pdf](http://www.local.gov.uk/sites/default/files/documents/25.177_Insight%20Project_layout_FINAL%20WEB.pdf) (accessed 27 February 2023). [↑](#footnote-ref-2)
3. University of Manchester and NIHR, ‘The Impact of Care Act Easements under the Coronavirus Act 2020 on older carers supporting family members living with dementia at home’ (November 2022) available at: https://documents.manchester.ac.uk/display.aspx?DocID=64273 (accessed 25 February 2023), 17. [↑](#footnote-ref-3)
4. Ibid. [↑](#footnote-ref-4)
5. Laura Pritchard-Jones, Monique Mehmi, Mark Eccleston-Turner, and Alison Brammer, ‘Exploring the changes and challenges of COVID-19 in adult safeguarding practice: qualitative findings from a mixed-methods project’ (2022) 24 (3/4) Journal of Adult Protection 132-148. [↑](#footnote-ref-5)
6. Ibid. [↑](#footnote-ref-6)
7. See, e.g. Panorama, Undercover Hospital: Patients at Risk, 2022; Dispatches, Bupa Care Homes Undercover, 2017; Panorama, Nursing Homes Undercover, 2016; [↑](#footnote-ref-7)
8. https://www.cqc.org.uk/sites/default/files/20210318\_dnacpr\_printer-version.pdf [↑](#footnote-ref-8)
9. Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 [↑](#footnote-ref-9)
10. The regulator provides limited information: only 7 prosecutions are reported as having taken place for breaches of Regulation 13, for example, and data on other measures (e.g. compliance notices, warning notices etc.) is not publicly available. [↑](#footnote-ref-10)
11. <https://www.cqc.org.uk/news/stories/update-cqcs-regulatory-approach> (2022) [↑](#footnote-ref-11)
12. CQC, How CQC Identifies and Responds to Closed Culture, 2022 (https://www.cqc.org.uk/guidance-providers/all-services/how-cqc-identifies-responds-closed-cultures). [↑](#footnote-ref-12)
13. Flynn, M. In Search of Accountability: A review of the neglect of older people living in care homes investigated as Operation Jasmine, 2015, Cardiff: Welsh Government. [↑](#footnote-ref-13)
14. Law Commission, Corporate Criminal Responsibility: An Options Paper, 2022, p114. [↑](#footnote-ref-14)