



Safeguarding adults at risk of harm: A legal guide for practitioners



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Introduction	1
Definition of 'vulnerable adult'	1
'Abuse'	1
The local authority as the lead coordinating agency	1
Who should read this guide?	1
Protection, justice and empowerment	2
Approach to the law in this guide	2
Summary of the guide	2
A Case studies	4
B Legal framework	43
Part 1: No secrets and using the law	43
1 No secrets guidance	43
2 Protection, justice, empowerment and the law	43
3 Legal action and complaints	43
1 No secrets guidance	44
1.1 Key points	44
1.1.1 Definitions	44
1.1.2 Protection, justice and empowerment	44
1.2 Legal status of the <i>No secrets</i> guidance	45
1.2.1 Local authorities should follow the guidance	45
1.2.2 Courts' acknowledgement of the guidance	45
1.2.3 Underlying legislative basis	45
1.2.4 Status of the guidance for other organisations	45
1.3 Vulnerable adults	45
1.4 Abuse	46
1.4.1 Vulnerable adults entitled to protection of law	46
1.4.2 Crown Prosecution Service guidance	47
1.5 Self-neglect	47
1.6 Psychological abuse	47
1.7 Perpetrators of abuse	47
1.8 Location of abuse	47
1.9 Decisions about intervention	47
1.9.1 Stranger abuse	48
1.10 Inter-agency working	48
1.10.1 Providers and regulators	48
1.10.2 Importance of local policies	48
1.11 Information sharing	49
1.12 Safeguarding Adults Boards	49
1.13 Overall principles	49
1.14 Protection, justice and empowerment	50
1.14.1 Achieving protection and giving people a voice	50
2 Protection, justice, empowerment and the law	51
2.1 Key points	51
2.1.1 Balancing exercise and presumption of mental capacity	51
2.1.2 Working together with people, not compelling them	51

2.2	Empowerment and protection: giving people information and choice	51
2.2.1	Empowerment part of the law	51
2.2.2	Choice as against compulsion as a last resort	52
2.2.3	Human rights and choice	52
2.2.4	Mental capacity, autonomy and choice	52
2.2.5	Ability to communicate choice because of coercion or undue influence	52
2.2.6	Community care assessments	53
2.2.7	Community care assessment directions: consulting with people	53
2.2.8	Community care: working with people, not compulsion	53
2.2.9	Disclosing information and consent	53
2.2.10	Criminal prosecution and consent	53
2.3	Protecting a person without consent (and with compulsion)	54
2.4	Proportionality in safeguarding	55
2.4.1	Striking a balance between protection and not interfering	55
2.4.2	Judging when to intervene	55
2.4.3	Proportionality: human rights and mental capacity legislation	55
2.5	Wider implications of law relevant to safeguarding	56
2.5.1	Vulnerable adults as perpetrators of harm	56
2.5.2	Protection of people who work with vulnerable adults	57
2.5.3	Legal protection of organisations providing services for vulnerable adults	57
3	Legal action and complaints	59
3.1	Key points	59
3.2	Finding the right bit of law	59
3.2.1	Knowledge of the law	59
3.3	Access to justice: taking legal proceedings	61
3.3.1	Who brings legal proceedings?	61
3.3.2	The prosecuting organisations	61
3.3.3	Victim, litigation friend, official solicitor	61
3.4	Criminal and civil standards of proof	62
3.4.1	Practical comparison of criminal and civil standards of proof	62
3.4.2	Professional conduct cases	62
3.4.3	Criminal and civil consequences for professional	62
3.5	Criminal justice	63
3.5.1	Range of offences	63
3.5.2	Role of the Health and Safety Executive	64
3.6	Civil legal remedies: judicial review and torts	64
3.6.1	Judicial review cases	65
3.6.2	Negligence: duty of care	65
3.6.3	Trespass to the person	65
3.6.4	False imprisonment	66
3.6.5	Vicarious liability	66
3.7	Making a complaint against a provider of services	66
3.7.1	Health and social care providers: complaints	66
3.7.2	Local Government Ombudsmen and the Health Service Ombudsman	66

	3.7.3	Housing providers: complaints	67
	3.7.4	Police: complaints	67
	3.7.5	Crown Prosecution Service: complaints	67
4		Human rights and safeguarding	69
5		Information sharing and disclosure	69
6		Whistleblowing	69
4		Human rights and safeguarding	70
	4.1	Key points	70
	4.1.1	Vulnerable adults	70
	4.1.2	Those working with vulnerable adults	70
	4.2	Human rights and safeguarding	70
	4.3	Public bodies and human rights	70
	4.3.1	Independent organisations carrying out functions of a public nature	71
	4.3.2	People's human rights in care homes	71
	4.3.3	Self-funding residents	72
	4.4	Article 2: Right to life	72
	4.4.1	Positive duty to take adequate steps to protect a person under Article 2	72
	4.4.2	Conducting an adequate inquiry or investigation under Article 2	73
	4.4.3	Positive actions and investigations to satisfy Article 2	73
	4.5	Article 3: Right not to be subjected to torture, or to inhuman or degrading treatment or punishment	74
	4.5.1	Threshold of treatment to breach Article 3	74
	4.5.2	Article 3 and safeguarding	74
	4.5.3	Leaving people in bodily waste	74
	4.5.4	Giving a voice and access to justice to a vulnerable adult	75
	4.5.5	Inhuman or degrading treatment: awareness of the person	75
	4.6	Article 5: Deprivation of liberty	75
	4.6.1	Avoid rescuing people only to perpetuate or cause more harm	75
	4.6.2	Importance of procedural safeguards	76
	4.6.3	The <i>Bournewood</i> case	76
	4.6.4	Guarding against professional lapses or misjudgements	77
	4.6.5	Deprivation of Liberty Safeguards	77
	4.7	Article 6: Right to a fair hearing	77
	4.7.1	Fair and speedy hearings for accused person working with vulnerable adults	77
	4.8	Article 8: Right to respect for a person's home, private and family life	78
	4.8.1	Article 8, qualified right: can be interfered with	78
	4.8.2	Article 8 and safeguarding	78
	4.8.3	Article 8: sometimes requiring a positive intervention	79
	4.8.4	Justifying an intervention under Article 8	79
	4.9	Article 10: Right to freedom of expression	80
	4.9.1	Article 10: qualified right, can be interfered with	80
	4.9.2	Publicity, privacy and safeguarding	81
5		Information sharing and disclosure	82
	5.1	Key points	82

5.1.1	Common law, human rights, data protection: sharing between agencies	82
5.1.2	Justification of disclosure decisions	82
5.1.3	Confidentiality and recognising when it can be breached	82
5.1.4	Individuals seeking information about themselves	82
5.1.5	Seeking information about other people	82
5.1.6	Data Protection Act 1998	83
5.1.7	Freedom of Information Act 2000	83
5.2	<i>No secrets</i> guidance and information sharing	83
5.2.1	'Need to know' principle	83
5.2.2	Not confusing confidentiality with secrecy	83
5.3.3	Knowing when to share information	83
5.3.4	Sharing information and linking complaints	84
5.4	Health and social care: Caldicott guardians	84
5.5	Making and recording of decisions by practitioners	84
5.5.1	Sharing of information: professional guidance and codes	85
5.5.2	Nursing and Midwifery Council on confidentiality	85
5.5.3	General Medical Council on confidentiality	85
5.5.4	General Social Care Council on confidentiality	85
5.5.5	Professional discretion or duty to disclose?	86
5.6	Law relevant to the disclosure of information	86
5.7	Specific legislation governing the sharing of information	86
5.8	Common law of confidentiality	87
5.8.1	The <i>Edgell</i> case	87
5.8.2	'Pressing need' test	87
5.9	Information disclosure and human rights	88
5.9.1	The balanced approach to disclosure	88
5.10	Disclosing personal information: Data Protection Act 1998	88
5.10.1	Data protection principles and 'sensitive personal data'	88
5.10.2	First set of principles: adequacy, relevance, purpose, accuracy, time etc	89
5.10.3	Second set of data protection principles: consent, legal obligations, vital interests, administration of justice etc	90
5.10.4	Third set of data protection principles: sensitive personal information	90
5.10.5	Vital interests	91
5.10.6	Statutory functions	91
5.10.7	Preventing or detecting an unlawful act	91
5.10.8	Sharing information within the same organisation	92
5.10.9	People seeking personal information in safeguarding matters	92
5.10.10	Accessing information about oneself: 'subject access'	92
5.10.11	People lacking capacity	93
5.11	Accessing personal information about somebody else: Freedom of Information Act 2000	93
5.11.1	Balance struck in Act: fairness	94
5.11.2	Exemptions from providing information	94
5.11.3	Exemptions: absolute, qualified and the public interest	94
5.11.4	Appeals to the Information Commissioner and Information Tribunal	95

5.11.5	Request for one's own and somebody else's personal information	95
5.11.6	Alleged perpetrator's request for information	95
5.11.7	Seeking information just about somebody else	95
5.11.8	Information given in confidence: absolute exemption	95
5.11.9	Information about dead people	96
5.11.10	Cost limits	96
6	Whistleblowing	97
6.1	Key points	97
6.2	<i>No secrets</i> guidance on whistleblowing	97
6.3	Confidentiality, secrecy and disclosure	97
6.4	Professional onus on practitioners to whistleblow	97
6.4.1	Nursing and Midwifery Council	97
6.4.2	General Medical Council	97
6.4.3	British Medical Association	98
6.4.4	General Social Care Council	98
6.5	Legal rules about whistleblowing	98
6.5.1	Victimisation and protected disclosures	98
6.5.2	Hierarchy of disclosure: employer and relevant regulatory body	98
6.5.3	Disclosure to the wider world	99
6.5.4	Reasonable belief etc	99
6.5.5	Justification of disclosure	99
Part 3:	Mental capacity and other interventions	102
7	Mental capacity	102
8	Inherent jurisdiction of the courts to intervene	102
9	Mental Health Act 1983	102
10	National Assistance Act 1948 and environmental health legislation	102
7	Mental capacity	103
7.1	Key points	103
7.1.1	Protection and empowerment	103
7.1.2	Five key principles	103
7.1.3	Challenge posed by unwise decisions	103
7.1.4	Care, treatment, restraint and deprivation of liberty	103
7.1.5	Lasting powers of attorney, deputies and the Court of Protection	103
7.1.6	Decisions that cannot be made in a person's best interests	104
7.1.7	Advance decisions about treatment: cover only refusal of treatment	104
7.1.8	Ill treatment or wilful neglect	104
7.2	Empowerment and protection	104
7.2.1	Protecting people	104
7.2.2	Empowerment, protection, unwise decisions and other legislation	105
7.2.3	Interface with other legislation	105
7.3	Five key principles	105
7.3.1	Capacity is issue and time-specific	106
7.3.2	Unwise decisions and safeguarding	106
7.3.3	Court's job is not to stop people with capacity taking unwise decisions	106

	7.3.4	Avoid assumptions of lack of capacity even in situations of risk	107
	7.3.5	Unwise decisions may be relevant to judgement about capacity	107
	7.3.6	Least restrictive option	107
7.4		Test for mental capacity	108
	7.4.1	Impairment or disturbance of mind or brain: issue and time-specific	108
	7.4.2	Capacity to take one type of decision but not another	108
	7.4.3	Fluctuating capacity	109
	7.4.4	Processing of information	109
7.5		Common law tests of capacity for particular matters	110
	7.5.1	Wills, gifts, marriage, sexual relations, medical treatment etc	110
7.6		Who makes decisions about a person's capacity and best interests?	110
	7.6.1	Determining who should be making decisions	110
	7.6.2	Protection for decision maker if reasonable steps taken	110
	7.6.3	Professionals taking reasonable steps	110
7.7		Gaining access to a person to assess mental capacity	111
	7.7.1	Lawful authority for assessment of capacity	111
	7.7.2	Making of interim orders and assessment for capacity	111
	7.7.3	Making of an interim order if reason to believe person lacks capacity	111
	7.7.4	Interim orders: for immediate, urgent decisions	112
7.8		Making 'best interests' decisions	113
	7.8.1	Taking account of what the person says	113
	7.8.2	Weight to be given to a person's wishes	113
	7.8.3	When wishes clash with best interests	114
	7.8.4	Drawing up the 'balance sheet' to determine best interests	114
7.9		Restraint	115
	7.9.1	Conditions necessary to justify restraint	115
	7.9.2	Protecting other people from harm	116
	7.9.3	Types of restraint and acceptability of restraint	116
	7.9.4	Unacceptable restraint techniques	116
	7.9.5	Getting policies and practices right on restraint	116
7.10		Deprivation of liberty	117
	7.10.1	Defining deprivation of liberty	117
	7.10.2	Factors that may indicate deprivation of liberty	117
	7.10.3	Three elements of deprivation of liberty	118
	7.10.4	Taking steps to avoid deprivation of liberty in the first place	118
	7.10.5	Minimising restrictions	118
	7.10.6	Restriction of liberty not the same as deprivation	119
	7.10.7	Transport and conveyance: restriction or deprivation	120
	7.10.8	Lawfully depriving a person lacking capacity of his or her liberty	120
	7.10.9	Court of Protection order required to deprive a person of liberty other than in hospital or care home	121
	7.10.10	Authorisation: the Deprivation of Liberty Safeguards	121
	7.10.11	Six assessments for a Deprivation of Liberty Safeguards authorisation of deprivation of liberty	121
	7.10.12	Procedural rules for standard authorisations depriving a person of liberty	122
7.11		Deprivation of liberty: Mental Health Act 1983	123

7.11.1	Treatment for mental disorder: 2005 Act or 2003 Act	124
7.11.2	Treatment for a physical disorder	125
7.12	Lasting power of attorney	126
7.12.1	Lasting power of attorney as a safeguard	126
7.12.2	Lasting power of attorney as risk factor	126
7.12.3	Lasting power of attorney: rules	127
7.12.4	Attorneys: implications of acting jointly or severally	127
7.12.5	Lasting power of attorney: safeguards	127
7.12.6	Validity and registration of powers	127
7.12.7	Common law duty of care on attorneys	127
7.12.8	Fiduciary duty of attorneys	128
7.13	Revocation of lasting power of attorney	128
7.13.1	Enduring powers of attorney	129
7.14	Court of Protection	129
7.14.1	Declarations, one-off orders and deputies	129
7.14.2	Advance decisions, deprivation of liberty	129
7.14.3	Statutory wills	129
7.14.4	Trigger for involvement of the court	130
7.14.5	Finances: state benefits and appointeeship	130
7.14.6	Application to the Court of Protection	130
7.14.7	Office of the Public Guardian	131
7.15	Advance decisions	131
7.15.1	Refusal of treatment	131
7.15.2	Validity of advance decision	131
7.15.3	Applicability of advance decision	132
7.15.4	Liability in relation to advance decisions	132
7.16	Decisions that cannot be made on behalf of a person lacking capacity	133
7.16.1	Marriage and sexual relationships	133
7.16.2	Courts' test of capacity for marriage and sexual relations	134
7.17	Independent mental capacity advocates	135
7.17.1	Who appoints independent mental capacity advocates?	136
7.17.2	People being placed in hospitals or care homes	136
7.17.3	Deprivation of liberty safeguards	136
7.17.4	Safeguarding and independent mental capacity advocates	136
7.18	Ill treatment or wilful neglect	136
8	Inherent jurisdiction of the courts to intervene	138
8.1	Key points	138
8.2	Inherent jurisdiction: adults at risk but with mental capacity	138
8.2.1	The position before October 2007	138
8.2.2	Vulnerable adults: undue pressure or coercion	138
8.2.3	Fear, duress or threat	138
8.2.4	Environment and circumstances preventing informed consent	139
9	Mental Health Act 1983	141
9.1	Key points	141
9.1.1	Detention	141
9.1.2	Guardianship	141
9.2	Definition of mental disorder	141

9.2.1	Learning disability	141
9.3	Short-term detention for assessment (and treatment)	141
9.3.1	Adhering to the rules for detention	142
9.4	Longer-term detention for treatment	142
9.5	Community Treatment Orders	142
9.6	Guardianship	143
9.6.1	Powers that come with guardianship	143
9.6.2	Conveyance, contact, deprivation of liberty under guardianship	143
9.6.3	Guardianship and people with learning disabilities: abnormally aggressive or seriously irresponsible conduct	143
9.7	Entry and inspection of premises	144
9.8	Warrant for search and removal	144
9.9	Removing a mentally disordered person from a public place	145
9.9.1	Up to 72 hours in a place of safety	145
9.9.2	Adhering to the rules	145
9.9.3	Informal mental health patients	145
10	National Assistance Act 1948 and environmental health legislation	147
10.1	Key points	147
10.1.1	National Assistance Act 1948, Section 47	147
10.1.2	Public Health Act 1936	147
10.2	Removal of a person from home: Section 47 of the National Assistance Act 1948	147
10.2.1	Compatibility with human rights	148
10.2.2	Human rights: Article 5	148
10.2.3	Human rights: Article 8	148
10.2.4	Department of Health guidance on Section 47	148
10.3	Protection of a person's property	149
10.4	Environmental health legislation	149
10.4.1	Public Health Act 1936	149
10.4.2	Environmental Protection Act 1990	150
11	Adult social services	154
12	Housing providers	154
13	Police, Crown Prosecution Service, coroners	154
14	Giving best evidence in the criminal justice system	154
11	Adult social services	155
11.1	Key points	155
11.1.1	Personalisation of care: balancing choice, risk and safeguarding	155
11.1.2	Provision of adequate services and wellbeing	155
11.2	The role of social services in safeguarding	155
11.2.1	Assessment, enquiries and 'investigations'	155
11.2.2	Definition of vulnerable adult linked with community care legislation	156
11.2.3	Legal underpinning to safeguarding investigations or enquiries	156
11.2.4	Community care assessment directions: working with people	156
11.2.5	Community care services: including help and support in safeguarding	156
11.2.6	Community care legislation and groups of people covered	156

	11.2.7 Urgent provision of support and services without assessment	157
11.3	Fair Access to Care Services: reference to abuse and neglect	157
	11.3.1 Risk to independence	157
	11.3.2 Abuse and neglect in top two eligibility categories	157
	11.3.3 Eligibility for other community care services	157
11.4	Legislation about informal carers	158
	11.4.1 Assessing and offering services to informal carers	158
11.5	Personalisation, direct payments and risk	158
	11.5.1 Empowerment of people	158
	11.5.2 Personal budgets and direct payments	158
	11.5.3 Risk assessment, personalisation and safeguarding	159
	11.5.4 Support for people receiving direct payments	159
	11.5.5 People choosing to take risks	159
	11.5.6 Limits to funding risk	159
	11.5.7 Distinguishing choice from abandoning people	159
	11.5.8 Risks, benefits and the law	160
	11.5.9 Legal protection for local authorities in negligence cases	160
	11.5.10 Direct payments: general safeguards	161
	11.5.11 Direct payments and criminal record checks	161
	11.5.12 Direct payments for a person lacking capacity	161
12	Housing providers	164
	12.1 Key points	164
	12.2 <i>No secrets</i>	164
	12.3 Homelessness	164
	12.3.1 Domestic violence as a priority category	165
	12.4 Housing allocation	166
	12.5 Home adaptations	166
	12.6 Possession proceedings to protect a vulnerable adult	166
	12.6.1 Options short of eviction	166
	12.6.2 Assured or secure tenancies	167
	12.6.3 Other tenancies	167
	12.7 Eviction of adults at risk of harm	168
	12.7.1 Guidance for local authorities on anti-social behaviour	168
	12.7.2 Equality Act, discrimination and eviction	169
	12.7.3 Importance of social services in averting a crisis necessitating eviction	170
	12.8 Housing-related Anti-Social Behaviour Injunctions	170
	12.8.1 Power of arrest attached to injunction	171
	12.8.2 Housing-related injunctions for breach of tenancy condition	171
	12.9 Anti-Social Behaviour Orders	172
	12.9.1 Against whom and on what grounds	172
	12.9.2 Length of order	172
	12.9.3 Application to court	172
	12.9.4 Order on conviction for another offence	172
	12.9.5 Safeguarding example	172
	12.9.6 Standard of proof for an Anti-Social Behaviour Order	173
	12.9.7 Special measures for witnesses	173
	12.9.8 Ancillary, interim, intervention orders	173

12.9.9	Vulnerable perpetrators and social services involvement	174
12.9.10	Understanding of the perpetrator	174
12.9.11	Closure orders, premises and drugs	174
12.9.12	Closure orders: standard of proof	174
12.9.13	Effect on vulnerable people of closure orders	175
12.9.14	Acceptable behaviour contracts or agreements	175
12.10	Difference between Anti-Social Behaviour Injunctions and Anti-Social Behaviour Orders	175
13	Police, Crown Prosecution Service, coroners	177
13.1	Key points	177
13.1.1	Police and Crown Prosecution Service	177
13.1.2	Other prosecuting authorities	177
13.1.3	Vulnerable adults in the criminal justice system	177
13.1.4	Sentencing rules and guidelines	177
13.1.5	Coroners	177
13.2	Police interventions	178
13.2.1	Police investigations and arrests	178
13.2.2	Entering and searching premises	178
13.3.3	Arrest without a warrant: prevention of harm and protection	180
13.4	Crown Prosecution Service: prosecution policies	180
13.4.1	<i>Code for Crown Prosecutors</i>	180
13.4.2	Prosecution: two-stage test	180
13.4.3	Victims' wishes	180
13.4.4	Prosecution against a victim's wishes	181
13.4.5	Protection, justice and empowerment	181
13.5	Witness intimidation	181
13.6	Older people: prosecution policy	181
13.7	Guidance on prosecution of crimes committed against people with mental health problems and people with learning disabilities	182
13.8	Domestic violence: prosecution policy	182
13.9	General support available for victims using the criminal justice system	182
13.9.1	Special measures for the giving of best evidence	182
13.9.2	Independent domestic violence advisers	183
13.9.3	Witness Care Units	183
13.9.4	Victim Support	183
13.9.5	Witness Service	183
13.9.6	<i>Code of practice for victims of crime</i>	183
13.9.7	<i>Prosecutor's pledge</i>	184
13.10	Sentencing	184
13.11	Coroners	184
13.11.1	Inquests, coroners and safeguarding	185
13.11.2	Production of reports and duties on other agencies to respond	185
14	Giving test evidence in the criminal justice system	187
14.1	Key points	187
14.2	Vulnerable and intimidated witnesses	187
14.3	Special measures under the Youth Justice and Criminal Evidence Act 1999	187

14.3.1	Video link	188
14.3.2	Intermediary	188
14.4	Support through the stages of the criminal justice system	188
14.4.1	Therapy for a victim	188
14.5	Admissibility of, and competence to give, evidence	189
14.5.1	Presumption of competence to give evidence, and displacement of that presumption	189
14.5.2	Giving sworn or unsworn evidence	190
15	Vulnerable suspects and offenders	191
15.1	Key points	191
15.1.1	Appropriate adults	191
15.1.2	Support for vulnerable defendants at trial	191
15.1.3	Diversion of offenders away from the criminal justice system	191
15.1.4	Conditional cautions	191
15.1.5	Sentencing and vulnerability of perpetrator	191
15.2	Appropriate adult for vulnerable suspects or perpetrators	191
15.2.1	<i>PACE Code of practice</i>	191
15.2.2	Mentally disordered or mentally vulnerable adult	192
15.2.3	Informing the appropriate adult	192
15.2.4	Clinical attention	193
15.2.5	Interviewing and signing statements	193
15.2.6	<i>Appropriate adult's role</i>	193
15.3	Support for vulnerable defendants in court	193
15.3.1	Vulnerable defendants and use of video link	194
15.3.2	Inherent power of the courts to ensure a fair trial	194
15.4	Prosecution of mentally disordered offenders	194
15.4.1	Alternatives to prosecution including cautions	194
15.4.2	Fitness to plead	195
15.5	Sentencing of vulnerable adults	195
15.5.1	Diminished responsibility	195
15.6	Conditional cautions and restorative justice	195
15.6.1	Conditions attached to the caution	195
15.6.2	Rehabilitation and restorative justice	196
15.7	Multi-agency public protection arrangements	196
15.7.1	Violent and sex offenders	196
15.7.2	Three levels of Multi-agency public protection arrangements	196
15.7.3	Cooperation between different agencies	197
15.7.4	Information sharing between agencies	197
15.7.5	Power to share information but avoiding pitfalls of excessive or unjustified sharing	197
15.8	Probation Service	198
	Part 5: Regulation of providers and the workforce	201
16	Regulation of social and health care providers	201
17	Vetting and Barring Scheme: regulation of workers	201
18	Criminal record certificates	201
19	Professional regulation	201

16	Regulation of social and health care providers	202
16.1	Key points	202
	16.1.1 Care Quality Commission	202
	16.1.2 Regulations and safeguarding	202
16.2	Standards of care and safeguarding	202
16.3	Care Quality Commission	202
	16.3.1 Warning notices, registration conditions, cancelling registration, prosecution etc	202
	16.3.2 Offences	203
16.4	Regulated activity	203
16.5	Health and social care	203
16.6	Reviews and investigations	203
16.7	Quality of services	204
16.8	Arrangements to prevent and respond to abuse	204
	16.8.1 Control or restraint	204
	16.8.2 Essential standards to safeguard adults at risk of harm and abuse	204
16.9	Unsafe care, nutrition, infection	205
	16.9.1 Nutrition and hydration	205
16.10	Infection control	205
16.11	Dignity	205
16.12	Suitable and sufficient staff, equipment and premises	206
16.13	Fitness of providers, managers and staff	206
	16.13.1 Information about managers and staff	206
	16.13.2 Recruitment procedures	207
16.14	Complaints system	207
16.15	Reporting harm to the Care Quality Commission (or National Patient Safety Agency)	207
	16.15.1 Death of a person who uses services	207
	16.15.2 Reporting injury, abuse, deprivation of liberty, police involvement	207
16.16	Safeguarding in the NHS	208
	16.16.1 <i>NHS and No secrets guidance</i>	208
	16.16.2 Reporting serious untoward incidents	208
	16.16.3 NHS provision of services under guidance and relevance to safeguarding	209
18	Criminal record certificates	211
18.1	Key points	211
	18.1.1 Enhanced disclosure	211
	18.1.2 Fairness in disclosure	211
18.2	Applying for a criminal record certificate	211
18.3	Type of information provided	211
	18.3.1 Standard disclosure	212
	18.3.2 Enhanced disclosure	212
18.4	Notification in the case of controlled activity	213
18.5	Implications for the employer of the disclosure	213
	18.5.1 Code of practice for employers	213

19	Professional regulation	215
19.1	Key points	215
	19.1.1 Professional bodies	215
	19.1.2 Code of conduct and practice	215
19.2	General Medical Council	215
19.3	General Social Care Council	215
	19.3.1 Sexual or financial impropriety	216
	19.3.2 Code of practice for employers	216
19.4	Nursing and Midwifery Council	217
	19.4.1 Reporting harm	218
19.5	Health Professions Council	218
Part 6: Finance and property harm		220
20	Criminal law: finance and property	220
21	Civil legal remedies for financial and property harm	220
20	Criminal law: finance and property	221
20.1	Key points	221
	20.1.1 Crimes against vulnerable people	221
	20.1.2 Common instances of crime	221
	20.1.3 Families and professionals	221
20.2	Financial crime and mental capacity	221
20.3	Theft	221
	20.3.1 Types of theft	222
	20.3.2 Perpetrator in professional position of responsibility	222
	20.3.3 Neighbours involved in theft	222
	20.3.4 Theft, gifts and mental capacity	223
20.4	Fraud	223
	20.4.1 Perpetrator in position of trust	224
20.5	False accounting	225
20.6	Forgery	225
20.7	Robbery	225
	20.7.1 Targeting vulnerable people and gaining their trust first	226
20.8	Burglary	226
	20.8.1 Distraction burglary	226
20.9	Cold calling on adults at risk: criminal offences	227
	20.9.1 Difficulties in prosecution	227
	20.9.2 Consumer protection, theft, forgery legislation etc	227
	20.9.3 Action against cold calling, doorstep selling etc	228
20.10	Suspicious activity reports	228
	20.10.1 Wide definition of money laundering	228
	20.10.2 Duty on banks and building societies	229
	20.10.3 Application to, for example, dishonest care workers	229
	20.10.4 Good practice guidance	229
21	Civil legal remedies for financial and property harm	230
21	Key points	230
	21.1 Undue influence	230
	21.2 Who will take a case?	230

21.2	Undue influence	230
21.2.1	Undue influence as a social trend involving older vulnerable people	230
21.2.2	Express undue influence	231
21.2.3	Presumed undue influence	231
21.2.4	Safeguarding interventions and undue influence	232
21.3	Lack of capacity: gifts and wills	233
21.3.1	Mental capacity and wills	233
21.3.2	Mental capacity and gifts	234
21.4	Relying on assurances or promises: proprietary estoppel	234
Part 7: Physical (and psychological) harm		237
22	Criminal offences: physical harm to the person	237
23	Sexual offences	237
24	Protective orders, injunctions and other interventions	237
22	Criminal offences: physical harm to the person	238
22.1	Key points	238
22.1.1	Assault, battery, manslaughter etc	238
22.2	Assault and battery	238
22.2.1	Assault: threat	238
22.2.2	Battery: unlawful touching	238
22.2.3	Assault, battery and safeguarding	239
22.3	Actual bodily harm	239
22.3.1	Type of injury	239
22.4	Unlawful wounding or infliction of grievous bodily harm	239
22.5	Common law offence of false imprisonment	240
22.6	Manslaughter	240
22.6.1	Involuntary manslaughter: gross negligence or recklessness	241
22.6.2	Voluntary manslaughter	242
22.6.3	Corporate Manslaughter and Corporate Homicide Act 2007	242
22.7	Murder	243
22.8	Attempted murder	243
22.9	Assisted suicide	243
22.9.1	Guidelines about assisted suicide	243
22.10	Wilful neglect or ill treatment	244
22.10.1	Wide application of the offences in the two Acts	245
22.10.2	Offences only apply in case of mental incapacity or mental disorder	245
22.10.3	Wilful neglect or ill treatment: Mental Capacity Act 2005	245
22.10.4	Examples of convictions under the 2005 Act	246
22.10.5	Wilful neglect or ill treatment: Mental Health Act 1983	246
22.10.6	Wilful neglect	246
22.11	Causing or allowing the death of a vulnerable adult	247
22.11.1	Where precise perpetrator is unknown	248
22.12	Harassment	249
22.12.1	Criminal offences associated with harassment	249
22.12.2	Protection from Harassment Act 1997	250
22.12.3	Criminal offence of putting people in fear of violence	250

22.12.4	Restraining order made by court	251
22.13	Health and safety at work legislation	251
22.13.1	Systems of work	251
22.13.2	Duty to non-employees under health and safety at work legislation	251
22.13.3	Poor health and safety practices putting vulnerable adults at risk	252
22.13.4	Relation of system of work to abuse and criminal offences	252
22.13.5	Reporting of injuries, diseases and dangerous occurrences	252
23	Sexual offences	254
23.1	Key points	254
23.1.1	Inability to consent	254
23.1.2	Ability to consent but vulnerable to inducement, threat or deception	254
23.1.3	Ability to consent but vulnerable to exploitation by care worker	254
23.2	General offences	254
23.3	Offences involving victims with a mental disorder	255
23.4	Victim unable, because of mental disorder, to refuse the sexual activity	255
23.4.1	Inability to refuse	255
23.4.2	Perpetrator knew or should have known about the mental disorder and the inability to refuse	255
23.4.3	Is capacity person or situation-specific, is it connected with irrational fear and what does inability to communicate mean?	256
23.4.4	Charge of rape or of special offence against victim with mental disorder	257
23.5	Sexual offences involving victims with mental disorder, irrespective of their ability to refuse the sexual activity	257
23.6	Sexual offences involving victims with mental disorder and care workers	258
23.6.1	Defining a care worker	258
23.6.2	Excluded situations: marriage, pre-existing sexual relationship	259
23.6.3	Conviction of a care worker: example	259
23.7	Sex Offenders Register and imposition of conditions	259
23.8	Sexual Offences Prevention Order	260
24	Protective orders, injunctions and other interventions	261
24.1	Key points	261
24.1.1	Civil orders but serious consequences	261
24.1.2	Less drastic solutions	261
24.1.3	Alternative to criminal proceedings	261
24.1.4	Orders against vulnerable adults	261
24.2	Protection from harassment	262
24.2.1	Civil remedies	262
24.2.2	Harassment: a course of conduct	262
24.2.3	Civil claim for damages for harassment	263
24.2.4	Restraining injunctions in civil proceedings	263
24.3	Elimination of harassment: Equality Act 2010	263
24.4	Non-Molestation Orders	263
24.4.1	Definition of molestation	263
24.4.2	Association between victim and perpetrator	264

24.4.3	Factors to be taken into account by the court	264
24.4.4	Urgency: application without letting the other person know	264
24.4.5	Undertakings given instead of an order	265
24.4.6	Breach of Non-Molestation Order	265
24.4.7	Non-Molestation Orders used against vulnerable adults	265
24.5	Occupation Orders	266
24.5.1	Association between victim and perpetrator	266
24.5.2	Duty or discretion to grant an order	266
24.5.3	Applicant who is entitled to occupy the dwelling	267
24.5.4	Matters that could be covered by an Occupation Order	267
24.5.5	Weighing up of factors by the court	267
24.5.6	Court's duty to make an order in case of significant harm	267
24.5.7	Urgency: orders without notice to the perpetrator and undertakings	268
24.5.8	Power of arrest attached to order	268
24.5	Forced Marriage Protection Orders	268
24.5.1	Definition of forced marriage	269
24.5.2	Making an order	269
24.5.3	Effect of the order	269
24.5.4	Who can apply for a Forced Marriage Protection Order? Application for orders by the person or other people	269
24.5.5	Urgency: giving an order without notice	270
24.5.6	Power of arrest	270
24.5.7	Undertakings instead of an order	270
24.5.8	Explanation of the rules: statutory guidance	271
24.6	Anti-Social Behaviour Orders and Injunctions	272
24.7	Common law injunctions	272
24.8	Inherent jurisdiction: injunctions	272
24.9	Seeking injunctions under Section 222 of the Local Government Act 1972	272

References

275

Introduction

This guide outlines the legal basis for the safeguarding of vulnerable adults at risk of harm in England.

The Department of Health (DH) commissioned this work in late 2009, and the document is up to date to December 2010. The DH was responding to requests from practitioners for a comprehensive guide to the legal framework underpinning adult safeguarding work. The DH has worked on the content of the paper alongside the main author. It is collaborating with the Social Care Institute for Excellence to create an easily accessible 'hub' for safeguarding materials to assist managers and practitioners in the exercise of their roles and responsibilities. This guide is an important element of the hub.

The guide is intended to give practitioners useful legal pointers but every case is different and should be taken on its own merits. Advice should be sought where necessary; the law is also constantly changing in terms of amendment of existing legislation, new legislation and legal cases.

Definition of 'vulnerable adult'

Vulnerable adults are defined by government guidance called *No secrets* as people (a) who are or may be in need of community care services because of mental or other disability, age or illness, and or (b) who are unable to care for themselves or unable to protect themselves from significant harm or exploitation.

'Abuse'

The guidance refers to harm in terms of 'abuse'. This might be physical, sexual, psychological, financial or material, neglect and acts of omission, discriminatory or institutional.

The local authority as the lead coordinating agency

Local social services authorities are the lead coordinating agency for safeguarding adults. These are Councils with Social Services Responsibilities (CSSRs), often known as Adult Services. Other organisations with responsibilities include the National Health Service (NHS), independent (private and voluntary) social and health care providers, housing providers, the police, the Crown Prosecution Service (CPS), the Probation Service and the Benefits Agency. Joint working between them all is seen as essential in safeguarding activity, including the appropriate (legal and proportionate) sharing of information.

Who should read this guide?

This guide is aimed primarily at practitioners working in various settings for organisations involved in safeguarding. But it may also be useful for volunteers, family carers and people with disabilities.

It aims to equip practitioners with information about how to assist and safeguard people. Knowing about the legal basis is fundamental, because the law defines the extent and limits of what can be done to help people and to enable people to keep themselves safe.

Assistance, and sometimes interventions, may prevent harm, reduce it or stop it by punishing or removing the person who is causing the harm. Information about the legal options can help practitioners think through what the most appropriate and effective course of action might be. In addition, practitioners will then be in a better position to talk about the options for people at risk of abuse – informed by the person’s perspective, concerns and individual circumstances – so that a decision can be made about what to do.

Sometimes there may be a choice of options, although a situation may be so serious that a particular course of action is both necessary and inevitable. Either way, it is important that the person being safeguarded or protected is, as far as practicable, informed about the decision making and kept aware of all new developments on an ongoing basis.

Protection, justice and empowerment

Government has pointed to three key concepts involved in safeguarding: protection, justice and empowerment (Minister of State, 2010). All of these are reflected in the law covered by this guide.

Approach to the law in this guide

This guide is intended to serve as a pointer to the law and to how it can be used. It tries to explain the law in reasonably simple terms, so it is selective and does not set out full details of each area of law covered. When it comes to the law, further advice will often be needed, but an awareness of it can help practitioners ask the right sort of question and explore possible solutions.

Summary of the guide

A series of case studies ('A') are included at the beginning of the guide.

The main part of the guide ('B') sets out the legal framework.

Part 1 outlines the government’s No secrets guidance and three key concepts of protection, justice and empowerment. It looks at the range of law available and how it can be used, at the importance of working with people in order to empower them and at the circumstances in which compulsion (as a last resort) may be justified. The distinction between criminal and civil law is made. It also refers to the importance of 'proportionality', that is, the balance between protecting people and being too intrusive in their lives (Sections 1–3).

Part 2 outlines and illustrates a number of key human rights. These include the right to life, the right not to be subjected to inhuman or degrading treatment, the right not to

be arbitrarily deprived of liberty and the right to respect for private and family life. It also covers legal issues about *passing on personal information* between organisations, and also what must be shown to people who ask to see their own information. *Whistleblowing* or raising the alarm is included because this has particular relevance to safeguarding vulnerable adults (Sections 4–6).

Part 3 covers the Mental Capacity Act 2005, illustrating its key principles in the context of safeguarding. Separately, this part also sets out a number of key interventions under the *Mental Health Act 1983*, and also under the *National Assistance Act 1948* (in relation to removing people from their homes) and the *Public Health Act 1936* (environmental health issues) (Sections 7–10).

Part 4 considers the role of key service providers. The role of *local social services authorities* is explained in relation to coordination of safeguarding activity at local level, enquiries or 'investigations' and community care services. The relevance of the law for *housing providers* is set out, including matters such as homelessness, possession proceedings (eviction) and Anti-Social Behaviour Orders (ASBOs) and Injunctions (ASBIs). A number of *police* interventions are outlined. The role of the *Crown Prosecution Service (CPS)* is explained, and how it approaches prosecution decisions in relation to vulnerable adults. The role of coroners and their relevance to safeguarding is also covered (Sections 11–15).

Part 5 looks at the regulation of social and health care providers under the Health and Social Care Act 2008. It also covers the regulation of individual workers in terms of a *Barring Scheme* for people working with vulnerable adults, *criminal record certificates* and *professional regulation* by bodies such as the Nursing and Midwifery Council (NMC) and the General Social Care Council (GSCC) (Sections 16–19).

Part 6 considers a range of criminal offences committed in relation to money and property, such as theft or fraud. It also looks at civil remedies, including 'undue influence' (Sections 20 and 21).

Part 7 covers physical (and psychological) harm. This includes a range of criminal offences such as assault, manslaughter, assisted suicide, ill treatment, wilful neglect, allowing or causing the death of a vulnerable adult, harassment etc. Sexual offences are also covered. In addition, a number of *civil orders* are explained, including protection from harassment injunctions, Non-Molestation Orders, Occupation Orders, Forced Marriage Protection Orders – and ASBOs and ASBIs (Sections 22–24).

A Case studies

The following case studies are designed as an introduction to this legal guide and as an illustration of how to use it. Government policy is that safeguarding adults at risk of harm should proceed on the basis of protection, justice and empowerment.

Empowerment

In the context of this guide, empowerment is about providing people with support, assistance and information, and enabling them to make choices and give informed consent. Protection is about keeping them from significant harm and justice enables them to exercise their legal rights or others to do so on their behalf.

Human rights

Legally, these principles are embodied particularly in the Human Rights Act 1998. Under human rights law a balance must be struck between the interventions of the state to protect people, and the right of people to live their lives without unwarranted or excessive interference, and to exercise autonomy and self-determination.

Mental capacity

In addition, under the Mental Capacity Act 2005 an assumption operates that people have the mental capacity to make their own decisions, unless this assumption can be displaced. And if a person does lack capacity, then assistance, support and intervention should be offered in the least restrictive way, in order to achieve a person's best interests.

What this boils down to practically are two principles that need to be borne in mind when working with vulnerable adults.

Principle 1: Self-determination and informed consent. There is a presumption that vulnerable adults will take their own decisions and that support, assistance, services and sometimes major intervention for an individual will be on the basis of that person's informed consent.

Principle 2: Proportionality and least restrictive intervention. Assistance and intervention should be based on a principle of proportionality and least intrusiveness. That is, the extent, nature and degree of a response should be commensurate with the extent, nature and degree of the risks in question.

How the case studies work

Each case study presents a situation before considering the relevant law, further details of which can be found in the main guide ('B').

The approach taken at the end of each case study is to consider, first, the law that underpins the rights of vulnerable adults to receive support, assistance, advice and

services – in order to explore choices and options. Sometimes this also relates to the right of the 'perpetrator' of harm toward a vulnerable adult to be supported.

Second, if less restrictive, supportive measures have failed, then further legal avenues are explored which may, as a last resort, entail compulsion or enforcement – again, in relation to both the vulnerable adult and any possible perpetrator.

Some of the case studies are based closely, and others more loosely, on real legal cases; still others are not derived from legal cases but are included to illustrate a particular issue.

Case study 1: Domestic violence and financial abuse

An 84-year-old man lives with his son and has always done so. He is gradually becoming more physically frail and has been diagnosed with Alzheimer's disease.

His son has mental health problems (he is bipolar) and uses drugs and alcohol excessively. Over the past few years, incidents of threatened, or actual, violence have been escalating. These are associated either with demands for money by the son or with drunken rages.

The father has been physically injured at times from punches, kicks and head butting. He became known to adult social services some years ago when he was finding shopping difficult. A home care service was withdrawn from him when the council raised its eligibility threshold for assisting people; instead, a neighbour now helps out with the shopping.

However, social services have remained in touch (with telephone calls every three months) because of the physical risk to the father.

The father has become so frightened at times that he has rung social services and his local councillor on a number of occasions – and, once or twice, the police. However, even when he has been assaulted, and after the initial fright has died down, he has steadfastly refused to make any official complaint against his son. As a consequence, the son has never been charged with any offence.

A social worker talks to the father about the risks of living with his son and the options about how he wants to manage this. They discuss options of providing support for his son for his mental health and drug use and finding him somewhere else to live. However, the father says his son has refused to consider living elsewhere. The social worker discusses his rights to have his son evicted and that he could be supported with this. However, the father has stated emphatically that he does not wish this; he feels guilty about certain things that happened in his son's childhood and partly responsible for his son's current problems.

The local authority also suggests to the father that if he will not talk to the police, he could seek an injunction in the form of a civil, Non-Molestation Order against his son. This would prohibit the latter from assaulting or threatening his father, with the threat of arrest if he breaches the order. The father is against this.

The local authority considers going to the High Court to ask them to grant an injunction having the same effect as a Non-Molestation Order. It is in two minds, however, as to do so would involve overriding the father's clearly stated wishes.

This situation continues for some years until the point is reached when social services, and the man's general practitioner (GP), take the view that the father may be losing mental capacity to make decisions about his living arrangements and about attendant risks. He continues, however, to express exactly the same wishes about his son that he always has.

Law to support the vulnerable adult and/or perpetrator

NHS and Community Care Act 1990, Section 47: In this situation, has a community care assessment been carried out in relation to both father and son? Both are eligible, because older people, and people with drug and alcohol problems, fall within the groups of people covered by community care.

No secrets guidance: Have the safeguarding aspects of this case been considered and the principles of protection, justice and empowerment upheld?

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Has consideration been given to the 'eligibility' of not just the father but also the son? This guidance is used to determine people's eligibility for assistance.

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: In this example, have advice and support for the father been offered and relevant services been identified? Has the need for an advocate been considered? Likewise for the son, because the 1948 Act covers both physical disability and mental health? Has the son been offered advice and support? If there are other family members, has a family conference been offered? Have alternative housing options been discussed for both?

Health Services and Public Health Act 1968, Section 45: In case the father is not considered to be sufficiently disabled to come under the National Assistance Act 1948, has similar advice and support been considered under the 1968 Act which covers older people in general, not necessarily those with a disability?

National Health Service Act 2006, Schedule 20: Have services and support been considered by social services staff for the son under Schedule 20 of the 2006 Act, which covers non-residential services for people with drug or alcohol problems? In this example, what services have been offered?

National Assistance Act 1948, Section 21: Alternatively, has any residential rehabilitation, for people with drug or alcohol problems, been considered for the son, as covered by Section 21 of the 1948 Act? Has consideration been given as to whether the son might qualify for such services?

Law that may involve compulsion or enforcement

Mental Capacity Act 2005: This Act governs assessment of a person's capacity, decisions to be taken in a person's best interests and applications to the Court of Protection for declarations and orders, including where a person should live and what contact they should have with others.

So, in this case, when it appears that the father is losing or has lost capacity to make some types of decision, has an assessment of capacity specifically in relation to safeguarding decisions been carried out? If the father is judged to lack capacity to make his own safeguarding decision, has a best interests decision been made, considering all the relevant issues? Has an independent mental capacity advocate (IMCA) been involved? Have all reasonable options been identified and considered? Has the final decision and the reasons for it been recorded?

And have the five key principles set out in Section 1 of the Act been taken into consideration: assumption of capacity, helping people take decisions, not assuming that unwise decisions indicate lack of capacity, acting in a person's best interests and giving consideration to the least restrictive option?

And does the documentation explain how this has been done?

Criminal offences: assault and battery: These offences have not been considered in the past, because the father did not wish to make a complaint. But now that he has lost capacity to decide about his living arrangements and the risk involved, further thought to prosecution might need to be given (always assuming there is sufficient evidence). With loss of capacity, other criminal offences may come into play at some point, for example, ill treatment or wilful neglect, under Section 44 of the Mental Capacity Act 2005.

Non-Molestation Order: An order could be available under the Family Law Act 1996, on application to a court by the victim. Has this been fully discussed with the father, to ensure he understands the implications?

Injunction: The High Court can exercise 'inherent jurisdiction' in cases involving a vulnerable adult. In some circumstances, a local authority could apply for an injunction under Section 222 of the Local Government Act 1972.

Has the local authority, and its lawyers, considered the advantages and disadvantages of applying for such an injunction, for example, weighing up the father's reluctance to support such a step against the degree of risk he is at from his son? And whether the father is, through coercion or pressure, not making a free choice? Has social services considered whether, *even with mental capacity*, the father is subject to any coercion and undue influence so that he is not making a free and informed decision for himself about what steps to take?

Case study 2: Capacity for personal relationships

A 39-year-old woman lives in supported accommodation (a group home) and receives substantial assistance and services from the local authority. Following the expression of reasonable concerns about her mental capacity to make the decision to marry or to decide where to live, her capacity to do this was assessed. The assessments concluded that she didn't have capacity to make these decisions. She is judged, however, to have capacity to engage in a personal, sexual relationship with her longstanding partner.

She has paranoid schizophrenia, characterised by visual, auditory and tactile somatic hallucinations. Stress makes things worse. She has limited insight into her illness, a moderate learning disability and poor cognitive functioning. She has significantly impaired or non-existent verbal recall and is functionally illiterate. Her childhood was one of chaos, emotional deprivation and sexual abuse by her older brother.

She met her partner some 15 years before at a homeless persons hostel. He has a diagnosed psychopathic personality disorder and has misused alcohol. Attempts to support him have failed because of a hostile attitude to professionals. He has led an unstable and nomadic life, to which she has been subjected; this has meant she has disengaged from psychiatric services and her mental health has then deteriorated. He has also been violent toward her and allegedly used her benefit money on alcohol.

Notwithstanding all this, the evidence is also that she derives immense psychological benefit from the relationship.

With this background in mind, the local authority is very concerned about her welfare. It has considered restricting her contact with him to two hours, supervised, each month. The authority was worried about the risks that might arise from more contact with him. These included non-compliance with medication and support, worsening of her mental health condition, homelessness and the domestic violence to which she had been subject in the past.

Resort is made to the Court of Protection; it points out that although the woman's physical safety is important, it is not everything, and that her happiness counts as well. The local authority's plan would, in the Court's view, be an excessive interference with her private life, notwithstanding the risks present. It would effectively terminate the personal, sexual relationship she has. The solution is to give the woman substantially more contact, including unsupervised contact, with her partner and for the local authority to provide extra support if this is required.¹

Law to support the vulnerable adult and/or perpetrator

NHS and Community Care Act 1990, Section 47: In this situation, has a full and proportionate community care assessment of the woman been carried out? Have sufficient attempts been made to engage with her partner and likewise to carry out a community care assessment? Both are eligible, she because of her mental health problems and learning disabilities, and he because of his mental health and alcohol problems.

No secrets *guidance*: Have the safeguarding aspects of this case been considered and the principles of empowerment, protection and justice upheld?

Guidance: Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care: Guidance on eligibility criteria for adult social care, England (2010): Has consideration been given to the 'eligibility' of not just the woman but also her partner? This guidance is used to determine people's eligibility for assistance.

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: In this example, have relevant advice, support and assistance been fully considered for the woman? And in particular, how could these be used to empower and enable her to maintain the relationship, while at the same time affording a degree of protection? Has the need for an advocate been considered? Likewise for her partner, because the 1948 Act covers mental health.

National Health Service Act 2006, Schedule 20: Have services and support been considered for her partner under Schedule 20 of the 2006 Act, which covers non-residential services for people with drug or alcohol problems? In this example, what services have you offered? How have you made the help accessible?

National Assistance Act 1948, Section 21: Alternatively, has any residential rehabilitation, for people with drugs or alcohol problems, been considered for her partner, as covered by Section 21 of the 1948 Act? Has consideration been given as to whether the partner might qualify for such services?

Human Rights Act 1998: Has proper consideration been given to human rights? Have staff applied Article 8 to the situation? Article 8 of the European Convention on Human Rights contains the right to respect for private life. Disproportionate interference with the woman's right to have a personal relationship with her partner, a relationship she has the capacity to have, would risk breaching Article 8.

Law that may involve compulsion or enforcement

Mental Capacity Act 2005: This Act governs assessment of a person's capacity, decisions to be taken in a person's best interests and applications to the Court of Protection for declarations and orders, including where a person should live and what contact they should have with others. So in this case, have local authority staff ensured that there are mental capacity assessments distinguishing, with evidence, between those decisions she can make and those she cannot? Where she cannot make decisions, are best interests decisions clearly formulated and recorded?

Has she been supported to make decisions? Has an IMCA been appointed? How have the wishes and the feelings of the person been considered? Where she can make decisions, have the staff clearly explained this and the implications? What options have been identified and how has she been supported to weigh up risks and benefits of her relationship?

And have the five key principles set out in Section 1 of the Act been taken into consideration: assumption of capacity, helping people take decisions, not assuming that unwise decisions indicate lack of capacity, acting in a person's best interests and giving consideration to the least restrictive option?

Mental Health Act 1983: Has consideration been given, if only to discount its legal appropriateness, to admission for treatment followed by a Community Treatment Order? Or, alternatively, to guardianship? Both are unlikely to be appropriate. Community Treatment Orders are primarily for 'revolving door patients', which she is not; most of the time she takes her medication and is compliant with the care plan.

Guardianship can require her to live in a particular place, but the main issue here is contact (with her partner), and guardianship is not primarily about regulating contact with other people. Inappropriate use of such interventions would raise human rights issues under Article 8 of the European Convention on Human Rights.

Case study 3: Hospital discharge

A 90-year-old woman was admitted to hospital with a severe urinary tract infection and following a fall, which although not breaking any bones, shook her up.

She lives alone in her own home. Although fiercely independent, she has been struggling for some years now to do the shopping and cleaning; more recently the neighbours have been concerned about her welfare including her nutrition, ability to wash, a degree of incontinence etc.

Social services has offered her some home care in the past but she has vehemently refused. She used to accept occasional help from one of her neighbours but recently she has declined even that.

Her stay in hospital becomes slightly prolonged, as the infection is more difficult to clear up than anticipated. It becomes quite clear that, probably as a result of a series of small strokes she has had over the last couple of years, that she has now a significant degree of vascular dementia.

During the treatment of the infection, she is adamant that as soon as she is better she wants to return home; this is even though a number of professionals involved, including the nurses, a geriatrician and a social worker, all believe that she would probably be better off in sheltered accommodation or even a care home. At the very least, if she returns home, they believe that she would require a significant care package; otherwise she will be at very high risk from infection, malnutrition and squalor.

She recovers from the infection and says she is going home and doesn't want any help. Some of the staff query whether she has the mental capacity to take this decision; they raise this particularly because they foresee disaster if she goes home unsupported. Other staff are adamant that she may be making an unwise decision but that she has capacity to make; she is simply obstinate and determined, as she appears to have been all her life.

A consultant psychiatrist comes to talk to the woman twice and concludes that she does in fact have capacity to go home which, in due course, she does. However, she has got to know the hospital social worker quite well (who is in complete agreement with the psychiatrist about her mental capacity) and agrees that she doesn't mind if social services checks up on her regularly. Social services do this and continue to offer support, even though she continues to decline it.

Law to support the vulnerable adult

National Health Service Act 2006, Sections 1–3: Have staff in the hospital provided assistance, support and help with planning a safe discharge for the woman? Have they been in contact, with the woman's consent, with their community colleagues including the woman's GP and the district nurses?

NHS and Community Care Act 1990, Section 47: Have social services staff, probably the hospital social worker, carried out a community care assessment on the basis of both past and present information about the woman?

No secrets guidance: Has a view been taken by social services staff about whether this is a safeguarding issue in terms of *No secrets*? Self-neglect, particularly when a person has mental capacity to take decisions, is not explicitly referred to in the guidance. But in any case, the local authority has to take a view so it is clear how it is going to try to support and assist the woman.

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly the woman's eligibility to be offered support and assistance? If so, this then governs the local authority's continuing duty to try to help her. The help may include, for example, the offer of a befriending service, a direct payment, contact with her local church or other organisation she was previously involved in.

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Have social services staff considered fully the range of advice, support and services they could offer the woman under the 1948 and 1970 Acts? What use has been made of the services offered by the voluntary sector? Have a range of relevant community-based options been identified and offered?

Human Rights Act 1998: Although some staff believe she lacks capacity, has the local authority clearly documented that not only does she in fact have capacity but that any heavy-handed intervention would risk breaching Article 8 of the European Convention on Human Rights? This Article allows intervention only if it is proportionate and according to the law; an intervention against the woman's wishes, in this particular situation, would not be according to the law.

Law that may involve compulsion or enforcement

Mental Capacity Act 2005: Has the local authority documented very clearly the conclusions it has reached in relation to the woman's mental capacity? In particular, the principles that capacity is assumed unless it can be shown otherwise, and that unwise decisions do not necessarily mean that the woman lacks capacity.

Case study 4: Manual handling of man by his parents with risk of injury

A 21-year-old man lives at home with his family; he cannot walk, talk, stand or care for himself. He sleeps downstairs on a sofa bed. His parents lift him out of bed in the morning; sometimes he is still carried up the stairs.

Occupational therapists from social services are concerned about the risk of injury both to him and to his parents. The nature of the dwelling makes major adaptations impractical and attempts to help the family move house have, so far, come to nothing.

The therapists offer the parents a portable hoist, so that they won't have to lift their son out of bed. The parents are keen, but the therapists express concern about how easy it will be to use the hoist safely with the sofa bed, so they offer the parents a hospital bed as well. The parents are not happy about this because it would effectively change what is a living room in the daytime into a permanent bedroom.

The parents request that social services give them a direct payment, so that they can take more responsibility for solving the problem, and the local authority, having given advice, can take a slight step backwards.

The therapists are extremely concerned, particularly about the son who, unlike the parents, is unable to take a decision about the risks being incurred because he lacks the capacity to do so. They consider what options are open to them including raising and progressing a safeguarding alert.²

They decide to raise an alert and to progress the case down the safeguarding route and even consider referring the matter to the police, without telling the family. However, they realise in hindsight that this was a mistake and largely counter-productive; it would have been better to hold a family group conference.

Within a family group conference wider members of the family would have been invited and the issue discussed, with an advocate representing the son. The family would have been invited to come up with the solution which the professionals would have considered and responded to. If the result was total disagreement between the family and professionals, then the local authority would have considered applying to the Court of Protection for directions, although only if the physical risk to the son had become so great as to outweigh all other considerations.

Law to support the vulnerable adult and/or perpetrator

NHS and Community Care Act 1990, Section 47: Have social services staff, including the occupational therapists, carried out a full community care assessment on the basis of both past and present information about the man and his family?

No secrets guidance: Has a view been taken by social services staff about whether this really is a safeguarding issue in terms of *No secrets*? Have they considered in this situation the distinction between a 'safeguarding' and a 'service provision' matter?

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly the man's eligibility for support and assistance?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Have social services staff considered the full range of options they could offer – advice, support, services, equipment, home adaptations.

Carers and Disabled Children Act 2000: Have the parents been offered a full assessment under the 2000 Act, exploring with them their needs and the different ways in which the local authority might assist them?

Housing Grants, Construction and Regeneration Act 1996: Have social services and housing staff considered, and discussed fully with the family, what possibilities there are for major adaptations that could alleviate the manual handling difficulties?

Housing Act 1996, Section 167: Have social services and housing staff looked fully into the possibilities of a move of house, and the priority of the family, for a move of house under the local authority's housing allocation functions – or in any other way?

Human Rights Act 1998: Has the local authority considered whether under Article 8 of the European Convention – the right to respect for private and family life – whether a safeguarding alert to the police, without talking to the family, would be a proportionate response to this situation? Or might it be disproportionate interference, at least at this stage?

Law that may involve compulsion or enforcement

Mental Capacity Act 2005: Has the local authority documented very clearly the assessment of the son's capacity? This would be particularly important because the staff's safeguarding concerns have been raised by his inability to accept the risk involved in the manual handling, a risk that, in contrast, his parents have the capacity to accept for themselves.

In addition, have staff considered fully the key principles in Section 1 of the Act? For example, the local authority is contemplating a course of action without his consent. In addition, has it explained how what it proposes to do is in the son's best interests and what it considers to be the least restrictive, yet effective, option?

Negligence: At the back of their mind, social services staff are worried that if a manual handling accident occurs and the son gets injured, they might be sued by the family.

Whatever they decide about the hoist and the bed, are the staff satisfied that they have documented the decision fully, explaining how they have tried to balance the competing practical and legal factors relevant to the situation? So that if something

does go wrong, and litigation is threatened, they can point to the reasoned, albeit difficult, decision that they took – and to its legal reasonableness?

Case study 5: Self-neglect

A woman with schizophrenia lives alone in a flat. Her family keep in touch. Mental health nurses visit regularly to administer medication. She is compliant with the care plan.

She lives in a state of self-neglect. The flat is dirty, damp and freezing. The flat smells. It is full of rubbish and largely unheated. She eats very badly and is in a state of malnutrition. She refuses to move to allow repairs, refurbishment or cleaning to be carried out. Vermin are occupying the flat with her.

Neighbours are concerned not only about the woman but also about the smell, fire risk and spread of vermin.

Members of the mental health team, which is a joint health service and social services team, are extremely worried that she is at high risk and that this could lead to her death. Despite many varied and continuing attempts to help her, she steadfastly resists. She has been consistently judged to have mental capacity to live in the way in which she does.

The team considers what the options are. These start from the continuing attempts to talk to her and to her family and to persuade her to allow them to make small modifications to her diet and to her flat. They consider, on the one hand, direct payments to enable her to direct her own support, as well as the involvement of advocacy and other voluntary sector support services. They also consider compulsory, proportionate, intervention.

Members of the team are aware of the acute physical risk to her; on the other hand, her capacity to determine how she lives should be respected. The team is aware that, whatever they decide, they have to work through the options systematically and explain how they have reached their decision.

Law to support the vulnerable adult

National Health Service Act 2006, Sections 1 and 3: The mental health team operates under both health service and social services legislation. Has it considered whether it is providing the woman with all reasonable and appropriate support under the NHS Act 2006? More particularly, is she receiving support and assistance as envisaged by the guidance on the Care Programme Approach for people with mental health problems? Under both its NHS and social services functions, has the team considered whether an advocate, or indeed anybody else, might be able to help and engage with the woman about how she is living?

NHS and Community Care Act 1990, Section 47: Under its social services responsibilities, has the team carried out a full community care assessment as to the woman's needs?

No secrets guidance: Has the team decided whether this is a safeguarding issue in terms of *No secrets*? Self-neglect, particularly when a person has mental capacity to take decisions, is not explicitly referred to in the guidance. But, in any case, a decision has to be taken about how the team is going to try to support and assist the woman.

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly the woman's eligibility for support and assistance under community care legislation?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Has the team considered the full range of options under the 1948 and 1970 Acts, including advice, support and services, which it could offer the woman?

Human Rights Act 1998: Has the local authority considered under Article 8 of the European Convention – the right to respect for private and family life – whether a possible compulsory intervention (see below) would be proportionate and justifiable, or disproportionate and unjustifiable?

Law that may involve compulsion or enforcement

Mental Capacity Act 2005: Has an assessment of the woman's capacity to live in this way been carried out and documented? So that the team can explain why, applying the key principles of Section 1 of the Act, they cannot intervene under the Act?

National Assistance Act 1948, Section 47: Has the team considered whether to use Section 47 of the 1948 Act? This allows, in some circumstances, removal to residential care of a chronically sick person from insanitary conditions in his or her own home, if they are unable to look after themselves. But care must be taken with this legal power to ensure that any use of it is compatible with human rights. Has the potential, together with limits, of this section been thought through? This is rarely used nowadays, because of concerns about human rights.

Mental Health Act 1983, Section 135: Has the team considered whether any intervention under the Mental Health Act 1983 would be appropriate? Is her choice of living thought to be associated with a mental disorder? Is she in need of mental health treatment? She is complying with her mental health care plan, but Section 135 of the Act allows removal to a place of safety of person with a mental disorder who is unable to look after themselves. Would this be a proportionate and appropriate response by the team if the risk to the woman has become very great, or would it be disproportionate and inappropriate no matter how great the risk has become and possibly breach human rights?

Public Health Act 1936: Have the staff considered whether the vermin in the dwelling would make an intervention by environmental health officers appropriate under the 1936 Act? If the woman also refuses to engage with them, might a court order be warranted, as a last resort, giving a power of entry to clean up the premises? Would a proportionate response be to focus on the premises, rather than on moving the

woman, in order to be more consistent in complying with the human rights of the woman?

Case study 6: Protection from local youths' anti-social behaviour

A physically disabled woman is the target of anti-social behaviour and harassment from local youths. She, and they, live on a housing estate. She is subject to persistent abuse in the street, to having her car vandalised, stones thrown at her window, rubbish put through her letterbox and her flat broken into.

She has tried to get on with life and not make too much of a fuss but over the last year she has made a number of increasingly desperate complaints to both the police and the local council.

The police and local authority get together to consider the options in terms of criminal offences, civil orders and possession proceedings by the council. These start with the gathering of evidence through putting up cameras, attempting deterrence through holding community meetings and police visiting neighbouring properties, youth workers organising a disability awareness course for youths linked to a social event involving go-karting and other attempts to identify and address the problem within the community.

If all this does not work, then legal measures will be considered, of escalating seriousness. If the case goes to court, the judge will ask for a victim statement, so that the person can describe her experiences to the court.

Law to support the vulnerable adult and/or perpetrator

NHS and Community Care Act 1990, Section 47: Under its social services responsibilities, has the team carried out a full community care assessment as to the woman's needs?

No secrets guidance: Have social services staff and police officers recognised the situation as a safeguarding issue in terms of *No secrets*? Have they engaged with the woman according to the principles of protection, justice and empowerment? Have housing staff been part of the safeguarding meetings and what options can they suggest? Has the woman been asked if she would like to be part of a strategy meeting? Has she been offered the help of an advocate to support her looking at options? What options has she been offered, and has she taken part in assessing the risks and benefits of the options?

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly the woman's eligibility for support and assistance under community care legislation?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Have social services staff considered the full range of options under

the 1948 and 1970 Acts, including advice, support and services, which it could offer the woman?

Law that may involve compulsion or enforcement

Criminal offences: Have police officers considered what criminal offences have been, and are, being committed? Have police officers visited the families and explained what criminal justice consequences there may be? For example, the criminal offence of harassment or fear of violence (both under the Protection from Harassment Act 1997, Sections 2 and 4), fear, alarm or distress under the Public Order Act 1986, the offence of burglary under Section 9 of the Theft Act 1968. Also whether any offences would be aggravated, as 'disability hate crime' (Criminal Justice Act 2003, Section 146), committed through hostility to a person because of his or her disability.

Potential injunctions/civil orders: Have social services staff considered whether, in addition or instead of possible criminal proceedings, a civil order or injunction might be possible? Has this been discussed with the woman, explaining the way in which they could work, the implications and how she could be supported and protected? For instance, she could apply for protection for harassment injunction under the Protection from Harassment Act 1997. The local authority could apply for an Anti-Social Behaviour Injunction (ASBI) under Section 153A of the Housing Act 1996. The police could apply for an Anti-Social Behaviour Order (ASBO) under the Crime and Disorder Act 1998, Section 1.

Housing Act 1985: possession proceedings: Have social services staff talked to housing staff about the possibility of possession proceedings against the perpetrators? Have warnings been issued, and families spoken to about the possibility that a consequence will be homelessness for the whole family as a result of the breach of tenancy?

Case study 7: Malnutrition and pressure sores in a care home

Within a space of a few days, five older people resident in a care home died from causes that appeared to be consistent with the effects of severe neglect, including malnutrition and pressure sores.

A serious case review was held after this had happened. Although it was obviously too late for the five residents who had died, it was important that genuine lessons were learned as to what could be done in the future to avoid this happening again.

The review made a number of key points. First, when the first resident was admitted to hospital, action was swift. Hospital staff had immediately raised a safeguarding alert. Within a week all residents had been removed, once it was clear how poor standards were at the home, although even this was not a kneejerk reaction. There had been a balancing of the safety of residents against the disruption of a sudden move.

It acknowledged that organisations such as a local authority, which place people in care homes, do rely on the grading given by the Care Quality Commission (CQC), but that, where the quality of a home is considered marginal, information should be sought from elsewhere, for instance, GPs or district nurses. Furthermore, those organisations that do place people in care homes have a duty to undertake regular reviews to make sure people's needs are being met safely and contractual obligations are being discharged.

The review also stressed the importance of good communication between relevant agencies, such as the local authority, the NHS and the CQC.

It also noted that a meeting held to share concerns about the care home at an earlier date was of indeterminate status, and nobody appeared to know what to do as a result.

A number of staff were referred by the local authority and CQC to the Nursing and Midwifery Council (NMC) and/or the Independent Safeguarding Authority (ISA).³

Law to support the vulnerable adult

NHS and Community Care Act 1990, Section 47: Do social services staff assess and reassess the welfare and needs of residents in care homes when concerns about their welfare arise? Will they assess 'self-funders' (people paying for themselves) if safeguarding concerns have arisen? The implication of the legislation is that they should do so.

Guidance: Prioritising need in the context of Putting People First (DH, 2010a) Has consideration been given to the 'eligibility' of residents of a care home even if they are self-funding?

National Assistance Act 1948, Section 21: Do social services staff regularly review and monitor residents whom they have placed in a care home under the 1948 Act, whether or not any specific concerns have arisen?

National Health Service Act 2006, Sections 1–3: Do NHS staff assess and reassess the welfare and needs of residents in care homes if a safeguarding concern has arisen, and if the NHS has placed the person in the care home because they have 'continuing healthcare' status? Even if the person has not been placed by the NHS, but the NHS is contributing financially 'funded nursing care' (£106.30 per week) for residents in a nursing home, will it respond to concerns? Even if no concerns have arisen, does the NHS regularly review those people it has placed in nursing homes?

Law that may involve compulsion or enforcement

Health and Social Care Act 2008: Is the CQC responding proportionately to concerns about a care home – in relation to its functions relating to the registration and regulation of healthcare and personal care providers?

SI 2009/3112. Care Quality Commission (Registration) Regulations 2009: Are care homes in the area properly reporting to the CQC serious incidents and deaths?

SI 2010/781. Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Do care homes in the area have adequate policies, procedures and practices to ensure the safety of residents?

Safeguarding Vulnerable Groups Act 2006: Are care homes in the area making appropriate referrals to the ISA, where staff have harmed residents (including through neglect) or put them at risk of harm, so the ISA can decide whether or not to bar such staff from working with vulnerable adults in the future?

Nursing and Midwifery Order 2001: Have any nurses implicated in serious neglect being referred to the NMC, with a view to possible sanctions being imposed on those nurses?

Mental Capacity Act 2005, Section 44: Wilful neglect or ill treatment: Possible criminal charge: Have police officers and the Crown Prosecution Service (CPS) considered whether to prosecute the offence of wilful neglect or even ill treatment, if a resident lacked mental capacity at the relevant time?

Mental Health Act 1983, Section 127: Wilful neglect or ill treatment: Have police officers and the CPS considered whether to prosecute the offence of wilful neglect or even ill treatment if a resident had a mental disorder at the relevant time?

Manslaughter (common law or under the Corporate Manslaughter and Corporate Homicide Act 2007): If the deaths of any residents are linked to 'gross negligence' have the police and CPS considered a criminal charge of manslaughter against an individual staff member or manager (in common law) or against the organisation (corporate manslaughter legislation)?

Negligence: Is the care home aware of the liability it may incur if it is sued in civil law, for negligence, in terms of the neglectful care of residents?

Case study 8: Petty theft by family member

A 90-year-old woman lives alone. Because of both a skin condition and a degree of urinary incontinence, she gets help from a private care agency once a week to have a bath. She has previously been assessed by social services as not eligible for help. But, other than that, she just about manages. Mentally she is as bright as a button.

For many years her favourite granddaughter, even as a child, visited twice a week and helped out with odd jobs around the house. Her granddaughter is now 20 and still visits. However, unknown to her grandmother she has fallen in with a bad lot and into bad habits; she now looks around for money in the house and takes it, sometimes with and sometimes without her grandmother's knowledge – but in any event without her consent. The grandmother says nothing although she is deeply upset.

There are no threats, or semblance of threats, being made.

Eventually she has a word with the paid carer who comes in once a week; with the woman's consent, the carer in turn gets in touch with somebody in social services. A social worker visits; the woman talks about what she considers to be stealing by her granddaughter. She is emphatic that she does not want the police involved; she still lays great store by what until recently was a special relationship with the granddaughter. She would be distressed if the police were to be involved.

The social worker talks to her manager. First of all they talk about whether she is eligible under the relevant criteria for assistance in relation to this safeguarding matter. Both are clear that although she was not in the past eligible for personal care assistance, the safeguarding matter alone means she has at least a 'substantial' need – and therefore she is eligible for assistance.

The manager suggests initially that a safeguarding referral be made and the police informed. The social worker is not happy about this, since the woman has mental capacity to make her own decisions, appears to be under no coercion and does not want to lay a complaint.

Furthermore, there is nobody else obviously at risk from the granddaughter. The social worker gets her manager to hold off informing the police for the moment and goes back to visit the woman. They reach a compromise; the woman is going to get a local locksmith to install a small hidden safe for her in the airing cupboard, in which to keep her money. If this doesn't work they will talk again about what to do.

In fact it does work; the social worker carefully records the decision that was taken – and why, in line with the interests and wishes of the woman, the police had not been informed. The woman continues to be visited by and to enjoy the company of her granddaughter.

Law to support the vulnerable adult

NHS and Community Care Act 1990, Section 47: Under its social services responsibilities, has the social worker carried out a proportionate community care assessment of the woman's needs?

No secrets guidance: In treating this as a safeguarding issue, have the social worker and her manager weighed up issues about protection, justice and empowerment, and struck a balance between them? A theft may have been committed, but they are aware that safeguarding is about working with people and empowering them to make choices about what to do.

Guidance: Prioritising need in the context of Putting People First (DH, 2010a) Have staff established clearly the woman's eligibility for support and assistance under community care legislation?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Has the team considered the full range of options under the 1948 and 1970 Acts, including advice, support and services, which it could offer the woman?

Law that may involve compulsion or enforcement

Theft Act 1968, Section 1: Criminal offence of theft: Are the social worker and manager aware of possible criminal offences, which would lead them to alert the police?

Personal information: disclosure: Data Protection Act 1998, common law of confidentiality, Human Rights Act 1998: Are the manager and social worker aware of the balancing act to be performed under these laws? On the one hand, the preservation of confidentiality and not sharing information without a person's consent; on the other hand, the public interest, in some limited circumstances, in sharing information without the informed consent of the person.

Case study 9: Observations by a hospital social worker

At an acute health service hospital, a social worker has become increasingly concerned about what he has been observing. Most of the wards, on which he sees patients and organises their discharge from hospital, he considers to be very good.

However, there are two wards in particular about which he has developed serious concerns. On these, he notices that at mealtimes, patients are not being helped to eat their food; on some occasions he has gone to talk to patients to find them lying in their own bodily waste, having apparently been in that state for some time and with no sign of nurses or healthcare assistants responding to the sound of call bells.

He has also become aware of how frequently patients are discharged prematurely, sometimes to potentially high-risk situations at home, and how often they are almost immediately readmitted to hospital.

He has raised the matter informally from time to time with the ward sister, but she has said that there is little she can do because she is short of both beds and staff. The social worker is aware of how hard the staff on the ward are working, but equally aware that, through no fault of their own, they appear to be putting the dignity and welfare of some of the patients at potential risk.

The social worker decides to raise a safeguarding alert about the matter.

Law to support the vulnerable adult

National Health Service Act 2006, Sections 1–3: Have staff on the ward been making sufficient efforts to raise with managers the problems they are having providing some of the basics of healthcare? Under the 2006 Act, there would be an assumption that services will be provided at least to a basic standard.

Clinical governance and adult safeguarding: an integrated process: guidance: Are staff on the ward adhering to this guidance from the Department of Health about the reporting of serious untoward incidents as well as raising safeguarding alerts in cases of neglect or abuse?

NHS and Community Care Act 1990, Section 47: Is the social worker carrying out assessments of potential community care needs (on discharge), and discussing the problems in achieving a successful discharge with staff on the ward, if these patients do not receive basic care?

No secrets guidance: Are staff on the ward aware of the *No secrets* guidance and that it states that the health service should be part of safeguarding activity?

Law that may involve compulsion or enforcement

Health and Social Care Act 2008: Are staff on the ward and their managers aware of the registration, regulation and standards of healthcare enforceable by the CQC? If repeated and constructive attempts to raise the matter with the hospital have not resulted in improvement, would the social worker and the manager get in touch with the CQC to express their concerns about this ongoing situation?

SI 2009/3112. Care Quality Commission (Registration) Regulations 2009: Are staff on the ward and their managers aware of the obligations on the hospital to report serious incidents, including neglect and abuse?

SI 2010/781. Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Are staff on the ward and their managers aware of the legal obligations of the hospital to ensure the safety of patients, to safeguard them from neglect and to ensure their dignity?

Safeguarding Vulnerable Groups Act 2006: Are staff aware that if they become implicated in neglectful care, they may be reported to the ISA, which will consider whether to bar them from working in the future with vulnerable adults?

Nursing and Midwifery Order 2001: Are the nurses on the ward aware that if they become implicated in neglectful care, they may face a professional conduct hearing and sanctions imposed by their regulatory body, the NMC?

Mental Capacity Act 2005, Section 44: Criminal offences of wilful neglect or ill treatment: Are staff on the ward and their managers aware that if they are implicated in the serious neglect of a patient lacking mental capacity, they may be prosecuted for the serious criminal offence of wilful neglect?

Mental Health Act 1983, Section 127: Criminal offences of wilful neglect or ill treatment: Are staff on the ward and their managers aware that if they are implicated in the serious neglect of a patient with some form of mental disorder, they may be prosecuted for the serious criminal offence of wilful neglect?

Negligence: Is the hospital and its staff and managers aware of the liability the hospital may incur, if it is sued in civil law for negligence, in terms of the neglectful care of residents?

Case study 10: Giving money to a carer as a gift

A man who was described as of 'limited intelligence', 53 years old, was assisted and cared for by a 38-year-old woman (the mother of a young son) on a private basis. He had inherited £60,000 from his father. Over a period of six months, nearly every day, they went to the building society; he withdrew £300, the maximum permissible, and it ended up being deposited in the carer's account. This continued until all of the £60,000 had gone.

There was some uncertainty about his capacity to make such financial transactions, that is, to make a gift. The carer was convicted of theft but appealed on the basis that if the man did have capacity to make a gift, it could never be theft.

On appeal, the House of Lords ruled that it was not crucial whether the man had capacity to make a gift or not. Instead, it was for the jury to decide whether, in all the circumstances, there was dishonesty, even if the man had technically consented to the money changing hands.

It was the prosecution case that the appellant had influenced and coerced the man to withdraw the money from his building society account, which was then deposited in into his carer's account.

The conviction stood.⁴

Law involving compulsion or enforcement

Theft Act 1968, Section 1: Are the police aware in such a situation, that even if a person is judged to have capacity to make a gift, such a 'gift' can still be 'dishonest' under the terms of the 1968 Act, for example, because of undue influence or coercion exercised by the perpetrator of the theft?

Proceeds of Crime Act 2002: Are bank and building society staff aware of their organisation's duty under the 2002 Act to look out for suspicious-looking transactions and to file 'suspicious activity reports'?

Case study 11: Paid carer stealing money from a person's own home

An elderly, frail and severely visually impaired man receives care on a private basis from a care agency. He mostly has the same carer, whom he trusts implicitly. The carer is very attentive and efficient and they get on well. The carer talks to him at some length about her personal life. She explains that her husband has just left her, that he was violent and that he drank to excess. However, she has three small children and is now really struggling to pay the utility and shopping bills from week to week, as well as monthly mortgage repayments.

One week she breaks down and says she almost doesn't know where the next meal is coming from. The man takes pity on her. He has already entrusted her with his PIN

card details, even though he knows he shouldn't do this. She takes it to the shops once a week to withdraw £30 for his weekly shopping. He says she should take out £50 for herself, just to tide things over for this week; she promises to repay it next week, insisting that it would only be a loan.

She does not repay it and he is nervous about raising the matter with her. Unknown to him, she now takes out extra money for herself every week when she goes shopping. In addition, he relies on her to pay bills for him; he signs a cheque and she fills in the details. She gets him to sign three at a time; every now and again she makes out one to herself. One week, she writes his signature on a cheque that she then makes out to herself.

Unease about the 'loan' not being repaid leads him to ring the care agency. The agency asks whether he would be happy if it put the social services safeguarding team in touch with him. Hesitantly, he agrees. Somebody comes round to visit; the social worker suggests that the police be contacted. They are, and they launch an investigation.

The man is ambivalent about the investigation because although uneasy about the carer, he also still feels loyalty and sympathy towards her. However, the police go through with him just how much money has left his account; having checked with the care agency and also to the carer, it also transpires she does not have children, nor has her husband left her.

The police also point out that, because she is a paid carer, she is a risk to other people as well; therefore, although they would fully respect his decision not to pursue the complaint, they urge him to proceed. Even if he doesn't, the police explain that they will have to share the information he has provided with other agencies, because of the wider risk she poses.

The man agrees to proceed with the complaint and furnish evidence. The carer is prosecuted and convicted of theft and forgery. She is also referred to the ISA.

Law to support the vulnerable adult

NHS and Community Care Act 1990, Section 47: Has the social worker who visited not just carried out a 'safeguarding enquiry' but assessed the man as to what community care needs he may have? Has the social worker started from the premise that the first step is to empower the man to identify his own wishes and needs?

No secrets guidance: Are the social worker and care agency both fully aware of the local safeguarding policy and procedures?

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly the man's eligibility for support and assistance under community care legislation? Even though his is a private arrangement with the carer?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Has the social worker considered what advice, support and services

could or should be offered to the man, now this situation has arisen? Has the social worker considered the use of advice and support to include support from a range of both local authority and voluntary sector sources?

Law that may involve compulsion or enforcement

SI 2009/3112. Care Quality Commission (Registration) Regulations 2009: Is the care agency aware of its duty to report serious incidents, including neglect and abuse, to the CQC?

SI 2010/781. Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Is the care agency aware of its obligations to ensure the safety of clients, to safeguard them from neglect and to ensure their dignity? In this situation, has the agency looked to see if there was anything it could have done to prevent the abuse in the first place? Are there any policies or procedures that need to be reviewed?

Safeguarding Vulnerable Groups Act 2006: Is the care agency clear about when it needs to refer workers to the ISA, for consideration as to whether they should be barred from working with vulnerable adults?

Theft Act 1968, Section 1: Are the social worker and the care agency aware of the sort of criminal offences that might be committed as part of financial abuse? Is there easily available information that can be shared with people who use services, to help them protect themselves?

Forgery and Counterfeiting Act 1981, Section 1: Are the social worker and the care agency aware of the sort of criminal offences that might be committed as part of financial abuse?

Personal information: disclosure: Data Protection Act 1998, common law of confidentiality, Human Rights Act 1998: Are the social worker, care agency and the police aware of the balancing act to be performed about information disclosure, if the man decided not to proceed with the complaint and asked for the information not to be shared? On the one hand, the preservation of confidentiality and not sharing information without a person's consent; on the other hand, the public interest (including risk and the performance of statutory functions, in some circumstances), in sharing information without a person's informed consent.

Case study 12: Allegation of rape

A 23-year-old woman lives by herself. She uses a floating support service and currently has eight hours of support per week. She is helped with debt issues, with accessing the support she needs to remain well (community psychiatric nurse and counselling) and with her aim of returning to college part time and volunteering at the local youth club. She wants to train to be a youth worker in the future.

Alleged rape: Her link worker visits and finds her, unusually dishevelled, still in her dressing gown and not very welcoming. They finally get talking and the woman explains that she was raped the night before and that she hasn't left the flat or

washed or anything much else since. The link worker asks some questions to assess whether there is an immediate risk of the alleged rapist returning. They agree some risk management measures, for example, increased security and an alternative place to go should she need it.

Reporting to police: The woman is adamant she does not want this reported to the police, certainly not yet. The link worker explains that if she changes her mind in the future the police's case would be strengthened by forensic evidence. She asks if the woman would be prepared to secure the forensic evidence, that is, put all the clothes including her undergarments into a sealed bag. The link worker offers to be with her if and when she reports it to the police. The woman still refuses and the link worker takes the view that further pressure is likely to be counter-productive.

Reporting to local authority safeguarding team: The link worker is minded to ask the woman to contact the local authority adult safeguarding team. However, she is worried that the woman will back off; in the past such pressure resulted in her breaking off contact with the floating support team. However, the woman does agree to contact her counsellor and tell her. The woman then agrees to the link worker contacting the safeguarding team asking for their advice, but without giving the woman's name.

Likewise the link worker suggests that if the woman will tell her the man's name, the safeguarding team could give the name of the alleged rapist to the police – still without mentioning her, the alleged victim's, name. This is so the police could say whether the alleged rapist is a known risk to women. The link worker suggests to the woman that she might want to know if this man has done similar things to other women. The woman agrees to this.

Local 'haven', sexual assault referral centre: The link worker also suggests to the woman that she could speak, in confidence, to staff at the local sexual assault referral centre (SARC), run jointly by the NHS locally and the police, where her choice and decision about what to do will be respected. At the very least, if she gave the bagged up forensic evidence to the centre, they could store it properly, so it would retain its forensic and evidential value. The woman says she will go with the link worker to this centre and talk to them about what has happened and what to do.

Decision of link worker and manager: The link worker goes back to talk to her manager. They have to decide whether to report the details to the local safeguarding team and to the police (quite separately from her going to the SARC), without the woman's consent. This is a difficult professional decision to make, which needs to be made by more than one person. They decide, for the time being at least, not to do so.

They carefully record their decision; this is on the basis that she will simply retract the allegation and refuse to speak to the police. Also there is a danger that she will withdraw from support services altogether, feeling that services had further undermined her rights to privacy and self-determination. The worker is mindful of the woman's history that disclosure against her wishes may further jeopardise her wellbeing. In the past, following an unwanted social services intervention, she had

left her hometown and fled to a city where she ended up as homeless and on the streets.

The manager and link worker consider the wider issues and conclude – *in this very particular set of circumstances* – that the risk to the woman of acting against her informed consent outweighs other public interest concerns. They are clear that she has mental capacity to take the decision she has.

In addition, they believe that the step-by-step approach (in particular going to the SARC) will provide a greater chance of the woman talking to the police and asking them to take action. (They are also aware that the alleged rapist did not know anybody else in the flats and there was no reason to suppose that other tenants were at risk from him.) They very carefully document their decision-making process and how they have weighed up the competing considerations in this case.

Law to support the vulnerable adult

No secrets guidance: Are the housing association staff and managers aware of local safeguarding policies and procedures, coordinated by social services under the terms of this guidance, including policies on the sharing of information?

Law that may involve compulsion or enforcement

Personal information: disclosure: Data Protection Act 1998, common law of confidentiality, Human Rights Act 1998: Are the housing association staff aware of the balancing act to be performed about information disclosure, if the woman asks that the information not be shared? On the one hand, the preservation of confidentiality and not sharing information without a person's consent; on the other hand, the public interest (including risk and the performance of statutory functions), in some circumstances, in sharing information.

Does the housing association have its own decision-making procedure to apply in cases like this? Has this been discussed with social services?

Sexual Offences Act 2003: Rape or sexual offence committed against a person with mental disorder: Are the housing association staff aware of the serious offence that may have been committed, rape or maybe a sexual offence against a person with some form of mental disorder?

Case study 13: Forced marriage

A local authority becomes aware that the parents of a young man with severe learning disabilities are planning that he marry a woman in Bangladesh. They are going to arrange a wedding ceremony on the telephone. Once this has taken place, she will come to England to live as his wife.

The local authority is concerned. Although it accepts that the parents believe they are acting in their son's best interests, it is clear that he lacks the mental capacity

to understand and to consent to either marriage or, indeed, sexual relations.⁵ Social workers have spoken at length with the parents but they seem determined.

The local authority goes to court seeking a Forced Marriage Protection Order under the Family Law Act 1996, forbidding the parents to take steps to arrange this marriage.

The court gives the Order. It also points out that if such a marriage were to take place, and even were it deemed to be valid in Bangladesh, it would not be valid here. Furthermore, the court points out that if his purported wife were to come to England, and were sexual relations to take place, both the woman – and the parents – would stand to be guilty of offences under the Sexual Offences Act 2003.

Law to support the vulnerable adult or perpetrator

NHS and Community Care Act 1990, Section 47: Have social services staff carried out a proportionate assessment of the man's community care needs?

No secrets guidance: Are social services staff aware of the local safeguarding policies and procedures?

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly the man's eligibility for support and assistance under community care legislation?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Have social services staff considered the range of information, advice, support and services that could be offered to the man?

Carers and Disabled Children Act 2000: Has an assessment of his parents as carers been offered and carried out? Have any support services been offered to them? Has the support offered been appropriate and accessible?

Mental Capacity Act 2005: Has full assessment of his mental capacity been carried out under the terms of the Act and recorded, following reasonable concerns on the part of the local authority that this young man may lack capacity to marry? Is there a clear understanding that if he lacks the capacity to understand marriage and sexual activity, then neither should take place? And that they cannot, under the 2005 Act, be arranged in his best interests?

Law that may involve compulsion or enforcement

Family Law Act 1996, Sections 63–63S: Are social services staff aware of the terms of this Act providing for Forced Marriage Protection Orders to be granted by the courts?

SI 2009/2023. The Family Law Act 1996 (Forced Marriage) (Relevant Third Party) Order 2009: Are social services staff aware that local authorities are formally recognised as a third party which can make an application to the court? Are the police aware that, although not mentioned in this order, they could apply as a third party to the court?

Case study 14: Locked room and restraint of young woman by parents

A young woman is cared for by her parents. She has Smith-Magenis syndrome. It is associated with development delay, learning disabilities, behavioural difficulties and disturbed sleep. Her parents lock her in her room at night by bolting her door.

Social services staff are worried that this may be legally wrong. They are anxious that it is a 'deprivation of liberty'; they are also concerned that even if it is not a *deprivation* of liberty, it is an unacceptable and unlawful *restriction* of liberty.

The young woman is judged to lack the mental capacity to decide whether she wants her bedroom door locked. The local authority considers carefully the circumstances, the subjective feelings and reactions of the woman, the objective nature of the restriction being applied, the reasons for it, what other options could be applied and whether they would be effective and less restrictive. It involves the woman as far as possible in its decision making, works closely with the parents and takes expert professional views as well.

The young woman suffers from very broken sleep patterns. If the door was open, she would go downstairs and destroy furniture and fittings, empty the contents of the fridge and cupboards, eat copious quantities of food (cooked or uncooked) and tamper with electrical appliances. During the night she shouts for her parents if she needs them or knocks on the door. She does sometimes kick the door but this is more associated with temper tantrums than trying to get out. She moves around her room at night, reading her books, but does not show signs of distress.

Other options have been tried. The house is open plan so internal doors cannot be locked downstairs. If she got out of the house she would wander the streets in various states of undress. If she were not locked in, her parents would have to be up all night with her; this would not be practical, as one of them has to work. At any time from 5am, if she wants to get up, her parents get up as well. Safety gates would not have worked as she is very destructive and shows remarkable strength.

The parents have tried unlocking the door once she has fallen asleep, but this does not work; she creeps past their room in the night and then goes downstairs.

A night-time carer would be a possibility but this would bring problems of its own. She would try to interact with the carer and this would further interrupt sleep patterns and ultimately increase risks. The carer would have to persuade her to stay within or return to her bedroom during the night; the carer would come to be a 'barrier' to her leaving the bedroom and would constitute an element of restriction.

The local authority is supportive of what the parents are doing. It is pretty sure that it and the parents have got it right, but decides to apply to the courts to make sure that this is so. It is confirmed that there is no deprivation of liberty, that there is a restriction of liberty, but that it is justified. The local authority has been careful to record how it has applied itself to this situation.

First, it has investigated to decide whether there was a deprivation of liberty, looking at the *subjective* issues (the person's reaction) and the *objective* restrictions being imposed.

Second, although there was no deprivation, it would need to continue to monitor the situation and work with the family.

Third, had there been a deprivation the local authority would have *worked with* the family to see how the restrictions could have been lessened so as to have avoided a deprivation of liberty, for example, by providing support services.

Fourth, had this not been possible, the local authority would indeed have had to apply to the Court of Protection for authorisation of the continuing state of deprivation of liberty.⁶

Law to support the vulnerable adult or perpetrator

NHS and Community Care Act 1990, Section 47: Have social services staff carried out a full community care assessment of this complex situation and taken independent expert advice as appropriate on any particular aspects? Are staff aware that, although there may be safeguarding issues, their primary legal duty is to work with the family, to carry out a community care assessment and to offer welfare services?

No secrets guidance: Are social services staff aware of local safeguarding policies and procedures and for the need to empower and work with vulnerable adults and their carers before considering drastic, protective interventions?

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly eligibility for the woman support and assistance under community care legislation?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970: Have social services staff considered the full range of information, advice, support, services, equipment and home adaptations that could be offered to assist with meeting the woman's needs?

Carers and Disabled Children Act 2000: Have social services staff offered the parents an assessment of need in relation to their role as informal carers? Have any services or assistance been offered to them?

Mental Capacity Act 2005: Have social services staff carried out, or arranged for, a full mental capacity assessment about the woman's ability to decide about her room and night-time arrangements, and about her best interests including consideration given to the least restrictive option? Are they also aware of the rule that if restraint is employed, then it must be to prevent harm coming to her and that it must be proportionate to the risk of that harm?

Are staff aware of the distinction under the Act between a restriction and deprivation of liberty, and what the legal rules are about the latter, not just when it occurs in a care home or a hospital but in a person's own home?

Human Rights Act 1998: Are social services aware of, and have they considered in this case, the human rights implications of the situation? That is, whether by not assisting sufficiently, or alternatively intervening excessively, there might be infringement of Article 3 of the European Convention on Human Rights (Degrading treatment), Article 5 (Deprivation of liberty without due legal procedure), or Article 8 (Right to respect for private life)?

Case study 15: Removal of adult from his adult placement because of safeguarding concerns about restraint

A man with severe learning disabilities, 19 years old, lives in an adult placement with a woman who was previously his foster carer under the Children Act before he became an adult. He also has a number of other complex medical conditions.

When still attending school he had sometimes displayed challenging behaviour including shouting and hitting other people. Over the years, professionals have voiced the view that he has been cared for well by his foster carer.

As a result of certain incidents, however, the local authority becomes concerned about his welfare; for instance, on one occasion, when collecting him from school, it was alleged that she was screaming and shouting at him, asking him why he behaved badly at school but not at home, wagging her finger at him, and saying that if he behaved badly he should be "put to the wall" as he was at home. She denied doing any of this. However, it had also become clear that his behaviour at home was sometimes becoming more difficult to manage. Equally, following a hospital operation, the surgeon commented on the immense contribution to his recovery made by his foster carer.

Subsequently a safeguarding adults referral was made by the school; this was on the basis that he had been talking about "sleeping in the wardrobe" and "don't lock me in". Somebody from the local authority visited, informed the foster carer about the safeguarding adults referral and had a look round the house; it was noted that there was no wardrobe in his bedroom.

It was also reported that the foster carer had talked to social workers about possible self-defence training, in case of any aggressive behaviour by the man, as had occurred recently on a holiday they had taken. It seemed clear to the local authority that physical restraint was having to be used sometimes to manage his behaviour, although the foster carer denied that this had hitherto ever been necessary.

It emerged that his foster carer had completed an adult carer application, so that the arrangement could become an adult placement arrangement rather than a fostering arrangement under the Children Act. As part of this application she had to compete

a Criminal Records Bureau (CRB) check and had to declare any past convictions; she declared one, for shoplifting in 1973. She failed to declare four others, received between 1975 and 1983; three were for theft and one for handling stolen goods. The offences had, however, been known to the social services children's department.

The local authority felt she was being dishonest, both in relation to the use of restraint and the previous convictions.

The local authority was considering whether to remove the man from this home and place him first in a respite place at a care home, before considering whether to arrange a supported living tenancy for him.⁷

The local authority will need to consider the reliability of the allegations, consult with all relevant people including the man as far as possible and his carer. It will need to carry out a best interests assessment, give consideration to the least restrictive option, and to the man's wishes, as far as they are ascertainable, both past and present.

It will need to consider, were it to try to remove the man from his carer, what alternative arrangements it might make, and whether these might run the risk of being more restrictive and even a deprivation of liberty. It will also need to think carefully through the human rights implications of separating him from his longstanding carer.

Law to support the vulnerable adult or perpetrator

NHS and Community Care Act 1990, Section 47: Have social services staff fully assessed the man's community care needs?

No secrets guidance: Are social services staff aware of local safeguarding policies and procedures, including the need to work with and empower vulnerable adults and their carers?

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly the man's eligibility for support and assistance under community care legislation?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970: Have social services staff considered the full range of information, advice, support, services, equipment and home adaptations that could be offered to assist with meeting the man's needs?

Carers and Disabled Children Act 2000: Have social services staff offered an assessment to the foster/adult placement carer of her role, and have any services or assistance been offered to her?

Mental Capacity Act 2005: Have social services staff been clear about the application of the Act? Is there a clear mental capacity assessment about his ability to decide where he wants to live? Are social services staff aware of the rules about restraint

under the Act, and also about what constitutes deprivation of liberty? And when it is necessary to make an application to the Court of Protection?

Human Rights Act 1998: Are social services staff aware of the human rights implications of the situation? That is, whether by not assisting sufficiently, or alternatively intervening excessively, there might be infringement of Article 3 of the European Convention on Human Rights (Degrading treatment), Article 5 (Deprivation of liberty without due legal procedure), or Article 8 (Right to respect for private life)?

Case study 16: Disclosing information about a care home worker's assault on her own child

A woman assaulted her eight-year-old daughter. As a consequence, her daughter was removed under the Children Act 1989 and placed in foster care.

The local authority where this had occurred then ascertained that the mother worked in a care home for older people in the area of a different local authority. The original local authority now wished to inform both the care home and the second local authority about the childcare proceedings.

The woman believed that the local authority was wrong to do this. This was a difficult case, involving the need to weigh up the confidentiality and private life of the mother and her child, as against the concern to safeguard vulnerable adults.

The judge emphasised the importance of a balancing exercise, weighing up the reasons for and against disclosure. In favour of disclosure were (a) the importance of the *No secrets* guidance and the inter-agency working and sharing of information to which it refers; (b) the gravity of the conduct; and (c) evidence that the local authority had conducted a pressing need test to disclose. Against disclosure were the facts that (a) the child would not benefit from the disclosure; (b) the consequences could be adverse for the family if the mother lost her job; (c) there was a risk to the child of publicity leaking out; and (d) since frankness was required in children's cases, the fear of publicity might generally deter that frankness.

Overall, however, the public interest and public safety factors outweighed the mother's right to respect for privacy under Article 8 of the European Convention on Human Rights. So with safeguards in place to limit publicity, disclosure would be justified.⁸

Law relevant to the situation and decision making

No secrets guidance: Are social services staff aware of local policies and procedures about safeguarding, especially about the sharing of sensitive personal information?

Personal information: disclosure: Data Protection Act 1998, common law of confidentiality, Human Rights Act 1998: Are social services staff and managers aware of the balancing act to be performed about information disclosure, especially when the woman asks that the information not be shared? On the one hand, the

preservation of confidentiality and not sharing information without a person's consent; on the other hand, the public interest (including risk and the performance of statutory functions), in some circumstances, in sharing information.

Does social services have a formal procedure to follow, to make sure they are asking all the right questions before making a decision about whether or not to disclose the information about the woman and her child to the care home?

Case study 17: Standard of care and assisted suicide comment

A husband and wife, in their late eighties, are both very ill and disabled.

They live at home and have extremely limited mobility; some days they remain in bed; on others they can just about get up. They both retain mental capacity to make day-to-day decisions about what they want, although both have limited mental stamina because of the debilitating nature of their physical conditions. They both require care and receive three visits a day organised by social services. This includes help with getting up, going to bed, washing, dressing, changing of incontinence pads, help with food etc.

Social services have contracted out the care to a care agency. Unfortunately, the carers sometimes come very late and not infrequently miss out a visit altogether; for instance, the midday visit effectively merges into late afternoon/early evening visits. One of the consequences of this is that one or both of them are left lying, sometimes for hours, in soiled pads. This distresses both of them greatly.

They don't like to kick up a fuss with the carers who, they can see, are under huge pressure, work immensely long hours and do their best. The care agency they work for is nearly always under-staffed. However, a family member has raised the issue – which she considers to be highly degrading for the couple – with a local authority duty social worker on a number of occasions about this continuing state of affairs. The issue has, in turn, been referred to the contracts department. Nothing has changed; the late or missed visits continue.

One morning, thoroughly depressed about this but retaining her lifelong sense of humour, the wife jokes to the carer that if things don't improve soon, she and her husband will have to go on holiday to a clinic in Switzerland, which facilitates assisted suicide.

The carer has recently had training on safeguarding adults. She panics and immediately rings her care coordinator, who in turn rings social services.

A social worker discusses the situation with a manager. They discuss the situation and think about raising an alert and contacting the police because of the reference to an unlawful act, namely, assisted suicide. However, having considered the couple's situation – namely, their virtual total lack of mobility – it was clear they were going nowhere. The comment was no more than an ironic joke; it would be an excessive

reaction to raise the matter with the police. Instead, however, they decided to raise an alert in relation to the continuing and significant missed visits and the risk this posed to the couple. They did this on the basis that the couple's dignity and potential safety was being significantly compromised.

Law to support the vulnerable adult

NHS and Community Care Act 1990, Section 47: Has there been a full assessment of each of the couple's individual's community care needs?

No secrets guidance: Are social services staff aware of substance of this guidance and that safeguarding concerns may arise not just from the possible committing of a criminal offence, but also from the neglectful provision of services?

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly eligibility for support and assistance under community care legislation, including ongoing monitoring of need relating to poor care and even neglect?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Have social services staff considered the full range of information, advice, support and services that could be offered to assist with meeting the couple's needs? In terms of the agency contracted to provide a service, are social services staff sufficiently monitoring, and responding to concerns about, the care agency?

Law involving compulsion or enforcement

Health and Social Care Act 2008: Are social services staff and the agency aware of the function of the CQC in regulating care providers?

SI 2009/3112. Care Quality Commission (Registration) Regulations 2009: Are social services staff and the agency aware of the agency's obligation to report neglect and abuse to the CQC, and of the local authority's power to report if the agency does not?

SI 2010/781. Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Are social service staff and the care agency aware of the care agency's obligations to ensure the safety of people who use services, to safeguard them from abuse and neglect, and to ensure their dignity?

Suicide Act 1961: Are social services staff and the care agency broadly aware of the law relating to assisted suicide?

Human Rights Act 1998: Are social services staff aware of the implications of Article 8 of the European Convention on Human Rights? That is, in this situation, that any safeguarding 'intervention' should be 'necessary' and proportionate to any (real rather than fanciful) risk (of assisted suicide)? But conversely, that any failure to step in and provide assistance – to ameliorate the degrading situation (lying in their own

bodily waste) in which the couple regularly find themselves – might mean a breach by the local authority of Article 8, and possibly even Article 3?

Case study 18: Sexual exploitation of woman with learning disabilities and mental health problems

A 33-year-old woman lives with her family, with some members providing care and assistance for her.

She has a learning disability as well as a schizo-affective disorder. Failures to take her anti-psychotic medication increase her vulnerability.

She longs for intimate male society, for marriage and for children. This makes her vulnerable to exploitation by men.

She has been judged to lack the capacity to marry, to decide where to live, to consent to a medical operation (an oophorectomy, removal of the ovaries); however, her capacity for sexual relations fluctuates. Sometimes she has capacity, at other times not. In any event, she is easy prey to sexual exploitation; she understands relationships poorly and has limited ability to assess other people's intentions.

The test of capacity for sexual relations was about whether she had sufficient knowledge and understanding of the nature and character – the sexual nature and character – of the act of sexual intercourse, and of the reasonably foreseeable consequences of sexual intercourse, to have the capacity to choose whether or not to engage in it, the capacity to decide whether to give or withhold consent to sexual intercourse (and, where relevant, to communicate that choice). The fact that she might think that a man would marry her, when it was clear that this was not so, would not be enough to show that she lacked capacity.⁹

Nonetheless, the local authority had to think through how to protect her, both when she had capacity and when she didn't. It would have to consider how it could intervene at the times when she lacked capacity to have sexual relations; this would be possible in her best interests under the Mental Capacity Act 2005. At times when she had capacity, it would have to try to support and protect her but could not prevent her.

Although the courts might use their 'inherent jurisdiction' to make orders or injunctions to enable a vulnerable adult (albeit with capacity) to make a free and informed decision, they would not do so in order to prevent an adult with capacity from performing a lawful act.

However, the local authority is aware that in some circumstances, exploitative sexual relations with a mentally disordered person – even if the victim has capacity to consent – can be a criminal offence. It will bear this in mind and talk to the police about this.

Law to support the vulnerable adult

NHS and Community Care Act 1990, Section 47: Have social services staff carried out a full assessment of the woman's community care needs?

No secrets guidance: Are social services staff aware of local safeguarding policies and procedures and, in particular, the need to empower vulnerable adults as well to protect them?

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly eligibility of the woman for support and assistance under community care legislation?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Have social services staff considered the full range of information, advice, support and services that could be offered to assist and support the woman?

Mental Capacity Act 2005: Are social services staff aware of the relevant rules under this Act? Has a full capacity assessment been carried out, which recognises that the woman has fluctuating capacity to consent to sexual activity? Are staff sufficiently aware that the fact she may be making an unwise decision does not necessarily mean she lacks capacity? And that they should not confuse capacity with a person's 'best interests'? Equally, are they aware of what permissible restriction or restraint under the Act may be at times when she lacks capacity?

Human Rights Act 1998: Have social services staff given consideration to the human rights implications of any restrictions they try to impose, in terms of human rights – under Article 8 of the European Convention and in relation to her private life?

Law involving compulsion or enforcement

Sexual Offences Act 2003, Section 35: Are social services staff and the police aware of the offence of inducement, threat or deception to cause a person with a mental disorder to engage in sexual activity, even if the victim has the mental capacity to consent?

Case study 19: Son denying access to his mother

Neighbours have become concerned about an elderly woman living next door; they haven't seen her for months. They knew that she had been physically unwell in the last year or so, and also they thought that she probably had some sort of mental health problems because she did sometimes behave 'oddly'.

They contacted social services who sent someone round just to pay a visit. However, the son refused them access, saying his mother was fine and how dare social services come round snooping. He had harsh words for the neighbours, whom he branded as "out and out troublemakers".

The woman had been known to social services because about two years ago, they had carried out an assessment of her physical and mental health needs but concluded that she didn't need any help, or at least wasn't eligible to receive it.

There are a number of possible options in such a situation but the local authority has to proceed carefully; it cannot just barge into somebody's house.

The first step is to talk to the son and to explain their role in a non-threatening way. If they carry out an assessment, they may be able to offer help.

Ideally they would then seek an informal way of getting contact with the woman, maybe seeing whether somebody else – such as the GP – might get access.

If there is a reasonable doubt about her mental capacity, it might be possible to seek an interim order for the Court of Protection, authorising an assessment of capacity under the Mental Capacity Act 2005.

Were there a doubt about her mental health and ability to care for themselves, an intervention under the Mental Health Act 1983 might be possible under Section 135 of that Act.

If there is evidence of immediate risk to life and limb, the police could enter the premises under the Police and Criminal Evidence Act 1984, Section 17.

Law to support the vulnerable adult

NHS and Community Care Act 1990, Section 47: Have social services staff made reasonable efforts to carry out a community care assessment of the woman, as far as practicable? In attempting this, have they made reasonable and varied attempts to engage with the son to persuade him to let them in?

No secrets guidance: Are social services staff aware of local safeguarding policies and procedures and what signs of abuse or neglect might be?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Have social services staff attempted to convey to the son, one way or another, the sort of information, advice, support and services that could be offered to assist his mother?

Law that may involve compulsion or enforcement

Mental Health Act 1983, Section 135: Depending on the circumstances, the severity of the risks and whether there is reason to believe the woman suffers from a mental disorder and is unable to look after herself, have social services staff given consideration to a comprehensive risk and benefit assessment and considered all options including removing the woman to a place of safety?

Mental Capacity Act 2005: Have social services considered whether there is any evidence that she may lack mental capacity to make decisions about her living

arrangements and everyday care? If so, has consideration been given to applying to the Court of Protection for an interim order (under Section 48), authorising an assessment of capacity?

Human Rights Act 1998: Has social services weighed up human rights issues, under Article 8 of the European Convention, concerned with the right to respect for private and family life? Would a compulsory intervention be a proportionate response on the evidence so far?

Police and Criminal Evidence Act 1984, Section 17: Is there any evidence of immediate risk to the 'life and limb' of the woman, warranting police entry? Are police and social services staff aware of the limits to Section 17 and that concern about a person's welfare generally is insufficient to trigger Section 17?

Case study 20: Care worker crossing boundaries with a person who uses services

A woman worked for an agency first as a cleaner, then as a carer when it became a care agency. She has a good relationship with one particular woman of low intellect, who is generally house-bound, partially sighted and has diabetes.

With the woman's money, she bought a new carpet, chairs and bed for the woman. Receipts were not kept. The carer's husband did the garden for £10 per hour. At the suggestion of a social worker, the husband also redecorated the house for £400. He cleaned the carpets monthly (necessary because of the woman's incontinence) for reasonable remuneration. The carer also took up to £35 a week to put into a Christmas Club. The carer also made some withdrawals from the woman's bank account. At a later date, the woman alleged she had been exploited.¹⁰

The care agency refers the carer to the ISA. The ISA has a difficult task. It was true that the decoration had been to a high standard, the woman enjoyed the holidays and the bank withdrawals had been authorised by the woman. There was no dishonesty or exploitation. But the carer had overstepped the boundaries of good practice; this had, in principle, put the woman at risk of harm.

On the other hand, it becomes apparent to the ISA that the carer had received no training, supervision or even basic management from the agency. Furthermore, she fully accepted her failings and was willing to be supervised. The ISA concluded that she was a caring person who just needed proper training, supervision and management. It should not bar her from working with vulnerable adults.

Law to support the vulnerable adult

NHS and Community Care Act 1990, Section 47: Has the social worker involved carried out sufficient reviews of the situation, to ensure that the woman's needs are being adequately and safely met?

No secrets *guidance*: Was the social worker familiar with local safeguarding policies and procedures and what signs of abuse or harm might look like?

Law that may involve compulsion or enforcement

SI 2010/781. Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Is the care agency aware of the need to protect people who use services from abuse or neglect under these regulations? And that if they don't, they may come under the scrutiny of the CQC under the Health and Social Care Act 2008?

Safeguarding Vulnerable Groups Act 2006: Is the care agency aware of its duty to make appropriate referrals to the ISA? Does it also have insight into when its own practices may be putting its staff into a position where they inadvertently place people who use services at risk of harm?

Case study 21: Assisting a woman make a decision about contraception

A woman with learning disabilities has had two children in the past; both babies were removed from her at birth because of her serious lack of insight into the needs of the children and what parenting would require.

She now has another partner, whom she has married. He has an extremely low level of intellectual functioning. There is evidence from a counselling psychologist that although he has limited insight, he appears to respond well to clear information, full explanation and the opportunity to ask questions.

There is no suggestion that she lacks the mental capacity to understand marriage and sexual relations. However, the local authority is greatly concerned that she may become pregnant again; it reports that her husband is being obstructive and not answering the door when social services visit.

Further safeguarding concerns are raised at college when she tells staff that she did not want an injection from social services, and that she and her husband want a baby. However, she also refers to him hitting her and shows staff marks and bruises. Other remarks she makes suggest that she may be ambivalent about having a baby. She has not been prepared to make a complaint to the police about her husband's behaviour.

The local authority triggers its safeguarding procedures in respect of the suspected domestic violence and the issue of contraception. It issues proceedings in the Court of Protection. A judge orders a mental capacity assessment to be conducted; this took place at the couple's home; the husband became at times extremely aggressive.

Her husband has to a degree been marginalised and sidelined by the local authority, but this was because he has been difficult to deal with; however, this has made his behaviour more difficult still. He complains that there were three parties to the marriage, social services being one of them. And that when the safeguarding

procedures were instigated, nobody spoke to him. A vicious circle was created and the couple had in effect 'pulled up the drawbridge'.

The case is now more fully considered by the Court of Protection. One view is that the woman simply lacks capacity to understand contraception and that this should, forcibly if necessary, be administered. However, it becomes clear that matters are not so straightforward. Even if she did definitely lack capacity, such compulsion would probably mean police assistance, manhandling, restraint and anaesthesia, which would be a horrendous and traumatic experience for the woman.

The Court considers all this; and it agrees that at present she is unable to make a decision about contraception. However, it believes that this is because the coercive pressure from her husband means she cannot make a free and informed decision. The Court therefore states that she should receive 'ability-appropriate' help and discussion so that she can take a capacitated decision, without undue contrary pressure from her husband.

The Court also considers whether to issue an injunction, under its 'inherent jurisdiction', against the husband, but notes that he has said he is happy for his wife to have contact with professionals, as long as he is not excluded from the process. He has given an assurance about this.

The Court considers an injunction to be unnecessary at this stage.¹¹

Law to support the vulnerable adult or perpetrator

NHS and Community Care Act 1990, Section 47: Have community care assessments been carried out (or at least attempted) by social services staff for the woman and her husband?

No secrets guidance: Are social services staff familiar with local safeguarding policies and procedures and the need to empower and work with vulnerable adults and their families as well as protect them?

Guidance: Prioritising need in the context of Putting People First (DH, 2010a): Have staff established clearly the eligibility of the woman for support and assistance under community care legislation?

National Assistance Act 1948, Section 29 and Chronically Sick and Disabled Persons Act 1970, Section 2: Have social services staff talked through with the couple the full range of advice, support and services that could be offered under this legislation?

Carers and Disabled Children Act 2000: If the husband is, in effect, also providing care and assistance for his wife, has a carer's assessment been offered and attempts made to support the husband? Are social services working in partnership with the husband?

Mental Capacity Act 2005: Have social services carried out, or arranged a mental capacity assessment of the woman, where reasonable concerns have been expressed about her capacity to make specific decisions, according to the rules under the Act?

Before they conclude that she lacks capacity, have they considered what assistance could be given to her, so that she could make her own informed decision?

Have social services staff sufficiently distinguished between the question of capacity and 'best interests'? In considering those best interests, have they considered closely what the least restrictive option would be?

Inherent jurisdiction: Are social services staff aware of the distinction between a court making an order under the Mental Capacity Act 2005, or under its inherent jurisdiction in respect of an adult who might have capacity but for the fact that their will is being overborne by undue influence or coercion?

Notes

¹ Facts of this case study, but not the commentary, are based on: *Local Authority X v MM* [2007] EWHC 2003 (Fam).

² Facts of this case study, but not the commentary, are based on a Local Government Ombudsman case (Local Government Ombudsman, 2008).

³ Facts of this case study, but not the commentary, are based on: Sloper and Seaton (2010).

⁴ Facts of this case study, but not the commentary, are based on *R v Hinks* [2001] 2 AC 241 (House of Lords).

⁵ Some, but not all facts in this case study, and not the commentary, are based on *KC v City of Westminster Social and Community Services Department* [2008] EWCA Civ 198.

⁶ Facts of this case study, but not the commentary, are based on *In the Matter of C: A Local Authority v C* [2010] EWHC 978 (Fam).

⁷ Facts of this case study, but not the commentary, are based on *G v E* [2010] EWHC 621 (Fam).

⁸ Facts of this case study, but not the commentary, are based on *Brent London Borough Council v SK* [2007] EWHC 1250 (Fam).

⁹ Facts of this case study, but not the commentary, are based on *Ealing London Borough Council v KS* [2008] EWHC 636 (Fam).

¹⁰ Facts of this case study, but not the commentary, are based on *Mrs P v Secretary of State for Education and Skills* [2005] 562 PVA/563 PC.

¹¹ Facts of this case, but not the commentary, are based on *A Local Authority v Mrs A* [2010] EWHC 1549 (Fam).

B Legal framework

Part 1: *No secrets* and using the law

1 *No secrets* guidance

2 Protection, justice, empowerment and the law

3 Legal action and complaints

1 No secrets guidance

1.1 Key points

There is a great deal of legislation relevant to different aspects of safeguarding vulnerable adults. However, one piece of government guidance in particular deals with safeguarding as a whole. This guidance in effect attempts to harness the work carried out by these different organisations and their staff.

Published in 2000 by the Department of Health and the Home Office, it is called: *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.*

1.1.1 Definitions

The guidance defines several key terms, including what is meant by *vulnerable adult*, *abuse* and *harm*. It refers to joint working at local level between different organisations, and states that local social services authorities should be the lead coordinating agency in each area. It also emphasises the importance of information sharing between agencies.

1.1.2 Protection, justice and empowerment

The government has stated that three particular concepts should underpin safeguarding: protection, justice and empowerment (Minister of State, 2010). The government has also identified key principles which should underpin all safeguarding:

Safeguarding principles

Empowerment: presumption of person-led decisions and informed consent

Protection: support and representation for those in greatest need

Prevention: it is better to take action before harm occurs

Proportionality: proportionate and least intrusive response appropriate to the risk presented

Partnership: local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse

Accountability: accountability and transparency in delivering safeguarding.

1.2 Legal status of the *No secrets* guidance

No secrets is not legislation. It is guidance only. However, in relation to local social services authorities it has the status of 'statutory guidance'. This gives it particular importance, because it was issued under Section 7 of the Local Authority Social Services Act 1970, which states that local authorities must act under the general guidance of the Secretary of State.

1.2.1 Local authorities should follow the guidance

Although this guidance does not amount to legislation, local social services authorities should – from a legal point of view – nevertheless follow it. If they don't – at least without very good reason – they might be held, in a type of legal case called 'judicial review', to be acting unlawfully.¹

1.2.2 Courts' acknowledgement of the guidance

The courts have recognised the significance of the *No secrets* guidance. In one case it was a significant factor in determining whether or not a local authority should share information with a care home about the risk they believed a care worker might pose.² In another case, it was relevant to the local authority's assessment of a situation, in which a person using services had proposed assisted suicide.³

1.2.3 Underlying legislative basis

Nevertheless, local authorities must still find a basis in legislation for their safeguarding activities; the *No secrets* guidance alone does not provide this. So most local authority 'safeguarding' activity, legally, is likely to be part of assessment under Section 47 of the NHS and Community Care Act 1990. And the provision of advice and support would in fact be a community care service under, for instance, Section 29 of the National Assistance Act 1948. If such activity related to a person who lacked mental capacity, then the Mental Capacity Act 2005 would be an additional legal underpinning for the local authority's decisions and actions.

1.2.4 Status of the guidance for other organisations

For other organisations mentioned in the guidance (for example, the NHS, the police and housing providers) it does not have the enhanced status that it has for social services.

1.3 Vulnerable adults

The guidance states that it is concerned with the support and protection of vulnerable adults who are at risk of abuse. A vulnerable adult is defined as a person 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him- or herself, and or unable to protect him- or herself against significant harm or exploitation' (DH and Home Office, 2000, p 8).

1.4 Abuse

The guidance states that abuse might consist of a single act or repeated acts. Abuse takes various forms: physical, sexual, psychological, financial or material, neglect and acts of omission, discriminatory or institutional. Some forms of abuse are criminal offences, for example, physical assault, sexual assault and rape, fraud, other forms of financial exploitation, and certain forms of discrimination, whether on racial or gender grounds etc (DH and Home Office, 2000, p 9).

The *No secrets* guidance illustrates each type of abuse

Physical abuse, including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions.

Sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting.

Psychological abuse, including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

Financial or material abuse, including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits.

Neglect and acts of omission, including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

Discriminatory abuse, including racist, sexist, that based on a person's disability and other forms of harassment, slurs or similar treatment.

1.4.1 Vulnerable adults entitled to protection of law

The guidance points out that vulnerable adults are entitled to the protection of the law in the same way as any other member of the public (DH and Home Office, 2000, p 9).

There have been some concerns that because the word 'abuse' does not correspond to any particular criminal offence, its widespread use in the context of safeguarding has meant that crimes against vulnerable adults have not always been treated as such (DH, 2009a, para 7.104).

1.4.2 Crown Prosecution Service guidance

Separate guidance issued by the Crown Prosecution Service (CPS) about prosecuting crimes against older people underlines this point. This documents lists different types of abuse and links them to criminal offences (CPS, 2008, Annex A).

1.5 Self-neglect

Self-neglect is not referred to explicitly in the *No secrets* guidance. However, there is legislation that may be applicable to it. This includes, for example, local authority social services legislation, the Mental Capacity Act 2005, the Human Rights Act 1998 and the Public Health Act 1936 (environmental health intervention).

1.6 Psychological abuse

There is sometimes uncertainty about the term 'psychological abuse' and what it might mean. Among other things it can include threats, verbal abuse, causing distress and upset, controlling a person's actions and contacts, harassment, emotional undermining and so on.

If applied to criminal offences, for example, a threat of violence may constitute an assault, a threat to kill may be an offence under Section 16 of the Offences Against the Persons Act 1861 and harassment might be an offence under the Protection from Harassment Act 1997. Civil orders, anti-harassment injunctions, Anti-Social Behaviour Orders (ASBOs) and Non-Molestation Orders may also be relevant (and are described later in this guide).

1.7 Perpetrators of abuse

The *No secrets* guidance refers to perpetrators as including relatives and family members, professional staff, paid care workers, volunteers, other people who use services, neighbours, friends and associates, other people who deliberately exploit vulnerable people and strangers (DH and Home Office, 2000, para 2.10).

1.8 Location of abuse

The guidance states that abuse can take place in different circumstances and locations: when a vulnerable adult lives at home alone or with a relative, in care homes or day care settings, in hospitals, in custodial situations, when support services are provided in people's own homes, in other places previously assumed safe and in public places (DH and Home Office, 2000, para 2.14).

1.9 Decisions about intervention

No secrets states that decisions about intervention should be based on the seriousness or extensiveness of abuse. It refers to several relevant factors: the vulnerability of the individual, the nature and extent of the abuse, the length of time it has been occurring, the impact on the individual and the risk of repeated or

increasingly serious acts involving the vulnerable adult or other vulnerable adults (DH and Home Office, 2000, para 2.19).

1.9.1 Stranger abuse

Safeguarding is sometimes thought by practitioners as applying only to people in positions of trust in relation to vulnerable people. However, the *No secrets* guidance clearly does refer to 'stranger abuse', but says this will require a different kind of response from that which is appropriate in an ongoing personal relationship or in a care location (DH and Home Office, 2000, para 2.13). Stranger abuse could include, for example, distraction burglaries, bogus tradespeople, exploitative 'cold calling' or street robbers who target vulnerable people. Community safety strategies may be put in place to try to combat this – 'no cold calling zones', information about not letting in strangers – and awareness about fraudulent tradespeople offering to carry out decorating or house repair work, garden maintenance etc.

Such matters can be addressed by local authorities, the police and the NHS – who all have obligations under Sections 5 and 6 of the Crime and Disorder Act 1998 to formulate strategies to reduce crime and disorder locally.

1.10 Inter-agency working

The guidance stresses the importance of inter-agency working at local level. The lead agency for coordinating this is the local social services authority. However, the guidance also makes clear that all agencies should designate a lead officer or member of staff for safeguarding.

1.10.1 Providers and regulators

The guidance refers to social services and the NHS, sheltered and supported housing providers, regulators of services, police and the CPS, voluntary and private sector agencies, local authority housing and education departments, probation services, benefits agencies, carer support groups, user groups and user-led services, advocacy and advisory services, community safety partnerships, services meeting the specific needs of groups experiencing violence, legal advice and representation services (DH and Home Office, 2000, para 3.3).

1.10.2 Importance of local policies

No secrets highlights the importance of local policies and procedures so that roles and responsibilities are clear between and within local agencies at different levels – including operational staff, supervisory or line managers, senior managers, different parts of the local authority (for example, corporate services), chief officers/chief executives and local authority members or councillors (DH and Home Office, 2000, pp 16–17).

1.11 Information sharing

The guidance states that, as part of inter-agency working, agreement on the sharing of information is required. It sets out a number of key points that essentially are about the importance both of confidentiality and of disclosing confidential information when necessary:

- a) information must be shared on a "need to know" basis only
- b) confidentiality should not be confused with secrecy
- c) informed consent should be obtained but, if this is not possible and other vulnerable adults are at risk, it might be necessary to override this requirement
- d) assurances of absolute confidentiality should not be given where there are concerns about abuse
- e) principles of confidentiality designed to safeguard and promote the interests of service users and patients should not be confused with those designed to protect the management interests of an organisation. (DH and Home Office, 2000, paras 5.6–5.8)

1.12 Safeguarding Adults Boards

The *No secrets* guidance suggests that agencies may wish to set up a local adult protection committee (in practice, most areas now have what they call Safeguarding Adults Boards).

1.13 Overall principles

The guidance states that agencies should adhere to a number of overall principles (DH and Home Office, 2000, para 4.3). In summary, these relate to both empowering people in terms of support, help, information and recognition of the right to self-determination – and to protecting people:

- *Inter-agency working*
- *Empowerment* and wellbeing of vulnerable adults through the services provided by agencies
- *Support* for the rights of the individual to lead an independent life based on self-determination and personal choice
- *Protection*: recognise those people who are unable to take their own decisions or protect themselves, their assets and bodily integrity
- *Self-determination and risk*: recognise that the right to self-determination can involve risk and ensure that such risk is recognised and understood by all concerned, and minimised whenever possible
- *Safety*: ensure the safety of vulnerable adults by integrating strategies, policies and services relevant to abuse within various legislation
- *Help*: ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help, including advice, protection and support from relevant agencies
- *Law*: ensure that the law and statutory requirements are known and used appropriately so that vulnerable adults receive the protection of the law and access to the judicial process.

1.14 Protection, justice and empowerment

Government stated in 2010 that protection, justice and empowerment are three key concepts underpinning the safeguarding of adults.

1.14.1 Achieving protection and giving people a voice

Protection is to be achieved through safe and high quality services and support. Justice requires access to and attention from the criminal justice process when people are victims of crime. The empowerment of people is to enable them to recognise, avoid and stop harm; to take decisions based on informed choices; to balance taking risks with quality of life decisions; and to enable them, if they have been harmed, to heal and to live with self-confidence and self-determination. It is crucial that vulnerable people are able to make views and choices known (Minister of State, 2010). These three concepts are reflected throughout this guide, in terms of how the law works.

2 Protection, justice, empowerment and the law

2.1 Key points

Government has stated that three concepts should underpin safeguarding: protection, justice and empowerment.

2.1.1 Balancing exercise and presumption of mental capacity

In some circumstances, the three concepts straightforwardly run together. In others, a balancing exercise may be required. The Human Rights Act 1998 and the Mental Capacity Act 2005 are of particular relevance when this balance is struck.

The Law Commission has identified that in striking the balance in terms of degree of intervention to protect people, the following must be borne in mind. It notes that: 'public intervention in the lives of children is often based on the assumption that they lack competence, but with adults a contrary assumption applies. Where an adult lacks capacity and is placed at risk as a result, the need for intervention may be heightened. However, the need for intervention can, in some cases, extend to those with decision-making capacity' (Law Commission, 2010, para 12.1).

2.1.2 Working together with people, not compelling them

Nonetheless, because of this starting assumption that adults have the capacity for self-determination, there is also a corresponding strong assumption that agencies involved in safeguarding will work with people to assist them in a way in which they wish to be assisted, rather than intervening against people's wishes and with compulsion.

The Law Courts have pointed out, for example, that the main function of local social services authorities is precisely to work with people and to arrange community care services, not tell people what to do and threaten them if they don't do it.⁴

2.2 Empowerment and protection: giving people information and choice

Empowerment of adults at risk of harm is referred to in the *No secrets* guidance. The views of victims need to be listened to; they may need help with options, information and support; and their rights to self-determination and family life must be respected (DH, 2009a, p 5).

2.2.1 Empowerment part of the law

From a legal point of view, empowerment and informed decision making are very much part of the law. Generally speaking, most interventions require the consent and participation of the vulnerable adult. And even in those cases when a person's wishes may sometimes be overridden (for instance, under the Mental Capacity Act 2005), they must still legally be taken into account. Likewise, although the CPS can ultimately override a victim's wishes in deciding to prosecute in the public interest,

it must – according to the *Code for Crown Prosecutors* – first take account of those wishes (CPS, 2004, para 5.12).

2.2.2 Choice as against compulsion as a last resort

So although in some circumstances, a person's choice may only go so far, that person's involvement in decision making about safeguarding should remain fundamental. That said, there are some circumstances, *as a last resort*, when compulsion legally may be used and indeed called for – when, in effect, public policy and the law demand protection.

2.2.3 Human rights and choice

Notions of empowerment (in terms of autonomy and self-determination), information and choice are supported by a number of key legal principles. For example, strongly supportive of the principle of individual self-determination, including one's own physical and psychological integrity, is Article 8 of the European Convention on Human Rights. This refers to a right to respect (by the state) for one's home, private and family life. Excessive intervention by the state will not be consistent with this.

2.2.4 Mental capacity, autonomy and choice

The Mental Capacity Act 2005 likewise is, at a general level, about empowering people in two different ways.

First, it is about not jumping to premature conclusions that a person lacks capacity. The practicable assistance to help people understand and take decisions may come in many various forms including various means of communication, timing, environment, reiteration (repeating things) etc.

Second, even when a person lacks capacity, the Act states that people must still be encouraged to participate in the decision and their past and present wishes taken into account. Although, by definition, these wishes are not legally decisive (they do not have to be followed), nonetheless, they still carry significant legal weight (Mental Capacity Act 2005, Section 1).

2.2.5 Ability to communicate choice because of coercion or undue influence

A person may, because of particular circumstances, be unable to communicate and thus be unable to give informed and free consent – even if he or she has mental capacity in principle to do so. In such circumstances the courts may on occasion intervene, precisely to enable the person to exercise free and informed choice:

Arranged marriage: free and informed consent. A woman who could communicate only in British sign language was going to Pakistan with her parents to contract an arranged marriage (which in principle she had mental capacity to consent to). She was likely to be in the position of not understanding what was going on and not being able to communicate her wishes. The court

used its inherent jurisdiction to put in place safeguards (independent, official corroboration that she was giving free and informed consent) to enable her to make a free and informed choice.⁵

Alternatively, a person might decline a particular, or even any, intervention because of undue influence or even coercion, in which case, such a choice may not be taken at face value. Support may be required to help a person make a decision free of such influence. The courts might sometimes intervene by exercising their inherent jurisdiction and overruling a person's apparent wishes, even if that person has mental capacity to take the decision. But such an intervention is in principle not to remove, but to restore, choice and control, thus enabling the person to make a free and informed decision.

2.2.6 Community care assessments

Section 47 of the NHS and Community Care Act 1990 governs the assessment for and provision of community care services – including safeguarding activities – by local social services authorities. Under the terms of Section 47, it is the local authority that must, legally, have the final word about someone's needs and what services to provide.

2.2.7 Community care assessment directions: consulting with people

However, legally binding directions issued under this Act state that the local authority must consult the person being assessed – and take all reasonable steps to reach agreement with that person about the provision of services (DH, 2004a). Legally, providing assistance to safeguard people is a community care service, whether in the form of assessment, arranging a service or just providing information and advice. The directions on assessment therefore support giving people choices in safeguarding situations.

2.2.8 Community care: working with people, not compulsion

This legislation is about working with people and arranging assistance for them; it is not about telling people what to do, nor is it about compelling people to do things.

2.2.9 Disclosing information and consent

Generally speaking, there is a legal presumption that a person's consent must be obtained before information is passed on about them. At times, this presumption is displaced; for example, if other people would be put at risk of harm. This is why the *No secrets* guidance states that practitioners should not promise to keep all information given to them by a vulnerable adult confidential (DH and Home Office, 2000, para 5.6).

2.2.10 Criminal prosecution and consent

There are some circumstances in which the CPS may decide that, having taken account of the victim's wishes (and the consequences for the victim), a prosecution is

still necessary in the public interest, given the seriousness of the offence committed. Nonetheless, even then, the victim's wishes must still be taken account of (CPS, 2004, para 5.12).

2.3 Protecting a person without consent (and with compulsion)

There will be times, as a *last resort*, when the law may be used to act without a person's consent, sometimes against their wishes and with compulsion.

Examples of law covered in this guide, which allow intervention without a vulnerable adult's consent and maybe with compulsion, include the following:

Mental Capacity Act 2005: if a person lacks capacity to take a particular decision, then a decision has to be taken in that person's interests, necessarily without their legally effective consent. Restraint and deprivation of liberty are permissible in some circumstances, if there is no other way of achieving those best interests. This is under the Mental Capacity Act 2005.

Mental Health Act 1983: if certain conditions relating to mental disorder, harm and necessity exist, the Mental Health Act 1983 allows a number of compulsory interventions. For example, Section 135 allows the police, under certain conditions, to remove a mentally disordered person from a dwelling – and Section 136 from a public place.

Police power to enter premises: life and limb: the police can enter premises in order to save life or limb or prevent serious damage to property, under Section 17 of the Police and Criminal Evidence Act 1984.

National Assistance Act 1948: Section 47 of this Act allows removal of a vulnerable person, self-neglecting or neglected, from their own home. In practice, this provision is little used nowadays.

Public Health Act 1936: in relation to public health problems (such as infestations of vermin) arising from severely neglected dwellings, local authorities can gain compulsory entry (if otherwise denied it), with a warrant signed by a justice of the peace.

Common law of necessity: preventing harm to others: at common law (this means not in legislation), there is a doctrine of 'necessity'. This is when a person acts to prevent significant harm occurring and there it was necessary so to act. For instance, under the Mental Capacity Act 2005, a person can be restrained to prevent harm coming to himself or herself. But the Act says nothing about restraint to prevent harm to other people. The Mental Capacity Act Code of Practice explains that were such restraint absolutely necessary, it could be justified under common law.

2.4 Proportionality in safeguarding

While there is some legislation that allows for interventionist and compulsory measures, they are measures of last resort. And of fundamental importance, in relation to their use, is the principle of proportionality.

2.4.1 Striking a balance between protection and not interfering

The *No secrets* guidance talks of protection, justice and empowerment. In relation to the latter it refers to independent life, self-determination and personal choices. Striking the balance between protection of people in their own, and in the public, interest – but not interfering excessively with the private and family life of that individual or other people – goes to the heart of what proportionality is about.

2.4.2 Judging when to intervene

From a practical point of view, the importance of proportionality lies in the fact that if practitioners and agencies do not adopt a proportionate approach, they may do the vulnerable person more harm than good. Alternatively, or as well, unjustifiable harm may be suffered by other people.

Agencies and practitioners involved in safeguarding may sometimes feel that they are caught between two stools. On the one hand, this may involve doing too little in the face of serious harm coming to a vulnerable adult. On the other, it may result 'going in with all guns blazing' in situations that do not in fact call for this – and which result in disproportionate and undue interference.

2.4.3 Proportionality: human rights and mental capacity legislation

The principle of proportionality is explicit in some legislation, particularly in the Human Rights Act 1998 and the Mental Capacity Act 2005. For instance, under Article 8 of the European Convention on Human Rights, there is a right to respect for family, home and private life. So, if a local authority (or any other public body) is considering a drastic action – such as saying where a person lacking capacity should live, whom they should see or what they should do – it must first consider less drastic options.

Likewise, under Section 1 of the Mental Capacity Act 2005, after a person has been assessed as lacking capacity to take a particular decision, the least restrictive option needs to be considered before a decision is taken in a person's best interests.

If a disproportionate approach is taken either way – too little or too much intervention – the vulnerable adult may be worse off. So the courts attach warnings to draconian intervention because the state, in 'rescuing' a person, can itself end up being abusive – 'out of the frying pan into the fire'.

Major intervention must be used with caution. And the court must be careful to ensure that in rescuing a vulnerable adult from one type of abuse it does not expose her to the risk of treatment at the hands of the state which, however

well intentioned, can itself end up being abusive of her dignity, her happiness and indeed of her human rights. That said, the law must always be astute to protect the weak and helpless, not least in circumstances where, as often happens in such cases, the very people they need to be protected from are their own relatives, partners or friends.⁶

The proportionality of response will be closely linked to the relevant evidence about risk. Clearly, the greater the risk to a person, the more substantial the intervention may need to be. It is about weighing up obvious concern for a person's welfare and the temptation always to 'play it safe' – against the danger of excessive intervention, unjustified on the evidence.

2.5 Wider implications of law relevant to safeguarding

As already stated, three key concepts underpinning the safeguarding of vulnerable adults at risk of harm are protection, justice and empowerment. The law supports all three. However, the law has implications beyond just vulnerable adults at risk of harm. There are, in addition, implications for (a) vulnerable adults as perpetrators of harm, (b) people who work with vulnerable adults and (c) organisations providing services for vulnerable adults.

2.5.1 Vulnerable adults as perpetrators of harm

Vulnerable adults may themselves be, and be seen as, perpetrators of harm. For example, Non-Molestation Orders (civil orders that the courts can make) are sometimes made against vulnerable people as perpetrators. ASBOs are sometimes made against people who are themselves vulnerable adults. Housing possession (eviction) proceedings are sometimes taken by a landlord against a vulnerable tenant, for breach of the conditions of the tenancy including anti-social behaviour. Criminal proceedings may be taken against vulnerable adults for minor or more serious offences.

Government guidance refers to the need to consider supporting vulnerable perpetrators of anti-social behaviour, with a view to avoiding draconian orders or evictions (ODPM, 2004a). In a number of legal cases, the courts too have referred to the importance of such support.

Under the Police and Criminal Evidence Act (PACE) 1984, for example, special rules apply to vulnerable adults who are suspects (as opposed to victims and witnesses). These are set out in a code of practice made under the Act.⁷ And sometimes, the courts will order 'special measures' related to court proceedings, not just for vulnerable victims and witnesses, but also for vulnerable people who are accused of a criminal offence.

It should be noted that if it appears that a vulnerable adult has a community care need – for example, practical assistance, support or advice – then he or she will be entitled to a community care assessment by the local authority and may also be entitled to services.

2.5.2 Protection of people who work with vulnerable adults

Safeguarding vulnerable adults has become an important part of public policy. However, people who work with vulnerable adults have legal rights too. Applying the Human Rights Act 1998, the courts have been astute in recognising that there needs to be a balance; if excessive rules and measures are put in place to safeguard vulnerable adults, the effect may sometimes be legally unfair on workers.

Speedy hearings for banned workers. The courts have stated that if workers are to be banned from working with vulnerable adults, there must from the outset be fair and speedy appeal procedures for those workers.⁸

Enhanced criminal record certificates: balanced provision of information by police. When the police supply to the Criminal Records Bureau (CRB) (and thence to employers), extra, 'soft' information in relation to enhanced criminal record certificates provided for workers – they must avoid indiscriminate provision of such information. Instead, they must carefully weigh up the arguments for and against disclosure – the importance of protecting vulnerable adults as against not unfairly blighting the worker's life.⁹

2.5.3 Legal protection of organisations providing services for vulnerable adults

If agencies fail in some situations to protect vulnerable adults, they may in some circumstances be legally liable, one way or another. However, equally, the law also affords a degree of protection from liability for those very same agencies. In particular it sometimes protects public bodies, such as local authorities, the NHS and the police.

The reason for this, overall, is in recognition of the difficult job that such public bodies have, and that to hold them liable in all circumstances when things go wrong would be not only unfair but also counter-productive. For instance, agencies might become so defensive, anxious and engaged in legal cases, that already over-stretched public services might become even more so. The courts will sometimes protect such bodies if the action or decision in question is related either to duties and powers under legislation or to a lack of resources.

Protection of people (including vulnerable adults) from harm and of public bodies from excessive litigation. Local authorities or the police are sometimes sued in negligence for failure to protect a person from a third party. Although the courts will not absolutely rule out liability such a case, they will generally argue that in principle the police should not be liable – for instance, if the police fail to protect a person from a suspect, who then murders the witness before trial.¹⁰

Likewise, for local authorities: when two people with learning disabilities suffered torture and abuse at the hands of a group of young people, the court held that the local authority social worker had not been negligent. But it also said that, even if the social worker had been negligent, the local authority would anyway not have been held liable.¹¹

However, it should be stressed that this is not a reason for statutory agencies to become complacent; this is a developing and changing area of law. In the example given immediately above, the local authority was held liable in the High Court and only succeeded with its arguments on appeal.

3 Legal action and complaints

3.1 Key points

Government has referred not just to protection and empowerment, but also to justice. There may be different routes to achieving 'justice'. The three main ones are criminal prosecutions, civil law actions and complaints made against providers of services for either failing to deal with abuse or actually perpetrating it.

3.2 Finding the right bit of law

There is a lot of law relevant to safeguarding vulnerable adults. Safeguarding is such a fundamental issue, cutting across so many situations in life, that it engages with the law on many fronts.

3.2.1 Knowledge of the law

The *No secrets* guidance states that agencies and practitioners should know about the law and use it appropriately. At the very least, this would seem to involve the following considerations.

Duties and powers to assist or intervene and their limits: the relevant law will signal not only whether there is (or, conversely, is not) a power or duty to assist, act or intervene, but also the extent and limits of what can be done. This is particularly important for three reasons.

- *Optimum outcome:* first, so that the agency knows what lawful options are available, can discuss these with the person who needs help, and work out how best they can be applied to a particular situation. This is in order to achieve the best outcome for the person at risk of harm.
- *Acting within the law:* second, not acting within the law may entail legal consequences for the agency. For instance, if a public body fails to act reasonably in relation to a vulnerable adult, it may be subject to a 'judicial review' legal case.

Judicial review for not keeping within legislation or the statutory guidance.

This happened when a local authority attempted unlawfully to charge highly vulnerable people for care home placements, but didn't keep to the rules set out in legal regulations about such charging.¹²

Likewise, the CPS was successfully challenged when it failed to apply statutory guidance, the *Code for Crown Prosecutors*, in relation to the ability of a person with mental health problems to give evidence.¹³

- *Acting within the law to avoid harmful consequences of intervention:* third, an agency might otherwise overstep the mark, go beyond what the law allows, and so act not just unlawfully but perhaps to the unintended harm of the person in need of safeguarding. Arbitrary use of power can go wrong, no matter how well intentioned. This is why, for example, there are now detailed procedural

rules about the circumstances in which it is permissible to deprive a person lacking capacity of his or her liberty. There are called the Deprivation of Liberty Safeguards (DoLS) under the Mental Capacity Act 2005.

Different legal options: because there is a lot of potentially relevant law, there may be more than one option that can be used to safeguard an adult at risk of harm. So if one option is not legally possible (because it does not apply to the situation that has arisen) – or will not result in a good outcome for the person at risk – then another may be available.

Choice of civil proceedings. A vulnerable person, subject to domestic violence, might be adamant that she will not give evidence in criminal proceedings; and the police and CPS might then conclude that prosecution is consequently either impractical or undesirable. However, the person might instead be prepared to consider civil proceedings in order to obtain, for instance, a Non-Molestation Order or an Occupation Order under the Family Law Act 1996.

It might not be one or the other. For example, both civil and criminal law, in conjunction with support services, might be required to protect a person in some situations. (CPS, 2009a, para 1.7)

When a person has mental capacity: alternatively, a person might legally have mental capacity to make a particular decision – for example, about money, or contact with other people – but nonetheless tend to make unwise decisions or be exploited. For example, a home care worker may be worried that a client is spending all their money on the lottery and not eating well. Social workers acting for a local authority will be unable to intervene using the Mental Capacity Act 2005. However, they can still provide support and advice for the person under Section 47 of the NHS and Community Care Act 1990 and Section 29 of the National Assistance Act 1948.

Considering different legal avenues: in the following example, several pieces of legislation are relevant.

Finding a legal underpinning for placement in a care home. A local authority may wish to make a care home placement for an adult at risk of harm, who lacks mental capacity and is at high risk of neglect in his or her own home. The local authority does not have a divine right to do this. Instead, its ability to do so rests on several pieces of legislation.

These include the NHS and Community Care Act 1990 (the assessment of the person), Carers and Disabled Children Act 2000 (the assessment of any informal carer), National Assistance Act 1948 (the care home placement), Mental Capacity Act 2005 (the decision about the person's capacity and about his or her best interests) and Human Rights Act 1998 (whether such a course of action is a proportionate response to the situation and consistent with respect for the person's private and family life).

The importance of exploring different legal avenues, in order to safeguard vulnerable adults, was noted in the much reported case of Fiona Pilkington:

Possible legal options: anti-social behaviour, hate crime, possession proceedings. A woman killed herself and her disabled adult daughter – by setting fire to the car they were in. She had been in despair at the persistent harassment received over a period of 10 years by a group of local youths. However, when asked, she had chosen not to support criminal prosecution.

A serious case review concluded that the local authority and the police should have looked much harder at how to classify what was going on and what they could do about it. At least three alternatives identified were anti-social behaviour (leading to voluntary good behaviour contracts or court injunctions), disability hate crime and possession proceedings against the perpetrators (Leicester, Leicestershire and Rutland Safeguarding Adults Board, 2008).

3.3 Access to justice: taking legal proceedings

Taking cases to court is of course a major step. There are various rules and issues that need to be sorted out first, sometimes relating to 'permission' to bring the case, sometimes to questions of funding and covering of legal costs.

3.3.1 Who brings legal proceedings?

There is also the question of who is going to take the case. Sometimes, it will be down to a particular agency, sometimes to the person him- or herself, or somebody acting on their behalf.

3.3.2 The prosecuting organisations

Most criminal prosecutions are the responsibility of the CPS (the police can decide to prosecute some more minor offences). The Health and Safety Executive (HSE) can prosecute under health and safety at work legislation, and the Care Quality Commission (CQC) can do so under the Health and Social Care Act 2008, likewise, local authority trading standards officers.

3.3.3 Victim, litigation friend, official solicitor

On the other hand, other types of legal proceeding would have to be brought by the 'victim', or somebody acting on their behalf. For instance, a 'litigation friend' can act on behalf of somebody else, including where the person lacks capacity. The 'official solicitor' can act for a person lacking capacity in a variety of civil proceedings – where there is nobody else suitable to act on behalf of the person. For instance, the official solicitor may get involved in negligence cases (seeking financial compensation for harm), judicial review cases (challenging the decisions made by public bodies such as local authorities, the NHS, the police etc) and mental capacity cases.

In the case of some civil protective orders, the applicant also has to be the victim or somebody acting on their behalf. However, in relation to Forced Marriage Protection Orders, the Family Law Act 1996 allows for a third party (such as a local authority or the police) to make the application. Under the Mental Capacity Act 2005, other interested parties can apply to the Court of Protection.

ASBOs or Injunctions (ASBIs) have to be applied for by a third party: local authorities, the police and some landlords.

3.4 Criminal and civil standards of proof

The standard of proof applied in criminal and civil law differs. In criminal law, the prosecution case has to be proved beyond reasonable doubt. This is not normally expressed in quantitative (percentage) terms, but does not mean '100 per cent' certainty; on the other hand, for example, the jury in a criminal case has to be sure of the person's guilt: roughly, 75 per cent certainty.

In civil law, the standard of proof is referred to as the balance of probability; this means that civil liability could be established on the basis of a 51 per cent likelihood that the person was responsible. So in some circumstances a civil case may succeed even though a criminal prosecution either fails or is not brought in the first place.

3.4.1 Practical comparison of criminal and civil standards of proof

For instance, in the following example, a prosecution for assault and battery failed but a civil case succeeded:

Criminal acquittal but civil legal consequences. Three care workers faced a criminal prosecution for alleged assault of an 87-year-old woman. This involved pouring talcum powder into her mouth. They had admitted using unnecessary force when washing and handling the woman. They were acquitted on the grounds of doubt about whether there was criminal intent or recklessness. However, the woman brought a civil negligence case against the agency; it settled out of court and agreed to pay £10,000 in compensation. (see Dayani, 2004)

3.4.2 Professional conduct cases

The standard of proof applied in professional conduct cases heard by professional regulatory bodies (such as the General Medical Council [GMC], Nursing and Midwifery Council [NMC], Health Professions Council [HPC] or General Social Care Council [GSCC]) is the civil standard.¹⁴ The effect of this, for example, is that a safeguarding-related allegation can be more easily proven against a practitioner than if the standard were set at the criminal level.

3.4.3 Criminal and civil consequences for professional

In the following case both criminal and civil consequences followed, involving conviction for a sexual offence and removal from the register of a social worker:

Criminal conviction and professional consequences. A mental health social worker had a sexual relationship with a depressed person who uses services whom he was meant to be helping. The Mental Capacity Act 2005 was irrelevant, because she had capacity to consent to the relationship. However, he was convicted under the Sexual Offences Act 2003, which makes it an offence

for a care worker to engage in sexual activity with a mentally disordered person who uses services. But, in addition, he was removed from the register of social workers by the General Social Work Council, under authority deriving from the Care Standards Act 2000.¹⁵

3.5 Criminal justice

Abuse barely features as a term in criminal law.

3.5.1 Range of offences

The CPS has issued guidance that links types of behaviour with criminal offences. In summary, it is as follows:

- *Hitting, slapping, pushing, kicking*: common assault under Section 39 of the Criminal Justice Act 1988; actual bodily harm under Section 47 of the Offences Against the Person Act (OAPA) 1861; grievous bodily harm/with intent in Sections 20 and 18 of the OAPA 1861.
- *Misuse of medication to manage behaviour*: assault, false imprisonment, application of stupefying over-powering drugs with intent to commit indictable offence under Section 22 of the OAPA 1861, poisoning with intent to injure, aggrieve or annoy under Sections 23 and 24 of the OAPA 1861, unlawfully administering medication under Section 58 of the Medicines Act 1968, failure to comply with conditions for medication under the Care Standards Act 2000 (now, the Health and Social Care Act 2008).
- *Inappropriate restraint*: false imprisonment, common assault, aggravated or grievous bodily harm under the OAPA 1861, kidnapping, contravention of care standards regulations, choking under Section 21 of the OAPA 1861.
- *Inappropriate sanctions*: false imprisonment, assault, ill treatment/wilful neglect under Section 44 of the Mental Capacity Act 2005 or Section 127 of the Mental Health Act 1983, breach of care standards regulations.
- *Sexual offences*: Sexual Offences Act 2003.
- *Threats of harm or abandonment*: threats to kill under Section 16 of the OAPA 1861, blackmail under Section 21 of the Theft Act 1968, common assault, ill treatment/wilful neglect under Section 44 of Mental Capacity Act 2005 or Section 127 of the Mental Health Act 1983.
- *Deprivation of contact, isolation or withdrawal from services or supportive networks*: false imprisonment, ill treatment/wilful neglect under Section 44 of the Mental Capacity Act 2005 or Section 127 of the Mental Health Act 1983, breach of care standards regulations.
- *Humiliation, intimidation, emotional blackmail, verbal abuse*: being shouted or sworn at: fear of violence under Section 4 of the Public Order Act (POA) 1986, intentional harassment or alarm or distress under Section 4A of the POA 1986, harassment or alarm or distress under Section 5 of the POA 1986, course of conduct amounting to harassment/causing another to fear under Sections 1 and 4 of the Protection from Harassment Act 1997, harassment of a person in their home under Section 42A of the Criminal Justice and Police Act 2001, blackmail under Section 21 of the Theft Act 1968, common assault.

- *Theft, fraud, exploitation, pressure in connection with wills, powers of attorney, financial transactions, or the misuse or misappropriation of property, benefits or possessions:* theft or robbery under Sections 1 and 8 of the Theft Act 1968, blackmail under Section 21 of the Theft Act, fraud under the Fraud Act 2006, forgery under Section 25 of Identity Cards Act 2006 and Forgery and Counterfeiting Act 1981.
- *Ignoring medical or physical care needs, failure to provide access to appropriate health services, withholding medication, adequate nutrition or heating, unmet physical needs such as bedding or clothing soaked in urine or faeces, decaying teeth, overgrown nails:* false imprisonment, wilful neglect or ill treatment of a person lacking mental capacity under Section 44 of the Mental Capacity Act or Section 127 of the Mental Health Act, breach of care standards regulations.
- *Impairment of, or an avoidable deterioration in physical or mental health, the impairment of physical, intellectual, emotional, social or behavioural development:* wilful neglect or ill treatment of a person lacking mental capacity under Section 44 of the Mental Capacity Act or Section 127 of the Mental Health Act, breach of care standards regulations.
- *Actions resulting in death:* murder, manslaughter, corporate manslaughter, causing or allowing death of a vulnerable person in a domestic setting under the Domestic Violence, Victims and Crime Act 2004, aiding or abetting suicide under Section 2 of the Suicide Act 1961, breach of care standards regulations (CPS, 2008, Annex A).

3.5.2 Role of the Health and Safety Executive

In addition, there may be some circumstances in which the HSE may investigate circumstances relevant to safeguarding – for example, where systems of work have failed and people have suffered serious harm as a result, systematically or otherwise. Local authority trading standards officers also have powers to prosecute relevant offences, for example, in the case of rogue tradespeople calling door-to-door and defrauding vulnerable people.

The factors that govern when and whether the CPS will prosecute are outlined in Section 16 of this guide.

3.6 Civil legal remedies: judicial review and torts

Various civil legal proceedings can be taken against providers of services. These include 'judicial review' of public bodies, and also what are called 'torts', that is, civil wrongs such as negligence, trespass to the person and false imprisonment. People use these remedies to sue for financial compensation for the wrong.

These civil wrongs can be directly relevant to safeguarding and may constitute an alternative or additional remedy to any criminal case. As explained in Section 5 of this guide, civil law operates on the balance of probability, whereas criminal law demands a more searching standard of proof – beyond reasonable doubt. Furthermore, these civil remedies have the potential to provide financial compensation for harm suffered.

3.6.1 Judicial review cases

Judicial review applies basically to public bodies only. If a public body has failed to adhere to legislation, otherwise behaved irrationally, failed to take account of relevant factors or imposed an excessively rigid policy (by 'fettering its discretion'), then a judicial review legal case might be possible.

In terms of safeguarding, a judicial review case could challenge a local authority in terms of failure to intervene and protect somebody.

Judicially reviewing public bodies on safeguarding matters. If a local authority refused to act in the role of 'deputy' to manage welfare issues relating to a person lacking capacity, the reasonableness of that decision could be challenged by a judicial review.¹⁶

Likewise if a local authority, in pursuance of its community care duties, failed nonetheless to act in the best interests of a person who lacks capacity – then the reasonableness of this decision might be challengeable.¹⁷

When the CPS failed to prosecute, because it had judged unreasonably that a man with mental health problems could not give reliable evidence, it was successfully challenged in a judicial review case.¹⁸

3.6.2 Negligence: duty of care

Civil negligence cases are brought in respect of physical harm; sometimes psychological or financial harm might underpin the case. The key elements that have to be shown are (a) the existence of a duty of care, (b) breach of that duty of care because of an action, omission or decision that falls beneath the reasonable standard, and (c) harm flowing from that breach of duty.

3.6.3 Trespass to the person

Trespass to the person is the civil law's version of assault and battery in criminal law.

In the following case, an active, life-preserving medical intervention, against a person's wishes, constituted trespass to the person:

Requirement on hospital not to provide treatment against a person's wishes. A former social worker had suffered a haemorrhage, leaving her paralysed and dependent on a ventilator. In hospital, she requested that the ventilator be turned off; physically, she was unable to do so herself. The staff had refused. The case went to court, which considered the evidence about her mental capacity. It judged that she did have capacity to take this decision. The failure of the NHS trust overall (as opposed to individual staff) to solve the issue urgently meant that it had committed a trespass to the person, for which the woman was awarded token damages. The NHS trust would now have to turn the ventilator off.¹⁹

3.6.4 False imprisonment

False imprisonment is the civil law equivalent of the criminal offence of the same name. It is a tort of strict liability. This means that the commission of the act means automatic liability. It involves the infliction of bodily restraint that is not expressly or impliedly authorised by the law.

Alleged false imprisonment and assault for excessive intervention under Section 136 of the Mental Health Act 1983. A person tried to bring proceedings in relation to the use of excessive force used under Section 136 of the Mental Health Act 1983 (removal of person from a public place). It involved a canister of CS gas that he claimed was sprayed too close to him for too long, causing serious blistering. Also there were doubts about whether the police explained that Section 136 was being used and whether they gave the necessary or any warning. The claim was for assault and false imprisonment. The court gave permission for the case to proceed on the basis that it had a real prospect of success.²⁰

3.6.5 Vicarious liability

In civil tort cases, the principle of vicarious liability applies. That is, where an employer is responsible for the acts of an employee. For instance, even if the employee has performed acts of abuse or neglect that were obviously no part of what he or she was employed to do, the organisation may still be held liable – if the tort was committed in the overall context of the employment.²¹

3.7 Making a complaint against a provider of services

Providers of services have complaints procedures that may be used in relation to safeguarding matters.

3.7.1 Health and social care providers: complaints

All health and social care providers must have complaints procedures under care standards regulations.²² There are additional rules for local authorities and NHS providers.²³

3.7.2 Local Government Ombudsmen and the Health Service Ombudsman

If complainants are dissatisfied with the outcome of a complaint in health or social care, they can take the complaint further to either the Health Service Ombudsman (for NHS bodies) (Health Service Commissioner Act 1993) or the Local Government Ombudsman (for local authorities) (Local Government Act 1974).

The Local Government Ombudsmen (there are three in England) can investigate not only local authorities but also the actions of independent providers under contract to local authorities. From October 2010, they can also investigate independent providers where the arrangement is purely private between the person who uses services

and the provider. The Health Service Ombudsman can currently also investigate independent providers, where they have been commissioned by an NHS body.

3.7.3 Housing providers: complaints

Social housing providers are obliged to join the Housing Ombudsman scheme (Housing Act 1996, Schedule 2). This includes all providers registered with the Tenant Services Authority including landlords, managing agents and developers (but does not include local authorities). This enables people to appeal complaints against social housing providers to the Housing Ombudsman.

3.7.4 Police: complaints

The Independent Police Complaints Commission operates under the Police Reform Act 2002 and can be appealed to if a person is unhappy about how a complaint against the police has been handled at local level through either a local resolution process or more formal police investigation.

3.7.5 Crown Prosecution Service: complaints

The CPS operates a complaints system that can deal with a complaint less or more formally. If a complainant remains dissatisfied, appeal can be made to the Parliamentary Ombudsman operating under the Parliamentary Commissioner Act 1967.

Notes

¹ *R v Islington London Borough Council, ex p Rixon* [1997] 1 ELR 477, High Court.

² *Brent London Borough Council v SK* [2007] EWHC 1250 (Fam).

³ *Re Z* [2004] EWHC Fam 2817, High Court.

⁴ *A Local Authority v A, B* [2010] EWHC 978 (Fam).

⁵ *Re SA* [2005] EWHC 2942 (Fam).

⁶ *Local Authority X v MM* [2007] EWHC 2003 (Fam).

⁷ Police and Criminal Evidence Act 1984. Code C. Code of Practice for the detention, treatment and questioning of persons by police officers, 2008.

⁸ *R (Wright) v Secretary of State for Health* [2009] UKHL 3.

⁹ *R (L) v Commissioner of the Police of the Metropolis* [2009] UKSC 3.

¹⁰ *Van Colle v Chief Constable of Hertfordshire* [2008] UKHL 50; *Smith v Chief Constable of Sussex* [2008] UKHL 50.

¹¹ *X & Y v Hounslow London Borough Council* [2009] EWCA Civ 286.

¹² *R v Sefton Metropolitan Borough Council, ex p Help the Aged* [1997] 3 FCR 573, Court of Appeal.

¹³ *R (B) v Director of Public Prosecutions* [2009] EWHC 106 (Admin).

¹⁴ Health and Social Care Act 2008, Section 112. And also GSCC (Conduct) Rules 2008, made under the Care Standards Act 2000.

¹⁵ *Bradford v General Social Care Council* [2006] 792 SW-SUS (Details in Care Standards Tribunal case).

¹⁶ *R (M) v Birmingham City Council* [2008] EWHC 949 (Admin).

¹⁷ *A v A health authority* [2001] EWHC 18 (Fam/Admin).

¹⁸ *R (B) v Director of Public Prosecutions* [2009] EWHC 106 (Admin).

¹⁹ *Re B (adult: refusal of treatment)* [2002] EWHC 429.

²⁰ *Johnston v Chief Constable of Merseyside Police* [2009] EWHC 2969 (QB).

²¹ *Lister v Hesley Hall* [2001] UKHL 22.

²² SI 2010/781. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

²³ SI 2009/309. The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009. Made under the Health and Social Care (Community Health and Standards) Act 2003.

Part 2: Human rights, information sharing and whistleblowing

- 4 Human rights and safeguarding
- 5 Information sharing and disclosure
- 6 Whistleblowing

4 Human rights and safeguarding

4.1 Key points

The *No secrets* guidance states that abuse is a violation of an individual's human and civil rights. Human rights are contained in the European Convention on Human Rights. The Human Rights Act 1998 integrated the Convention into UK law. Such rights are fundamental to protecting people – either from being directly harmed by the state or sometimes not being sufficiently protected by the state from harm.

4.1.1 Vulnerable adults

The proportionality principle is part of how human rights law works. It is to ensure that the state does not itself overstep the mark and, by trying to protect people, end up subjecting them to worse. This principle of proportionality relates to government policy that safeguarding is about protecting people, but also about people's autonomy, independence and freedom to make choices.

4.1.2 Those working with vulnerable adults

The principle also operates to protect *those people working with vulnerable adults*. This is to try to ensure that they are not subjected to unfair and excessive detriment, in the name of safeguarding vulnerable adults.

The human rights that typically stand out in relation to safeguarding include the right to life (Article 2 of the Convention), the right not to be subjected to torture or to inhuman or degrading treatment or punishment (Article 3), the right not to be deprived arbitrarily of liberty (Article 5), the right to a fair hearing (Article 6) and the right to respect for home, private and family life (Article 8).

Overall, human rights law is about ensuring that we enjoy certain freedoms, that we are protected *from* the state in terms of excessive interference and sometimes *by* 'the state' from particular forms of harm.

4.2 Human rights and safeguarding

The Human Rights Act 1998 imported into UK law the European Convention on Human Rights. The *No secrets* guidance states that: 'Abuse is a violation of an individual's human and civil rights by any other person or persons' (DH and Home Office, 2000, para 2.5).

4.3 Public bodies and human rights

Obligations under the Human Rights Act 1998 are imposed primarily on public bodies. In the context of safeguarding, these include, for example, government departments, local authorities, NHS bodies, the police, the Crown Prosecution Service (CPS) and the Probation Service.

4.3.1 Independent organisations carrying out functions of a public nature

On the face of it, independent organisations – for example, care homes, home care or nursing agencies, independent hospitals or social housing providers – are not public bodies. As such, they would not have human rights obligations toward people who use services, no matter how vulnerable.

However, the position is more complicated, because the Act applies also to anyone carrying out functions of a public nature. This means that in some circumstances an independent organisation – which is clearly not a public body in the formal sense – nevertheless comes within the Act in relation to some of its activities.

Housing association or independent mental health hospital: subject to Human Rights Act. A housing association that had taken over – lock, stock and barrel – the housing stock of a local authority, was held to be carrying out functions of a public nature in relation to possession proceedings.¹

Registered housing providers generally will be 'hybrid' bodies; that is, some of their acts will be public, some will be private.²

Likewise, an independent hospital which was accommodating and treating a person detained under the Mental Health Act 1983 was also held to be carrying out functions of a public nature. This was because the hospital, through its contract with the NHS, was exercising statutory coercive powers.³

4.3.2 People's human rights in care homes

The question has arisen about whether care homes perform public functions and so have human rights obligations toward residents. It is an important question because many residents are vulnerable, and safeguarding issues can easily arise. If a care home belongs to a local authority, the position is straightforward; it is part of a public body. If the care home is run independently, the position is less clear.

In a major legal case, the courts held that – under the Human Rights Act as it stood – an independent care home did not have human rights obligations in respect of its residents:

Eviction of 84-year-old woman with Alzheimer's disease from care home. An independently operated care home wanted to evict an elderly woman. The woman had been placed there by Birmingham City Council. The company had now written to the woman's daughter, referring to a 'continuing and irreconcilable breakdown in relationship' between the daughter and the care home. The care home had also referred to its unhappiness about the alleged behaviour of the woman's husband toward staff. The Official Solicitor launched proceedings on the woman's behalf. The House of Lords confirmed that such care homes did not perform functions of a public nature. This was so, whether the residents had been contractually placed in the home by a public body, or whether they were self funding (that is, had their own contracts with the home).⁴

As a result of this case, the government passed a new legal rule contained in the Health and Social Care Act 2008. This now means that a care home does in fact perform functions of a public nature – in the case of anybody placed in the care home by a local authority under Sections 21 and 26 of the National Assistance Act 1948. In which case, the care home does, after all, have human rights obligations in respect of that resident (Health and Social Care Act 2008, Section 145).

4.3.3 Self-funding residents

But such obligations will not arise in the case of 'self-funding' residents, that is, people who have placed themselves in the home.

4.4 Article 2: Right to life

Article 2 of the European Convention on Human Rights states that: 'Everyone's right to life shall be protected by law'. This means that the state must take reasonable steps positively to safeguard people's rights to life, as well as not take people's lives intentionally and unlawfully. It can mean setting up adequate enquiries in certain circumstances when people have died in connection with the acts or omissions of public bodies.

4.4.1 Positive duty to take adequate steps to protect a person under Article 2

Safeguarding situations sometimes raise the issue of ongoing protection (of the life) of a vulnerable adult. The extent of such a positive duty, to protect people's lives, has been tested out in relation to police intervention, and as to whether failings could in some circumstances engage and breach Article 2:

Adequate protection by the police of a boy and his father. In a case involving the wounding of a 15-year-old boy and murder of his father by a teacher, the police had been warned about the dangers posed by the teacher some months earlier. They had not put in place protective measures. The English courts held that the police had not been negligent, and that even if they had been, they would not have been liable because it would not have been in the public interest. The European Court of Human Rights subsequently held that there had been no actual breach of Article 2 because it could not be shown that the police knew or should have known about any real or immediate risk. However, it held that the blanket immunity conferred on the police, from negligence cases, was a breach of Article 6 of the European Convention (right to a fair hearing).⁵

The decision in this case was therefore to the effect that there might in principle have been a breach of Article 2, had the police been aware of a real and immediate risk to members of the family and not acted on it.

A similar approach has been applied to NHS trusts in relation to patients detained under the Mental Health Act 1983; Article 2 might in principle be engaged if staff know of a real and immediate risk of suicide and fail to take reasonable measures to protect the patient.⁶

Article 2 arose in a very different context – personal care in people's homes – in a case about the manual handling of physically disabled people:

Balanced approach to manual handling and human rights. The case involved the manual handling of two adult sisters, with profound physical and learning disabilities. The local authority allegedly operated strict and blanket 'no lifting' policies. The court stated that Article 2 might be engaged if the building caught fire or if they slipped under the water in a bath and could be saved only by being lifted out.⁷

The implication in this last case was that, in respect of Article 2, reasonable steps might need to be taken to save people's lives in such situations, strict health and safety policies notwithstanding.

4.4.2 Conducting an adequate inquiry or investigation under Article 2

Article 2 may sometimes require an enquiry or investigation, following the death of a person – for example, somebody in custody or prison – or somebody who has otherwise died violently or potentially unlawfully at the hands of the state. The following case under Article 2 was about whether an adequate enquiry had been held about the murder of a number of children by a nurse:

Adequate inquiry into killings by nurse. A nurse had been convicted of killing a number of children at Grantham Hospital. It was argued that the inquiry set up was inadequate because, for example, it was not public and did not have the power to compel witnesses. However, the European Court found that the state (the government) had taken adequate steps. First, the inquiry was adequate because it had an independent chair and its findings were made public. Second, criminal prosecution and the possibility of civil proceedings meant there were sufficient safeguards.⁸

4.4.3 Positive actions and investigations to satisfy Article 2

A combination of legal regulations, remedies (criminal and civil) and inquiries might be needed to satisfy Article 2, following somebody's death.

The European Court made this clear in a case involving the disappearance of a woman with dementia from a nursing home in Bulgaria. A breach of Article 2 occurred because, over time, insufficient attempts were made to establish what had actually happened to her. However, there was no breach in respect of the actual police actions at the time in terms of trying to find her:

Disappearance of woman with dementia from a nursing home. A 63-year-old woman with Alzheimer's disease had disappeared from the medical unit of a nursing home. She needed constant supervision; staff had been instructed not to leave her unattended. She was left alone in the yard of the nursing home by a medical orderly. She disappeared and was never seen again; 10 years later, the court assumed she was dead. Her son suspected she had been abducted by a gang trading in human organs.

First, the court held that despite three different avenues of legal redress – criminal, disciplinary and civil – the authorities in practice did not take steps to establish the facts of the disappearance and responsibility for any breach of duty. This was a breach of Article 2.

Second, although the police had not immediately tried to find her, this was not unreasonable and not a breach of Article 2. The staff of the nursing home (who, unlike the police, knew what she looked like), had already failed to find her, and the police had other calls on their resources.⁹

4.5 Article 3: Right not to be subjected to torture, or to inhuman or degrading treatment or punishment

Article 3 states that people have a right not to be subjected to torture or to inhuman or degrading treatment or punishment. This is an absolute right, which is not subject to any provisos or conditions (compared with Article 8 below).

4.5.1 Threshold of treatment to breach Article 3

The European Court of Human Rights has stated that inhuman or degrading treatment means that the ill treatment in question must reach a minimum level of severity, and involve actual bodily injury or intense physical or mental suffering. Degrading treatment could occur if it 'humiliates or debases an individual showing a lack of respect for, or diminishing, his or her human dignity or arouses feelings of fear, anguish or inferiority capable of breaking an individual's moral and physical resistance'.¹⁰

4.5.2 Article 3 and safeguarding

So what might this mean in relation to safeguarding? The following case involved a physically disabled woman subjected to degrading treatment in a police cell:

Degrading treatment of disabled woman in police cell and prison hospital. A severely physically disabled woman had not disclosed her assets in a legal debt case and was sent to prison for contempt of court. In the police cell where she was first held, she could not use the bed, slept in her wheelchair and became very cold (a police doctor had to wrap her in a space blanket during the night). Subsequently in the prison hospital, she required assistance to use the toilet, the female duty officer could not manage alone and male staff had to help.

The European Court held that detaining a severely disabled person – in conditions where she was dangerously cold, risked developing pressure sores because her bed is too hard or unreachable, and was unable to go to the toilet or keep clean without the greatest difficulty – constituted degrading treatment.¹¹

4.5.3 Leaving people in bodily waste

In the manual handling dispute (already mentioned above under Article 2), the court stated that Article 3 might well be engaged, for example, if the failure to lift the two

severely disabled sisters manually meant they were left sitting in bodily waste or on the lavatory for hours, unable to be moved because of overly rigid manual handling rules and policy.¹²

4.5.4 Giving a voice and access to justice to a vulnerable adult

In one case, a breach of Article 3 was established not because of physical harm directly perpetrated by the state, but because of its failure effectively to allow a victim to be heard and have access to justice – one of the main planks of the *No secrets* guidance. The case involved the failure of the CPS to prosecute an assailant who had allegedly bitten off, partially, the ear of a man with mental health problems.¹³

4.5.5 Inhuman or degrading treatment: awareness of the person

Some people say that if a person is unaware of the degrading treatment to which they are being subjected, then it is not in fact distressing to them – in which case Article 3 is not breached.

Legally, this is the wrong approach – it would leave open the door to highly degrading treatment of a person, simply because he or she cannot perceive what is happening (because of cognitive impairment or unconsciousness). The courts have stated that it would be 'demeaning to the human spirit to say that, being unconscious, he can have no interest in his personal privacy and dignity, in how he lives or dies'.¹⁴ Likewise they have stated:

Degrading treatment even if the person is unaware of it. Treatment is capable of being 'degrading' within the meaning of Article 3, whether or not it arouses feelings of fear, anguish or inferiority in the victim. It is enough if judged by the standard of right-thinking bystanders – human rights violations obviously cannot be judged by the standards of the perpetrators – it would be viewed as humiliating or debasing the victim, showing a lack of respect for, or diminishing, his or her human dignity.¹⁵

4.6 Article 5: Deprivation of liberty

Article 5 states that everyone has a right to liberty and security and that nobody should be deprived of then – unless he or she falls into a particular category of person, and only then in accordance with procedures prescribed by law. The categories of people referred to include people of unsound mind, alcoholics or vagrants or drug addicts – or if the deprivation is to prevent the spread of infectious disease.

4.6.1 Avoid rescuing people only to perpetuate or cause more harm

As far as safeguarding is concerned the importance of this right is clear. If people are deprived of their liberty arbitrarily, ostensibly to protect them, the consequences of the deprivation may themselves cause further harm. Equally of course, depriving

people of liberty in the first place – even if it is not arbitrary – is a potential cause of harm and should be a last resort.

4.6.2 Importance of procedural safeguards

So, the courts place great emphasis on the presence of procedural safeguards. Even if a local authority is acting in good faith, by depriving a person of his or her liberty in a care home or group home, the absence of legal, procedural safeguards will make the deprivation unlawful.¹⁶

4.6.3 The *Bournewood* case

Likewise, the informal detention in hospital, marked by an absence of legal safeguards, of an autistic man by an NHS trust, constituted a breach of Article 5 in the eyes of the European Court of Human Rights.

This case was known as the *Bournewood* case, giving rise to what was called the 'Bournewood gap'. This referred to people who because of their 'compliance' did not need to be detained under the Mental Health Act 1983, but who lacked the mental capacity to be voluntary, informal mental health patients (as referred to in Section 131 of the Mental Health Act 1983). The upshot was that they were effectively being detained without their consent, and with inadequate legal safeguards.

Need to avoid arbitrary detention of people lacking mental capacity. A 48-year-old man with autism had lived at a hospital for some 30 years. He now lived in the community, having been placed with a family. He lacked the ability to communicate consent or dissent about treatment or where he should live. He experienced frequent agitation. One particular day, he became agitated at a day centre and was hitting his head against a wall.

A doctor was called and gave a sedative; the man ended up being taken to Accident & Emergency at the hospital he had previously lived in. He was then assessed by a psychiatrist as needing inpatient treatment. But because he seemed to be compliant and did not resist admission, he was not formally detained under either Section 2 or Section 3 of the Mental Health Act 1983. He remained in hospital on this informal basis for several months, before eventually being sectioned, and then discharged shortly afterwards.

The House of Lords judged that this informal detention was lawful, and justified by the common law of necessity; however, misgivings were expressed about the lack of detailed safeguards for such vulnerable patients. The European Court of Human Rights subsequently gave substance to these misgivings by ruling that his detention had breached Article 5 of the European Convention. This was on the basis that his detention, for a substantial period of time, had been arbitrary and without fixed procedural rules – and he was not afforded a speedy review of whether his detention was lawful.¹⁷

4.6.4 Guarding against professional lapses or misjudgements

The European Court did not doubt that the professionals involved had acted in good faith. But they had assumed full control of the liberty and treatment of a vulnerable, mentally incapacitated person. This had been on the basis of their own clinical assessments, which had been carried out as and when they had seen fit. And the purpose of procedural safeguards was precisely to protect individuals against misjudgements or professional lapses.¹⁸

4.6.5 Deprivation of Liberty Safeguards

As a result largely of the *Bournewood* case, the Mental Capacity Act 2005 was amended. This led to a set of Deprivation of Liberty Safeguards (DoLS) being implemented in April 2009. They are described below, together with the factors the courts have identified as indicative of a deprivation of liberty.

4.7 Article 6: Right to a fair hearing

Article 6 states that in the determination of a person's civil rights and obligations or of any criminal charge against him, he or she is entitled to a fair and public hearing within a reasonable time, held by an independent and impartial tribunal established by law.

4.7.1 Fair and speedy hearings for accused person working with vulnerable adults

For example, in the context of barring people from working with vulnerable adults, Article 6 required a fair and speedy hearing for the accused worker:

Importance of fair and speedy hearing for people banned from working with vulnerable adults. In the context of safeguarding, Article 6 was breached in the case of some workers who had been provisionally barred from working with vulnerable adults.

This was under the old Protection of Vulnerable Adults (POVA) list, under which workers were barred from working with vulnerable adults. Before a final decision was made, workers would be placed on the list provisionally. The final decision might take many months.

In the meantime, workers might lose their job and suffer irreparable damage – without being able to challenge the provisional listing in timely fashion. This was a breach of Article 6.¹⁹

Although the POVA list was replaced by a 'barred list' (under the Safeguarding Vulnerable Groups Act 2006), the new scheme will need to be operated – by the Independent Safeguarding Authority (ISA) – in such a way as to be compliant with Article 6.²⁰

Article 6 was referred to in the following case by the Court of Appeal, when it decided that a man who had suffered a stroke had not been given a fair trial:

Vulnerable witness who had suffered a stroke. A man was conducting his own defence. This was in relation to his alleged failure to comply with a statutory notice under the Housing Act 1985. He had previously suffered a stroke. This had caused brain damage; it affected his ability to work, concentrate and remember things.

On the day of the trial, he waited all day in court before the hearing was held. When his case was called, he explained to the judge that he was exhausted – because of his stroke – and unable physically and mentally to conduct his case. The judge insisted on proceeding with the case.

The Court of Appeal held that the man had not been given a fair hearing. The stress and fatigue arising from the stroke had not been taken account of. The court referred specifically to Article 6 of the European Convention and to the importance of a fair trial.²¹

4.8 Article 8: Right to respect for a person's home, private and family life

Article 8 creates a right to respect for a person's home, private and family life. The courts have held that private life includes physical and psychological integrity.²² Private life can also raise issues of confidentiality.

4.8.1 Article 8, qualified right: can be interfered with

However, unlike Article 3, Article 8 is not absolute. The right it contains can be interfered with under certain conditions. In safeguarding, therefore, decisions about intervention have to balance the desirability of not interfering unduly – and the justification in terms of risk to the person involved or other people. The conditions allowing interference are that it is:

- in accordance with the law
- necessary in a democratic society
- for a specified purpose, including for the protection of health or morals, for the protection of the rights of other people, for the economic wellbeing of the country, for the prevention of crime.

4.8.2 Article 8 and safeguarding

In the context of safeguarding, Article 8 may therefore involve justifying an intervention, to show that it is not excessive and not disproportionate. For instance, in the following case, the court held that the local authority's intervention was too heavy handed. This was because it had not adequately balanced the woman's emotional welfare with its desire to make her physically safe – notwithstanding her vulnerability and the degree of risk involved.

Safeguarding a woman without imposing excessive restriction on her personal life. A woman with severe mental health problems was being supported by a local authority. She lacked the mental capacity to marry, to decide where to live and with whom, generally, to have contact. She had capacity to engage in a personal, sexual relationship with her longstanding partner who himself had mental health problems.

The local authority decided to restrict her contact with him to two hours, supervised, each month. The authority was worried about the risks that might arise from more contact with him. These included the risk that she would not take her medication and accept support, worsening of her mental health condition, homelessness and repeats of the domestic violence which she had experienced from her partner in the past. However, evidence suggested that she derived considerable psychological benefit from the relationship.

The court found a breach of Article 8, stating that the local authority had to arrive at a better balance between the risk and her emotional welfare; it should develop a new care plan allowing her more, unsupervised contact.²³

4.8.3 Article 8: sometimes requiring a positive intervention

Article 8 might, on occasion, be not just about justifying an intervention, but on some occasions it might demand it. For instance, a local authority breached Article 8, having left a severely disabled woman and her family for two years in what the court described as 'hideous conditions', without having intervened by providing community care services.²⁴

In the following case, the court held that Article 8 required a positive intervention to step in and prevent undue interference with a person's private life:

Positive intervention: removal of man from the care of his father. A man with learning disabilities lacking capacity was in the care of his father. The man was at risk. This involved physical injury and the risk of physical or emotional abuse. All things being equal, Article 8 would usually point to preservation of family life; sometimes it might point to the local authority. In this case, the balance sheet pointed toward the local authority, which wanted to place the man elsewhere away from the home. The father had buckled under the strain, did not accept responsibility for injuring his son and had made unreasonable demands on the local authority. Thus the 'local authority, may have a positive obligation to intervene, even at the risk of detriment to the father's family life, if such intervention is necessary to ensure respect for the son's Article 8 rights'.²⁵

4.8.4 Justifying an intervention under Article 8

In order to justify interference with private or family life, the public body has in principle to show three things:

Lawful authority: first, that it is acting in accordance with the law. For instance, if a local social services authority intervenes in respect of a person lacking capacity, it

would have to point – at least – to legislation such as the Mental Capacity Act 2005 (best interests decision), the NHS and Community Care Act 1990 (assessment) and the Carers and Disabled Children Act 2000 (assessment of any carer).

Necessity and proportionality: second, the intervention has to be 'necessary in a democratic society'. That is, less drastic options have been considered and been found wanting. This goes to the heart of the proportionality principle. In the following case – already referred to under Article 6 (above) – the scheme to protect vulnerable adults was disproportionate in its effects on workers such as nurses:

Fairness of listing workers provisionally as unsuitable to work with vulnerable adults. The court considered elements of a scheme (superseded in October 2009) for listing people provisionally as unsuitable to work with vulnerable adults. This was the POVA list under the Care Standards Act 2000. The court held that the scheme could, in some cases at least, breach Article 8. This was because the way the scheme operated (when people were placed on the list for an interim period pending a final decision) could, in effect, have a disproportionate effect on the private life of at least some workers.

The effect could include prohibiting people affected from a wide range of employment, putting people under a stigma affecting their standing with colleagues and the community, interfering with personal relationships with colleagues and with vulnerable people.²⁶

The court pointed out in this last case that the adverse effects of an unbalanced approach might be experienced not just by the workers but also by vulnerable adults themselves. This was because the personal relationships of the worker unfairly affected might include those with vulnerable people – relationships that are important for the welfare of those very vulnerable people.

Purpose of intervention: third, the public body needs to show the purpose for which it seeks to intervene, namely, a particular purpose as set out in Article 8. This might be protection of health, prevention of crime, protection of the rights and freedoms of others and so on. All these are highly relevant to safeguarding. For instance, the Public Health Act 1936 might be used to allow, as a last resort, forcible entry into a dwelling – occupied by an older person who has fallen into extreme self-neglect – overrun with vermin. The purpose could be explained as to protect the health of the occupier, as well as that of his or her neighbours.

4.9 Article 10: Right to freedom of expression

Article 10 states that everyone has the right to freedom of expression. This right includes the freedom to hold opinions and to receive and impart information and ideas without inference from the state.

4.9.1 Article 10: qualified right, can be interfered with

Like Article 8, this right is not absolute. It is subject to a number of provisos. These are that, because freedom of expression carries with it duties and responsibilities,

it may be subject to formalities, conditions and restrictions. However, these in turn would only be justified if they were necessary in a democratic society for a number of specified purposes. These purposes include public safety, the prevention of disorder or crime, the protection of health or morals, the protection of the reputation or rights of others, and preventing the disclosure of information received in confidence.

4.9.2 Publicity, privacy and safeguarding

The right to freedom of expression, juxtaposed with Article 8, has arisen in the context of safeguarding. In the following case, the welfare of care home residents was an issue. The case hinged on whether publicity about allegedly poor care unduly interfered with the private life of the residents:

Secret filming in care home: balancing public interest with private life of residents.

The right to freedom of expression might not readily spring to mind as a safeguarding issue, but it was raised in a case in which the media wished to broadcast a programme about standards of care in a care home. The care home sought an injunction to prevent the programme from being broadcast.

The BBC argued that it be allowed to show the programme in line with the freedom of expression and the fact that it was in the public interest to do so. The care home claimed that its objection was based on Article 8; namely, that such filming, even with the identity of individual residents obscured, was still an interference with the private life of the residents. The court found in favour of the BBC and refused to grant an injunction to the care home.²⁷

5 Information sharing and disclosure

5.1 Key points

When things go badly wrong in the failure to safeguard a child or a vulnerable adult, inadequate sharing of information is often a significant factor. This may be because of poor policies or procedures or because of misunderstanding about the law relating to confidentiality. The *No secrets* guidance therefore emphasises the importance of agencies and practitioners sharing information appropriately.

5.1.1 Common law, human rights, data protection: sharing between agencies

Three main areas of law apply to the disclosure and sharing of people's personal information. The first is the common law of confidentiality. The second is the Human Rights Act 1998. And the third is the Data Protection Act 1998. The latter contains three sets of data protection principles. These govern the 'processing' (including retention and disclosure) of people's personal information. Effectively they are safeguards that aim to prevent the arbitrary or cavalier use of people's personal details.

5.1.2 Justification of disclosure decisions

Most cases reaching the courts, involving disputes about disclosure of confidential information (without consent), revolve around whether the disclosing worker or organisation can justify the disclosure in terms of risk and the public interest.

5.1.3 Confidentiality and recognising when it can be breached

A common thread running through these three areas of law is that confidentiality of personal information is of great importance but that sometimes it can be breached, even without a person's consent. Generally, such a breach is permissible if it is in the public interest or if it is demanded by legislation or a court. Striking this balance reflects very much the proportionality approach required in safeguarding generally. On the one hand, it is about protecting people even at the cost of confidentiality; on the other, it is about not excessively and unnecessarily interfering with people's private lives.

5.1.4 Individuals seeking information about themselves

In addition, information-sharing issues may arise in another way. Vulnerable adults – or alleged perpetrators of harm – may wish to see information held about them by organisations such as local authorities and the NHS.

5.1.5 Seeking information about other people

Equally, people sometimes wish to access information about a relative or friend in relation to a safeguarding matter – particularly, for example, where that person died in seemingly suspicious circumstances.

5.1.6 Data Protection Act 1998

If a person requests access to personal information about themselves, the request has to be made under the 'subject access' provisions of the Data Protection Act 1998.

5.1.7 Freedom of Information Act 2000

If a person wants to find out personal information about somebody else (rather than themselves) – or about how a system has worked (for example, a safeguarding investigation) – from a public body, then they must make the request under the Freedom of Information Act 2000 Act.

The 2000 Act states that public bodies must provide information if requested, unless an exemption applies. Broadly, the way in which the exemptions apply is to balance the public interest in access to information – with the public interest in maintaining confidentiality (a) in connection with the functioning of the organisation and (b) of staff and people who use services. It can be a fine balancing act.

5.2 No secrets guidance and information sharing

The *No secrets* guidance emphasises the importance of appropriately sharing personal information if safeguarding is to work effectively.

5.2.1 'Need to know' principle

It states that information will only be shared on a 'need to know' basis when it is in the best interests of the vulnerable adult.

5.2.2 Not confusing confidentiality with secrecy

It emphasises that confidentiality must not be confused with secrecy. Informed consent should be obtained but, if this is not possible and other vulnerable adults are at risk, it may be necessary to override the requirement. It is inappropriate for agencies (and practitioners) to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other vulnerable people may be at risk.

The guidance further points out that principles of confidentiality 'should not be confused with those designed to protect the management interests of an organisation' (DH and Home Office, 2000, paras 5.5–5.8).

5.3.3 Knowing when to share information

The importance of maintaining confidentiality, but knowing when to share information, would thus seem to be fundamental to safeguarding practice. For instance, lack of information sharing between agencies was pinpointed as contributing to the death of Steven Hoskin in Cornwall. He was a man with learning disabilities living in a housing association bedsit; over a period of about a year, he was exploited and cheated. Several local young people increasingly took control of

his money, his flat and his life – before he was murdered by two of them. Relevant information was held by social services, the police, the health service and the housing association. Put together, this information might have saved Mr Hoskin (Cornwall Adult Protection Committee, 2007, paras 5.2–5.8).

5.3.4 Sharing information and linking complaints

The same message emerged in another widely reported case, involving the deaths of Fiona Pilkington and her 18-year-old daughter. They had been subject to years of anti-social behaviour and harassment from local youths. Despite many requests for help to the local authority and the police, no effective action was taken. Finally, Mrs Pilkington killed herself and her 18-year-old daughter by setting fire to the car they were in.

A serious case review concluded that information had not been shared with other agencies by the police, and that the police had not linked together the complaints or recognised the vulnerability of the family (Leicester, Leicestershire and Rutland Safeguarding Adults Board, 2008).

5.4 Health and social care: Caldicott guardians

Department of Health guidance states that NHS bodies and local authorities should appoint 'Caldicott guardians' (DH, 1992, 2002a). The role of these guardians is to develop local protocols and perform a number of other functions in order to ensure that six principles are adhered to in relation to the handling of personal information.

Six principles: the principles are (a) justify the purpose(s) for using confidential information, (b) only use it when absolutely necessary, (c) use the minimum that is required, (d) access should be on a strict need-to-know basis, (e) everyone must understand his or her responsibilities, and (f) understand and comply with the law (DH, 2006).

Caldicott guardians (sometimes referred to locally as data protection officers) should in practice be of considerable help to practitioners in understanding when to maintain confidentiality and when to share information.

5.5 Making and recording of decisions by practitioners

Agencies and practitioners may sometimes understandably struggle with balancing their duty of confidentiality against disclosure in the wider public interest (including safeguarding concerns). From a legal point of view, if public interest in terms of risk is to justify the overriding of confidentiality, the justification must be shown in the decision-making process (and its documentation or recording). The process needs to be consistent with legal rules, have taken account of the relevant evidence and factors for and against disclosure, and employed a reasoning process to explain the decision reached.

5.5.1 Sharing of information: professional guidance and codes

Professional codes of conduct and practice give practitioners advice about balancing confidentiality with the public interest. These codes and guidance generally reflect the law, emphasising both the importance of maintaining confidentiality and when it is permissible to breach that confidence.

Sometimes there is no discretion about this, for example, if regulatory bodies have access to information as part of their legal powers. Even so, as the General Medical Council's (GMC) guidance points out, people should still be informed where practicable, even if their consent is not required (GMC, 2009, para 19).

5.5.2 Nursing and Midwifery Council on confidentiality

The Nursing and Midwifery Council's (NMC) code, *The code: Standards of conduct, performance and ethics for nurses and midwives*, states that confidentiality must be protected, but that nurses and midwives 'must disclose information if you believe someone may be at risk of harm, in line with the law of the country in which you are practising' (NMC, 2008).

5.5.3 General Medical Council on confidentiality

The GMC has issued detailed guidance on confidentiality – when there is not an absolute, explicit obligation to disclose, but when the doctor must weigh up the risk of disclosure as against non-disclosure.

General Medical Council guidance about breach of confidentiality. The guidance makes quite clear that in some circumstances it will be justifiable for doctors to breach confidentiality even without the patient's consent. This might be in the public interest, for example, to protect individuals or society from risk of serious harm, including serious crime or serious communicable disease.

In deciding whether to disclose, the doctor has to weigh up the harm that could arise from non-disclosure from the harm that would come from disclosure to the patient and also to the overall trust that patients place in doctors. It also emphasises the importance of recording reasons for disclosure, including attempts to gain consent, informing the person of the disclosure or the reasons for not informing the person. (GMC, 2009, paras 36–39)

5.5.4 General Social Care Council on confidentiality

The General Social Care Council's (GSCC) code of practice for social care workers states that social care workers must use established processes and procedures to challenge and report dangerous, abusive, discriminatory or exploitative behaviour and practice. Also they must bring to the attention of the employer or appropriate authority resource or operational difficulties – or unsafe practices – affecting the delivery of safe care (GSCC, 2002, paras 3.2–3.5).

5.5.5 Professional discretion or duty to disclose?

Such codes of practice, together with the legal principles on which they are based, may mean that a practitioner may not just have a *discretion* to disclose and break confidentiality in a particular situation, but, from a professional point of view at least, a *duty* to do so:

Social worker's obligation to report harm suffered by child. A social worker became aware that a social work colleague was having a sexual relationship with a 14-year-old girl. He had had sufficient opportunity to report the 'inappropriate and illegal' relationship, had failed to do so and had only cooperated in providing information when challenged. He was found guilty of misconduct for failing to report the matter and was suspended from the Register for a year. (GSCC, 2010)

5.6 Law relevant to the disclosure of information

Generally, three main areas of law apply to the disclosure and sharing of people's personal information. The first is the common law of confidentiality (common law means that the courts have developed the rules; there is no Act of Parliament setting them out). The second is the Human Rights Act 1998. And the third is the Data Protection Act 1998, and to some extent the Freedom of Information Act 2000.

A common thread running through these three areas of law is that confidentiality of personal information is of great importance but that sometimes it can be breached, even without a person's consent. Very generally, such a breach is permissible if it is in the public interest or if it is demanded by legislation or a court.

5.7 Specific legislation governing the sharing of information

Other legislation covers particular aspects of information sharing. This includes, for example, the Police Act 1997 governing the issue of criminal record certificates. Also the Safeguarding Vulnerable Groups Act 2006 which involves the vetting and barring of people who work with vulnerable adults, and the reporting and sharing of information on a potentially large scale.

Section 115 of the Crime and Disorder Act 1998 states that any person, who would not otherwise have the power to disclose information to a 'relevant authority', does in fact have the power – where disclosure is necessary or expedient for the purposes of the Act (reduction and prevention of crime and disorder). A relevant authority is defined to include the police, local authority, probation committee and NHS primary care trust (PCT).

Home Office advice about this legislation stresses two points. First, that it puts beyond doubt the *power* of other organisations to disclose information to one of the relevant authorities. But second, that this is not the same as a *duty* to disclose. Thus, it does not override other legal considerations including the common law duty of confidentiality, the Data Protection Act 1998 or the Human Rights Act 1998 (Home Office, 1998). So, even under Section 115, the principles set out below still apply.

5.8 Common law of confidentiality

The common law of confidentiality traditionally involves balancing the private and public interests of confidentiality against the private and public interests of disclosure. It recognises the importance of, but also the limits to, the duty of confidentiality.

5.8.1 The *Edgell* case

For example, in the following case, the public interest in terms of risk posed by a patient outweighed a consultant psychiatrist's duty of confidentiality to that patient:

Breach of confidentiality by a practitioner: justified by risks posed by a mental health patient. A patient prepared for a mental health review tribunal hearing under the Mental Health Act 1983, by requesting a consultant psychiatrist to prepare a report. It was not favourable and the patient withdrew his application for the review. However, the consultant had become concerned about the risks posed by the patient. He consequently sent a copy of his report to both the hospital and the Home Office. The patient took a legal case against the psychiatrist; the court found the latter's breach of confidentiality to be justified in the public interest.²⁸

5.8.2 'Pressing need' test

Even when it might seem obvious to practitioners that disclosure would be justified, nevertheless the courts are keen to see that a proper justification is present. That is, a weighing up of competing interests for and against disclosure. Sometimes this has been referred to as a 'pressing need' test.

Pressing need test for the police in disclosing information. The courts referred to the 'pressing need' test in a case involving a couple previously convicted of sexual offences against children. The police informed a campsite owner of the presence of the couple on the campsite. The disclosure was justified on the basis of a pressing need.²⁹

In the following case, the question was whether a mother could gain access to the records of her son, who lacked capacity:

Mother accessing her son's records. A mother wished to access her son's medical records; she was his 'nearest relative' as defined in the Mental Health Act 1983. He lacked capacity to consent or dissent to this. The court stated that the Data Protection Act 1998 helped little; it was so general, it could be used to argue the matter either way. Taking account of both the common law confidentiality and the Human Rights Act 1998, the judge found in favour of the mother having such access.³⁰

5.9 Information disclosure and human rights

Article 8 of the European Convention on Human Rights refers to a right to respect for a person's private life. However, this right can be interfered with if this takes place in accordance with the law, it is necessary (that is, justified in terms of risk) and is for a particular purpose (for example, protection of a person's health, prevention of crime, protection of the rights and freedoms of others).

5.9.1 The balanced approach to disclosure

This human right has arisen in a number of cases relating to confidentiality and disclosure. Essentially it entails a balancing act – can the interference with the right to respect for private life be justified by the degree of risk posed by non-disclosure? In the following case, a local authority was justified in breaching confidentiality because it had acted proportionately with a view to protecting other people:

Justifying disclosure in relation to risk posed by a would-be social worker. A local authority disclosed its concerns to a university about a woman studying to become a social worker. This was on the basis of its knowledge of her care of her own child. Although the court stated that good practice would have dictated that the authority inform her first, about what it was going to do, nonetheless the authority's actions were justified under Article 8. The authority had adopted proportionate (that is, necessary) means for the purpose of protecting other people from unsuitable social workers.³¹

5.10 Disclosing personal information: Data Protection Act 1998

The Data Protection Act 1998 governs the processing by 'data controllers' of personal information. Processing includes obtaining, recording, holding, organising, adapting, altering, retrieving, disclosing, combining, erasing or destroying. The Act contains 'data protection principles'. There are also particular rules about the access that people should have to personal information about themselves.

5.10.1 Data protection principles and 'sensitive personal data'

The Act lays down three sets of principles to govern the processing of personal information. One of these sets applies to 'sensitive personal information' that is particularly relevant to safeguarding. Sensitive personal information is defined as information about a person's racial or ethnic origin, physical or mental health or condition, sexual life, and about commission of an alleged offence, proceedings for any offence and any sentence.

The Data Protection Act 1998 is not an easy read, but many of the principles it sets out are fairly straightforward. This seems an important point for practitioners to bear in mind.

Data Protection Act not to blame for non-retention of information about a future murderer. In a high profile case (known as the Soham case) involving the murder of two school girls by a school caretaker, it transpired that the police blamed in

part the 1998 Act, for their failure to retain and share certain information about the perpetrator from previous years. The inquiry into the murders concluded that the Data Protection Act was not to blame for non-retention of that information. All that was required was better guidance for police, social workers and other professionals so that they would feel more confident about using the legislation. (Bichard, 2004, paras 21–23)

Effectively what had been needed in this case – in order to have retained rather than not retained particular information – was a justification in terms of the continuing relevance of such information.

5.10.2 First set of principles: adequacy, relevance, purpose, accuracy, time etc

The first set of principles within the 1998 Act means that all personal information must be processed fairly and lawfully and for a particular purpose. It must be adequate, relevant and not excessive for the purpose. It should be accurate, up-to-date, and not kept for longer than necessary for the original purpose. It should also be held securely.

These are broad-brush principles enabling information to be processed and disclosed, as long as there is a justification.

Retention by police of information

Questions have arisen as to whether the police are justified in retaining (part of processing) a range of information about even quite minor offences for lengthy periods of time.

The police now take the view that, although certain convictions can be 'stepped down' on the Police National Computer (and deemed then to be for police eyes only), convictions should not be deleted other than exceptionally (ACPO, 2006).

The issue goes to the heart of how to strike a balance between protecting vulnerable adults (and children), while at the same time not unduly interfering with the private life of those concerned, under Article 8 of the European Convention on Human Rights.

Retention of information for minor convictions

The following case about the holding of information about convictions or cautions for relatively minor offences is therefore notable. The court held that either Article 8 of the Convention was not engaged at all by *retention* (as opposed to subsequent *disclosure*, which might engage Article 8), or such retention was justified under Article 8.

Justifiable purpose of the police keeping old information about even minor convictions. Details of old, minor criminal convictions were stored on the Police National Database. Five individuals had complained about this:

- a) A 40-year-old man had received a £15 fine for theft from a shop when he was 15.
- b) A woman now aged 20 wanted to train as a care worker, but at the age of 13 had been reprimanded for common assault against a 15-year-old girl, and had now been told by the police that her reprimand had not been deleted from the records, as originally promised.
- c) A 48-year-old man had, aged 21, been convicted of deception in obtaining electrical goods and was fined £250.
- d) A 46-year-old man had, aged 15, been convicted of two offences of attempted theft and been fined £25 – he had inserted metal blanks into a roulette machine in an amusement arcade.
- e) A 44-year-old woman had, aged 18, been convicted of theft using a cash point card belonging to somebody else; she was given a suspended prison sentence, and fined £185.

This meant that when these individuals required a criminal record certificate (standard or enhanced), these details emerged. The court stated that if the police stated rationally and reasonably that retention of convictions, however old or minor, had a value in the work they do then that should be end of the matter.³²

5.10.3 Second set of data protection principles: consent, legal obligations, vital interests, administration of justice etc

All personal data must be processed according to at least one of the principles contained in the second set of data protection principles. Either the person must have consented or the processing must be necessary for other reasons.

These include, for example, that the information is being processed to comply with a legal obligation, to safeguard the vital interests of the data subject, for the administration of justice, for the exercise of a statutory function, for the exercise of public functions in the public interest, in the legitimate interests of the data controller or a third party (as long as the data subject's rights and freedoms or legitimate interests are not prejudiced).

5.10.4 Third set of data protection principles: sensitive personal information

In addition to compliance with the first two sets of data protection principles, sensitive personal data must be processed in accordance with at least one principle in the third set. Sensitive personal information is particularly relevant to safeguarding matters.

Explicit consent of the data subject is required or the processing must be necessary for other reasons including:

- in respect of a *right or obligation* conferred on an employer
- to protect the *vital interests* of the data subject, where either he or she cannot give consent or it is not reasonable for the data controller to obtain it, or to

protect the vital interests of someone else, where consent by or on behalf of the data subject has been unreasonably withheld

- the information contained in the personal data has been *made public* because of steps taken deliberately by the data subject
- for the purpose of *legal proceedings* etc
- for the *administration of justice*
- for exercising *statutory functions*
- for *medical purposes* and is undertaken by a health professional, or by a person who in the circumstances owes a duty of confidentiality which is equivalent to that which would arise if that person were a health professional.

So, with safeguarding in mind, there are various justifications for sharing information.

5.10.5 Vital interests

It should be noted – at least in terms of a person’s ‘vital interests’ – that even if the data subject (for example, a vulnerable adult but with mental capacity) will suffer harm as a result of refusing to consent to the sharing of information, disclosure cannot be straightforwardly justified. If somebody else needs to be protected, however, then disclosure could be justified in terms of ‘vital interests’.

5.10.6 Statutory functions

Even without explicit consent, and for safeguarding purposes, disclosure may be justifiable in other ways, for example, in relation to the carrying out of statutory functions, such as those performed by social services and the police.

Department of Health guidance states that local social services authorities can share information without consent (if necessary) in performing such functions. This could involve sharing information with line managers, other people caring for a client, such as a voluntary body or adult placement carers, and other departments or agencies including health, education, child protection, inspection teams, legal advisers, finance staff and the police (DH, 2000a, para 6.18).

5.10.7 Preventing or detecting an unlawful act

A separate order permits the processing of sensitive personal data if it is in the ‘substantial public interest’ and for a specified purpose. One of the purposes listed is that the processing is necessary for the prevention or detection of any unlawful act, and must necessarily be carried out without the explicit consent of the data subject, so as not to prejudice those purposes (Data Protection [Processing of Sensitive Personal Data] Order 2000).

Another purpose is that the processing has to be necessary for the exercise of any functions conferred on a police constable by any rule of law.³³

Police forces sharing personal information and passing it on to the local education authority. Two police forces shared non-conviction information about a person. The second police force told a local education authority – the subject of the

information had applied for a teaching job. The job offer was withdrawn. The court held that the Data Protection Act had not been breached at any stage; this was because the information sharing came under the Order, which covered the processing of sensitive personal data by a constable under any rule of law, and also the prevention or detection of unlawful acts.³⁴

5.10.8 Sharing information within the same organisation

The Information Commissioner has published guidance that sharing information between two separate local authorities is clearly subject to disclosure rules under the Act. However, sharing information between two departments in the same local authority does not come under the Act, unless the second department is going to use the information for a secondary purpose, different to the purpose for which the information was initially processed (Information Commissioner's Office, 2008).

5.10.9 People seeking personal information in safeguarding matters

People may seek information from a public body about themselves or about other people in respect of deaths, injuries, safeguarding actions, procedures and investigations etc. The person applying for the information might be the person who may need to be safeguarded, the alleged perpetrator or other people with a genuine concern about what is going on (for example, the family). If the person – victim or perpetrator – is asking for information about themselves, then the 'subject access' provisions of the Data Protection Act 1998 apply. Otherwise, the Freedom of Information Act 2000 might apply.

5.10.10 Accessing information about oneself: 'subject access'

In summary, people have a right under the Data Protection Act to access and get copies of personal information about themselves. There are some provisos, however.

Access to information also containing details of somebody else

The first arises when the information requested by the data subject contains information about somebody else as well. That is, it contains information about a third party. The data controller is then not obliged to disclose the information unless one of the following three conditions applies.

First, the other person (the third party) has consented. Second, it is nevertheless reasonable in all the circumstances to disclose without this consent. Or third, the other party is either a health professional who has compiled or contributed to the information or has been involved in caring for the data subject, or is a 'relevant person' (such as a social worker) who has supplied the information in an official capacity or in connection with provision of a service.

Even if these three conditions do not apply, the data controller can still pass on that part of the information that will not result in disclosure of the identity of the other person concerned.³⁵

Prevention or detection of crime

There are further provisos justifying non-disclosure of the information being requested. One is where disclosure would prejudice the prevention or detection of crime (Data Protection Act 1998, Section 29).

Not disclosing because serious harm would result

Refusal to disclose can also be justified if disclosure would be likely to cause serious harm to the physical or mental health or condition of the data subject or of any other person. (If the data controller is not a health professional, then the data controller must consult the appropriate health professional about whether the exemption applies.)³⁶

Not disclosing because of prejudice to social work functions

Disclosure can also be denied if it would be likely to prejudice the carrying out of social work functions, because serious harm would be caused to the physical or mental health or condition of the data subject or of any other person.³⁷

Guidance from the Department of Health states that refusal to disclose should be exceptional and restricted to cases of serious harm, for instance, risk of harm to a child to the extent that a child protection plan is in place (DH, 2000a, para 5.37). The same principle could apply to vulnerable adults.

5.10.11 People lacking capacity

If a person lacks mental capacity to decide about their own personal information, the Mental Capacity Act 2005 *Code of practice* states that certain other people may nevertheless be able to request access to that information. This would be somebody with a lasting power of attorney, an enduring power of attorney or who is a deputy appointed by the Court of Protection (DCA, 2007, para 16.9).

Regulations under the Data Protection Act cover access to information about the physical or mental health of a person lacking capacity. They state that a person (a deputy) appointed by the court to manage a person's affairs can make a request, under the subject access rules of the Act, although some restrictions apply.³⁸

5.11 Accessing personal information about somebody else: Freedom of Information Act 2000

In the context of safeguarding, a person might be seeking information about somebody else, and not about themselves at all. Or the information sought might be of an impersonal nature about, for instance, an agency's safeguarding procedures. Either way, the request comes under not the Data Protection Act 1998 but the Freedom of Information Act 2000, which applies to public bodies.

5.11.1 Balance struck in Act: fairness

The Act strikes a balance. The specified exemptions from disclosure, of which there is a significant number, serve to protect both the organisation and its employees. For instance, full disclosure of all the evidence provided in an investigation might be unfair to people who gave that evidence in confidence. It might also hinder the organisation from conducting effective future investigations – if staff hesitate to give frank and full evidence for fear of it being made public.

5.11.2 Exemptions from providing information

Under the Freedom of Information Act 2000, public authorities must respond to requests for information. However, a number of exemptions apply, which excuse the provision of the requested information. Some of these exemptions are relevant to requests about information relevant to safeguarding. In brief, the exemptions include information that is, or relates to:

- otherwise reasonably accessible to the applicant (Section 21)
- intended for future publication (Section 22)
- security matters (Section 23)
- public authority investigations and proceedings (Section 30)
- the prevention or detection of crime, apprehension or prosecution of offenders, administration of justice, functions of public bodies (including issues around compliance with the law, improper conduct, regulatory action, health and safety, accidents) (Section 31)
- court records (Section 32)
- audit functions (Section 33)
- formulation of government policy (Section 35)
- inhibition of free and frank advice and expression of views, or prejudice to the conduct of public affairs that would otherwise be prejudiced (Section 36)
- health and safety (Section 38)
- personal information – of applicant or of somebody else (Section 40)
- information provided in confidence (Section 41)
- legal professional privilege (Section 42)
- commercial interests (Section 43).

5.11.3 Exemptions: absolute, qualified and the public interest

Some of the exemptions are 'absolute'. Some are only 'qualified'; this means that refusal to disclose in the case of the latter must be justified by arguing that the public interest in non-disclosure outweighs what is otherwise the presumption of disclosure under the Act.

In respect of safeguarding, the request might come from concerned family members, an alleged perpetrator or even the person about whom safeguarding concerns have arisen. The request could be about details and names of staff involved in an incident, care plans, reports of investigations, minutes of meetings and so on.

5.11.4 Appeals to the Information Commissioner and Information Tribunal

If the applicant is not satisfied with the response of the public body, a request to the Information Commissioner can be made. Beyond the Information Commissioner, appeal can be made to the Information Tribunal (now officially called the First Tier Tribunal [Information Rights]).

5.11.5 Request for one's own and somebody else's personal information

If the request includes information about the person who is making that request, there is an absolute exemption, under Section 40, from disclosure under the 2000 Act. Instead the request should be made under the Data Protection Act 1998 and in particular the 'subject access' rules.

5.11.6 Alleged perpetrator's request for information

So, if an alleged perpetrator in relation to a safeguarding matter wants to find out who has made the allegations, the request should be made under the 1998 Act. For instance, this was the case when the parents of a baby wanted to know which hospital staff had made allegations. The parents had wrongly made the request under the Freedom of Information Act 2000 (Information Commissioner, 2007b).

5.11.7 Seeking information just about somebody else

If, however, the request involves personal information about somebody else only, the public body must – under Section 40 of the 2000 Act – still cross-refer to the Data Protection Act in order to decide whether to make disclosure.

Absolute exemption

In two cases, there is an absolute exemption, meaning that the disclosure simply cannot be made. It applies, first, if disclosure would contravene the data protection principles under the Data Protection Act 1998 (see above) or Section 10 of that Act. Section 10 is about whether substantial damage or distress would be caused to the subject of the information. It applies, second, if any of the 'subject access' exemptions under the 1998 Act (see above) apply.

Competing considerations in safeguarding matters

This means that for people to obtain information about safeguarding matters involving somebody else may not be straightforward, because of seriously competing considerations.

5.11.8 Information given in confidence: absolute exemption

An absolute exemption from disclosure applies under Section 41 of the Act, if the information that is requested was (a) obtained from other people in confidence, and (b) disclosure would found a legal action for breach of confidence.

The exemption is slightly complicated because it is not as absolute as it seems. This is because the common law of confidentiality itself involves the test of whether the presumption of non-disclosure (that is, maintaining confidentiality) is outweighed by a public interest in disclosure. So disclosure could be possible, even though the initial presumption would be against it (Information Commissioner, 2008a). In the following case, another example of a relative pursuing his own investigation, the exemption applied:

Father-in-law's death in a nursing home: information from GP exempt. A man wanted to find out about the care his late father-in-law had received in a nursing home. Relevant information included correspondence from various people including a GP, the police, the coroner and the nursing home itself. The Information Commissioner decided that the information provided by the GP in confidence to the PCT should not be disclosed. It had been given with confidentiality assured, and the public interest, in such information being provided confidentially, outweighed the public interest in disclosure. (Information Commissioner, 2008a)

5.11.9 Information about dead people

Sometimes requests are made in relation to dead people. For example, a family may suspect a safeguarding issue preceded or led to a relative's death. However, the Data Protection Act 1998 does not apply to information relating to dead people (Section 1). Such a request would therefore come under the Freedom of Information Act 2000 or sometimes under the Access to Health Records Act 1990 (this gives a right of access to information by a dead patient's representative or any person who might have a claim arising out of the patient's death).

Matters may not be straightforward under the 2000 Act, because the duty of confidence to a person (for example, the victim) survives death. That is, there could be a legally actionable breach of confidence (for example, by a relative or personal representative), even after the person has died.

5.11.10 Cost limits

A public body does not have to disclose information under Section 12 of the Freedom of Information Act 2000, if the cost would exceed the prescribed cost limit (currently £600 for central government, £450 for local authorities, NHS bodies and the police).⁴⁰

Nevertheless, if the request would take too long to answer within the cost limits, good practice is that the public body would write back asking that the request be scaled down.

6 Whistleblowing

6.1 Key points

Another form of information disclosure is 'whistleblowing' by employees. This may in some circumstances be a way of alerting the outside world to organisational practices that are leading to serious harm to vulnerable adults. When employees feel obliged to disclose matters in the public interest, they should be protected legally from subsequent victimisation by the employer. This protection comes under the Public Interest Disclosure Act 1998, which amended the Employment Rights Act 1996.

6.2 *No secrets* guidance on whistleblowing

The *No secrets* guidance states that principles of confidentiality for safeguarding and promoting the interests of people who use services 'should not be confused with those designed to protect the management interests of an organisation' (DH, 2000).

It notes that management interests do have a role but should not conflict with the interests of people who use services and patients. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of vulnerable adults, then a duty arises to make full disclosure in the public interest (DH and Home Office, 2000, para 5.8). The implications of such a statement raise the question of 'whistleblowing'.

6.3 Confidentiality, secrecy and disclosure

An example of whistleblowing gained a high profile in 2009, when, what a nurse considered as her duty to raise concerns about poor standards of nursing care, clashed with the duty to maintain the confidentiality of patients. The NMC struck the nurse off its register for breach of confidentiality, but subsequently faced widespread public and professional disquiet and successful legal action against it (Smith, 2009).

6.4 Professional onus on practitioners to whistleblow

As a result of the case mentioned above, guidance was issued in 2010, with a foreword from the Health Secretary, about the importance of whistleblowing in the NHS (PCaW and SPF, 2010).

6.4.1 Nursing and Midwifery Council

The NMC's *The code: Standards of conduct, performance and ethics for nurses and midwives* states that the professional must act without delay if patients are at risk, raising the issue with 'someone in authority' and reporting his or her concerns.

6.4.2 General Medical Council

The GMC's *Good medical practice* states plainly that medical doctors may sometimes have a professional duty to take concerns further. It says that if patient safety is

compromised, the employer or contracting body must be informed. But if they take inadequate action, then the doctor should take independent advice as to how to take matters further, and record his or her concerns and the steps taken (GMC, 2006, para 6).

6.4.3 British Medical Association

Likewise the British Medical Association (BMA) has issued specific guidance on whistleblowing that points out that raising concerns may not be just a matter of personal conscience but of professional obligation (BMA, 2009, p 4).

6.4.4 General Social Care Council

The GSCC *Code of practice* states that social workers should challenge and report dangerous or abusive behaviour and problems with delivering safe care, and inform an 'employer or an appropriate authority where the practice of colleagues may be unsafe or adversely affecting standards of care' (GSCC, 2008, paras 3.1–3.8).

6.5 Legal rules about whistleblowing

The legal rules about whistleblowing are contained within the Public Interest Disclosure Act 1998, which amended the Employment Rights Act 1996.

6.5.1 Victimisation and protected disclosures

In principle, the rules protect an employee from victimisation by his or her employer, if the employee has behaved reasonably and considered a hierarchy of steps. To be protected, the employee must make a 'protected disclosure'. A protected disclosure means that it is a 'qualifying disclosure' that has been made under certain conditions. A qualifying disclosure constitutes 'disclosure of information which, in the reasonable belief of the worker, concerns a criminal offence, breach of a legal obligation, a miscarriage of justice, health and safety, damage to the environment, or concerns concealment of any of these.

6.5.2 Hierarchy of disclosure: employer and relevant regulatory body

The requirements about the way in which the disclosure is made are as follows. If they are adhered to, the employee is protected, at least in principle. The hierarchy of steps need not always be adhered to. For instance, wider disclosure (at the third step below) can also be justified if the employee had a reasonable belief that going through either of the first two steps would result in detriment to him or her.

The first step is to raise the matter with the employer. The second step is to disclose the concern to a regulatory body. The disclosure must be made in good faith, the person must reasonably believe that the matter is relevant to that regulatory body, and also that the information and allegation are substantially true. Examples of organisations in this category include the CQC, the HSE and the Information Commissioner.⁴¹

6.5.3 Disclosure to the wider world

Beyond disclosure to the employer or relevant regulatory body comes the third step, disclosure to the wider world, such as the Press. The person is protected if the disclosure is:

- in good faith
- in the reasonable belief that the information and any allegation are substantially true
- the disclosure is not made for personal gain
- in all the circumstances of the case, it is reasonable to make the disclosure.

6.5.4 Reasonable belief etc

In addition, the worker must (a) reasonably believe that he or she would be subjected to detriment if the disclosure were made instead either to the employer or to the regulatory body; or (b) if there is no relevant (regulatory) body, evidence about the failure would be concealed if disclosure was made to the employer; or (c) had previously made a disclosure of substantially the same information to the employer or to a regulatory body.

6.5.5 Justification of disclosure

In determining whether such wider disclosure was justified, a number of factors in particular have to be considered. These are:

- the identity of the person to whom disclosure was made
- the seriousness of the issue
- whether the failure is continuing or is likely to reoccur
- whether the disclosure breached a duty of confidentiality owed by the employer to any other person
- where disclosure was previously made to the employer or regulatory body, whether either has taken any action which might reasonably have been expected
- whether in disclosing to the employer, the worker complied with any procedure he or she was authorised to use.

Notes

¹ *Donoghue v Poplar Housing Association* [2001] EWCA Civ 595.

² *R (Weaver) v London & Quadrant Housing Trust* [2009] EWCA Civ 587.

³ *R (A) v Partnerships in Care Ltd* [2002] EWHC 529 (Admin).

⁴ *YL v Birmingham City Council* [2007] UKHL 27, House of Lords.

⁵ *Osman v United Kingdom* (23452/94) [1998] ECHR 101 (28 October 1998). Also, more recently, *Chief Constable of Hertfordshire v Van Colle* [2008] UKHL 50.

- ⁶ *Savage v South Essex Partnership NHS Trust* [2008] UKHL 74.
- ⁷ *R (A&B, X&Y) v East Sussex County Council (no 2)* [2003] EWHC 167 (Admin).
- ⁸ *Taylor and Others v UK* [August 30 1994] 79 DR 127.
- ⁹ *Dodov v Bulgaria* (application no 59548/00) 17 January 2008.
- ¹⁰ *Pretty v United Kingdom* [2002] 2 FCR 97, European Court of Human Rights.
- ¹¹ *Price v United Kingdom* [2001] Application 33394/96, European Court of Human Rights.
- ¹² *R (A&B, X&Y) v East Sussex County Council (no 2)* [2003] EWHC 167 (Admin).
- ¹³ *R (B) v DPP* [2009] EWHC 106 (Admin).
- ¹⁴ *Airedale NHS Trust v Bland* [1993] AC 789 (Lord Hoffman's comments).
- ¹⁵ *R (Burke) v General Medical Council* [2004] EWHC 1879 (Admin).
- ¹⁶ *JE v DE and Surrey County Council* [2006] EWHC 3459 (Fam).
- ¹⁷ *R v Bournemouth Community and Mental Health NHS Trust, ex p L* [1998] 1 CCLR 390 (House of Lords); *HL v United Kingdom* [2004] 40 EHRR 761 (European Court of Human Rights).
- ¹⁸ *HL v United Kingdom* [2004] 40 EHRR 761 (European Court of Human Rights).
- ¹⁹ *R (Wright) v Secretary of State for Health* [2009] UKHL 3.
- ²⁰ *R (Royal College of Nursing) v Secretary of State for the Home Department and the Independent Safeguarding Authority* [2010] EWHC 2761.
- ²¹ *R v Isleworth Crown Court, ex p King* [2001] EWCA 22 (Admin).
- ²² *Botta v Italy* [1998] Case no 21439/93, European Court of Human Rights.
- ²³ *Local Authority X v MM* [2007] EWHC 2003 (Fam).
- ²⁴ *R (Bernard) v Enfield London Borough Council* [2002] EWHC 2282 (Admin).
- ²⁵ *Sheffield City Council v S* [2002] EWHC 2278 (Fam).
- ²⁶ *R (Wright) v Secretary of State for Health* [2009] UKHL 3.
- ²⁷ *BKM v British Broadcasting Association* [2009] EWHC 3151 (Ch).
- ²⁸ *W v Edgell* [1990] 1 All ER 835, Court of Appeal.

- ²⁹ *R v Chief Constable of North Wales, ex p AB* [1998] 3 WLR 57, Court of Appeal.
- ³⁰ *R v Plymouth City Council, ex p Stevens* [2002] EWCA Civ 388.
- ³¹ *Maddock v Devon County Council* [2003] EWHC 3494 (QB).
- ³² *Chief Constable of Humberside Police v Information Commissioner* [2009] EWCA Civ 1079.
- ³³ SI 2000/417. Data Protection (Processing of Sensitive Personal Data) Order 2000.
- ³⁴ *R v Chief Constables of C and D, ex p A* [2001] 2 FCR 431 (Admin) (High Court).
- ³⁵ Data Protection Act 1998, Section 7. And: SI 2000/413. Data Protection (Subject Access Modification) (Health) Order 2000. And also SI 2000/415. Data Protection (Subject Access Modification) (Social Work) Order 2000.
- ³⁶ Data Protection Act 1998, Section 30. And SI 2000/413. Data Protection (Subject Access Modification) (Health) Order 2000.
- ³⁷ SI 2000/415. Data Protection (Subject Access Modification) (Social Work) Order 2000.
- ³⁸ SI 2000/413. Data Protection (Subject Access Modification) (Health) Order 2000. And also SI 2000/415. Data Protection (Subject Access Modification) (Social Work) Order 2000.
- ³⁹ *Galloway v Central and North West London NHS Foundation Trust* [2009] Information Tribunal EA/2008/0036, March 2009.
- ⁴⁰ SI 2004/3244. Freedom of Information and Data Protection (Appropriate Limit and Fees) Regulations, Regulation 3 and Schedule 1.
- ⁴¹ SI 1999/1549. Public Interest Disclosure (Prescribed Persons) Order 1999.

Part 3: Mental capacity and other interventions

7 Mental capacity

8 Inherent jurisdiction of the courts to intervene

9 Mental Health Act 1983

10 National Assistance Act 1948 and environmental health legislation

7 Mental capacity

7.1 Key points

Mental capacity is in some ways at the heart of safeguarding. If a person cannot make a particular type of fundamental decision, then he or she is likely to be vulnerable and at greater risk of harm.

This guide does not fully cover the Mental Capacity Act 2005. This is fully and helpfully explained and illustrated in the *Mental Capacity Act 2005 Code of practice*. Instead this section summarises the main principles and rules of the Act and illustrates them specifically in the context of safeguarding.

7.1.1 Protection and empowerment

Overall, the Act embodies both protection and empowerment, two key concepts in the *No secrets* guidance and in government policy (Minister of State, 2010).

7.1.2 Five key principles

Of specific relevance to safeguarding are the five key principles running through the Act. These are that:

- people should be assumed to have capacity unless otherwise proved
- people should be assisted to take decisions, before it is decided they lack capacity
- unwise decisions do not mean necessarily that a person lacks capacity
- if a decision is taken in respect of a person lacking capacity, it must be in that person's best interests
- consideration must then be given to adopting the least restrictive option.

7.1.3 Challenge posed by unwise decisions

Clearly, of these principles, the one referring to unwise decisions will sometimes raise difficult questions for practitioners who wish to protect a person who, although vulnerable to exploitation, undoubtedly has capacity to take the decision in question.

7.1.4 Care, treatment, restraint and deprivation of liberty

The Act also refers to protection given to those (including carers and practitioners) providing care or treatment for people lacking capacity. If they have taken reasonable steps to ascertain a person's capacity and his or best interests, they are protected under the Act for liability if things go wrong. The Act also sets out specific principles of proportionality in relation to restraint, and detailed rules about when it is lawful to deprive a person of his or her liberty.

7.1.5 Lasting powers of attorney, deputies and the Court of Protection

Lasting powers of attorney, whereby a person authorises somebody else to make decisions about their finances or health or welfare, when the person loses capacity,

are obviously relevant to safeguarding, because, inevitably, such powers are sometimes abused.

The Court of Protection has powers of intervention in relation to capacity, people's best interests, making declarations and orders, and sometimes appointing 'deputies' to manage people's finances or welfare.

7.1.6 Decisions that cannot be made in a person's best interests

Importantly, the Act states that certain decisions cannot be made in a person's best interests – either the person has capacity to do these things or they cannot be done at all. For example, marriage and sexual relationships are among these. Again, in relation to safeguarding, these are highly relevant matters.

7.1.7 Advance decisions about treatment: cover only refusal of treatment

The Act also covers what are known as 'advance decisions'. This is when – in advance of losing capacity – a person specifies that they do not want certain (often lifesaving) treatment if something happens to them. There are particular rules associated with these decisions; from a safeguarding point of view, acquaintance with these rules is important both to protect the vulnerable adult as well practitioners from potential liability for breaching the rules.

7.1.8 Ill treatment or wilful neglect

The Act also contains a specific offence of ill treatment or wilful neglect of a person lacking capacity. This offence applies to all staff and carers.

7.2 Empowerment and protection

On the one hand, the key principles of the Act are about empowering people. In effect, they emphasise autonomy and self-determination. Their purpose is to ensure that people's capacity to make decisions is not to be written off too readily, and that if there is to be interference it should be kept to a minimum, with the person still involved in the decision as far as practicable.

To do otherwise, too readily, is to remove from people fundamental rights affecting, for example, their private life, their property and money, their healthcare, where to live, whom to see, the value of their evidence as witnesses in criminal justice proceedings and so on.

7.2.1 Protecting people

On the other hand, the Act is clearly also about protecting people. It demands that 'best interests' decisions be made when a person lacks the capacity to take a particular decision. The decision about best interests might sometimes relate to a very clear safeguarding issue, such as protecting the person from neglect, physical mistreatment or financial exploitation and crime.

Even considered in this protective light, the Act retains empowering principles by stating that the person should still be fully consulted about the decision, and consideration should be given to the least restrictive intervention.

7.2.2 Empowerment, protection, unwise decisions and other legislation

These two principles, then, empowerment and protection, complement each other. Along with justice, they form the key concepts in the safeguarding of adults at risk of harm. But putting these two principles together may not always be straightforward. It is sometimes difficult both to empower and protect a person at the same time. For instance, a person might be assessed as having the capacity to take an extremely unwise decision, which then clearly puts him or her at significant risk of harm.

7.2.3 Interface with other legislation

Practitioners may nonetheless still be charged with trying to protect the person. They may then have to look to other legislation to do so. Indeed, the Mental Capacity Act *Code of practice* states at its outset the importance of not taking the Mental Capacity Act in isolation, and of an awareness of other legislation (DCA, 2007, para 1.12).

For instance, in the following case, having considered issues of mental capacity, the local authority would have to support the woman with a care plan under community care legislation (for example, Section 47 of the NHS and Community Care Act 1990 and Section 29 of the National Assistance Act 1948):

Supporting a woman to manage risks in her personal relationships. A woman with mental health problems, in the care of the local authority, had been assessed as having the mental capacity to conduct a personal, sexual relationship with her longstanding partner. This meant that the Mental Capacity Act could not be used to stop this relationship, even though there were risks attached, including domestic violence and other potentially detrimental consequences. In addition, excessive restrictions imposed on the relationship would breach her human rights. Thus, the local authority would have to prepare a care plan to allow her to see her partner, while at the same time managing the risks. The court added that the local authority could not 'toll the bell of scarce resources' to avoid having to do this.¹

7.3 Five key principles

The Mental Capacity Act 2005 sets out five key principles that permeate the Act (Section 1). From the point of view of practitioners, it is, above all, these five principles that need to be adhered to when working with people who may, or do, lack capacity to take a particular decision.

First, a person is assumed to have capacity unless it is established otherwise. Second, a person should not be treated as lacking capacity unless all practicable steps have first been taken to help the person take the decision. Third, an unwise decision does not necessarily mean that the person lacks capacity. Fourth, an act done or decision

made for a person lacking capacity must be in the person's best interests. Fifth, when any such act is done or decision made, consideration must be given to whether the purpose can be achieved as effectively in a way that is less restrictive of the person's rights and freedom of action.

7.3.1 Capacity is issue and time-specific

Furthermore, it is clear that under the statutory test (see below), a person's capacity is both issue and time-specific. This means that a person might be able to make some decisions but not others. Equally, a person might be able to make a decision at one time but not another.

7.3.2 Unwise decisions and safeguarding

Taking these principles together can result, for instance, in a person being judged to manage their own financial affairs in order to live the life they wish to, even if they take some unwise decisions. Sometimes this will give rise to safeguarding concerns on the part of practitioners charged with safeguarding activities.

Financial affairs, lack of capacity and vulnerability. A man had suffered brain injuries in a road traffic accident. Some years later, for various reasons, it became legally necessary to establish whether he could manage his affairs. He now had dysexecutive syndrome and obsessionality, immaturity, rigidity of thinking, eccentricity and emotional outbursts. His organisational ability was affected; his relationships with other people did not quite 'mesh'.

It was argued that he lacked capacity because, among other things, he was unwise with money and his memory was bad. He tended to be over generous in giving gifts to girl friends. He had likewise been generous to the Vegan Society and to anti-hunt protestors, whose bail money he offered after they had been arrested. He would over stock his fridge; he broke a cooker valve, bought the replacement and lost it. But when major financial issues had to be decided, he knew he needed to seek advice. There was in any case evidence that by and large he could look after himself – he advised friends on social security benefits, alerted the police to a risk to three young girls at a naturist swimming pool and wrote impressive letters of advice to his nephew at boarding school.

The court held that he had capacity to manage his affairs. It was important to distinguish capacity from outcomes. It also noted that anybody could lose cooker valves and over stock the fridge.²

7.3.3 Court's job is not to stop people with capacity taking unwise decisions

The court pointed out in the above case that (a) it was not its job to prevent people with capacity from making what other people deem rash or irresponsible decisions, and (b) many people make such rash and irresponsible decisions but are 'full of capacity' when they do so.³

7.3.4 Avoid assumptions of lack of capacity even in situations of risk

It might not be financial affairs, but personal, sexual relationships, for instance. The following case put starkly both the concerns of practitioners to safeguard a woman with learning disabilities, and also the rules under the Mental Capacity Act against making unwarranted assumptions about lack of capacity, even in the face of seemingly obvious risk:

Woman with learning disabilities wanting to marry convicted sex offender. A 23-year-old woman with learning disabilities wanted to marry a 37-year-old man, previously convicted of sexually violent crimes. The council argued she lacked capacity and that it would not be in her best interests to marry. The court pointed out that the question of capacity was different than the question of wisdom. It was no part of the legal question to decide whether she was wise to marry such a man. Legally, therefore, 'best interests' were irrelevant. Either she had the capacity to marry in which case she could marry, or she did not, in which case she could not marry.⁴

7.3.5 Unwise decisions may be relevant to judgement about capacity

However, the fact that an unwise decision may not indicate a lack of capacity does not mean that it cannot indicate a lack of capacity. For instance, the courts have pointed out that the unwise decision may nevertheless 'shed a flood of light' on a person's capacity.⁵ In other words, practitioners need to be aware that while unwise decisions may not be decisive in determining a person's capacity, they may be highly relevant.

7.3.6 Least restrictive option

The principle of considering the least restrictive intervention is a further safeguarding matter. This principle is likely to be a safeguard against practices that could all too easily become oppressive and abusive. For example, on the basis that at least some of the people who use services concerned lacked capacity, it was illustrated by the findings of the Healthcare Commission and the Commission for Social Care Inspection (CSCI) at an NHS trust in Cornwall:

Need to consider and put in place less restrictive options. The Commissions identified what they called physical, emotional and environmental abuse of people with learning disabilities. Independence, choice and inclusion were absent. Care planning was poor. Physical restraint was excessive, as was the use of *pro re nata* (PRN) medication to control behaviour. More particularly, one person, at the hands of another service user, had suffered multiple injuries over time, including a fractured skull. Another service user was tied up in his wheelchair for 16 hours a day. Taps and light fittings were removed. The money of patients was simply pooled in a common budget. (Healthcare Commission and CSCI, 2006, pp 4–6)

7.4 Test for mental capacity

The test of mental capacity is simple, at least superficially. It has two major components, the first concerning impairment or disturbance of the mind or brain, the second the person's ability to process information and communicate.

Nonetheless, for practitioners involved in safeguarding, it is of fundamental importance. Without a knowledge and application (and documenting) of this test, intervention under the Act is not possible and could subsequently be indefensible from a legal point of view. It could also result in serious detriment coming to the person concerned – through mistakenly (a) failing to intervene or (b) intervening.

7.4.1 Impairment or disturbance of mind or brain: issue and time-specific

First, a person (aged at least 16 years old) lacks capacity in relation to a particular matter if at the relevant time he or she is unable to make a decision for him- or herself in relation because of an impairment of, or a disturbance in the functioning of, the mind or brain. The impairment or disturbance might be temporary or permanent.

The reference to 'particular matter' and 'relevant time' means that decision-making capacity is both issue and time-specific. For instance, doubt – arising from concerns about safeguarding and exploitation – may sometimes be raised about a person's capacity to make a lasting power of attorney. But great attention has to be paid to just which decision the person's capacity is being judged on. In the following two cases, the courts drew a distinction between the capacity to decide about one property and affairs issue, and the capacity to decide about another.

7.4.2 Capacity to take one type of decision but not another

In the first, the circumstances might have suggested a possible safeguarding issue, had this distinction not been made.

Capacity to make a power of attorney but incapacity to manage affairs generally. In one case, in which the validity of a power of attorney might otherwise have aroused suspicion (on grounds of lack of capacity when it was made), a woman was held to have lacked the capacity to manage her financial affairs but at the same time to have retained the capacity to make the enduring power of attorney.⁶

Likewise in the following case:

Capacity to revoke enduring power of attorney is not necessarily the same as capacity to make a new lasting power of attorney. The Court of Protection held that the revocation of an enduring power of attorney is a different transaction from the creation of a lasting power of attorney, and that capacity to create the latter does not necessarily mean capacity to revoke the former.⁷

Two further cases, both posing safeguarding questions, involved time and issue-specific capacity. In the first, a woman lacked the capacity to litigate, to decide

generally with whom to have contact, to decide where to live and whom to marry. She had, however, the capacity to have a personal and sexual relationship with her longstanding partner who posed various risks to her.⁸

7.4.3 Fluctuating capacity

In the second case, another vulnerable woman had fluctuating capacity to consent to sexual relationships, which the local authority argued were exploitative.⁹

7.4.4 Processing of information

The second part of the test is to the effect that a person is unable to take a decision if he or she is unable:

- to understand the information relevant to the decision
- to retain that information
- to use or weigh that information as part of the process of making the decision
- to communicate his or her decision (whether by talking, using sign language or any other means).

The application of this test can clearly point to a person having capacity, even if the outcome of the decision is likely to lead to an unfortunate outcome, and cause practitioners great concern:

Capacity of mental health patient to refuse amputation of gangrenous leg.

A man had chronic paranoid schizophrenia and was detained in a secure mental hospital. His leg developed gangrene; the doctors advised amputation, without which death was likely. He refused; the court found that despite the schizophrenia, he understood the decision he had taken. It granted an injunction to prevent the amputation, since he had legal capacity to refuse it.¹⁰

Equally, as already pointed out, unwise decisions may nevertheless shed a flood of light on a person's capacity. The Mental Capacity Act 2005 *Code of practice* makes this very point. It states that it is important to distinguish between unwise decisions which a person has the right to make, and decisions based on a lack of understanding of risks or inability to weigh up the information.

It further points out that 'information about decisions the person has made, based on a lack of understanding of risks or inability to weigh up the information, can form part of a capacity assessment – particularly if someone repeatedly makes decisions that put them at risk or result in harm to them or someone else' (DCA, 2007, para 4.30).

In sum, the Act is designed to prevent unwarranted assumptions about lack of capacity, but it is not meant unduly to deter or to frighten practitioners from making findings of lack of capacity.

7.5 Common law tests of capacity for particular matters

Prior to the Mental Capacity Act 2005, the courts had developed their own tests of a person's capacity specific to different situations.

7.5.1 Wills, gifts, marriage, sexual relations, medical treatment etc

These common law tests are generally consistent with the Mental Capacity Act. They are highly pertinent to safeguarding, covering such matters as wills, gifts, marriage, sexual relations, medical treatment and decisions about where to live and with whom to have contact. The tests for wills and gifts are set out below, as are those for marriage and sexual relations. The tests for medical treatment, where to live and with whom to have contact are very similarly worded to the test set out in the Mental Capacity Act 2005.¹¹

7.6 Who makes decisions about a person's capacity and best interests?

Practitioners are sometimes unsure about who is meant to take decisions about a person's capacity and best interests under the Act. Sometimes practitioners are hesitant and nervous about making decisions, worrying about getting it wrong and the consequences. If there are safeguarding matters at stake, the anxiety may be pronounced.

7.6.1 Determining who should be making decisions

However, the Mental Capacity Act 2005 does not prescribe who should be taking these decisions. It does not state that it must be a medical doctor. In fact, the ultimate legal responsibility lies with the person making the decision or intervention, although that person may quite properly be relying on advice or assessment from somebody else such as a medical doctor.

7.6.2 Protection for decision maker if reasonable steps taken

The Act provides some reassurance for people involved in what can be very difficult decisions. It states that in relation to care and treatment, a person will not be liable if he or she took reasonable steps to ascertain a person's capacity and reasonably believed that the act performed was in the person's best interests (Mental Capacity Act 2005, Sections 5–6).

7.6.3 Professionals taking reasonable steps

The *Code of practice* points out that what are reasonable steps will depend on the circumstances. More would be expected from professionals than from family members without formal qualifications. But if a complex or major decision has to be made, then a professional opinion may be required, for example, from a general medical practitioner (GP), a consultant psychiatrist, psychologist or speech and language therapist (DCA, 2007, paras 4.38–4.51).

Equally, however, medical opinion may not be decisive or even best placed to make the judgement:

Judgement about capacity to give evidence in criminal proceedings. A woman, now in her sixties, had been in the care of a local authority for many decades. During a prolonged period she had been subjected to sexual assaults. She had been judged not competent to participate in criminal proceedings; this judgement had been made only by psychiatrists and psychologists. But, in the view of the Mental Welfare Commission for Scotland, such an important and complex assessment should not have been made without the input also of those closely involved in caring for the woman. In addition, it did not appear as if thought had been given as to who she might be supported by in order to give evidence. (Mental Welfare Commission for Scotland, 2008, p 2)

7.7 Gaining access to a person to assess mental capacity

Practitioners sometimes face a situation in which an adult at risk may lack capacity but is refusing to be assessed.

7.7.1 Lawful authority for assessment of capacity

The *Code of practice* states that nobody can be forced to undergo an assessment of capacity and that their front door cannot simply be forced open. It goes on to say that, were there serious concerns about a person's mental health, then it may be possible to obtain a warrant and force entry under Section 135 of the Mental Health Act 1983. At the same time, the *Code* emphasises that refusal of an assessment capacity does not by itself provide a ground for compulsory assessment under the 1983 Act (DCA, 2007, para 4.59). But in some circumstances, the Act may be used as set out immediately below.

7.7.2 Making of interim orders and assessment for capacity

If there is a serious question about a person's mental capacity, the Court of Protection can be applied to, for a declaration about this under Section 15 of the Act.

Where there is doubt about a person's capacity, the Mental Capacity Act 2005 also empowers the Court of Protection to make an interim order under Section 48 of the Act. For such an interim order, there has to be reason to believe that a person may lack capacity. However, it does not require that lack of capacity be established on the balance of probability (a higher test), which is required for the court to make an ordinary (rather than an interim) order.

7.7.3 Making of an interim order if reason to believe person lacks capacity

So, there may be some safeguarding situations where a vulnerable person is refusing assistance, matters have taken a serious turn and there is some question about the person's capacity. When such a situation arises, it can be difficult for practitioners to know what to do:

Question of capacity to refuse or not to cooperate with services. A 52-year old woman had a dissociative disorder of movement and a somatisation disorder. This had for a long time left her in pain, bed bound and largely unable to move. The local authority found her behaviour antagonistic and uncooperative, making it impossible to provide appropriate care for her. Consequently, only minimum nursing care was provided; she was left for long periods with her physical needs unattended. However, the local authority had concerns about her mental condition.

The question of capacity arose. Hitherto she had been treated as having capacity to accept or reject care services. The local authority was not sure whether this was still correct. If it was not, the court could make a declaration under Section 15 of the Act and then decide on her best interests.

The court recognised that the test of incapacity, for the court to proceed under Section 15 or Section 16, is whether on the balance of probability, a person lacked capacity. But that could sometimes take time to establish, and sometimes things needed to be done quickly. But under Section 48 of the Act, the court could make an interim order, for which the threshold was lower. It required only that there was reason to believe that the person lacks capacity.¹²

7.7.4 Interim orders: for immediate, urgent decisions

Given a question about a person's capacity an interim order from the court could cover matters such as taking immediate safeguarding steps, or giving directions to resolve the issue of capacity quickly. But the steps to be taken under the interim order would depend on the individual facts and circumstances of the case, the urgency involved and the principle that the person's autonomy should be restricted as little as is consistent with the person's best interests. Possibly even the only direction, were capacity still uncertain, would be to obtain the evidence to enable capacity reliably to be determined.¹³

In another case, an interim order was associated not only with the person's probable lack of capacity, but also with achieving proper overall assessment and treatment of his condition, with a degree of force to be used *if necessary*:

Interim order concerning capacity, assessment and treatment. A 22-year old man had severe, complex and currently uncontrolled epilepsy. He lived with his adoptive mother. Secure, adequate medical assessment and treatment were required as he was not complying with the treatment being provided. On the basis of medical evidence, the court had previously granted an interim declaration of incapacity in relation to decisions about his health and social care. The primary care trust (PCT) then put forward two options for assessment and treatment, the first being community based, the second residential. Everybody, it seems, was in favour of the latter, but the arrangements for the place broke down. Various options then were discussed; in the end the court stated that something had to be done to sort out proper assessment and treatment. Because the man was generally compliant, force would probably not have to be used, but a proportionate degree of force could be used if necessary.¹⁴

7.8 Making 'best interests' decisions

Safeguarding an adult at risk who lacks capacity to decide particular issues means that a best interests decision has to be taken by somebody else. The Act stipulates how such a decision is to be reached. In short, the key points are:

- *Not making assumptions*: that decisions should not be taken simply on the basis of a person's age and appearance or condition and behaviour (which might lead people to make unjustified assumptions).
- *Regaining of capacity*: whether the person is likely to regain capacity.
- *Participation of the person*: allowing and encouraging the person to participate as fully as possible in the decision.
- *Motivation*: the decision maker must not be motivated by a desire to bring about the person's death.
- *Past and present wishes etc*: the decision maker must consider the person's past and present wishes and feeling (in particular any written statements made when the person had capacity), and also the person's beliefs, values and other factors.
- *Consultation with others*: the decision maker must take into account, where consultation is appropriate and practicable, the views of anyone named person by the person, any person caring for the person or interested in the person's welfare, any donee of a lasting power of attorney, any Court of Protection appointed deputy (Mental Capacity Act 2005, Section 4).

7.8.1 Taking account of what the person says

If a safeguarding intervention is being contemplated, and the person lacks capacity to give legally effective consent, the practitioner has then still to take account of what the person is saying and appears to want. The question can then arise as to what legal priority or weight to give to what the person is saying.

7.8.2 Weight to be given to a person's wishes

The Act does not state that any of these factors should take precedence over any others. However, the courts have taken the view that the 'further capacity is reduced, the lighter autonomy weighs'.¹⁵

Conversely, the nearer to capacity a person is, so the greater weight should be placed on the person's wishes in determining the best interests.¹⁶

Giving wishes weight. If the wishes of a person (now lacking capacity) are not irrational, impracticable or irresponsible, then the weight to be given to them will be all the greater. This was referred to in a case where a court had overruled the wishes of an elderly couple for an independent deputy to be appointed a lasting power of attorney, by appointing a close family member instead. On appeal, the court restored the parents' wishes.¹⁷

7.8.3 When wishes clash with best interests

Nonetheless, a person's wishes will not always coincide with best interests; in the following safeguarding case, the woman's wishes had in effect resulted in her leaving all her assets in a will to an apparently exploitative carer. The court ended up ordering a statutory will (that is, a will authorised by the court), even though this was not in accordance with what her wishes had been:

Weight to be given to a person's wishes. An elderly, vulnerable woman made an enduring power of attorney in favour of a man with whom (and whose family) she lived and was cared for. The local authority had a number of concerns including questions of capacity, undue pressure, the suitability of the man as attorney, the woman's best interests and her wishes.

The court stated that a person's wishes will always be a significant factor, that the weight to be attached to them will always be case specific, and that all relevant matters must be considered. Such matters include the degree of capacity (the nearer the borderline is capacity, so the greater weight to be attached to a person's wishes), strength and consistency of wishes, impact on the person if wishes are not given effect to, extent to which wishes are rational, sensible, responsible and pragmatic – and the extent to which the wishes fit overall into a judgement about best interests.¹⁸

Thus, just because a person would have made an unwise decision, had they still retained capacity, does not mean that a third party – a carer, a deputy or the court itself – should therefore also make an unwise decision. A consciously unwise decision should rarely, if ever, be made, and characterised as being in a person's best interests.¹⁹

7.8.4 Drawing up the 'balance sheet' to determine best interests

The courts have in the past referred to the drawing up of a balance sheet in order to determine where a person's best interests lie. Effectively this is about weighing up the factors in favour and against a particular decision or course of action.

The proposed action may be drastic and a very careful weighing up may be required. For practitioners, this should be both a useful and essential exercise. Only to weigh up one set of risks (for example, in preserving the status quo) without weighing up alternative risks (of changing the status quo) will not give the full picture necessary for a best interests decision.

For instance, local authorities sometimes conclude that a seemingly irrevocable situation of neglect has arisen in the home of a person lacking capacity (for instance, a younger adult with severe learning disabilities or an older person with dementia). A court order is then sought authorising removal of that person. The courts have pointed out caution is required in exercising such powers, but that they are indeed necessary in particular cases.²⁰

The balance sheet in the following case was finely balanced but came down in favour of the daughter being effectively removed from her father on general welfare grounds:

Establishing best interests for the welfare of a woman with learning disabilities. A 33-year-old woman of Afro-Caribbean background and with moderate to severe learning disabilities, autism and epilepsy lived with her father, who had some help from mainly privately arranged support workers. She lacked capacity to decide about her care and where to live. Her father was 66 years old; her mother had died some years before.

The local authority had triggered adult protection procedures following an allegation that he had struck his daughter. The authority wanted to place her in a care home and limit contact with the father. It raised various other safeguarding allegations stretching back many years in support of its application to the court. The judge dismissed virtually all of these as unreliable, but considered wider matters.

He considered the father's general ability to care for his daughter. He was 66 years old and had diabetes and arthritis; there was no contingency plan should he fall ill. Cooperation with social services was not good; there had been disputes in the past and he was not easy to deal with. He was a proud man, verging on authoritarian. He was a member of his local Pentecostal Church. He felt duty bound to care for his daughter; he loved her. His relationship was broken with his two other children, so they did not come to the house to visit their sister. Professional evidence pointed to the advantage of alternative accommodation. The balance sheet pointed toward her living elsewhere, in her best interests.²¹

7.9 Restraint

Intervention under the Mental Capacity Act is sometimes about safeguarding a person. However, excessive intervention may itself put adults at risk of harm and become a safeguarding matter. This is particularly obvious in the case of restraint.

7.9.1 Conditions necessary to justify restraint

The Act therefore states that a person lacking capacity cannot lawfully be restrained unless certain conditions are met. The person doing the restraining must reasonably believe that the restraint is to prevent harm coming to the person lacking capacity. In addition, the restraining act must be a proportionate response to the likelihood and seriousness of that harm.

Restraint occurs if somebody (a) uses, or threatens to use, force to secure the doing of an act which the person lacking capacity resists, or (b) restricts the person's liberty of movement, whether or not he or she resists (Section 6).

If restraint goes beyond restriction of liberty to a deprivation of liberty, then separate rules apply under the Mental Capacity Act 2005 (see below).

7.9.2 Protecting other people from harm

The Mental Capacity Act *Code of practice* notes that, aside from the Act, there remains a common law duty of care that might make restraint lawful. This means that if a person lacking capacity behaves in such a way that might harm other people, then restraint could be used proportionately to prevent harm not only to the person concerned but also anybody else (DCA, 2007, para 6.43).

7.9.3 Types of restraint and acceptability of restraint

From a safeguarding point of view, restraint is a major issue. On the one hand, it may be sometimes both justified and necessary in a person's best interests. Equally, it is all too easy for restraint to be used to excess, without justification and potentially contrary to people's human rights. Excessive restraint could also give rise to a criminal offence, for example, ill treatment under Section 44 of the Mental Capacity Act.

7.9.4 Unacceptable restraint techniques

The CSCI, before it ceased to exist, referred to a range of restraint practices (used for people without or with capacity) that were unacceptable. These included people fastened into wheelchairs or kept in chairs by means of trays, use of low chairs to stop people getting up, wrapping up people in bed to the point of immobility so they could not remove their incontinence pads, excessive use of bed rails, tying people to chairs, excessive drug-based sedation, not taking people to the toilet when they wanted to go, punishing people by leaving them sitting in soiled pads, and so on (CSCI, 2007).

In line with what the Mental Capacity Act states, the Commission stated that restraint had to be justified in each case. This might be possible as long as a number of considerations were in place, including:

- other methods had been tried without success first
- the least amount of force was used for the shortest time
- it was used according to agreed guidelines, a risk assessment and recorded decisions
- it was a last resort.

Guidance was also issued by the Department of Health in 2002, *Guidance on physically restrictive interventions for people with learning disability and autistic spectrum disorder in health, education and social care settings* (DH, 2002b), both for people with and without capacity.

7.9.5 Getting policies and practices right on restraint

Practitioners and organisations may nonetheless find it difficult to get this right. On the one hand, they may lapse into degrading and even cruel practices, such as tying hospital patients to commodes while they eat breakfast (CHI, 2000, p 10). On the other, they might impose blanket policies about what can or cannot be done,

such as banning the use of chair trays or bed rails. For example, there has long been concern about the use of bed rails both as unacceptable restraint, or when a proper assessment has not been carried out and health and safety hazards are created. However, matters appear not so simple as to warrant a blanket ban, which could itself lead to injury in individual cases:

Judging the use of bed rails. A report from the National Patient Safety Agency (NPSA) found that accidents might occur without them. Individual assessment was most important, and patients with bed rails were mainly positive or neutral about their use, with some patients being reluctant to manage without them. It concluded that the evidence suggested that there should not be blanket policies about their use, and policies should reflect individuals' needs and preferences. (NPSA, 2005)

7.10 Deprivation of liberty

From April 2009, there have been special legal provisions in the Mental Capacity Act 2005 about depriving of liberty a person lacking capacity. If such a person is detained under the Mental Health Act 1983, then various safeguards apply under that Act. However, if the detention does not come under the 1983 Act, then a person lacking capacity must be detained under the 2005 Act, in which case these new safeguards apply.

Deprivation of liberty has a double edge. It might be used to safeguard a person from risk of harm; misused, however, it is a draconian measure that may itself become a safeguarding matter and indeed put a person at risk of harm. Furthermore, if a person is deprived of liberty without procedural legal safeguards, then his or her human rights will be breached. This is under Article 5 of the European Convention on Human Rights.

There are three key points to make: about the definition of deprivation of liberty, about how it is distinguished from restriction of liberty and about how such deprivation can be lawfully imposed. In addition, there is sometimes uncertainty about whether the Mental Capacity Act 2005 or the Mental Health Act 1983 should be used.

7.10.1 Defining deprivation of liberty

The Mental Capacity Act does not define 'deprivation of liberty' directly. Instead, it states that it has the same meaning as referred to in Article 5 of the European Convention on Human Rights. Article 5 itself does not provide a definition, so European Court and English case law has to be looked to.

7.10.2 Factors that may indicate deprivation of liberty

The *Code of practice* on deprivation of liberty lists a number of factors that have been emerged from this case law, factors that may indicate a deprivation of liberty. These are:

- Restraint is used, including sedation, to admit a person to an institution where that person is resisting admission.
- Staff exercise complete and effective control over the care and movement of a person for a significant period.
- Staff exercise control over assessments, treatment, contacts and residence.
- A decision has been taken by the institution that the person will not be released into the care of others, or permitted to live elsewhere, unless the staff in the institution consider it appropriate.
- A request by carers for a person to be discharged to their care is refused.
- The person is unable to maintain social contacts because of restrictions placed on their access to other people.
- The person loses autonomy because they are under continuous supervision and control (Ministry of Justice, 2009, para 2.5).

The fact that a person is not resisting or is compliant does not necessarily mean that he or she is not being deprived of his or her liberty.²²

7.10.3 Three elements of deprivation of liberty

The courts have held that there are three elements in particular required for establishing a deprivation of liberty. First is the objective element that relates to matters such as confinement, freedom to leave, duration, effects and (maybe) the reason or purpose for the deprivation. Second is the subjective element involving matters such as whether the person is objecting, acquiescing, happy or validly consenting. Third is whether the state is responsible either actively for the deprivation or more passively for failure to intervene when the deprivation is being perpetrated by a private individual or body.²³

7.10.4 Taking steps to avoid deprivation of liberty in the first place

In line with one of the key principles under the Act – that the least restrictive intervention should be considered – the aim should be to avoid having to deprive people of their liberty unnecessarily.

7.10.5 Minimising restrictions

The *Code of practice* states that commissioners of care should take steps to minimise the restrictions placed on a person. This should involve good practice in care planning, proper assessment of a person's capacity, consideration of less restrictive ways of meeting the person's needs, ensuring that any restrictions imposed in a hospital or care home are kept to the minimum necessary and for the shortest possible period, helping the person retain contact with family and friends etc, involvement of local advocacy services to support the person and reviewing the care plan on an ongoing basis (perhaps with an independent element involved) (Ministry of Justice, 2009, para 2.7).

7.10.6 Restriction of liberty not the same as deprivation

The courts have distinguished restriction of liberty from deprivation of liberty. The former is less drastic than the latter, and is covered by the restraint rules set out in Section 6 of the Mental Capacity Act 2005 (see above). It does not therefore require the application of the Deprivation of Liberty Safeguards (DoLS). The courts have stated that the distinction is a matter of degree or intensity:

Depriving a person of liberty or restricting liberty? To determine whether there has been a deprivation of liberty, the starting-point must be the specific situation of the individual concerned and account must be taken of a whole range of factors arising in a particular case such as the type, duration, effects and manner of implementation of the measure in question. The distinction between a deprivation of, and restriction upon, liberty is merely one of degree or intensity and not one of nature or substance.²⁴

The *Code of practice* gives examples of what it considers the distinction is likely to be.

Distinction between restriction, and deprivation of, liberty. For instance, not allowing a person to leave hospital unaccompanied because of the risk of him or her being run down in the road, would be restriction but not deprivation; likewise locking a door to guard against immediate harm. Because duration of restriction is a legally relevant factor, the *Code* states that if restraint is frequent, cumulative and ongoing, it may indicate that matters have gone beyond permissible restraint (under Sections 5 and 6 of the Act) and become deprivation. (Ministry of Justice, 2009, para 2.10)

In the following case, there was no deprivation of liberty, although there were some restrictions:

Restriction but not a deprivation of liberty in care home. An elderly man lacking capacity was placed in a care home. The question was whether he had been deprived of his liberty. Some of the relevant factors were that the care home was an ordinary care home where only ordinary restrictions of liberty applied. The family was able to visit on a largely unrestricted basis and could take him on outings. He was personally compliant and expressed himself happy. On no occasion was he objectively deprived of his liberty.²⁵

In the following case, by contrast, there was a deprivation:

Depriving a person of liberty in a care home. A 76-year-old man was cared for by his wife. He suffered a stroke. He was blind, had loss of memory and had dementia. He could say what he wanted with force but the evidence was that he lacked capacity to decide where to live. His wife, struggling to cope, left him outside on the pavement one day. He was then placed in two care homes by the local authority.

In the care homes the man had considerable freedom and contact with the outside world. He was not restrained physically or chemically. However, the

one thing he was not allowed to do was to go home, even on a visit, and even at Christmas. His wife was also told that she should not remove him from the care home; the police would be called if she tried to. For over a year he asked to go home and was repeatedly told that he couldn't. The local authority claimed it would not have stopped him going home, despite the reference to the police being called. The court noted that, even if the police would not have been called and would (as the local authority claimed) not have had the power to intervene, the 'misuse or misrepresentation of even non-existent authority could amount to deprivation as much as locked doors or physical barriers'. In sum, it amounted to a deprivation of liberty.²⁶

7.10.7 Transport and conveyance: restriction or deprivation

The *Code* states that transporting a person to a hospital or a care home will not usually constitute a deprivation of liberty, even if deprivation may take place once the person has arrived at the hospital or care home. It concedes that, exceptionally, deprivation might occur where it is 'necessary to do more than persuade or restrain' the person for the purpose of transportation, or where the journey is exceptionally long. In which case, an order from the Court of Protection would have to be sought to ensure that the journey proceeded on a lawful basis (Ministry of Justice, 2009, para 2.15).

The courts have stated also that, if restraint was required during the journey, Sections 5 and 6 of the Mental Capacity Act 2005 would provide a justification for restraint, rather than be a deprivation (going beyond restraint). And, if an authorisation were already in place, it would cover conveyance to the place where the person was to be deprived of liberty. This was in a case in which restraint might need to have been used in relation a journey of some 100 miles taking two-and-a-half hours, and thus the question of deprivation could arise.²⁷

7.10.8 Lawfully depriving a person lacking capacity of his or her liberty

The Mental Capacity Act 2005 states that a person lacking capacity can only be deprived of his or her liberty in certain circumstances.

The rules about this are to ensure that vulnerable people are not arbitrarily deprived of a fundamental right. Arbitrary detention and its consequences may place adults at risk of harm and are themselves safeguarding matters. The circumstances are as follows.

First, if the Court of Protection has made an order (for deprivation in a hospital, a care home or anywhere else). Second, if the deprivation in a hospital or care home has been 'authorised' by a local authority or NHS PCT under DoLS set out in the Act. Third, if the deprivation relates to life sustaining treatment or a vital act, while a decision is being sought from the Court of Protection. A vital act is defined as doing anything that the person doing it reasonably believes to be necessary to prevent a serious deterioration in the person's condition (Mental Capacity Act 2005, Sections 4A–4B).

7.10.9 Court of Protection order required to deprive a person of liberty other than in hospital or care home

These rules mean that if a person is being deprived of his or her liberty somewhere other than a care home or hospital, then it will be anyway necessary to seek a Court of Protection Order, because the second option, the authorisation procedure, applies only to deprivation in hospitals or care homes.

7.10.10 Authorisation: the Deprivation of Liberty Safeguards

A 'supervisory body' – defined as a local authority or NHS PCT – is able to authorise the deprivation of a person's liberty in a hospital or care home if certain 'qualifying requirements' are met. This is under Schedule A1 of the Mental Capacity Act 2005. The authorisation is called a 'standard authorisation'.

7.10.11 Six assessments for a Deprivation of Liberty Safeguards authorisation of deprivation of liberty

The qualifying requirements for such a deprivation are defined in terms of a number of assessments. These assessments relate to the person's age, mental health, mental capacity, best interests, 'eligibility' and 'no refusals':

- *Age*. In terms of age, the person must be at least 18 years old.
- *Mental health*. In relation to mental health, the person must be suffering from a mental disorder as defined in the Mental Health Act 1983. However, the exclusions in the Mental Health Act 1983 for people with learning disabilities do not apply. (The 1983 Act excludes, for certain purposes, people with learning disabilities from the definition of mental disorder, unless their disability is associated with abnormally aggressive or seriously irresponsible conduct.)
- *Mental capacity*. The person's lack of mental capacity must relate to his or her incapacity to decide whether to be accommodated in a hospital or care home in order to receive care or treatment.
- *Best interests*. The best interests assessment is to establish whether it is in the person's best interests to be detained, the detention is required to prevent harm to the person and the detention is a proportionate response to the risk of harm (in terms of seriousness and likelihood of that harm).
- *Eligibility*. The eligibility requirement is concerned with whether an authorisation cannot be given under the Mental Capacity Act 2005 because the Mental Health Act 1983 must be used instead to detain the person. This is summarised below.
- *No refusals*. The 'no refusals' requirement is about whether the person has made a valid 'advance decision' (see below) that is applicable to some or all of the relevant treatment. Alternatively, it is about whether receiving care or treatment in a care home or hospital would conflict with a valid decision made by the donee of a lasting power of attorney or a deputy appointed by the Court of Protection. In either case, deprivation of liberty would not be possible under the Act (Mental Capacity Act 2005, Schedule A1, paras 12–20).

7.10.12 Procedural rules for standard authorisations depriving a person of liberty

There are detailed procedural rules governing how standard authorisations are given (Mental Capacity Act 2005, Schedule A1). It is beyond the scope of this guide to go into detail. They are explained in the *Code of practice* (Ministry of Justice, 2009). However, in summary, they are as follows.

Supervisory bodies granting standard authorisations to managing authorities

Standard authorisations are granted by supervisory bodies, defined either to be a local authority or NHS PCT. Requests for standard authorisations will come normally from managing authorities, defined as hospitals or care homes; requests could be made alternatively by an interested third party. The managing authority must make such a request if it thinks that it is already depriving a person of liberty or is likely to do so within the next 28 days.

Who carries out assessments and when

There are rules about who can carry out the specified assessments. For example, mental health assessments must be carried out by a doctor approved under Section 12 of the Mental Health Act 1983 or by a doctor with special experience in the diagnosis and treatment of mental disorder.

Best interests assessments can be carried out by approved mental health professionals (as referred to in Section 114 of the Mental Health Act 1983), registered social workers, first level nurses in mental health or learning disabilities, occupational therapists or chartered psychologists. Mental capacity assessments can be carried out by anybody approved to carry out best interests or mental health assessments. However, the same person should not carry out the best interests and mental health assessment.

Time limits

Assessments should be completed within 21 days of the local authority or PCT receiving a request for a standard authorisation. If an authorisation is granted, the period must be specified; the maximum period is 12 months.

Urgent authorisations managing authorities lasting seven days

If there is insufficient time to request or obtain a standard authorisation, the managing authority (the hospital or care home) can itself grant an 'urgent authorisation', pending grant of the standard authorisation. An urgent authorisation can last up to seven days only; in exceptional circumstances an extension for a further seven days can be requested of the supervisory body.

Reviews, personal representatives and independent mental capacity advocates

The supervisory body must appoint a personal representative to maintain contact with, represent and support the person, who is being deprived of his or her liberty. Prior to this, when an application for deprivation of liberty is first made and if there is nobody appropriate to consult – other than people engaged in providing care or treatment professionally or for payment – then an independent mental capacity advocate (IMCA) must be appointed by the supervisory body. The IMCA's role ceases when the personal representative has been appointed.

There are also rules about regularly reviewing an authorisation.

7.11 Deprivation of liberty: Mental Health Act 1983

It is not legally possible to deprive a person of liberty under the Mental Capacity Act 2005 if the Mental Health Act 1983 could be used instead to effect such a deprivation. Whether this is the case is assessed under the 'eligibility' qualifying requirement which has to be assessed by the supervisory body. This rule applies also to any order made by the Court of Protection.

When a person is not eligible to be deprived of liberty under the Mental Capacity Act

A person is not eligible to be deprived of his or her liberty under the Mental Capacity Act 2005 if any of the following applies. The rules are quite detailed (Mental Capacity Act 2005, Schedule 1A). They are, in summary, as follows:

- a) *Detention*: he or she is subject to detention under the Mental Health Act (under Sections 2, 3, 4, 17, 35, 36, 37, 38, 44, 45A, 47, 48, 51).
- b) *Not detained*: he or she is subject to the hospital treatment regime but not detained. This means on leave of absence from detention (Section 17) or conditionally discharged (Sections 42, 73), *and* (i) the action to be authorised under the 2005 Act is inconsistent with a requirement in place under the 1983 Act, or (ii) the care or treatment required consists in whole or in part of medical treatment for mental disorder in a hospital.
- c) *Community Treatment Order*: he or she is subject to the community treatment regime (Section 17A) *and* (i) the action to be authorised under the 2005 Act is inconsistent with a requirement in place under the 1983 Act, or (ii) the care or treatment required consists in whole or in part of medical treatment for mental disorder in a hospital.
- d) *Guardianship*: he or she is subject to guardianship *and* (i) the action to be authorised under the 2005 Act is inconsistent with a requirement in place under the 1983 Act, or (ii) the authorisation under 2005 Act would mean the person becoming a mental health patient in hospital for medical treatment for mental disorder, *and* the person objects to being a mental health patient or to being given some or all of the mental health treatment, *and* no valid consent has been given by a person with a lasting power of attorney or a deputy appointed by the Court of Protection.

- e) *Within the scope of the Mental Health Act:* he or she is within the scope of the 1983 Act (that is, would meet the criteria for detention under Section 2 or Section 3), *and* the authorised action under the 2005 Act would make him or her a mental health patient in hospital for treatment for mental disorder, *and* the person objects to being a mental health patient or to being given some or all of the mental health treatment, *and* no valid consent has been given by a person with a lasting power of attorney or a deputy appointed by the Court of Protection.

In determining whether the person objects (under [d] and [e] above), his or her behaviour, wishes, feelings, views, beliefs and values must be had regard to. Past circumstances are only to be had regard to insofar as it is still appropriate to do so. But any such objection can be overridden (and the 2005 Act still be used) if the donee (the person given the power) of a lasting power of attorney or a deputy has validly consented to the detention and treatment.

This is by no means straightforward, and practitioners will be concerned to know that they are doing the right thing. For example, the following case was about whether a woman requiring assessment and treatment, to which she was objecting, should be detained under the Mental Health Act or the Mental Capacity Act:

Deprivation of liberty in a care home for assessment and treatment. A woman with a very rare bone disorder and a brain injury needed a neuro-psychiatric assessment and treatment. She objected to being at the institution in question, which was a care home rather than a hospital. The question was whether she should therefore be deprived of her liberty under the Mental Capacity Act or the Mental Health Act 1983. She appeared to come within category (e) above. However, that refers to a person being a mental health patient, which in turn requires being accommodated in a hospital. The care home was not a hospital, so (e) did not apply, and it was the Mental Capacity Act 2005 that should apply, the woman's objections to being at the care home notwithstanding.²⁸

7.11.1 Treatment for mental disorder: 2005 Act or 2003 Act

Separate from the question of which Act (Mental Capacity or Mental Health) should be used to *deprive* a person of liberty is the further question about which Act should be used to authorise *treatment* for mental disorder of a person lacking capacity.

No treatment under Mental Capacity Act 2005 if treatment regulated by Mental Health Act 1983

It is beyond the scope of this guide to set out the detail that, again, is somewhat complicated. However, generally, patients cannot be given treatment for mental disorder under the Mental Capacity Act, if their treatment is regulated by Part 4 of the Mental Health Act, that is, they are liable to be detained under the 1983 Act or are under a Community Treatment Order (Mental Capacity Act 2005, Sections 28–28[1a]). This includes patients on leave of absence. However, this does not include emergency, very short-term detention provisions or conditional discharge under the

1983 Act; people under these provisions would be subject to treatment under the 2005 Act. People under guardianship may be treated under the 2005 Act.

Invasive treatments

There are one or two provisos. For all patients, certain highly invasive treatments cannot in any case be given under the 2005 Act; they are subject to the safeguards of Section 57 of the 1983 Act. Section 57 covers surgical operation for destroying (the functioning of) brain tissue.

And, under Section 58A of the 1983 Act, electro-convulsive therapy can only be given to a person lacking capacity (even if the other conditions under Section 58A for treatment are met) if the treatment does not conflict with a valid and applicable advance decision made by the person (under the 2005 Act) or with a decision made by a donee of a lasting power of attorney or a deputy appointed by the Court of Protection.

7.11.2 Treatment for a physical disorder

If a person lacks capacity and requires treatment for a physical disorder, the general rule is that the treatment must be given under the Mental Capacity Act 2005, even if, for example, the person is already detained in hospital under the Mental Health Act 1983.

However, even this may not always be straightforward. If physical treatment flows from, or will directly affect the mental disorder – for which a person is, or could be, detained under the Mental Health Act 1983 – then the detention and treatment might come under the 1983 Act rather than the Mental Capacity Act 2005.

Treatment for mental disorder or physical disorder. In one case, a caesarean section could come within the Mental Health Act 1983 because it was viewed as part of the treatment of the person's mental disorder.²⁹

Equally, in other circumstances, the very same treatment would not come under the Mental Health Act.³⁰

In one case, naso-gastric tube feeding, to avert starvation related to self-harm – itself associated with a borderline personality disorder – amounted to treatment for the person's mental disorder under the 1983 Act.³¹ Whereas, in another case, proposed amputation of the leg of a schizophrenic man was not treatment for mental disorder and could not come under the 1983 Act.³²

If, however, the reason for the detention is only to provide the physical treatment, then the detention and treatment will come under the 2005 Act.

Treatment of diabetes. In the case of a man with diabetes, this physical condition did not flow from the mental disorder, and treatment for it would not directly affect the mental disorder. Thus, the detention and treatment for it in hospital lay under the Mental Capacity Act 2005.³³

7.12 Lasting power of attorney

Somebody with a lasting power of attorney (the donee) has the legal authority to make decisions directly on behalf of a person lacking capacity (the donor). The decisions that can be taken may cover finance, property, health or welfare.

7.12.1 Lasting power of attorney as a safeguard

From a safeguarding point of view, a lasting power of attorney should act indeed as a safeguard, namely, that best interests decisions will be taken by somebody whom the donor trusts (or trusted in the past).

7.12.2 Lasting power of attorney as risk factor

Conversely, it means that somebody else is now in control of major decisions made on behalf of a person who is no longer able to understand those decisions. Inevitably, in some instances, the attorney may not only fail in his or her obligation to act in the person's best interests, but may also positively abuse the position. This could then give rise to safeguarding concerns.

By way of example, there have been cases involving enduring powers of attorney (predecessor of last powers of attorney) indicating the potential for abuse of such powers:

Social worker committing theft through a power of attorney. A social worker was meant to apply for an order for the Court of Protection for a person who uses services; this had been recommended by a consultant psychiatrist who had assessed the mental capacity of an elderly woman. The latter was now in a care home, 79 years old, had dementia and had no known relatives. She had £25,000 savings and owned her own home.

Instead of applying to the Court of Protection, the social worker obtained an enduring power of attorney for herself. She did not register it with the Court of Protection. She then withdrew £8,180 from cash machines, and made other withdrawals at a rate of about £250. She then sold the woman's house for £87,000, and began to write out cheques to herself including one for £42,000. Another cheque for £5,000 was made out to Age Concern, where the social worker's husband was regional manager.

Finally, another social worker became suspicious, having been asked to reassess the woman, when she discovered the first social worker still visiting. In fact the latter had asked the care home to remove the woman's name from the records, and the woman's social services file was missing. In total the social worker had stolen £65,000. The judge referred to a deliberate, cynical and gross breach of trust and imposed a prison sentence for the theft, of three- and-a-half years.³⁴

7.12.3 Lasting power of attorney: rules

The rules in brief about lasting power of attorney are as follows. An adult aged 18 years or over, with the mental capacity to do so, can make such a power. This authorises the attorney to make decisions about property and financial affairs and (or) welfare matters when the donor loses capacity to take such decisions. The donor can decide which matters should be within the power and which should be excluded. Welfare decisions can include matters such as healthcare, place of residence, contact etc.

Separate forms are required to register power of attorney covering property and finance, and to register a power covering welfare decisions.

7.12.4 Attorneys: implications of acting jointly or severally

More than one attorney can be appointed in which case they can act what is called jointly, or jointly and severally. Acting jointly is a safeguard against abuse of the power, because it requires involvement of all the attorneys, but it is also more cumbersome. Another possible safeguard would be to appoint one attorney to manage money and property, and another to take welfare decisions. Again, however, this could prove more cumbersome when decisions are needed involving both finance and welfare.

There are restrictions on gifts that can be made. Beyond reasonable, customary gifts, application must be made to the Court of Protection.

7.12.5 Lasting power of attorney: safeguards

The principles of the Act apply to attorneys, including that they must act in the best interests of the person lacking capacity and do so in the least restrictive way.

7.12.6 Validity and registration of powers

To be valid, the power of attorney must be registered with the Office of the Public Guardian (OPG). There are certain formalities that must be complied with in the application process including the witnessing of signatures and certification by a third party that the donor understands what he or she is doing. A lasting power of attorney involving welfare decisions cannot be used before a person loses capacity.

7.12.7 Common law duty of care on attorneys

In addition, the Mental Capacity Act *Code of practice* states that attorneys have a common law duty of care to apply reasonable standards of care and skill, a fiduciary duty (trust, good faith, honesty, not taking advantage of the position), a duty of confidentiality, a duty to keep accounts, a duty to keep the donor's money and property separate from their own etc (DCA, 2007, paras 7.52–7.58).

7.12.8 Fiduciary duty of attorneys

The reference to fiduciary duty was underlined by the court in a case involving the abuse of an enduring power of attorney:

Son using his mother's money for himself: rigorous fiduciary duty. A man had enduring power of attorney for his mother. He used her money to obtain a house in his name (rather than hers), a sports car and a powerboat. He moved large sums into the account of a company owned by his wife. He sold shares, the proceeds going into an account drawn on by his wife. The mother had gained no benefit from these transactions. She was left bereft of assets, with nothing to pass on to her grandchildren or with which to meet her own needs at the end of her life. After her death, a case was brought on behalf of her estate against the son.

The court stated that the law imposed rigorous and inflexible duties on fiduciaries who enter into transactions with the person to whom the duty is owed, that is, the son was arranging for his mother's assets to flow to him. This would mean justifying that the transaction was fair and that proper and independent advice had been obtained. In this case, the son was clearly in breach of his fiduciary duty.³⁵

However, clearly not all gifts and transactions between the donor and donee will be suspicious from a safeguarding point of view, even if, in the following case, the Court of Protection should have been approached first for authorisation:

Making gifts with an enduring power of attorney. A daughter had enduring power of attorney for her mother, now in a nursing home. The daughter had two siblings. Hostility existed between the three. The daughter made £20,000 gifts to herself and her two siblings, even-handedly. This was for estate planning purposes. She should have sought permission from the Court of Protection. But this did not make her an unsuitable attorney. She should have known what law demanded of her in such an 'important fiduciary position'. But there was no evidence of greed. The fact of hostility also did not make her unsuitable in the present case. In other circumstances, it might have. For example, if the donor's estate had been complex and required decision making requiring consultation and cooperation with the other siblings.³⁶

7.13 Revocation of lasting power of attorney

Lasting powers of attorney can be revoked and this may be necessary for safeguarding. For instance, the donor – so long as he or she still has capacity – can revoke the power (Mental Capacity Act 2005, Schedule 13). The Court of Protection can intervene. It can decide whether a lasting power of attorney has been properly created, whether it has been revoked, whether fraud or undue influence were involved, whether the attorney is going beyond the authority given him or her by the power or whether the attorney is not acting in the donor's best interests (Mental Capacity Act 2005, Schedule 22).

7.13.1 Enduring powers of attorney

Practitioners will continue to come across valid enduring powers of attorney, made before October 2007 (when they were replaced by lasting powers of attorney). By definition enduring powers of attorney can cover only property, business and finance; they cannot extend to welfare decisions.

7.14 Court of Protection

The Court of Protection deals with decision making for adults who may lack capacity to make specific decisions. It can make decisions and orders not just about property, and financial affairs but also about people's health and welfare (Mental Capacity Act 2005, Sections 15–23).

7.14.1 Declarations, one-off orders and deputies

In brief the court can make declarations about a person's capacity and about the lawfulness of acts done in relation to the person. It can make decisions about people lacking capacity by means of one-off orders. Where there are ongoing decisions that have to be made, the court can appoint a deputy to manage a person's property and affairs and also the person's welfare. There can be more than one deputy.

There are restrictions on deputies; for example, a deputy cannot settle a person's property or execute a will, cannot refuse consent to lifesaving treatment and cannot prevent a named person having contact with the person lacking capacity.

7.14.2 Advance decisions, deprivation of liberty

The court can make declarations about advance decisions, and make decisions about the application of DoLS under the Act.

7.14.3 Statutory wills

The Court of Protection also has the power to make a statutory will (Mental Capacity Act 2005, Schedule 18). Such a will is made under the principles under the Act, namely in a person's best interests. This means that although a person's past or present wishes must be taken account of, they will not be decisive. The making of such a will could be directly relevant to safeguarding, as it was in the following case:

Making a statutory will overriding a previous valid one: in a person's best interests. A woman had lived with a man and his family who cared for her. She had previously made a will leaving money to nine charities. She then revoked this will. The new one left her entire state to the man, who also had power of attorney. She then lost capacity to take various decisions and, at the direction of the court, was now living in a care home. There was a question about whether she had had capacity when she changed her will; or, alternatively, whether she had been unduly influenced in changing it. Either way, the Court of Protection had no jurisdiction, under the Mental Capacity Act 2005, to rule on the validity of the will. But what it could do now was to authorise – in her best interests –

the making of a statutory will, thus superseding the previous one, which hark back to her original intention of leaving her money to the charities.³⁷

The court in this last case also pointed out that the woman's best interests not only related to her when still living, but also in death, in terms of funeral arrangements and how she would be remembered.

7.14.4 Trigger for involvement of the court

Court of Protection involvement is intended to be a last resort for welfare issues. The *Code of practice* expects that advocacy, second opinions, case conferences, mediation or complaints procedures may mean that the court's involvement is not called for (DCA, 2007, para 5.68). Equally, the court's involvement may be necessary in case of entrenched disagreements and difficult decisions, such as may arise in safeguarding situations.

There are some decisions that are so serious, that the court's involvement will be required in any case. In the past, the courts have stated that this will be needed in cases about artificial nutrition and hydration for patients in a persistent vegetative state,³⁸ bone marrow donation³⁹ and non-therapeutic sterilisation.⁴⁰

On the other hand, for property and affairs, the court's involvement will usually be necessary unless the only income involved is from state benefits or an enduring or lasting power of attorney already exists (DCA, 2007, paras 8.27–8.35).

7.14.5 Finances: state benefits and appointeeship

If a person lacks capacity to manage their money, but the only money in question is in the form of state benefits, then somebody else can be made 'appointee' to receive and spend the money on the person's behalf. Such an arrangement does not come under the Mental Capacity Act 2005.

Social security regulations state that if a person is entitled to benefits, but is unable 'for the time being to act', then a person can be appointed to receive and deal with benefit payments. This presupposes that no deputy (or under old legislation, receiver) has been appointed by the Court of Protection.⁴¹

Appointment is by the Department for Work and Pensions. Obvious people to take the role would be relatives or close friends, but local authorities sometimes take on this role. There is no formal system of monitoring but if concerns arise, the Department for Work and Pensions can check that the appointee is acting in the persons' best interests, and can revoke the appointeeship if necessary (Thompson, 2003, p 82).

7.14.6 Application to the Court of Protection

Some people can make applications to the Court of Protection without needing permission first. These are a person lacking, or alleged to lack, capacity, by a person with a parental responsibility for a person under 18 years old, by a donor or donee of

a lasting power of attorney, by a court-appointed deputy or by a person named in an existing court order (with which the application is concerned). Anybody else requires permission.⁴²

7.14.7 Office of the Public Guardian

The OPG functions under the Mental Capacity Act to protect people lacking capacity and specifically to:

- set up and manage registers of lasting powers of attorney, of enduring powers of attorney and of court order appointed deputies
- supervise deputies
- send Court of Protection visitors to people who may lack capacity and to those acting formally on their behalf
- receive reports from attorneys and deputies
- provide reports to the Court of Protection
- deal with complaints about attorneys and deputies.

Clearly, these functions are directly relevant to safeguarding. The OPG has published a document outlining procedures and timescales to be followed in response to allegations, suspicions or reports of abuse of a vulnerable adult. It envisages that such concerns may be raised from a variety of sources (OPG, 2008).

7.15 Advance decisions

Practitioners may find themselves in certain situations involving an adult at risk, a life-threatening situation and an 'advance decision'. In such circumstances, knowledge of the rules concerning such a decision will be needed. This would be in order to safeguard the vulnerable adult, but also to protect a practitioner from possible legal liability.

In brief, the rules are as follows (Mental Capacity Act 2005, Sections 24–26). Two key points to be established are the validity and applicability of an advance decision.

7.15.1 Refusal of treatment

An advance decision involves a person stating that if he or she loses capacity, he or she refuses specified *treatment*. (Treatment is defined as including a diagnostic or other procedure.) It can be made by a person aged 18 or over with the mental capacity to make it. The decision can be altered or withdrawn after it is made; withdrawal need not be in writing.

7.15.2 Validity of advance decision

An advance decision becomes invalid if the person (a) withdraws it, (b) subsequently gives authority for such a decision to be made under a lasting power of attorney, or (c) has done anything inconsistent with the advance decision.

If the decision is about life-sustaining treatment, it must be specifically verified by the person that the decision is to apply even if life is at risk. The decision must also be in writing, signed and witnessed.

Thus, a person's actions, since the decision was made, may cast doubt on the validity or applicability.

Religious beliefs and validity of advance decision. A young woman had aortic valve heart disease. She made a detailed advance decision, absolutely refusing blood transfusions in any circumstances, in accordance with her Jehovah's Witness beliefs. Two years later she was rushed to hospital, unconscious and requiring a blood transfusion. Her mother insisted the advance decision be respected. The case urgently went to court.

The father produced evidence that the woman had become engaged a few months ago to a Muslim, on condition she gave up her Jehovah's Witness beliefs and reverted to being a Muslim. She had stopped attending Witness meetings. Recently, during a hospital admission, she had told her aunt she didn't want to die. She had also announced that nothing would stop her marrying her fiancé and that she would become a Muslim.

The judge held the evidence either showed that the advance decision was no longer valid because her actions strongly suggested a rejection of the Jehovah's Witness beliefs on which the decision was founded. If the judge was wrong about this, at least the evidence threw sufficient doubt on the decision as to warrant the saving of her life.⁴³

7.15.3 Applicability of advance decision

An advance decision is not applicable if:

- *persisting capacity*: at the time the treatment is needed, the person has capacity to make the decisions
- *treatment not specified*: the treatment required is not that specified in the advance decision
- *circumstances specified not arisen*: the circumstances specified in the advance decision have not arisen
- *new circumstances*: there are reasonable grounds to believe that circumstances now exist that the person did not anticipate at the time the decision was made, but which would have affected the decision had they been anticipated.

If the advance decision is valid and applicable, it has legal effect as though the person still had capacity, and has made the decision, at the time he or she needs the treatment.

7.15.4 Liability in relation to advance decisions

A person providing treatment will not be held legally liable for providing treatment unless he or she knew about the existence, validity and applicability of an advance

decision. If a decision is being sought from the Court of Protection, then an apparent advance decision does not prevent interim life-sustaining treatment being given.

The consequences of a valid and applicable advance decision may put practitioners in an extremely difficult position, hence the importance of knowing the rules. In the following case, as reported, the doctors respected the advance decision, knowing that to do otherwise could incur liability:

Implications for medical doctors of an advance decision under the Mental Capacity Act. A woman had made an advance decision under the Mental Capacity Act 2005, to the effect that she did not want to be treated for self-poisoning. When she rang up the hospital so that she would not die alone and could receive pain relief, the doctors did not try to save her life. The woman died. This was because the doctors could have otherwise have been liable (for example, for trespass to the person) if they had intervened, against the provisions of the woman's apparently valid and applicable advance decision. The coroner did not blame the hospital for the woman's death. (Gabbatt, 2009)

7.16 Decisions that cannot be made on behalf of a person lacking capacity

There are certain decisions that cannot be made in a person's best interests under the Mental Capacity Act 2005. In other words, either a person has capacity to take those decisions or not. If the person has capacity, then best interests are legally irrelevant because he or she can take the decision anyway without interference. If the person lacks capacity, then the person cannot legally take the decision at all, in which case best interests also do not arise.

This can leave agencies and practitioners in a difficult position when they wish to protect a person from the consequences of an unwise decision, but find that best interests are simply not relevant.

The decisions covered by this rule include, among other things, consent to marriage or civil partnership, consent to sexual relations and voting (Mental Capacity Act 2005, Section 27).

7.16.1 Marriage and sexual relationships

The courts have held that if a person understands the nature of marriage in general, then he or she can marry the person of choice. This is even if a local authority is understandably concerned, from a safeguarding point of view, about the consequences, for instance, when a woman with learning disabilities wanted to marry a convicted, violent sex offender.⁴⁴

Equally, the courts have been clear that if a person clearly lacks the capacity to understand marriage, then he or she simply cannot marry lawfully, even if, for example, there are complicating cultural issues in play.

Invalid marriage: potential sexual offences. A man with learning disabilities was married on the telephone, in a Muslim ceremony, to a woman in Bangladesh. He lacked the capacity to understand marriage. The intention was that the woman would come to live in England as his wife. The court accepted that the marriage would be valid in Bangladesh, but held that it was invalid in England. Furthermore, the marriage could be extremely injurious to the man's equilibrium and emotional state. Offences could be committed under the Sexual Offences Act were sexual intercourse or other physical intimacy to take place. The telephone marriage was potentially abusive of the man. The court had to protect him by refusing to recognise the marriage.⁴⁵

In another case of this type, the court was equally clear about the law, but not minded to make a formal order when the parents were prepared to give an undertaking:

Parents giving undertaking to court not to arrange a marriage for their son. A 25-year-old man had a marked autistic disorder. He had limited understanding of the needs of others, impaired communication and very little language. He exhibited challenging and unpredictable behaviour. The evidence was that he lacked the capacity to marry. His parents had long had plans for him to marry his cousin who lived in Pakistan. This was understandable; the parents might typically be concerned about his future care and welfare. Marriage would be a reassurance about this.

The local authority became concerned and went to court. An order was made that the man's passport be taken away; in error the parents' passports were confiscated as well (and returned later).

The matter then went back to court. The parents undertook not to cause or permit him to be married and not take him out of the country. The judge accepted these undertakings because, in his view, the parents were decent, responsible, conscientious, honourable and law abiding. On this basis, he ordered that their son's passport be returned.⁴⁶

7.16.2 Courts' test of capacity for marriage and sexual relations

The courts have developed their own tests of capacity for marriage and sexual relationships. In both cases they have emphasised that the legal threshold for either is not a high one, although understanding marriage requires the higher level of capacity.

So, understanding marriage would include understanding about sexual relations as well as other matters, whereas an understanding of sexual relations would not necessarily entail an understanding of marriage.⁴⁷

Test of mental capacity to marry. There are thus, in essence, two aspects to the inquiry whether someone has the capacity to marry. (1) Does he or she understand the nature of the marriage contract? (2) Does he or she understand the duties and responsibilities that normally attach to marriage? The duties and responsibilities that normally attach to marriage are as follows: marriage,

whether civil or religious, is a contract, formally entered into. It confers on the parties the status of husband and wife, the essence of the contract being an agreement between a man and a woman to live together, and to love one another as husband and wife, to the exclusion of all others. It creates a relationship of mutual and reciprocal obligations, typically involving the sharing of a common home and a common domestic life and the right to enjoy each other's society, comfort and assistance.⁴⁸

It may be tempting for practitioners to extend the capacity test for sexual relationships which basically is whether a person understands the sexual nature of the act and the reasonably foreseeable consequences such as pregnancy or disease.

In one case, a local authority had argued for this because it wanted to protect a woman whom it regarded as vulnerable to exploitation. The court intimated that the local authority was trying to blur the distinction between capacity and best interests. But best interests had no place in such matters; either somebody had capacity to engage in sexual relations or not.

Not mixing up best interests and capacity to engage in sexual relations. A local authority had wanted to extend the test of what would indicate lack of capacity to engage in sexual relations. This was in order to protect a woman with mental health problems from what it considered to be exploitative sexual relations.

It argued that understanding the reasonably foreseeable consequences of sexual relations should also relate to, for example, (a) the risk in deterioration in her mental state should she become pregnant or a romantic relationship collapse, (b) the social and emotional consequences of having sexual intercourse (whether or not it leads to pregnancy), (c) her beliefs about whether she would be allowed to keep any baby born to her, (d) her belief that any man who had sexual intercourse would marry her, and (e) her belief that she would only be happy when married and a mother.

The court was not prepared to go along with this. For instance, the judge commented on the point that she thought that sexual relations would lead to marriage. He pointed out that many young women (not vulnerable like this woman), 'similarly persuade themselves as to the attitude and intentions of their man towards them'. Such false beliefs did not constitute lack of capacity.⁴⁹

The court was not prepared to consider and judge minutely the realism of the woman's beliefs and translate this into questions of capacity. In short, the court would not stop an adult with capacity performing a lawful act.

7.17 Independent mental capacity advocates

The Act established IMCAs. Part of their role is particularly associated with safeguarding.

7.17.1 Who appoints independent mental capacity advocates?

IMCAs are appointed either by local authorities or by NHS trusts for people lacking capacity to take certain decisions. Their core role is to provide support, obtain and evaluate relevant information, to ascertain the person's wishes, feelings, beliefs and values and alternative courses of action, and obtain a further medical opinion where treatment is proposed. The advocate must prepare a report.⁵⁰

7.17.2 People being placed in hospitals or care homes

A duty arises to appoint an IMCA if a person lacking capacity is being placed in a care home for longer than eight weeks or a hospital for longer than four weeks, or if the person requires serious medical treatment. However, this duty arises only if the person is unbefriended. This means that if there is nobody else – other than a person providing care or treatment professionally or for payment – whom it would be appropriate to consult about the person's best interests (Mental Capacity Act 2005, Sections 37–39).

7.17.3 Deprivation of liberty safeguards

In addition, a duty may arise to appoint an IMCA in respect of the DoLS under the Mental Capacity Act (see above). If a person is subject to the deprivation of liberty rules and does not have a personal representative, or the PCT or local authority (the supervisory bodies) believes that the person lacking capacity and the personal representative are not exercising their rights, then the supervisory body must appoint an IMCA (Mental Capacity Act 2005, Sections 39A–39E).

7.17.4 Safeguarding and independent mental capacity advocates

A power exists to appoint an IMCA in relation to safeguarding. It arises if the NHS body or local authority proposes to take, or has taken, protective measures for a person lacking capacity (a) following receipt of allegation of abuse or neglect (by another person) or (b) in accordance with arrangements made under adult protection guidance issued under Section 7 of the Local Authority Social Services Act 1970. The guidance referred to is *No secrets*.

Protective measures are defined to include measures to minimise risk of abuse or neglect. In contrast to the duty to appoint an IMCA (above), this power to appoint an IMCA for safeguarding purposes is not dependent on the person being unbefriended.⁵¹ (IMCAs can apply to the Court of Protection for permission to bring a case in the same way as any third party can.)

7.18 Ill treatment or wilful neglect

The Act creates offences of ill treatment or wilful neglect, with a maximum sentence of five years in prison (Mental Capacity Act 2005, Section 44). They may be committed:

- by any person who has the care of another person who lacks capacity, or who the first person reasonably thinks lacks capacity, or
- by any deputy or person with lasting power of attorney, or
- any person with enduring power of attorney.

8 Inherent jurisdiction of the courts to intervene

8.1 Key points

The courts have what is called an 'inherent jurisdiction' which sometimes enables them to intervene legally in relation to vulnerable adults, even when there is no legislation sanctioning it. They no longer exercise this jurisdiction in relation to people lacking capacity, because the rules are now in the Mental Capacity Act 2005.

However, there may be occasions when the courts are prepared to intervene in the case of a vulnerable adult, even when he or she legally has the capacity to consent. For example, this may happen in certain cases of undue pressure or coercion, or in other circumstances (that is, other than lack of capacity), in which the person is unable effectively to give informed consent.

8.2 Inherent jurisdiction: adults at risk but with mental capacity

Prior to the implementation of the Mental Capacity Act 2005, the courts exercised their 'inherent jurisdiction' to make decisions about people's mental capacity and people's best interests. The term means the courts' own power, aside from legislation, to make and apply legal rules.

8.2.1 The position before October 2007

Before the Mental Capacity Act 2005, the courts exercised their inherent jurisdiction in cases involving mental capacity. Many of these legal principles – such as the test for capacity and the approach to be taken to 'best interests' – found their way into the Mental Capacity Act 2005.

8.2.2 Vulnerable adults: undue pressure or coercion

However, the Act creates something of a 'hard line' as to whether a person does or doesn't have capacity to take a particular decision. Sometimes, even if a person legally does have the capacity, he or she may still be in a very vulnerable position because of undue pressure or coercion being exercised, or of other circumstances preventing the person giving informed consent.

The question has therefore arisen about whether the courts might continue to exercise this inherent jurisdiction in respect of people not covered by the Mental Capacity Act 2005. Such an exercise could be very important in safeguarding situations, where practitioners are attempting to assist an adult at significant risk of harm, but are unable to do this under the Mental Capacity Act, for the simple reason that the person does not lack capacity.

8.2.3 Fear, duress or threat

The courts have on occasion used their inherent jurisdiction to intervene in the case of an adult who in principle has the mental capacity to understand marriage, but

whose exercise of that capacity is overborne by fear, duress or threat, such that he or she is deprived of the capacity to make relevant decisions.⁵²

In an earlier case involving a medical decision, the question arose whether a woman should have a blood transfusion. The court stated that it could intervene either in the case of lack of capacity or if the woman's had been overborne by outside influence:

Overbearing, by mother, of daughter's will in making a decision about lifesaving treatment. A young woman, 34 weeks pregnant, had been in a car accident. Her parents were separated; her mother was a Jehovah's Witness, her father was not. She herself had held some Jehovah's Witness beliefs but had never formally been accepted as into the faith. Before losing consciousness in the hospital, she had spent some time alone with her mother. Following this time, she said she did not want a blood transfusion; the doctors hesitated to give one. The case went urgently to the courts.

The Court of Appeal held that, in all the circumstances, that she lacked capacity to take the decision that the transfusion could be given. The court would make a declaration to that effect. However, in addition, if she had capacity, it would also have found that the influence of her mother had vitiated her ability to make a decision. In this respect, it was one thing for a person to be persuaded, but another to have their will overborne. In such circumstances, doctors could take the view that the decision was not a true decision, and apply to the courts for help.⁵³

8.2.4 Environment and circumstances preventing informed consent

In another case, communication difficulties were added to constraint and undue influence as grounds on which judicial intervention could be made. It concerned a woman who had the mental capacity to understand the nature of marriage, but communicated only in sign language. The plan was for her parents to take her to Pakistan for an arranged marriage. The local authority's concern was that in Pakistan she would be unable to give informed consent, because she would not understand what was going on:

Intervention in the case of communication difficulties. The court stated that it could intervene in the case of a vulnerable adult 'even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint, or (ii) subject to coercion or undue influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing real or genuine consent'.

This meant that the court could intervene in the case of a 'vulnerable adult who there is every reason to believe may, by reason of her disabilities, and even in the absence of any undue influence or misinformation, be disabled from making a free choice and incapacitated or disabled from forming or expressing a real and genuine consent'.⁵⁴

The courts have stated that they see the inherent jurisdiction – in relation to an adult with capacity to take a decision – as about facilitating decision making free of external pressure or physical restraint. But that the jurisdiction is not about *imposing* decisions concerning welfare or finance on a person.⁵⁵

9 Mental Health Act 1983

9.1 Key points

Compulsory intervention under the Mental Health Act may be an essential way of safeguarding a vulnerable adult if less formal attempts have either failed or are not possible for some other reason. In relation to safeguarding, such interventions will constitute a measure of last resort but may be essential.

9.1.1 Detention

Such interventions include detaining a person for shorter-term assessment (and maybe treatment), longer-term detention for treatment (Section 3), entry into premises by an approved mental health professional (Section 115), removal of a person from premises (Section 135) and removal from a public place (Section 136).

9.1.2 Guardianship

In addition is guardianship that, among other things gives the guardian, often a local authority, the power to require a mentally disordered person to live in a particular place (Sections 7 and 8).

Note: It is beyond the scope of this guide to cover the Mental Health Act 1983 in any detail. Full explanation and illustration is given in the *Code of practice* (DH, 2008a).

9.2 Definition of mental disorder

For the Mental Health Act to be used at all, the definition of mental disorder must be satisfied. In contrast with the Mental Capacity Act, the person need not lack the capacity to take the relevant decision. Mental disorder is defined as any disorder or disability of mind.

9.2.1 Learning disability

Learning disability is excluded from the definition of mental disorder, unless it is associated with abnormally aggressive or seriously irresponsible conduct.

This exclusion does not, however, apply to short-term detention under Section 2 of the Act, Section 115 (entry by approved mental health professional), Section 135 (search and removal) or Section 136 (removal from public place). In other words, these sections of the Act can be used in respect of a person with learning disabilities, even if there is no abnormally aggressive or seriously irresponsible conduct, always supposing other relevant conditions are satisfied.

9.3 Short-term detention for assessment (and treatment)

Under Section 2 of the 1983 Act, people can be detained for up to a period of 28 days primarily for assessment (or for assessment followed by medical treatment).

This can only be done if two grounds are made out. First, that the person is suffering from mental disorder of a nature or degree that warrants such detention in hospital. Second, that the person ought to be detained in this way in the interests of his or her own health and safety, or with a view to protecting other people.

Such detention can be applied for by the patient's 'nearest relative' (as defined under the Act) or by an approved mental health professional, and has to be based on the written recommendations of two registered medical doctors.

If practitioners are sufficiently worried about harm coming to a vulnerable adult, they might consider using Section 2 of the Mental Health Act 1983 but must adhere to the rules even if they are acting in total good faith.

9.3.1 Adhering to the rules for detention

The following example was a reminder about the rules under both mental health and mental capacity law; the failure to follow them meant that a trespass to the person (a civil wrong) had been committed.

Unlawful detention and treatment. A woman in the late stages of pregnancy had pre-eclampsia threatening her own life and that of her unborn baby. She was refusing medical intervention. So alarmed were the professionals involved that they arranged for her to be detained in hospital under the Mental Health Act 1983. It was then claimed that she lacked capacity to take the decision, and an emergency declaration was obtained approving the carrying out of a caesarean section. It was successful. The woman subsequently went to court, which found the Mental Health Act had been misused and that in fact she had had capacity to decide. The carrying out of the operation had therefore been a trespass to the person.⁵⁶

9.4 Longer-term detention for treatment

Under Section 3 of the 1983 Act, people can be detained in the longer term for treatment if the following conditions are satisfied.

First is that the person is suffering from a mental disorder. Second, that appropriate medical treatment is available. Third, that it is necessary for the health or safety of the person or for the protection of other people that the person receives such treatment, and that it cannot be provided unless he or she is detained.

Such detention can be applied for by the patient's nearest relative or by an approved mental health professional, and has to be based on the written recommendations of two registered medical doctors.

9.5 Community Treatment Orders

Under Sections 64A–6K of the Mental Health Act 1983, patients who have been detained in hospital for treatment can be made subject to Community Treatment

Orders when they are discharged. This means that if they fail to comply with their treatment plan, they can be recalled to hospital.

9.6 Guardianship

Under Sections 7 and 8 of the 1983 Act, guardianship may be an appropriate way of safeguarding an adult at risk. As with other Mental Health Act interventions, particular conditions must be satisfied.

First, under Section 7, the person must be at least 16 years old and be suffering from mental disorder. Second, the mental disorder must be of a nature or degree that warrants his or her reception into guardianship. Third, this must be necessary in the interests of the welfare of the patient, or for the protection of other people.

9.6.1 Powers that come with guardianship

Under Section 8, the guardian (often a local social services authority) has a number of powers. First is to require the person to live at a specified place. Second, to require the person to attend at specified places and times for medical treatment, occupation, education or training. Third, to require access to the person to be given, at any place where the person is living, to any registered medical practitioner, approved mental health professional or other specified person.

9.6.2 Conveyance, contact, deprivation of liberty under guardianship

Under Section 18 of the 1983 Act, the person subject to guardianship can be both taken and conveyed to the place of residence and also fetched back if he or she leaves that place of residence.

Sometimes an issue arises outside of these specified powers, and the local authority, for example, would have to consider the legal basis for any decision or action. On the one hand, the courts have held that, up to a point, it is implicit that the guardian can promote the welfare of the person. For instance, this could be preventing the person seeing a sexually provocative magazine; this could also extend to limiting a person's contact, but would not allow the local authority to act in a totalitarian fashion.⁵⁷ However, a major contact issue, involving a person lacking capacity, might necessitate a separate court order.⁵⁸

The Mental Health Act *Code of practice* states that requiring a person under guardianship to live somewhere does not extend to depriving that person of his or her liberty. It states that this would only be possible (a) in the case of a person lacking capacity, and (b) only then if authorisation was obtained under the Mental Capacity Act 2005 (DH, 2008a, para 26.3).

9.6.3 Guardianship and people with learning disabilities: abnormally aggressive or seriously irresponsible conduct

Local authorities sometimes consider guardianship for people with learning disabilities. However, as already explained, guardianship is not available unless that

learning disability is associated with abnormally aggressive or seriously irresponsible conduct.⁵⁹ The courts have warned against setting too low a threshold.

For instance, in a safeguarding case, a woman with learning disabilities wanted to live with her mother, despite the risk of sexual exploitation if she did so. However, this did not mean she was acting abnormally irresponsibly.

Question of guardianship for woman at risk living at home. An 18-year-old woman, currently in the care of the local authority, wanted to return to her family, who wanted her back. She had learning disabilities and intellectual functioning of a child between five and eight years old. The local authority was concerned. The home situation involved chronic neglect, lack of minimum standards of hygiene and cleanliness, serious lack of adequate parenting and exposure to people engaged in sexual exploitation and possible abuse. When she was 17, the courts had ruled that guardianship was not a legal possibility; her wanting to return to her mother could not be characterised legally as seriously irresponsible conduct. However, if the woman lacked mental capacity to make this decision about where to live, the courts could intervene on those grounds and make a decision about her best interests.⁶⁰

Likewise, with a view to obtaining guardianship, the lack of road sense of a person with learning disabilities did not mean that the person was acting abnormally irresponsibly.⁶¹

9.7 Entry and inspection of premises

Under Section 115 of the 1983 Act, an approved mental health professional (often abbreviated to AMHP) has the power to enter and inspect premises (other than a hospital) if he or she has reasonable cause to believe that a mentally disordered person is living there and is not 'under proper care'. There is no power of removal attached, but if the AMHP is obstructed, then an offence may be committed (Mental Health Act 1983, Section 129).

(AMHPs may be social workers, first level nurses practising in the mental health or learning disability fields, occupational therapists or chartered psychologists, with appropriate training and competencies.)

This power may be exercised at all reasonable times, after the AMHP has produced (if asked) a duly authenticated document showing that he or she is such a professional.

In safeguarding work, concerns sometimes arise about a person's welfare, but practitioners are unable to gain access to that person to find out what is going on. This section of the Mental Health Act 1983 may in some circumstances provide a legal basis for gaining that access.

9.8 Warrant for search and removal

Under Section 135 of the 1983 Act a police constable can enter premises, using force if necessary, to remove a person to a place of safety. A warrant from a justice

of the peace must be obtained first. The purpose must be with a view to making an application under the Mental Health Act 1983 or making other arrangements for care and treatment.

For the warrant to be issued, it must appear to the justice of the peace that there is reasonable cause to suspect that two particular conditions apply to a person believed to be suffering from mental disorder. The first is that he or she has been, or is being, ill-treated, neglected or not kept under proper control. Second, that he or she is unable to care for himself or herself and is living alone. The justice of the peace must base his or her decision on information received on oath from an AMHP.

9.9 Removing a mentally disordered person from a public place

Under Section 136 of the 1983 Act a police constable has the power to remove from a public place – and take to a place of safety – a person who appears to be suffering from mental disorder. Two conditions must be satisfied. The first is that the person appears to be in immediate need of care and control. Second, that the police constable thinks it is necessary in the interests of the person or other people.

9.9.1 Up to 72 hours in a place of safety

The person can then be detained for up to 72 hours in the place of safety, so that he or she can be examined by a medical practitioner and interviewed by an AMHP. In turn, this is so that necessary arrangements for treatment or care can be made.

9.9.2 Adhering to the rules

If the rules are not observed, civil proceedings may be possible, although permission (under Section 139 of the Act) must be given by the courts to bring the case. In the following case, a man sought to bring civil proceedings against the police:

Assault and false imprisonment case against the police. The police went to where a man with a history of mental health problems was staying, because of concerns raised about his behaviour. He initially ran away. CS gas was sprayed at the man by a police constable. This resulted in severe skin blistering and other injury. He was put into handcuffs, detained and taken to hospital. He then sought to bring a civil case against the police. This was for assault and false imprisonment, on the basis that the police had used excessive force in terms of holding the gas canister too close to the man's face or spraying the gas for too long. Permission of the court was first required, under Section 139 of the Act, for proceedings to be brought. Permission was granted on the basis that it had a real prospect of success.⁶²

He subsequently won the case and was awarded compensation.

9.9.3 Informal mental health patients

The 1983 Act states that there is nothing to stop people voluntarily entering hospital for mental health treatment, without being formally detained (Mental Health Act

1983, Section 131). However, this assumes that the person has capacity to take this decision. It was such informal admissions, involving people who lacked capacity, which led to the *Bournewood* case and the subsequent amendments to the Mental Capacity Act 2005 about deprivation of liberty.

10 National Assistance Act 1948 and environmental health legislation

10.1 Key points

Sometimes practitioners become aware that a vulnerable person is in a state of neglect and is unable to persuade the person concerned to accept help. The local authority might simply be denied entry. The person may not lack mental capacity, nor have a mental disorder as to warrant intervention under either the Mental Capacity Act 2005 or Mental Health Act 1983. If so, the legal basis for an unwanted intervention may be unclear.

10.1.1 National Assistance Act 1948, Section 47

However, there may be two options. The first, Section 47 of the National Assistance Act 1948, allows the removal by a local authority of a person to institutional care. It is an intervention that is now seldom used.

10.1.2 Public Health Act 1936

The second comes in the form of intervention under environmental health legislation, in particular the Public Health Act 1936.

10.2 Removal of a person from home: Section 47 of the National Assistance Act 1948

Under Section 47 of the National Assistance Act 1948, local authorities with environmental health responsibilities (unitary, district or borough councils) can seek to remove a person to institutional care by obtaining a magistrates' order. The grounds for such removal are that the person:

- is suffering from grave chronic disease or, being aged, infirm or physically incapacitated, is living in insanitary conditions, and
- is unable to devote to himself or herself, and is not receiving from other persons, proper care and attention.

There are a number of other procedural rules attached:

Medical certification. The 'medical officer of health' (often an NHS public health consultant) must certify that removal is necessary either in the person's own best interests, or for prevention of injury to the health of, or serious nuisance to, other people.

Notice given to person. Application is made to a magistrates' court. The person must be given seven days' notice before the court considers the application.

Emergency procedure without notice. Under the National Assistance (Amendment) Act 1951, notice to the person can be dispensed with if the medical officer of

health and another registered medical doctor certify that this is necessary because immediate removal is in the best interests of the person. However, in this case, the period of detention is limited to three weeks.

Three months' detention, renewable. An order may authorise the person's detention in a hospital or other suitable place for up to three months. This period can be extended by a court order for up to periods of three months at a time. The order cannot authorise medical treatment. After six weeks, the person removed or somebody acting on their behalf can apply to the court for the order to be revoked. If the order was made without notice, then the application for revocation can be made after three weeks.

The Act does state that if somebody wilfully disobeys or obstructs the execution of a removal order, it is an offence attracting a fine. However, there is no explicit power to enter premises by force.

This section of the National Assistance Act 1948 has no application when a person lacking capacity is being deprived of their liberty under the Mental Capacity Act 2005. It is thought that local authorities use the power rarely, perhaps once or twice a year, as a last resort (Law Commission, 2010, para 12.63).

10.2.1 Compatibility with human rights

Care must be taken to ensure that Section 47 of the National Assistance Act 1948 is used compatibly with the Human Rights Act 1998.

10.2.2 Human rights: Article 5

The particular concern is that, on the face of it, Section 47 could be used for a person who does not lack capacity or have a mental disorder. However, under Article 5 of the European Convention on Human Rights, only certain people may be deprived of their liberty in accordance with procedures prescribed by law. The groups listed include people of unsound mind, alcoholics or vagrants, but not people who simply neglect themselves and who are of sound mind (insofar as they have mental capacity and do not have a mental disorder and are not alcoholic).

10.2.3 Human rights: Article 8

In addition, were Section 47 too lightly used, it might offend against Article 8 of the European Convention and the right to respect for private life. Although the intervention may be for the protection of health (a ground listed in Article 8), care is needed to ensure that the intervention is not disproportionate so as to breach Article 8.

10.2.4 Department of Health guidance on Section 47

Past Department of Health advice raised these issues and also referred to other possible interventions that might be used instead of Section 47. These included examination and removal to hospital of people with a notifiable disease under the

Public Health (Control of Disease) Act 1984; mental health legislation; and other health and social care legislation that could be used, albeit without compulsion (DH, 2000b).

Since the advice was issued, there is also now the Mental Capacity Act 2005. In addition there is environmental health legislation in the form of the Public Health Act 1936 and Environmental Protection Act 1990.

10.3 Protection of a person's property

Under Section 48 of the National Assistance Act 1948, local authorities have a duty to prevent loss or damage to people's property – when they go into hospital, are placed in a care home under Part 3 the 1948 Act, or are removed from their own home under Section 47 of the Act.

The duty arises if there is a danger of damage to or loss of movable property, because a person is unable to protect or deal with it and nobody else is doing this. Pets are arguably covered by this section.

10.4 Environmental health legislation

Local authorities with environmental health responsibilities have powers to deal with public health problems, including as a last resort powers of entry to a dwelling. These powers are sometime relevant to vulnerable adults who may be subject to extreme self-neglect or neglect from other people, and where the consequence is that a public health issue has been created.

10.4.1 Public Health Act 1936

Under the Public Health Act 1936, local authorities have a duty to give notice to the owner or occupier of a dwelling to take certain steps to clean and disinfect a dwelling, and destroy vermin. The duty is triggered if the local authority believes the filthy and unwholesome state of the premises is prejudicial to health, or if the premises are verminous.

If the person does not do what the notice requires, the local authority has the power to carry out the work itself and make a reasonable charge. The person is also liable to a fine.

If a person, or their clothing, is verminous, the local authority can remove him or her – with their consent or with a court order – for cleansing (Public Health Act 1936, Sections 83–86).

As a last resort the council has a power of entry to premises, using force if necessary. An order can be obtained from a magistrates' court (Public Health Act 1936, Section 287).

10.4.2 Environmental Protection Act 1990

Under the Environmental Protection Act 1990, the local authority has powers of entry applying to statutory nuisances and can take action to deal with them. In the case of residential property, 24 hours' notice is required, unless it is an emergency or there is danger to life and health (Environmental Protection Act 1990, Schedule 3).

A statutory nuisance includes a dwelling that is in a state prejudicial to health or nuisance, smoke, fumes, gases, accumulation of deposits, noise etc (Environmental Protection Act 1990, Section 79).

A local authority has a duty to serve an abatement notice if a statutory nuisance exists. If the notice is not complied with, the local authority may itself abate the nuisance and recover reasonable expenses (Environmental Protection Act 1990, Sections 80–81).

Notes

¹ *Local Authority X v MM* [2007] EWHC 2003 (Fam).

² *Masterman-Lister v Brutton* [2002] EWCA Civ 1889.

³ *Masterman-Lister v Brutton* [2002] EWCA Civ 1889.

⁴ *Sheffield CC v E* [2004] EWHC 2808 (Fam).

⁵ *Masterman-Lister v Brutton* [2002] EWCA Civ 1889.

⁶ *Re K* [1988] 2 FLR 15, High Court.

⁷ *Re Cloutt* [2008] Court of Protection, 7 November 2008.

⁸ *Local Authority X v MM* [2007] EWHC 2003 (Fam).

⁹ *Ealing London Borough Council v KS* [2008] EWHC 636 (Fam).

¹⁰ *Re C (Adult: refusal of treatment)* [1994] 1 WLR 290.

¹¹ *Re MB (caesarean section)* [1997] 2 FLR 426, Court of Appeal. Also *Local Authority X v MM* [2007] EWHC 2003 (Fam).

¹² *Re F* [2009] Court of Protection (case no 11649371, 28 May 2009).

¹³ *Re F* [2009] Court of Protection (case no 11649371, 28 May 2009).

¹⁴ *A Primary Care Trust v P* [2008] EWHC 1403 (Fam).

- ¹⁵ *Re C (Adult: refusal of treatment)* [1994] 1 WLR 290.
- ¹⁶ *Local Authority X v MM* [2007] EWHC 2003 (Fam).
- ¹⁷ *Re S and S (Protected Persons)* [2008], Court of Protection, 25 November 2008.
- ¹⁸ *ITW v Z* [2009] EWHC 2525 (Fam).
- ¹⁹ *Re P* [2009] EWHC 163 (Ch).
- ²⁰ *Sheffield City Council v S* [2002] EWHC 2278 (Fam).
- ²¹ *Newham London Borough Council v BS* [2003] EWHC 1909 (Fam).
- ²² *HL v United Kingdom* [2004] 40 EHRR 761 (European Court of Human Rights).
- ²³ See, for example, *Local Authority v A, B* [2010] EWHC 978 (Fam).
- ²⁴ *HL v United Kingdom* (2004) 40 EHRR 761 (European Court of Human Rights).
- ²⁵ *LLBC v TG* [2007] EWHC 2640 (Fam).
- ²⁶ *JE v DE and Surrey County Council* [2006] EWHC 3459 (Fam).
- ²⁷ *DCC v KH* [2009] Court of Protection (Birmingham County Court), 11 September 2009.
- ²⁸ *WPCT v TB* [2009] EWHC 1737 (Fam).
- ²⁹ *Tameside and Glossop Acute Services Trust v CH* [1996] 1 FLR 762.
- ³⁰ *R v Collins, Pathfinder Mental Health Services NHS Trust and St George's Healthcare NHS Trust, ex p S* [1998] 1 CCLR 578 (Court of Appeal).
- ³¹ *B v Croydon Health Authority* [1995] WLR 294.
- ³² *Re C (Adult: refusal of treatment)* [1994] 1 WLR 290.
- ³³ *GJ v The Foundation Trust* [2009] EWHC 2972 (Fam).
- ³⁴ *R v Hardwick* [2006] EWCA Crim 969.
- ³⁵ *Hodson v Hodson* [2006] EWHC 2878 Chancery.
- ³⁶ *Re a power given by Mrs W, a donor* [2000] 3 WLR 45.
- ³⁷ *ITW v Z* [2009] EWHC 2525 (Fam).
- ³⁸ *Airedale Trust v Bland* [1993] AC 789 (House of Lords).

- ³⁹ *Re Y (Mental incapacity: bone marrow transplant)* [1996] 2 FLR 787.
- ⁴⁰ *SL v SL* [2000] 3 WLR 1288 (Court of Appeal).
- ⁴¹ SI 1987/1968. Social Security (Claims and Payments) Regulations.
- ⁴² Mental Capacity Act 2005, Section 50. And SI 2007/1744. Court of Protection Rules.
- ⁴³ *HE v A Hospital NHS Trust* [2003] EWHC 1017 (Fam).
- ⁴⁴ *Sheffield CC v E* [2004] EWHC 2808 (Fam).
- ⁴⁵ *KC v City of Westminster Social and Community Services Department* [2008] EWCA Civ 198.
- ⁴⁶ *X City Council v MB* [2006] EWHC 168 (Fam).
- ⁴⁷ *X City Council v MB* [2006] EWHC 168 (Fam).
- ⁴⁸ *Sheffield CC v E* [2004] EWHC 2808 (Fam).
- ⁴⁹ *Ealing London Borough Council v KS* [2008] EWHC 636 (Fam).
- ⁵⁰ Mental Capacity Act 2005, Section 36. And SI 2006/1832. Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations.
- ⁵¹ SI 2006/2883. Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (Expansion of Role) Regulations.
- ⁵² *Re SK* [2004] EWHCD 3202 (Fam).
- ⁵³ *Re T* [1992] 3 WLR 782.
- ⁵⁴ *Re SA* [2005] EWHC 2942 (Fam).
- ⁵⁵ *LBL v RYJ* [2010] 2665 (COP).
- ⁵⁶ *R v Collins, Pathfinder Mental Health Services NHS Trust and St George's Healthcare NHS Trust, ex p S (no 2)* [1998] 3 WLR 936 (Court of Appeal).
- ⁵⁷ *R v Kent County Council, ex p Marston* [1997] (High Court, unreported).
- ⁵⁸ *Lewis v Gibson* [2005] EWCA Civ 587.
- ⁵⁹ *Re F (A child)* [1999] 2 CCLR 445 (Court of Appeal).
- ⁶⁰ *Re F (Adult patient)* [2000] 3 CCLR 210 (Court of Appeal).

⁶¹ *Newham London Borough Council v BS* [2003] EWHC Fam 1909.

⁶² *Johnston v Chief Constable of Merseyside* [2009] EWHC 2969.

Part 4: Vulnerable adults receiving care, support and services

11 Adult social services

12 Housing providers

13 Police, Crown Prosecution Service, coroners

14 Giving best evidence in the criminal justice system

15 Vulnerable suspects and offenders

11 Adult social services

11.1 Key points

Local social services authorities have two key roles. First, they have been given the lead role, through the *No secrets* guidance, in coordinating safeguarding activity at local level. Second, the role of local authorities in safeguarding is based legally on their duties to assess for and provide community care services. This means that the primary function of local authorities in safeguarding is to assess, advise, support and provide services for vulnerable adults.

11.1.1 Personalisation of care: balancing choice, risk and safeguarding

In addition, within their role of providing community care services, local authorities are implementing a government policy called personalisation or self-directed support. This policy aims to give people greater choice, control and independence over their lives, and part of this is to be achieved by giving people what are called personal budgets and direct payments. The policy places a considerable onus on local authorities to balance this choice and control with, at the same time, safeguarding people at risk of harm. This calls for balanced risk assessments, that is, weighing up the risks and benefits of a particular course of action.

11.1.2 Provision of adequate services and wellbeing

The *No secrets* guidance refers to the importance of providing services for the empowerment and wellbeing of vulnerable adults. Local authorities, particularly as the lead coordinating agency for safeguarding, have also to be aware of when their own policies, practices and procedures either fail to protect adults at risk of harm, or in some cases actually cause the very harm from which they are meant to be protecting those adults.

11.2 The role of social services in safeguarding

Legislation governing the functions of local authority social services does not explicitly mention safeguarding. Sometimes practitioners believe that their safeguarding role is based legally, wholly, on the *No secrets* guidance. However, this is not the case because such guidance cannot by itself create new legal functions for local authorities.

11.2.1 Assessment, enquiries and 'investigations'

Under Section 47 of the NHS and Community Care Act 1990, local authorities have a duty to assess people who may be in need of community care services. This is ultimately what underpins safeguarding investigations. The *No secrets* guidance steers local authorities to see safeguarding as part of their existing functions and role under Section 47.

11.2.2 Definition of vulnerable adult linked with community care legislation

The *No secrets* guidance defines a vulnerable adult as an adult 'who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him- or herself, or unable to protect him- or herself against significant harm or exploitation'.

The definition contained in the guidance makes a direct link with the Section 47 of the NHS and Community Care Act 1990. This is for the very reason that safeguarding is based on the Section 47 function.

The *No secrets* guidance is statutory guidance, made under Section 7 of the Local Authority Social Services Act 1970. As such it carries legal weight, in that local authorities cannot simply ignore it.

11.2.3 Legal underpinning to safeguarding investigations or enquiries

So, when local authorities carry out what they call 'investigations' or when they 'make enquiries', legally they are in fact carrying out their assessment duties under Section 47 of the NHS and Community Care Act 1990. The courts have seen it in this way.¹

11.2.4 Community care assessment directions: working with people

Furthermore, directions issued under Section 47 of the 1990 Act state that the local authority must consult the person being assessed, and take all reasonable steps in order to reach agreement about the provision of services (DH, 2004a). This obligation is consistent with giving people information and choice, and with empowering people, as urged by the *No secrets* guidance (DH and Home Office, 2000, para 4.3).

11.2.5 Community care services: including help and support in safeguarding

The NHS and Community Care Act 1990 contains no services itself. It refers instead to five further pieces of legislation, under which local authorities have duties and powers to arrange a variety of community care services.

The services include residential care, care in people's own homes, day services and many other services. Importantly, with safeguarding in mind, these services also include advice, support and visiting. The provision of these various services dovetails with the *No secrets* guidance, which refers to the need to support people. It also refers generally to the empowerment and wellbeing of vulnerable adults through the services provided by local authorities and other agencies.

11.2.6 Community care legislation and groups of people covered

The five pieces of legislation are the National Assistance Act 1948 (Sections 21 and 29), Chronically Sick and Disabled Persons Act 1970 (Section 2), Health Services and Public Health Act 1968 (Section 45), NHS Act 2006 (Section 245 and Schedule 20) and the Mental Health Act 1983 (Section 117).

The main groups of people covered by this legislation are those with a physical disability, learning disability, sensory impairment, mental health problem, alcohol problem, drug problem and also some older people (even without any of the preceding characteristics).

11.2.7 Urgent provision of support and services without assessment

Sometimes safeguarding situations call for the urgent provision of services. Under Section 47 of the NHS and Community Care Act 1990, local authorities are empowered to provide services as a matter of urgency, without first having carried out an assessment. Assessment then must take place as soon as is practicable.

Some adult safeguarding will, where there are *children* involved, link across to child protection. For local authorities this comes under the Children Act 1989 and guidance such as *Working together to safeguard children* (DfE, 2010).

11.3 Fair Access to Care Services: reference to abuse and neglect

A second piece of statutory guidance, in addition to *No secrets*, completes the main picture. This guidance is about how a local authority should decide whether a person is 'eligible' for assistance.

It is called: *Prioritising need in the context of Putting People First: A whole system approach to eligibility for social care: Guidance on eligibility criteria for adult social care, England* (DH, 2010a). It replaced guidance about 'Fair Access to Care Services', but is often still referred to by the latter term.

11.3.1 Risk to independence

The guidance states that local authorities should assess people's needs in terms of risks to their independence. It sets out four levels of need and risk: critical, substantial, moderate and low. Councils do not have to meet all four levels; they can choose where to set a threshold, beneath which they will not arrange to meet people's needs. However, a majority of councils meet people's needs at least at the critical and substantial levels. Very few meet critical needs only.

11.3.2 Abuse and neglect in top two eligibility categories

The significance of this is that abuse and neglect are covered by these top two categories. The critical category refers to serious abuse or neglect that has occurred or will occur; the substantial category refers to abuse or neglect only, without it necessarily being serious (DH, 2010a, para 54).

11.3.3 Eligibility for other community care services

There may sometimes be a misconception about what makes a person eligible for help if a potential safeguarding matter has arisen. In short, it is not necessary that a person be receiving – or be eligible – for other community care services in order to benefit from help and intervention on a safeguarding matter. If the person falls into

the defined groups of people eligible for community care (including physical disability, learning disability, sensory disability, mental disorder, age, drugs and alcohol etc) then a safeguarding matter alone would be sufficient to take him or her into the critical or substantial category.

This is because the eligibility guidance makes clear that abuse or neglect themselves mean that a person has eligible (critical or substantial) needs for support and services. There is no requirement that the person should have a prior need for other services, such as shopping, cleaning, personal care etc.

11.4 Legislation about informal carers

Local social services authorities are subject to legislation about informal or family carers. This carers' legislation is significant for safeguarding. Informal carers may take on huge physical and mental problems in caring for family members. Sometimes they struggle to cope to such an extent that their care may become neglectful, albeit unintentionally. The carers' legislation is an obvious legal opportunity to provide support for carers, precisely so that a caring situation does not start to deteriorate in this way.

11.4.1 Assessing and offering services to informal carers

The effect of this legislation is that it places obligations on social services to assess the needs of carers who are providing a substantial and regular amount of care. The local authority has then to consider also whether to provide services for that carer. This legislation comprises, in the main, the Carers (Recognition and Services) Act 1995, the Carers and Disabled Children Act 2000 and the Carers (Equal Opportunities) Act 2004.

11.5 Personalisation, direct payments and risk

Within community care, local social services authorities are currently implementing a policy known as personalisation or self-directed support.

11.5.1 Empowerment of people

Overall the policy is about empowering people who are in need of community care services to exercise more choice, control and independence. It is about helping people to express their own views about their needs and to plan how best they could be met. It also involves the allocation of a sum of money, called a personal budget, with which the person can plan how to meet his or her needs (DH, 2009b).

11.5.2 Personal budgets and direct payments

A major part of this policy of personalisation and personal budgets comes in the form of community care direct payments. These involve local authorities giving people a sum of money so that they can arrange their own services directly, rather than have the local authority make the arrangements for them (eligibility criteria and means

testing still apply). The rules about this are under the Health and Social Care Act 2001 and regulations.²

11.5.3 Risk assessment, personalisation and safeguarding

Guidance, issued by the Department of Health, acknowledges that there 'is a delicate balance between empowerment and safeguarding, choice and risk. It is important for practitioners to consider when the need for protection would override the decision to promote choice and empowerment'. It states that safeguarding measures will be required when risks, from supporting a person to do what they want, suggest that there is a danger of abuse, either of themselves or others (DH, 2007, para 2.50). The Department has published additional guidance about risk and balanced decision making for people with dementia (DH, 2010b).

11.5.4 Support for people receiving direct payments

Further guidance on direct payments states that in order to get this balance right, recipients of direct payments will require support, timely information, knowledge of how to get help when things go wrong and confidence that that they will be listened to when they raise concerns (DH, 2009b, paras 127–128).

11.5.5 People choosing to take risks

Giving people more choice and independence may mean that they wish to take certain risks. Department of Health guidance recognises that practitioners might find it difficult to step back and watch a person take a risky path. The guidance overall states that benefits have to be balanced with risk of harm, and people supported to live in a way that best suits them. It emphasises the importance of good record keeping, so that if something goes wrong, a clear and reasonable decision-making process is evident.

11.5.6 Limits to funding risk

Nonetheless, the guidance suggests that this may not be plain sailing. On the one hand, people with mental capacity can choose to take risks. On the other, while people may choose this, local authorities are accountable for the use of public funds and are not obliged to fund particular levels of risk. Furthermore, local authorities should make a clear distinction between putting people at risk as opposed to enabling them to manage risks appropriately (DH, 2007, para 2.27).

11.5.7 Distinguishing choice from abandoning people

A serious case review into the murder of a person with learning disabilities in Cornwall put bluntly the importance of getting the balance right: 'it is essential that health and social care services review the implications of acceding to people's "choice" if the latter is not to be construed as abandonment'. This point was highlighted by a police report on the case that noted that the opposite of choice and control had resulted. Mr Hoskin 'had lost all control of his own life within his home. He had no say, choice or control over who stayed or visited the flat. He had no voice

or influence over what happened within the premises' (Cornwall Adult Protection Committee, 2007, paras 5.13, 5.16).

11.5.8 Risks, benefits and the law

The gist of Department of Health guidance about risk, emphasising the importance of balancing risks and benefits, but placing a limit on the risk that a local authority should be supporting, is consistent with various legal principles. For instance, weighing up a person's best interests under the Mental Capacity Act 2005 might involve just such an exercise when considering the benefits of returning from hospital as against the risks or hazards of doing so.

And, in the law of negligence, the term reasonableness is all important and may also involve the weighing up of risks and benefits, not the straightforward elimination of risk.

Road traffic accident. A local authority judged that a man with learning disabilities had reached a level of independence and road safety competence to cross a particular road on a daily basis. A subsequent road traffic accident did not automatically mean the local authority was liable to pay compensation in a negligence case.³

11.5.9 Legal protection for local authorities in negligence cases

In taking reasonable steps both to empower vulnerable adults, but also to protect them against exploitation and harm at the hands of third parties (that is, other people), local authorities will undoubtedly be challenged from time to time in negligence cases.

Nevertheless, the courts will to a degree protect local authorities. If the local authority is performing its statutory functions in legislation or the issue is directly related to a shortage of resources, the courts may be reluctant to impose liability in negligence. This is especially so, where the harm has been perpetrated by a third party, rather than the local authority itself:

Negligence case for failure to protect couple with learning disabilities. A couple with learning disabilities brought a negligence case against a local authority.

They lived together in a flat with two children. They were vulnerable. For some time before the incident, they had been befriended and taken advantage of by local youths. The latter used the flat to take drugs, engage in sexual activity, leave stolen goods and generally misbehave.

This culminated in a particular weekend, over which the youths made the couple perform sexual acts, threw their possessions over the balcony, locked the man in the bathroom in the dark, forced pepper and fluid into his eyes. They made him drink urine, dog biscuits, dog faeces and human faeces. They threatened to stab him if he did not. They made him put a vibrator up his bottom and lick it. He had kitchen cleaner sprayed in his mouth, face and hair. They slashed him repeatedly

all over his body with knives. His partner was treated similarly. The children too were abused, assaulted and locked in their bedroom; even the family dog was abused.

The legal argument was that under either housing legislation (Section 188 of the Housing Act 1996) or social services legislation (Section 21 of the National Assistance Act 1948) the council should have moved them before that weekend. And, that by failing to do so, the local authority was liable in the common law of negligence. The court confirmed that while a judicial review case (a different type of legal case not involving suing for money) might have been possible, no common law duty of care in negligence automatically attached to that legislation. In some limited circumstances, a separate duty of care might arise in negligence.⁴

The courts attempt to balance both the harm suffered by vulnerable adults and the difficult task faced by local authorities and practitioners.

11.5.10 Direct payments: general safeguards

The possibility of financial harm arising from direct payments can in part be dealt with by imposing conditions on the making of a direct payment, such that, for instance, a dedicated bank account is used, receipts kept, monthly statements produced etc (CIPFA, 2007).

More generally, local authorities are expected to review direct payments, with the frequency of review depending on individual circumstances, but at any rate on an annual basis.

One question that often rises is whether direct payment recipients can, or must, request criminal record certificates in respect of a person who they intend to employ.

11.5.11 Direct payments and criminal record checks

Adult direct payment recipients do not have a duty to ensure that a criminal record check is carried out (with the Criminal Records Bureau [CRB] under the Police Act 1997). The guidance on direct payments states that councils should inform direct payment recipients of the benefit of such checks, but that those recipients will retain the choice about this (DH, 2009b, para 129).

Direct payment recipients cannot request directly enhanced criminal record certificates themselves, because only bodies registered with the CRB can do this. Nonetheless, a request could be made by the recipient to an 'umbrella' body, that is, an organisation (such as a local authority or local voluntary body) registered with the CRB to request check on other people's behalf.

11.5.12 Direct payments for a person lacking capacity

From November 2009, it became lawful for a local authority to make direct payments to 'suitable' persons in respect of people lacking capacity.

Special rules and safeguards apply, which seek to strike a balance between allowing people with a lack of capacity to benefit from direct payments, while at the same time recognising that they will be more vulnerable and at potentially higher risk of harm, precisely because of their lack of capacity. There are five key points.

Consent of other person receiving the direct payment

First, the intended recipient must consent. If there is a 'surrogate' for the person, and the surrogate is not going to be the recipient, then this surrogate must consent also. A surrogate is either a deputy appointed by the Court of Protection, or the donee of a lasting power of attorney made under the Mental Capacity Act 2005. However, in either case, the deputy or attorney's specified powers must be relevant to community care services.⁵

Finding a suitable person

Second, as to suitability, the intended recipient will be suitable automatically, if he or she is the 'representative' of the person lacking capacity. A representative is someone who is either a deputy appointed by the Court of Protection or the donee of a lasting power of attorney. However, it is not necessary that the deputy's or attorney's powers cover community care services. Alternatively, the intended recipient might not be such a representative and be somebody else instead. But in this case, the person is not automatically suitable; the local authority (and a surrogate if there is one) must be satisfied that he or she is suitable (Health and Social Care Act 2001, Section 57[1C]).

Consultation etc

Third, the local authority must then take a number of steps in the decision-making process. It must consult with:

- anyone named by the person lacking capacity who should be consulted with
- anyone engaged in caring for the person or interested in their welfare
- any surrogate or representative.

It must also as far as is reasonably practicable consider the person's past and present wishes and feelings (and in particular any written statement made before capacity was lost), the person's beliefs and values and any other factors the person would have considered had capacity been retained.

Criminal Records Bureau check

Fourth, the local authority must obtain an enhanced criminal record certificate, but only in certain circumstances. This is when the recipient is not going to be (a) a partner or spouse, (b) a close relative living in the same household, or (c) a friend involved in the provision of care for the person lacking capacity.

Then, overall, the local authority must be satisfied that the direct payment will meet the person's needs, the recipient will act in the best interests of the person, the

recipient has the ability to manage the payment, and that in all the circumstances, it is appropriate to make the payment.⁶

Obligations on the suitable person

Last, the suitable person, the recipient, must:

- act in the best interests of the person lacking capacity
- provide information on request to the local authority
- inform the authority if the person regains capacity
- use the payment as agreed.⁷

In addition, if the suitable person is not a spouse, partner or close relative of the person lacking capacity, then he or she must obtain a criminal record certificate in respect of anybody being paid to provide the service. This is because, in these circumstances, the suitable person is defined as a 'regulated activity provider' under the Safeguarding Vulnerable Groups Act 2006 (DH, 2009b, paras 153–155).

12 Housing providers

12.1 Key points

Providers of housing, such as local authorities themselves, registered providers, sheltered housing providers and supported living providers are referred to in the *No secrets* guidance. They are among the local agencies expected to be an integral part of local safeguarding policy, procedures, protocols etc.

The guidance does not in itself place legal obligations on local authorities in respect of their housing functions or on other housing providers, but it is in effect urging them to perform their existing functions with safeguarding very much in mind.

These existing functions do, however, have a direct bearing on safeguarding matters. These include local authority duties concerning homelessness and allocation of housing, possession proceedings by landlords and Anti-Social Behaviour Injunctions and Orders (ASBIs and ASBOs).

However, these functions are sometimes relevant not just to protecting vulnerable adults from harm, but also to situations in which it is the vulnerable adult who is the perceived perpetrator of harm toward other people. In this respect, a government code of guidance urges local authorities to consider supporting such people before, or as well as, resorting to more draconian measures (ODPM, 2004a).

12.2 *No secrets*

The *No secrets* guidance refers to housing providers and providers of housing-related support services (including Supporting People providers) as integral to inter-agency working at local level. They are expected to have policies and procedures in relation to safeguarding. However, the guidance does not impose legal duties on housing providers. Nor does it have the status of statutory (that is, 'strong') guidance in respect of local authorities carrying out *housing* functions. (It does have that stronger status in relation to local authorities, as far as their *social services* functions go.)

12.3 Homelessness

Under the Housing Act 1996, local authorities must give priority to certain groups when they provide accommodation for (unintentionally) homeless people. Several of these categories refer to groups of people who might be vulnerable adults. These include:

- people who are vulnerable as a result of old age, mental illness, learning disability, physical disability or for some other special reason
- people aged at least 21 years, who in the past have been looked after by the local authority, accommodated or fostered (under the Children Act 1989) and are now aged 21 years or more
- people who have been in custody or detention

- people who are ceasing to occupy accommodation because of violence from another person or threats of violence from another person which are likely to be carried out.⁸

In relation to vulnerability, the test is whether the person 'when homeless, [is] less able to fend for himself than an ordinary homeless person, so that injury or detriment to him will result when a less vulnerable man would be able to cope without harmful effects'.⁹

Thus, in the following case, the person – although accused of a criminal offence – was undoubtedly vulnerable:

Delusions of grandeur: psychotic illness. A man was prosecuted for theft from a supermarket. His defence was that he was a member of the Yugoslavian royal family and had a particular kind of credit card on which purchases were automatically registered without having to produce the card at the checkout. He was diagnosed as suffering from a psychotic illness that took the form of delusions of grandeur. The applicant admitted the facts, was acquitted by reason of his mental condition and admitted to hospital under the charge of a consultant psychiatrist. The court was clear that common sense and the evidence meant he would be incapable of managing his financial affairs satisfactorily.¹⁰

Another category of priority is emergency, caused by fire, flood or other disaster. In the legislation this does not cover an emergency caused by a safeguarding issue. But local authorities and registered providers generally have a local emergency transfer or re-housing procedure. In certain circumstances they may consider using this to safeguard or protect a vulnerable adult.

12.3.1 Domestic violence as a priority category

The legislation states that there are certain circumstances in which it is not reasonable for a person to go on occupying a property, and that therefore the person is homeless. For example, it may not be reasonable for a person to continue to occupy accommodation if it is probable that this will lead to domestic or other types of violence against the person.

Wide definition of domestic violence

Violence means violence from another person, or threats of violence that are likely to be carried out. For the behaviour to constitute domestic violence, there needs to be a (defined) association between the perpetrator and victim. The domestic violence need not be within the dwelling; it can extend to outside the home (Housing Act 1996, Section 177).

In guidance, the government has stated that, in this context, domestic violence should not be interpreted restrictively. It should be understood to include threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between persons who are, or have been, intimate partners, family members or

members of the same household, regardless of gender or sexuality (DfES, 2008, para 8.21). A wide range of safeguarding issues in the home could come within this definition.

The courts, in the context of housing legislation about homelessness, have accepted that violence includes physical violence, threatening or intimidating behaviour and any other form of abuse which, directly or indirectly, may give rise to the risk of harm.¹¹

In the different context of criminal law, the Crown Prosecution Service (CPS) has given a broad definition of domestic violence (CPS, 2009a).

12.4 Housing allocation

Under Section 167 of the Housing Act 1996, local authorities must have a housing allocation scheme. They must operate the scheme so that 'reasonable preference' is given to certain groups of people. These include homeless people and also people who need to move on 'medical or welfare' grounds – both categories could be relevant to safeguarding matters.

12.5 Home adaptations

Sometimes home adaptations may alleviate a situation that is giving rise to safeguarding concerns, for example, the manual handling of vulnerable adults, particularly when they lack capacity to make decisions about this for themselves.

Pieces of portable equipment may be of help, such as a portable hoist or a bath lift; sometimes more major adaptations such as stairlifts or ceiling track hoists can be very useful. For these more major items, some assistance is available from housing authorities, by way of 'disabled facilities grants' under the Housing Grants, Construction and Regeneration Act 1996.

12.6 Possession proceedings to protect a vulnerable adult

There will be some circumstances in which a safeguarding issue has arisen, involving behaviour by a perpetrator who is also a tenant, behaviour that represents a clear breach of a condition of the tenancy.

12.6.1 Options short of eviction

Government guidance points out there are various options for registered providers to consider before taking the drastic step of seeking possession of a person's home, even if he or she has engaged in anti-social behaviour. Options include acceptable behaviour contracts, ASBOs, Injunctions and court action to enforce tenancy conditions (ODPM, 2004b, p 1).

Local authorities and registered providers must also have a published policy on anti-social behaviour, explaining how the landlord will deal with it (Housing Act 1996, Section 218A).

However, possession proceedings may be appropriate if other attempts have failed. There are various grounds on which a landlord could take possession proceedings and there are different rules depending on the type of tenancy involved.

12.6.2 Assured or secure tenancies

The rules for people with assured tenancies (not before 15 January 1989), including most housing association tenants and some private sector tenants, come under the Housing Act 1988.

Possession proceedings can be taken if the tenant or a person living there or visiting has been guilty of conduct causing or likely to cause a nuisance or annoyance to somebody living, visiting or 'otherwise engaging in a lawful activity in the locality'. Alternatively, that the tenant or person living there or visiting has been convicted of using the dwelling, or allowing it to be used, for immoral or illegal purposes, or has been convicted of an arrestable offence committed in, or in the locality of, the dwelling (Housing Act 1988, Schedule 2, Ground 14).

For secure tenants (local authority), the same ground on which possession can be sought comes under the Housing Act 1985 (Schedule 2, Ground 2).

When considering whether to grant possession, the courts must consider the effect of the nuisance or annoyance on other people, and the continuing and likely effect of the nuisance. The court still does have to consider circumstances (such as mental health issues) that may have led to the anti-social behaviour but must bear in mind the effect on the victim and wider local community (Housing Act 1985, Section 85A; Housing Act 1988, Section 9A; ODPM, 2004b, pp 6–7).

12.6.3 Other tenancies

There are other tenancies, in relation to which the landlord does not need to demonstrate to the court grounds for possession, although the notice to tenant must contain certain information and reasons (Housing Act 1996, Sections 124–128).

Introductory tenancies for local authorities are where the tenant is 'on probation', usually for 12 months. Tenants do, however, have a right to an internal review of the decision (Housing Act 1996, Sections 124–128).

Starter tenancies, in relation to housing associations, are likewise probationary in nature. Such tenants can be evicted in the same way as any other assured short-hold tenant, at any time after the first six months of the tenancy. Two months' notice is required but the landlord does not have to prove grounds of fault on the part of the tenant (Housing Act 1988, Section 21).

Sometimes secure tenants can be demoted by court order, on grounds of anti-social behaviour, to a less secure tenancy. The tenant will then have a status similar to an introductory tenancy (Housing Act 1996, Section 143). A Demotion and Possession Order may be sought; alternatively a demotion, without possession proceedings, would serve as a warning to the tenant (ODPM, 2004b, p 7).

12.7 Eviction of adults at risk of harm

Sometimes landlords take possession proceedings against the very adult who may be vulnerable or at risk of harm. Vulnerable on one view, on another (for example, held by neighbours) the person may be regarded as anti-social and a nuisance. In such circumstances, the landlord will need to weigh up competing considerations – the welfare of neighbours and other tenants as against the needs and welfare of the vulnerable adult.

12.7.1 Guidance for local authorities on anti-social behaviour

The government has published a code of guidance for local authorities about anti-social behaviour. The guidance refers generally to the need to try to deal with problems in other ways, before resorting to drastic interventions. For instance, it talks about giving support to perpetrators, in particular if they are vulnerable because of drug use, alcohol use, mental health or disability. Also it states the importance of multi-agency working, between the police, neighbourhood wardens, youth offending teams, schools, health services, drug action teams, social services and probation services (ODPM, 2004a, para 3.22).

Local authorities must legally have regard to this guidance (Housing Act 1996, Section 218A). This means generally adhering to it, except where there is good reason not to. Thus, in the following case, the local authority was held by the court to have acted unreasonably by not considering such support:

Emphasis on local authority seeking alternatives to possession in order to prevent anti-social behaviour. A local authority tenant had learning disabilities and a personality disorder. An incident arose, about the clearing up of some broken glass, in which he assaulted the caretaker of the block of flats. The man accepted a caution from the police under Section 4A of the Public Order Act 1984. The local authority then launched possession proceedings. The case went to court. There were two ways in which such possession proceedings could, in principle, be challenged. The first was on human rights grounds. The second was where the local authority was behaving in a legally unreasonable way.

In this case, the court held that the local authority had behaved unreasonably in a legal sense. The court referred to the government's code of guidance for local authorities on anti-social behaviour. Furthermore, the local authority's own policy had stated that other alternatives to possession should first be explored in relation to vulnerable people. Yet apparently it had applied the policy in practice, without regard to the disability and mental health issues of the tenant.¹²

In the following case, the disability of the tenant was balanced against the nuisance to neighbours – and wish of the landlord to evict – by a compromise, in the form of a suspended possession order:

Vulnerable tenant unable to control her adult son. The landlord sought possession because of the anti-social behaviour of the tenant's son (20 years old). The tenant herself was described as immature and vulnerable, lacking assertiveness,

unable to control her son, and unable to throw him out of the house because of her emotional attachment, her need for help and support around the house. She could not read or write beyond the level of a nine-year-old. She was represented by the official solicitor.

A suspended possession order was granted by the court. Usually such an order does not require that the landlord return to court before applying for a warrant, in the event of a breach of the terms of the order. However, in this case, such a requirement was attached. One of the reasons for this was because with her disability and with the involvement of the official solicitor, there was greater room for unfairness to her and of an administrative oversight than in the case of other tenants.¹³

12.7.2 Equality Act, discrimination and eviction

In relation to possession proceedings for breach of tenancy conditions, including anti-social behaviour, all landlords will also need to bear in mind the Equality Act 2010.

In short, it is unlawful for a landlord to discriminate against disabled people in the selling, letting or management of residential premises (Equality Act 2010, Section 35). This includes the taking of possession proceedings.

The Equality Act makes it unlawful to treat a disabled person unfavourably because of an issue arising from or as a consequence of a person's disability. It requires landlords to be able to demonstrate that possession proceedings against a disabled person are 'proportionate' and registered providers need to explore every other avenue first, communicate appropriately, provide an advocate where appropriate and liaise with other agencies before taking action.

Under the Disability Discrimination Act 1995 (before being superseded by the Equality Act), there were three key questions. First, it needed to be established whether the tenant was disabled within the meaning of the Equality Act. Second, whether the reason for the anti-social behaviour or other breach of a tenancy condition was because of that person's disability. Third, whether the landlord knew, or should have known, of the disability.

If the answer to all those questions was yes, it meant the tenant is deemed to have been treated less favourably as result of his or her disability. However, the landlord could still avoid a finding of discrimination if it could show that the less favourable treatment was justified.

Justification for less favourable treatment on health and safety grounds. A person with depressive mental illness was defined as being defined for the purposes of the Disability Discrimination Act 1995 (now the Equality Act 2010). However, the court doubted whether the loud hammering and music played through the night was linked to the disability. Even had it been, less favourable treatment toward her, in terms of the possession proceedings, could be justified on health and safety grounds in respect of neighbours (a driving examiner becoming sleep deprived). Likewise, a person with a personality disorder used abusive language

towards a neighbour and her children. The behaviour was linked to the disability, but possession could be justified on health and safety grounds because of the effect on the neighbour.¹⁴

In another instance, a person had got into rent arrears because the landlord had increased the rent. However, his disability (obsessive compulsive personality disorder) was unconnected to the reason for non-payment of rent. So there was no unlawful discrimination.¹⁵

It remains to be seen whether the Equality Act will signal a different legal approach.

12.7.3 Importance of social services in averting a crisis necessitating eviction

In such cases, reference has sometimes been made to the importance of social services, perhaps where their intervention might prevent a crisis arising. In one such case the courts did recognise the potential detriment to a mentally disordered person of losing his or her home, and the importance of involving adult services to avert crises:

Liaison between housing and social services before possession proceedings. This judgement shows that landlords whose tenants hold secure or assured tenancies must consider the position carefully before they decide to serve a notice seeking possession or to embark on possession proceedings against a tenant who is or might be mentally impaired. This is likely to compel a local housing authority to liaise more closely with the local social services authority at an earlier stage of their consideration of a problem that might lead to an eviction than appears to be the case with many authorities, to judge from some of the papers the DRC [Disability Rights Commission] placed before the court. To remove someone from their home may be a traumatic thing to do in the case of many who are not mentally impaired. It may be even more traumatic for the mentally impaired.¹⁶

Equally, the fact that adult social services has heavy involvement is no guarantee that a crisis point, followed by possession proceedings, will not be reached, for example, in the case of known and persistent disturbed, aggressive and anti-social behaviour from a psychotic tenant.¹⁷

12.8 Housing-related Anti-Social Behaviour Injunctions

Under Section 153A of the Housing Act 1996, certain landlords may seek ASBIs from the county court or High Court.

Anti-social behaviour is conduct capable of causing nuisance to somebody else (who does not necessarily have to be identified), and which directly or indirectly relates to the housing management functions of the landlord.

The conduct must be capable of causing a nuisance or annoyance to (a) a person with a right to live in accommodation owned or managed by the landlord or in other housing vicinity; (b) a person with a right to live in other housing in the

neighbourhood; (c) a person engaged in lawful activity in or in the vicinity of that accommodation; or (d) a person employed in connection with the landlord's management functions.

A relevant landlord is a local authority or registered housing provider (Housing Act 1996, Section 153E).

A court can grant an ASBI against a person who is engaging or threatening to engage in housing-related conduct. This can extend quite widely; it is not limited purely to tenants of the landlord:

Former tenant waging campaign against both local authority tenants and owner-occupiers in area. The perpetrator had been a secure tenant of the local authority. He had since been evicted as a result of his anti-social behaviour caused by alcohol. However, he kept on returning to the area and conducting a continuing campaign against his former neighbours. It was now argued that because he was no longer a local authority tenant, and the main victims were not local authority tenants either, his anti-social conduct was not housing-related. The court held that peace in the neighbourhood, whether for council tenants or owner-occupiers, was related to the housing management functions of the local authority.¹⁸

Injunctions are also available in respect of a person using or threatening to use the landlord's accommodation unlawfully (Housing Act 1996, Section 153B).

12.8.1 Power of arrest attached to injunction

The court can attach a power of arrest to an injunction if the conduct involves the use or threat of violence, or if there is a significant risk of harm to the person in need of protection (Housing Act 1996, Section 153C). In some circumstances, a power of arrest can be attached to even a 'without notice' application, that is, where the perpetrator is not informed about the application (Housing Act 1996, Section 154).

12.8.2 Housing-related injunctions for breach of tenancy condition

Injunctions can be sought by landlords (local authority, registered housing provider) for breach of a tenancy condition, where a person is (a) engaging or threatening to engage in conduct that is capable of causing nuisance or annoyance to any person, or (b) is allowing, inciting or encouraging any other person to engage or threaten to engage in such conduct.

The court can grant an injunction if it is satisfied that (a) the conduct includes the use or threatened use of violence, or (b) there is a significant risk of harm to any person. A power of arrest may be attached (Housing Act 1996, Section 153A). For example:

Vulnerable people put in fear: arrest and sentence for breach of injunction. An alcoholic man put in fear the residents of a block of flats who were mainly vulnerable by way of age, frailty or mental ability. He had the status of introductory tenant in the block. His behaviour included loud music, threats and

abuse. He had been made subject to an ASBI under Section 153D of the Housing Act 1996; a power of arrest was attached. He did not adhere to its terms; he was sentenced to six months in prison; the sentence was upheld on appeal.¹⁹

12.9 Anti-Social Behaviour Orders

Under Section 1 of the Crime and Disorder Act 1998, an ASBO can be applied for by a 'relevant authority': a local authority, the police or a registered housing provider.

12.9.1 Against whom and on what grounds

An ASBO can be sought against any person who is at least 10 years old, on two grounds, both of which must be made out. First, that he or she has acted in a way that caused or was likely to cause harassment, alarm or distress to one or more people not within the same household as the perpetrator. Second, that such an order is necessary to protect relevant persons from further anti-social acts. A relevant person is, generally, anybody in the area of the council.

12.9.2 Length of order

An order must be for at least two years. If the order is breached without a reasonable excuse, there is a maximum sentence of five years' imprisonment.

12.9.3 Application to court

Application is to a magistrates' court. However, if other proceedings are taking place in a county court, a relevant authority may in certain circumstances make an application for an ASBO in that court.

12.9.4 Order on conviction for another offence

If a person is convicted of another criminal offence, the court can in certain circumstances make an ASBO, additional to any sentence for the original offence and to any conditional discharge order (Crime and Disorder Act 1998, Section 1C). This is called an 'order on conviction'; it is considered at a separate civil hearing after conviction for the offence.

12.9.5 Safeguarding example

In the following case, an ASBO was granted against a builder who exploited older people:

ASBO imposed on rogue builder targeting vulnerable people. A builder had targeted a 73-year-old woman, calling at her house and telling her that her roof needed repairing. Next day he called back, telling her he had done the work and wanting payment. It turned out that he had done no work, but had actually damaged the roof. He pleaded guilty to attempting to obtain property by deception and threatening to damage the woman's property.

The court sentenced him to 60 hours unpaid community work and ordered him to pay his victim £450 compensation. In addition, an ASBO was imposed, prohibiting him from making unsolicited visits to dwelling houses for the purpose of obtaining building or gardening work for a period of five years. (Cumbria County Council, 2007)

The following example involved an order placed on somebody who was targeting vulnerable and elderly people:

A teenager targeted vulnerable, elderly people with repeated verbal abuse, insults or homophobic language. He also took and damaged a wheelchair from an elderly resident. He was given an Anti-Social Behaviour Order to last for two years to prevent this behaviour. (Brown, 2010)

12.9.6 Standard of proof for an Anti-Social Behaviour Order

Although ASBO proceedings are civil in nature, the standard of proof to be applied is the criminal standard.²⁰ However, because the proceedings are essentially civil, hearsay evidence is allowable.²¹ This may be particularly useful. For instance, it means that a police officer could provide a statement on behalf of a witness or witnesses who wish to remain anonymous. Such evidence could relate, for instance, to dates, places, times, specific descriptions of actions, who was present and who said what (Home Office, 2006, p 26).

12.9.7 Special measures for witnesses

In addition, vulnerable or intimidated witnesses can benefit from the 'special measures' available in criminal proceedings under the Youth Justice and Criminal Evidence Act 1999 (Crime and Disorder Act 1998, Section 1I, as inserted by the Serious Organised Crime Act 2005). This would enable, for example, a witness to give evidence from behind a screen or by remote video link.

12.9.8 Ancillary, interim, intervention orders

Sometimes a court must in addition make an individual support order (for a child or young person) setting out specific requirements in order to prevent breach of the ASBO. Such requirements can include participating in particular activities or reporting to a certain place and person at particular times. Breach of such a support order attracts a fine (Crime and Disorder Act 1998, Sections 1AA–1AB).

Interim orders can also be made, pending a court's final decision about whether to make an ASBO (Crime and Disorder Act 1998, Section 1D).

Intervention orders may be added to an ASBO if the person concerned misuses controlled drugs. The purpose of the order is to prevent repetition of the behaviour in question and to impose certain conditions on the person (such as participating in particular activities or reporting to a particular person at a particular time). Breach of the order attracts a fine (Crime and Disorder Act 1998, Sections 1G, 1H).

12.9.9 Vulnerable perpetrators and social services involvement

Guidance from the Home Office states that if the person against whom an order is sought may have drug, alcohol or mental health problems, or be on the autistic spectrum disorder, then support should be provided by social services. Social services have a duty to assess vulnerable adults under Section 47 of the NHS and Community Care Act 1990 to find out whether they need community care services.

The guidance states that such support should run parallel with the collection of evidence and application for the ASBO (assuming application for such an order is deemed necessary). This will then give the court the material with which to balance the needs of the community with the needs of the alleged perpetrator (Home Office, 2006, p 21).

12.9.10 Understanding of the perpetrator

Sometimes it will be argued that an ASBO should not be made against a vulnerable perpetrator if he or she is not capable of understanding it, and/or will be unable to comply with it:

Question of whether person could understand simple order. The person concerned had a substantial criminal record. She had been convicted of 68 offences of affray and other public order, assaults on the police, criminal damage, theft, being drunk disorderly, and breaches of a previous ASBO. She had been sentenced to community orders and to imprisonment; but these had not had a deterrent effect.

An ASBO, five years in duration, was now sought because of her regular attendance at a residential block of flats, where she was abusive, aggressive and drunk. The court concluded that the reports about the woman fell short of showing that she was incapable of understanding a simple instruction that she was not to do something.²²

12.9.11 Closure orders, premises and drugs

Under the Anti-Social Behaviour Act 2003, closure orders may be sought by the police for premises used in connection with the unlawful use, production or supply of a Class A controlled drug, where this is associated with the occurrence of disorder or serious nuisance to the public. Application is to a magistrates' court. The order can last up to three months, but can be extended up a total of six months (Anti-Social Behaviour Act 2003, Sections 1–5).

12.9.12 Closure orders: standard of proof

The standard of proof required in considering closure orders is the civil standard, rather than the criminal standard. The Act is silent about this, but the courts have decided this on the basis that the effects of a closure order on a person are less draconian than the effects of an ASBO, for example, in terms of duration (shorter), restriction of liberty and penalties for breach (fine rather than imprisonment).²³

12.9.13 Effect on vulnerable people of closure orders

Nonetheless, such orders can be particularly relevant to vulnerable adults in terms of the impact on them of losing their home or their heightened risk, for example, to exploitation by drug dealers who may deliberately seek out vulnerable adults for this purpose. The lower standard of proof might make it easier for closure to be ordered, and thus easier for a vulnerable adult to lose his or her home.

However, the view of the courts is that the person may then have rights under homelessness legislation if they can show that they have become homeless unintentionally. But in the end, even though 'some people who have done nothing wrong themselves will be displaced and will, at least for a period of time, suffer some hardship', that simply is the consequence of the legislation.²⁴

12.9.14 Acceptable behaviour contracts or agreements

The Home Office encourages the use of 'acceptable behaviour contracts'. They are designed to stop the anti-social behaviour, short of a formal order. They are written agreements between the perpetrator and, for example, the local authority, landlord or police. Consequences of breach of the agreement should also be spelt out, such as application for an ASBO or possession proceedings by the landlord. Such contracts or agreements are not statutory. There are therefore no legal rules about them; as a result they can be used flexibly. By the same token they are voluntarily entered into.

The Home Office has published guidance on their use. It suggests, for example, that such an agreement might cover issues such as presence in a particular area, damage to property, throwing of stones, verbal abuse or damaging cars.

The guidance suggests that in the case of children under 10 years old, parenting contracts might be preferred. These can be made under the Anti-Social Behaviour Act 2003 by youth offending teams, local authorities and registered providers (Home Office, 2007).

12.10 Difference between Anti-Social Behaviour Injunctions and Anti-Social Behaviour Orders

ASBIs are available under the Housing Act 1996, ASBOs under the Crime and Disorder Act 1998. ASBOs are more drastic than ASBIs:²⁵

- *Subject*: an ASBO can be obtained against anyone over the age of 10, whereas an ASBI can only be obtained against an adult.
- *Criminal or civil implications*: breach of an ASBO entails criminal sanctions, whereas an ASBI remains a civil remedy, even if a power of arrest and relief by way of committal can be invoked.
- *Different level of conduct*: the condition of granting an ASBO is that the defendant 'has acted ... in a manner that caused or was likely to cause harassment, alarm or distress', whereas the conduct that may trigger an ASBI is only such as is 'capable of causing a nuisance or annoyance'.

- *Standard of proof:* the standard of proof in the obtaining of an ASBI remains the civil standard, whereas the standard of proof in the case of an ASBO is the criminal standard.
- *Type of conduct and class of victim:* the detailed provisions of the ASBI which require 'housing-related' conduct and specific classes of victims do not apply to the ASBO, whose only limitation on a victim is that he or she should not be of the same household as the defendant.

13 Police, Crown Prosecution Service, coroners

13.1 Key points

As stated in *No secrets* vulnerable people should have access to criminal justice.

13.1.1 Police and Crown Prosecution Service

The police, CPS and the courts are central to the safeguarding of vulnerable adults in relation to criminal justice. Essentially, the police investigate and gather evidence, the CPS then decides whether to prosecute and the courts then decide on guilt and sentence.

13.1.2 Other prosecuting authorities

Some other bodies have powers to prosecute including, for example, the Care Quality Commission (CQC), the Health and Safety Executive (HSE) and local authority trading standards officers.

13.1.3 Vulnerable adults in the criminal justice system

Within criminal justice, a range of legislation, codes of practice and guidance are relevant to vulnerable adults. Some of these bear on how vulnerable adults are assisted in the criminal justice system, to understand what is going on, to give evidence and be otherwise generally supported and sometimes protected.

In particular guidance has been issued in relation to victims of domestic violence, older people, people with mental health problems and people with learning disabilities.

13.1.4 Sentencing rules and guidelines

Once a prosecution has been successful, there are some sentencing rules and guidelines that are relevant to vulnerable adults; in other words, circumstances surrounding a criminal offence that 'aggravate' it and empower the courts to impose a heavier sentence. In addition, what is commonly referred to as disability 'hate crime' is referred to in legislation; this means hostility shown toward a disabled person because of their disability, which aggravates the seriousness of an offence.

13.1.5 Coroners

Coroners' inquests also play a key role in establishing how people died in questionable circumstances, including vulnerable adults. Coroners now have a statutory power to produce reports, to send them to relevant organisations and to require a response from those organisations. Such reports may highlight particular issues relating to the safeguarding of vulnerable adults.

13.2 Police interventions

The *No secrets* guidance emphasises the importance of early police involvement. Among other points, it states the following:

- *Early referral* or consultation with the police will enable them to establish whether a criminal act has been committed.
- *Early involvement* of the police will help ensure that forensic evidence is not lost or contaminated.
- *Investigating and interviewing*: police officers have considerable skill in investigating and interviewing – early police involvement may avoid the need for unnecessary subsequent interviewing.
- *Joint approaches*: police investigations should proceed alongside those dealing with health and social care issues.
- *Witness protection*: some witnesses will need protection (DH and Home Office, 2000, para 6.7).

A small but notable example of the importance of early police intervention was perhaps illustrated in the following case, as reported:

Conviction through drop of sweat on wheelchair. A drug addict who tricked his way into the homes of elderly people was given a prison sentence of eight years. He was identified by a drop of sweat he had left behind on a wheelchair, when he lifted the lady out of it in the sheltered housing she lived in and stole £400. She had, at the time, a broken leg and wrist. (*The Times*, 2009)

13.2.1 Police investigations and arrests

Under the Police and Criminal Evidence (PACE) Act 1984, the police have a number of powers relevant to safeguarding adults.

13.2.2 Entering and searching premises

Under Section 17(1)(e) of the PACE 1984, the police have a power to enter and search premises without a warrant, in order to save life or limb or prevent serious damage to property. In case of serious concerns about a person coming to harm, this is an important intervention. The term 'life and limb' clearly covers serious harm.

Police entry after report of a person going berserk with a knife. It was reported that a woman had gone berserk with a knife. Police entered the house and intended to search one of the women inside, and had not informed the person why they had entered. The court confirmed that the police could enter and search premises under Section 17 without permission. Saving life and limb would cover saving a person from harming himself or herself, or a third party, from serious harm. And although it is desirable for the police to explain why they are entering and searching, there is no hard and fast rule about this.²⁶

However, it is not enough that the police are concerned more generally about somebody's 'welfare'. This therefore places limits on the use to which Section 17 can be legitimately be put when safeguarding concerns have arisen:

Neighbours had telephone the police, reporting a disturbance. The police went to the house explaining that they had power to enter in relation to a concern about a person's welfare. The occupants took a different view. There was no report of injury, no sign of damage, no indication that a criminal offence had been committed. One of the occupants explained there had been a verbal argument. The court held that concern about a person's welfare was not enough. Life and limb connotes something more serious. The court referred back to the *Baker* case [above], in which 'serious bodily injury' was referred to. Examples would be, though not limited to, knife or gunshot wounds.²⁷

Entering and searching premises without warrant for indictable offence

The police can enter and search premises without a warrant to effect arrest for an indictable offence (an offence that can be tried in the Crown Court, for example, theft, fraud or more serious physical harm) (PACE Act 1984, Section 17[1][b]).

Entering and searching premises to recapture a person unlawfully at large

The police can also enter and search premises of recapturing somebody who is unlawfully at large and whom they are pursuing (PACE Act 1984, Section 17[1][d]).

There are limits to what this can cover. For instance, somebody who has absconded from detention under the Mental Health Act 1983 is unlawfully at large, but there has to be a pursuit for Section 17 to be used legitimately to recapture the person:

Pursuing a mental health patient unlawfully at large. A woman had been detained under Section 2 of the Mental Health Act 1983. Her husband visited her in hospital at 3.30pm three days later. Half an hour later she was back at home. Three hours later, the police went to the house believing the patient to be unlawfully at large, and thus they effected entry using reasonable force, purportedly under Section 17. The court held that there was no pursuit or chase, however short in time or distance, and thus Section 17 could not be used in this way.²⁸

Common law power to enter premises

The police retain a common law power of entry to deal with a breach of the peace. Breach of the peace is defined as behaviour that causes a constable to believe that a breach of the peace has occurred or will occur. It has to be related to violence. It occurs if harm is actually done or is likely to be done to a person or to his or her property. It also occurs if the person is put in fear of being harmed through an assault, affray, riot, unlawful assembly or other disturbance, in which case, the police can arrest the perpetrator without a warrant.²⁹

13.3.3 Arrest without a warrant: prevention of harm and protection

Under Section 24 of the PACE 1984, the police can arrest, without a warrant, somebody who is or is about to commit or an offence, or where there are reasonable grounds for suspecting this is about to happen. Likewise if an offence has been committed or there are reasonable grounds for suspecting this.

However, this 'summary' power of arrest is dependent on the police believing that certain conditions are made out, which necessitate the arrest. Among these grounds are that the arrest will prevent the person physically harming him- or herself or anybody else, causing loss of damage to property, or that it will protect a child or other vulnerable person.

13.4 Crown Prosecution Service: prosecution policies

The CPS is responsible (in most cases) for taking the decision to prosecute; it is then responsible for conducting the prosecution.

13.4.1 Code for Crown Prosecutors

The CPS must apply the *Code for Crown Prosecutors* when making prosecution decisions. The CPS has also issued a range of guidance about prosecution in relation to domestic violence, older people, people with mental health problems and people with learning disabilities.

13.4.2 Prosecution: two-stage test

In deciding whether to prosecute, the CPS has to apply a two-stage test. The first, the evidential stage, is whether there is enough evidence to provide a realistic prospect of conviction. The evidence has to be capable of being used in court and to be reliable. If there is enough evidence, the second, the public interest stage, is about whether it is in the public interest to prosecute.

13.4.3 Victims' wishes

Sometimes victims, including vulnerable adults, may be reluctant or simply refuse to make a complaint in the first place, or to participate in criminal proceedings later in the process. There may be good reasons for this such as loyalty or emotional attachment to the perpetrator, or intimidation or fear inspired by the perpetrator, family or the local community. This sort of issue may typically arise in cases of domestic violence or in crimes against older people.

The CPS states that it is committed to supporting victims giving evidence and to managing their safety. It further recognises that some people won't participate in the criminal justice route, in which case, they might need information and support in relation to using civil law – for example, protection from a harassment, Non-Molestation or Occupation Order.

13.4.4 Prosecution against a victim's wishes

Nonetheless, in some circumstances, the CPS will consider prosecution against a victim's wishes, assuming there is sufficient evidence without the victim's participation. This is because the public interest stage is not just about the victim's wishes; it is about the wider public issue of protecting the victim (and other people) from serious harm. However, the *Code for Crown Prosecutors* emphasises that before taking such a decision, the victim's views, and the consequences for the victim, will be taken into account.

13.4.5 Protection, justice and empowerment

The decision making of the CPS in this respect reflects the three key concepts in safeguarding of protection, justice and empowerment. In particular it is weighing up the importance of people's choice, independence and freedom to take their own decisions with the importance of protecting vulnerable adults.

13.5 Witness intimidation

There are specific offences of intimidating or harming a witness under Section 51 of the Criminal Justice and Public Order Act 1994.

13.6 Older people: prosecution policy

In 2008, the CPS published guidance specifically about prosecuting crimes against older people (CPS, 2008, para 4.8). It emphasises that it regards crime against older people as serious and that it is therefore likely that a prosecution will be needed in the public interest. It lists a number of factors making prosecution more likely. These include that:

- the offence is serious
- the defendant was in a position of authority or trust
- there are grounds for believing that the offence is likely to be continued or repeated
- the victim is vulnerable
- the victim is injured
- the defendant was motivated by prejudice or discrimination
- a weapon was used
- the defendant has made threats before or after the attack
- the defendant planned the attack
- there is a continuing threat to the health and safety of the victim or anyone else who is, or may become, involved
- the defendant has a criminal history, particularly involving convictions for offences against older people.

13.7 Guidance on prosecution of crimes committed against people with mental health problems and people with learning disabilities

The CPS has published two further pieces of guidance, dealing with prosecution of crimes against people with mental health problems and people with learning disabilities. In particular, this guidance warns against making assumptions that people cannot give evidence. It points out that mental capacity is only relevant to the competence of the witness in terms of assessing the ability of the witness to understand questions asked and to give replies that can be understood (CPS, 2009b, 2009c).

13.8 Domestic violence: prosecution policy

The CPS policy on domestic violence states that the CPS regards it as particularly serious (CPS, 2009a). The wide definition given to domestic violence in the guidance applies perhaps to a wider range of safeguarding situations than is commonly appreciated. The CPS policy on prosecuting domestic violence is therefore both relevant and informative as to how a range of safeguarding matters may be approached by the CPS (CPS, 2009a).

There is no specific statutory offence of domestic violence. However, the policy refers to an agreed government definition: 'any incident of threatening behaviour, violence or abuse [psychological, physical, sexual, financial or emotional] between adults who are or have been intimate partners or family members, regardless of gender or sexuality' (CPS, 2009a, para 2.2).

Guidance from the Association of Chief Police Officers sets out the approach to risk assessment and management of risk, including keeping witnesses safe, and the use of non-statutory multi-agency risk assessment conferences (MARACs) (ACPO and NPIA, 2008, para 6.2.2).

A MARAC is a meeting convened to share information to enable an effective risk management plan to be developed in cases involving high risk of domestic violence. A range of professionals will be involved including independent domestic violence advisers, NHS staff, victim support workers, Women's Aid, housing, children's services, adult services, substance misuse services, probation etc. The focus is on the victim and to ensure that there is a protective plan in place (Ministry of Justice et al, 2009, paras 5.1–5.6).

13.9 General support available for victims using the criminal justice system

In order to support victims of crime, a range of support may be needed, for vulnerable adults.

13.9.1 Special measures for the giving of best evidence

Measures contained within legislation, and specific guidance, are covered below.

13.9.2 Independent domestic violence advisers

In the majority of areas independent domestic violence advisers are available to support and assist high risk victims of domestic violence. They are trained and work with, and support, victims from the point of crisis onward; they can coordinate services to ensure the safety of the victim. There are also specialist domestic violence support organisations, for example Women's Aid and Refuge, as well as local groups who provide advice and support.

13.9.3 Witness Care Units

The CPS and the police run Witness Care Units. Witness Care officers provide telephone advice, support and information for witnesses.

13.9.4 Victim Support

Victim Support is an independent charity. It uses specially trained volunteers to give help to victims and witnesses, free of charge and confidentially. It provides emotional support, information and practical help, as well as running the Witness Service.

13.9.5 Witness Service

The Witness Service is provided at magistrates' courts and Crown Courts by an organisation called Victim Support. For example, it can arrange pre-trial visits for people to familiarise themselves with the court; on the day of the trial the Service provides a separate waiting area in the court building so that the witness does not come into contact with the defendant and his or her supporter. If the court agrees, a trained Witness Service volunteer may accompany the witness while they give evidence in court in order to give emotional support, if the victim is concerned and worried about giving evidence court.

Witnesses can be legitimately familiarised in advance of the process through which they will have to go, as long as this does not include discussion about the evidence. This is because 'witness training' is generally not permitted as this could lead to the evidence from the witness being disregarded as 'tainted':

Witness training. An NHS nurse was accused of murder. Witness training was in fact given to other staff giving evidence. In the particular circumstances, the judge concluded that this was not unfair because primarily it had simply been attempting to familiarise the witnesses with giving coherent evidence rather than been an orchestration of the evidence.³⁰

13.9.6 Code of practice for victims of crime

More generally, the statutory *Code of practice for victims of crime* sets out the support and services victims should receive from a number of bodies within the criminal justice system including the police and CPS (Criminal Justice System, 2005).

It includes various provisions including the identification and support of vulnerable or intimidated witnesses. It also makes clear that victims must be kept informed about police decisions on investigations and passing a file to the CPS, and about CPS decisions on whether to charge, what to charge and on dropping or significantly altering a charge.

If the *Code* is not adhered to, a complaint can be made to the service involved and ultimately to the Parliamentary Ombudsman (Parliamentary Commissioner Act 1967, as amended by Schedule 7 to the Domestic Violence, Crime and Victims Act 2004).

13.9.7 *Prosecutor's pledge*

A further vehicle for trying to ensure that victims are supported and kept informed is the *Prosecutor's pledge*. For instance, the impact of a prosecution on the victim will be considered when a decision to prosecute is made; the victim must be informed when a charge is withdrawn or significantly altered; the victim will be consulted in relation to any guilty plea made by the perpetrator; support will be given for giving evidence (including special measures), and so on (CPS, 2005).

13.10 Sentencing

Sentencing is a matter for the courts to determine in accordance with the law, taking into account relevant sentencing guidelines.

It is an aggravating feature of an offence if the offender showed hostility toward the victim based on the latter's disability, or if the offence was motivated by hostility toward people who have a disability (Criminal Justice Act 2003, Section 146). Hostility is required; it is not enough because a person was vulnerable and so was an easy target (CPS, 2007). The CPS has issued guidance on the distinction between hostility and vulnerability (CPS, 2010).

More generally the court must – in considering the seriousness of any offence – assess the offender's culpability in committing the offence and any harm which the offence caused, was intended to cause, or might foreseeably have caused (Criminal Justice Act 2003, Section 143).

13.11 Coroners

Deaths need to be registered with the local registrar of deaths. Usually, a medical doctor signs a medical certificate giving the cause of death; the death will then be registered with the registrar. However, if the circumstances or cause of a person's death are unclear, the case will be referred to the coroner.

If, after a post mortem, the coroner believes that the death was violent, unnatural or sudden (with cause unknown), or if the person died in prison or other particular place (for example, police custody), then an inquest must be held (Coroners Act 1988, Section 8). An inquest is held with or without a jury in open court. It hears evidence from witnesses but is not a trial. The purpose is to establish how a person died.

Coroners currently operate under the Coroners Act 1998, due to be superseded by the Coroners Act 2009.

13.11.1 Inquests, coroners and safeguarding

The role of coroners is directly relevant to safeguarding. For example, the verdicts that can be returned at inquests include natural causes, accident or misadventure, which indicate that nothing untoward caused the death.

In contrast, something amiss would be indicated by a verdict such as unlawful killing (including murder or manslaughter), self-neglect or neglect. Neglect has been defined in this context as 'a gross failure to provide adequate sustenance, medical attention or shelter for a person in a position of dependency, whether by reason of a physical or mental condition'.³¹

Prison sentence for wilful neglect, following coroner involvement. In one case, it was following the involvement of a coroner that a care home owner was charged and sent to prison for six months for wilful neglect. The resident concerned had died of septicaemia and pneumonia, having been found previously by his family in soiled clothing, sweating and unconscious, and having been dehydrated and lost two stones in weight in the period prior to his death. (Narain, 2008)

13.11.2 Production of reports and duties on other agencies to respond

Coroners have in the past contacted relevant services if they have been concerned about their involvement or lack of involvement in a death, and about recurrence of similar matters in the future.

In 2008, Rule 43 of the Coroners Rules 1984 was amended. In summary the amendments meant a more formal system for producing reports for other agencies and requiring a response from them:

- *Wider remit:* coroners have a wider remit to make reports to prevent future deaths. It does not have to be a similar death.
- *Written response:* a person who receives a report must send the coroner a written response (a new statutory duty).
- *Copies of report:* coroners must provide interested persons to the inquest and the Lord Chancellor with a copy of the report and the response.
- *Copies of reports to interested organisations:* coroners may send a copy of the report and the response to any other person or organisation with an interest.
- *Lord Chancellor:* the Lord Chancellor may publish the report and response, or a summary of them; and the Lord Chancellor may send a copy of the report and the response to any other person or organisation with an interest (Ministry of Justice, 2008).

Thus, in the following case, the coroner required the local authority's chief executive to produce a report to respond to the coroner's concerns:

Death of 88-year-old woman: report to social services requiring a response. An 88-year-old woman lived alone following the death of her husband. She was not always compliant with her medication, and was always very reluctant to accept medical care. Neighbours offered to help support her but became concerned when they had not seen her for some time.

The police and ambulance service were called on 21 July. They did not find her in need of medical attention; she seemed clean and well cared for, as did the property. Her blood sugar levels were low, but restored with sugared drinks and glucose. She was judged mentally competent to look after herself and the property. On 23 July, the ambulance service faxed the details through to social services.

The referral was taken by a non-qualified, temporary member of staff, and passed to the duty manager, who considered it non-urgent. That same day a neighbour rang social services with her concerns. She rang twice more, the third call being four days later, on 28 July. A social worker visit was then scheduled for five days later on 4 August. But by 30 July, the woman had been found dead.

The inquest recorded an open verdict but the coroner sent a report under Rule 43 to the chief executive of the council. The coroner drew attention to the need for further training on eligibility criteria, better communication about how decisions were reached, better investigation where information is lacking, clear investigation and responses to external concerns, clearer distinction between social work and medical responses. (Gardiner, 2009)

14 Giving test evidence in the criminal justice system

14.1 Key points

A number of 'special measures' are available under the Youth Justice and Criminal Evidence Act 1999 to assist vulnerable and intimidated witnesses give their best evidence in court.

Government guidance for criminal justice practitioners includes guidance on police interviewing of vulnerable and intimidated witnesses and sets out the support that should be provided to such witnesses (Criminal Justice System, 2007).

Entitled *Achieving best evidence in criminal proceedings*, it is not a legally binding code of conduct, but if it is not followed in a particular case, the courts might query why.

The guidance deals extensively with evidence given by children as well as vulnerable adults; however, this guide covers only the provisions relating to adults.

14.2 Vulnerable and intimidated witnesses

The special measures and supporting guidance apply to certain types of witness. In relation to safeguarding, one category, vulnerable witnesses, is obviously relevant.

They are defined in Section 16 of the 1999 Act as witnesses who:

- have a mental disorder as defined in the Mental Health Act 1983
- are significantly impaired in relation to intelligence and social functioning, that is, witnesses with learning disabilities, or
- are physically disabled witnesses.

A second category of witnesses are those who are intimidated. They are defined in Section 17 of the 1999 Act as people suffering from fear or distress in relation to testifying in the case. Complainants in sexual offence cases automatically fall into this category, unless they wish to opt out.

14.3 Special measures under the Youth Justice and Criminal Evidence Act 1999

Vulnerable and intimidated witnesses are eligible for special measures under the Youth Justice and Criminal Evidence Act 1999. These measures include:

- screens in the court room shielding the witness from the defendant
- giving evidence via live video link from outside the court room
- evidence given in private (clearing the public gallery in sexual offence cases and those involving intimidation)
- aids to communication.

14.3.1 Video link

For instance, in the following case, evidence was given by live video link by two elderly women:

Giving live link evidence. In a theft case, two elderly women gave evidence from their living room, by means of a mobile video conferencing kit. They were giving evidence against a carer who had stolen money from them in their own homes. The carer was convicted and sentenced to prison for 18 months (*R v Atkins*, reported in Humberside CPS, 2004, p 5).

14.3.2 Intermediary

An intermediary communicates questions to the witness and answers from the witness, and explains these so that the witness or person putting the question can understand them.

Decisions on applications for special measures are for the court to determine after taking into account the views of the witness.

14.4 Support through the stages of the criminal justice system

The guidance outlines the stages through which a witness will pass:

- *Planning and conducting interviews with vulnerable adult witnesses*, including support, interpreters, intermediaries, therapeutic help.
- *Planning and conducting interviews with intimidated, reluctant and hostile witnesses.*
- *Witness support and preparation*, including supporters such as Victim Support volunteers, Witness Service volunteers, Witness Care officers, independent sexual violence advisers, independent domestic violence advisers, intermediaries, domestic violence officers, early special measures meeting, pre-trial therapy, risk assessment, for example, in domestic violence for managing a witness' safety during the pre-trial period.
- *Witnesses in court* – explanation of special measures including role of intermediary to communicate questions and answers to and from the witness.

Further specific guidance is available on therapy for vulnerable witnesses (Home Office et al, 2002), and on working with intimidated witnesses (Office for Criminal Justice Reform, 2006).

14.4.1 Therapy for a victim

The guidance on therapy notes the importance of therapy for the welfare of the victim, and also of taking precautions so that the therapy does not contaminate the evidence to be given by the vulnerable witness. The guidance does state that, ultimately, if there is a tension, priority should be given to the best interests of the witness.

14.5 Admissibility of, and competence to give, evidence

The policy aim is assist vulnerable and intimidated witnesses give their best evidence with the assistance of the special measures and support before, during and after the trial. Thus, witnesses whose evidence might have been dismissed or simply not heard in the past are now able to have access to justice. However, even so, various rules apply as to admissibility of, and competence to give, evidence.

14.5.1 Presumption of competence to give evidence, and displacement of that presumption

The general rule is that all people, whatever their age, are competent to act as witnesses in criminal proceedings unless they cannot understand questions asked of them in court, or cannot answer them in a way that can be understood (with, if necessary, the assistance of special measures) (Youth Justice and Criminal Evidence Act 1999, Section 53).

So, in the following case, the court held that the video evidence of an older woman with Alzheimer's disease should be admitted despite doubts about reliability:

Admissibility of video evidence of elderly woman in rape trial. The defendant was accused of attempting to rape and of indecently assaulting an 81-year-old woman who had longstanding delusional problems associated with early Alzheimer's disease. He attempted to have video testimony given by the woman excluded from the trial, partly on the grounds that the woman lacked competence to give evidence under Section 53 of the 1999 Act.

The Court of Appeal upheld the judge's decision to admit the video. Considering the video, the judge had applied the test of whether the woman had 'been able to understand the questions being put to her' and whether she was 'giving answers which could be understood'. The court stated that it agreed with the judge's view on this. But, further, she 'prima facie has a right to have her complaint placed before a jury and a right to have a jury assess whether they are sure that the complaint is established and the putting of the video before the jury is the only way in which that right can be upheld'. The defence would then be able to bring medical evidence and argue as to the reliability of the video at the time it was made.³²

In a further case, the court emphasised the presumption at the outset, that everybody is competent to give evidence.

Giving of evidence by an 81-year old person with Alzheimer's disease. The victim, an 81-year-old woman suffering from Alzheimer's disease, was spotted one morning in someone's front garden, behaving strangely. The police were called. She made various rude comments suggestive of a sexual incident having taken place. She ultimately gave a video interview. At the time of the interview, and after it, she would not have been capable of giving evidence in court.

In respect of Section 53 of the Act and her competence, the judge had taken the approach that she did not understand all the questions and not all her answers were understandable. But she understood, and was understood in part, sufficiently for a jury to evaluate her evidence. The Court of Appeal approved this approach, and the defendant's (a mini cab driver) sentence for rape was upheld.³³

14.5.2 Giving sworn or unsworn evidence

Section 55 of the Youth Justice and Criminal Evidence Act 1999 sets out how courts are to decide whether a witness should swear an oath (or affirm) before giving evidence.

An adult can give sworn evidence if he or she has a sufficient appreciation of the solemnity of the occasion and of the particular responsibility to tell the truth which is involved in taking an oath. This is presumed if he or she is able to give intelligible testimony; intelligible testimony means that the witness can understand questions and give comprehensible answers.

If the witness cannot give intelligible testimony according to these rules, then under Section 56 of the Act unsworn evidence can still be given as long as the witness is still competent (under Section 53).

15 Vulnerable suspects and offenders

15.1 Key points

Sometimes, a vulnerable adult is a suspect in criminal proceedings rather than a witness. Questions then arise about how the criminal justice system responds to that vulnerability. It is beyond the scope of the guide to go into great detail. However, a few key points are as follows.

15.1.1 Appropriate adults

First are provisions under the PACE Act 1984. These relate to the provision of an 'appropriate adult' for vulnerable suspects being interviewed by the police. These rules are an important safeguard to ensure that a person's vulnerability does not lead to an erosion of their rights as a suspect, and to unsafe conclusions being drawn at such interviews.

15.1.2 Support for vulnerable defendants at trial

Second is the support that may be needed in court for vulnerable defendants to enable them to effectively participate in the trial.

15.1.3 Diversion of offenders away from the criminal justice system

Third, in some circumstances, mentally disordered offenders may be 'diverted' away from the criminal justice system, for instance, Mental Health Act provisions may be used instead.

15.1.4 Conditional cautions

Fourth, in some circumstances, conditional cautions may be used with a view to reparative or restorative justice or rehabilitation, short of prosecution but more than a simple caution.

15.1.5 Sentencing and vulnerability of perpetrator

Fifth, following conviction, sentencing by the courts will sometimes take account of the vulnerability of the perpetrator.

15.2 Appropriate adult for vulnerable suspects or perpetrators

Vulnerable adults may not only be witnesses but sometimes are suspects, rightfully or wrongfully accused. Separate, therefore, from the provisions described above for vulnerable or intimidated witnesses, are rules for vulnerable suspects.

15.2.1 PACE Code of practice

The PACE Act 1984 states that juries must be warned about the reliability of a confession made by a person with a learning disability ('mentally handicapped')

(PACE Act 1984, Section 77). But the real detail is within *Code of practice C*, made under the PACE Act 1984.³⁴ The *Code* must be had regard to; it is 'statutory' and any departure from it would require strong justification in court. The details for mentally disordered or mentally vulnerable adults are summarised in Annex E of the *Code*.

15.2.2 Mentally disordered or mentally vulnerable adult

The provisions concern the identification of a mentally disordered or mentally vulnerable adult and the provision of an appropriate adult.

If a police officer has any suspicion, or is told in good faith, that a person of any age may be mentally disordered or otherwise mentally vulnerable – or mentally incapable of understanding the significance of questions or their replies – that person must be treated as mentally disordered or otherwise mentally vulnerable. For example, in the following case:

Appropriate adult justifiably not provided for person of limited intelligence and who was suggestible. An elderly man was strangled at home. A 23-year-old man of limited intelligence and abnormally suggestible was arrested. He denied the allegation that he was the murderer. He was then interviewed ten times over a period of six days. In the first nine interviews, there was no solicitor or independent person present. In the first six, he denied the murder; then admitted it in the next three. Only, in the tenth was an appropriate adult, an independent social worker, present. The man appealed against his subsequent conviction. The appeal failed.

The medical evidence of the time did not suggest he had a learning disability. Furthermore, there was no evidence at the trial suggesting that the interviewing police officers knew or suspected or believed that the man might have had learning disabilities, thus requiring the presence of an independent person or appropriate adult at the interviews.³⁵

An appropriate adult is (a) a relative, guardian or somebody else responsible for their care or custody, (b) someone experienced in dealing with mentally disordered or mentally vulnerable people, or (c) some other responsible adult over 18 who is not a police officer or employed by the police.

Although the *Code* does refer to the assistance to be given to people who are blind, seriously visually impaired, deaf, unable to read or speak or who have difficulty orally because of a speech impediment, the appropriate adult rules apply only to people with mental disorder or mental vulnerability.

15.2.3 Informing the appropriate adult

Custody officers should inform the appropriate adult of the grounds for the detention and the whereabouts of the person, and ask the adult to come to the police station.

15.2.4 Clinical attention

If the person is suffering from a mental disorder, the custody officer must ensure he or she receives appropriate clinical attention as soon as reasonably practicable, and be assessed as soon as possible if he or she has been detained under Section 136 of the Mental Health Act 1983.

15.2.5 Interviewing and signing statements

The vulnerable suspect should not be interviewed or asked to sign a written statement in the absence of the appropriate adult. This rule can be waived if the delay would be likely to result in interference with the evidence, interference with or harm to other people, serious loss or damage to property, the alerting of other suspects or hindering the recovery of property.

In the following case a successful appeal was made after a confession and conviction, without an appropriate adult being present:

Confession of person with learning disabilities without appropriate adult present. The suspect had learning disabilities. He confessed to attempted murder and also, alternatively, to grievous bodily harm with intent. He had refused the presence of a solicitor. No independent adult was present. During 18 hours of interview he had refused food, cried and been very emotional. The judge at the trial had found him not to be mentally handicapped. He also failed to direct the jury under Section 77 of the PACE 1984. This states that the jury must be warned about the special need for caution in convicting a 'mentally handicapped' person who has confessed without an independent person present.

The appeal succeeded. The judge should have given such a direction; and the judge had been wrong to suggest the absence of an appropriate adult was of little importance.³⁶

15.2.6 Appropriate adult's role

The appropriate adult should be told that he or she is not just there to observe but to advise the suspect, observe that the interview is being conducted properly and fairly, and to facilitate communication. If the suspect is charged, this must be done in the presence of the appropriate adult.

15.3 Support for vulnerable defendants in court

The special measures available under the Youth Justice and Criminal Evidence Act 1999 are primarily for vulnerable witnesses, not vulnerable suspects.

The main guidance on the treatment of vulnerable defendants in court is set out in Section III, para 30 of the Consolidated Criminal Practice Direction.

15.3.1 Vulnerable defendants and use of video link

In addition, the 1999 Act allows the court to direct that evidence be given by certain vulnerable defendants through a live link, if certain conditions are met.

In the case of an adult (over 18 years) these are, first, that the person has a mental disorder (as defined in Section 1 of the Mental Health Act 1983) or otherwise has a significant impairment of intelligence and social function. Second, that because of this the person is unable to participate effectively in giving oral evidence in court. Third, a live link would enable more effective participation (Youth Justice and Criminal Evidence Act 1999, Section 33A).

15.3.2 Inherent power of the courts to ensure a fair trial

The Act does not provide for intermediaries for a suspect (as opposed to a witness). However, the courts retain an inherent power to take steps to ensure that a person has a fair trial. So, in particular circumstances, an intermediary could be appointed for a suspect.³⁷

Intermediary for suspect with low IQ finding questions difficult. When a man of low IQ was accused of rape, the Court of Appeal confirmed that the courts had an inherent power to allow the equivalent of an intermediary, to give assistance to the defendant to understand questions, to be a supporter and to be the equivalent of an interpreter.³⁸

Intermediary for a man with learning disabilities. A man with learning disabilities and severe cognitive impairment was appealing against his conviction for murder. A clinical psychologist was appointed as intermediary to help follow the progress of the case. (O'Neill, 2007)

15.4 Prosecution of mentally disordered offenders

The *Code for Crown Prosecutors* states that a prosecution may be less likely if the defendant is elderly or is (or was at the time of the offence) suffering from significant mental or physical ill health, unless the offence is serious or there is real possibility of repetition. A balance has to be struck between the desirability of diversion away from the criminal justice system and the need to safeguard the public (CPS, 2004, para 5.10).

15.4.1 Alternatives to prosecution including cautions

The *Code* refers to alternatives, where appropriate, to prosecution by way of suitable rehabilitative, reparative or restorative justice processes. These can include cautions. 'Simple' cautions can be given when conviction would have been likely, the person admits the offence and the person or appropriate adult understands the significance of the caution (CPS, 2004, para 8.2).

15.4.2 Fitness to plead

Once a decision to prosecute is made, the question of fitness to plead arises. Sometimes people are remanded to hospital under Section 35 or 36 of the Mental Health Act 1983, for assessment or treatment, while awaiting trial. Fitness to plead may sometimes be decided before trial or during the trial.

If a judge decides in a trial that the person is unfit to plead, the jury still decide whether the person did the act or omission in issue. If so, the court must make a Hospital Order under Section 37 of the Mental Health Act 1983 (with or without a restriction under Section 41), a Supervision Order (involving a social worker or probation officer) or give an absolute discharge (Criminal Procedure [Insanity] Act 1964, Sections 4, 4A, 5, 5A).

15.5 Sentencing of vulnerable adults

When people with a mental disorder have not been diverted, and are fit to plead, nonetheless, sentencing may reflect the mental disorder or vulnerability.

15.5.1 Diminished responsibility

In the following case, for example, what would otherwise have been murder was reduced to manslaughter because of diminished responsibility:

Care home resident with mental disorder prosecuted for killing another resident. An 82-year-old woman had spent many years in secure hospitals and had also been convicted 10 years earlier for assaulting an elderly woman with a chair. However, her medical records and criminal history had not been passed to the home. She now bludgeoned to death, with an ornamental iron, a fellow resident, aged 93. She was convicted of manslaughter (rather than murder) because of diminished responsibility. (Norfolk, 2005)

15.6 Conditional cautions and restorative justice

Conditional cautions are made under Sections 22–27 of the Criminal Justice Act 2003. These are instead of a simple caution or prosecution.

A *code of practice* summarises the purpose (CPS, 2003). They involve the imposition of specified conditions which are appropriate for addressing the offender's behaviour or making reparation to the victim or community. If the conditions are not adhered to, the conditional caution is cancelled and criminal proceedings instituted. The CPS, rather than the police, authorises such a caution.

15.6.1 Conditions attached to the caution

The *code of practice* on conditional cautions states conditions should be proportionate.

Conditions that amount to far less than the punishment that would probably be given by a court are unlikely to satisfy the public interest or engender confidence in the criminal justice system. Conditions must be clearly defined in terms of what must be done and within what period of time.

Conditions must be realistic and should take account of the particular offender's circumstances, including physical and mental capacity, so that the offender could reasonably be expected to achieve them within the time set; otherwise the only result will be a delayed prosecution.

15.6.2 Rehabilitation and restorative justice

The conditions might involve rehabilitation. They might involve also repairing goods, apologising or making financial compensation. Conditions might also be based on the notion of restorative justice. This brings together victims and offenders, and sometimes community members, into contact – directly or indirectly – to focus on the impact of a particular crime, and agree what can be done to repair the harm caused by that crime. Such processes must always be voluntary for both the victim and the offender.

15.7 Multi-agency public protection arrangements

The Criminal Justice Act 2003 places a duty on 'responsible authorities' to establish arrangements for assessing and managing risks in relation to certain high-risk offenders. They are known as multi-agency public protection arrangements (MAPPAs). The responsible authorities are defined as the chief of police, Probation Board and Prison Service.

15.7.1 Violent and sex offenders

The duty applies to specified categories of violent and sex offenders, as well to other people who have committed offences and who a responsible authority considers pose a risk of serious harm to the public.

15.7.2 Three levels of Multi-agency public protection arrangements

Arrangements function on three levels. The first is single agency (usually the Probation Service) where there is a lower level of risk. The second level involves a higher risk, but one not requiring complex management; normally this will involve more than one agency. At the third level are critical cases involving high-risk and/or difficult risk management issues. These require multi-agency public protection panel (MAPPP) meetings (DH, 2004b).

The relevance to safeguarding adults is that such offenders may pose a risk to vulnerable adults, as well as being vulnerable themselves. For instance, in one case the risk to be managed concerned the risk to other residents in sheltered accommodation, posed by a man in his sixties, who had just been released from prison after killing his wife.³⁹

15.7.3 Cooperation between different agencies

Other specified organisations must cooperate in the context of MAPPA insofar as such cooperation is compatible with their own statutory functions (Criminal Justice Act 2003, Sections 325–327).

These other organisations include local social services authorities, primary care trusts (PCTs), other NHS trusts, strategic health authorities (SHAs), Jobcentres Plus, local youth offending teams, registered housing providers that accommodate MAPPA offenders, local housing authorities, local education authorities and electronic monitoring providers (DH, 2004b).

15.7.4 Information sharing between agencies

Cooperation between agencies 'may' include the exchange of information. MAPPA guidance states that each MAPPA agency (with a 'duty to cooperate') that is sharing information must have a statutory or common law power to do so, and that Section 325 of the Act creates such a statutory power. However, Section 325 does not provide the legal power for a MAPPA agency to share information with a non-MAPPA agency.

Separately, there is a power under Section 115 of the Crime and Disorder Act for any person to pass information to specified bodies, including the police, Probation Service, local authorities and NHS bodies (although this power does not work in reverse, so as to confer power on those authorities to give information to any person).

15.7.5 Power to share information but avoiding pitfalls of excessive or unjustified sharing

The guidance maintains that MAPPA agencies therefore have a legal power to share information with each other, but warns against casual disclosure; any sharing should be on the grounds of necessity, and be carried out safely and with accountability. It must accord with the principle of proportionality and be consistent with the Data Protection Act 1998, the Human Rights Act 1998 and the common law of confidentiality (Ministry of Justice et al, 2009, paras 5.1–5.6).

In the following MAPPA case, albeit heard under now superseded legislation, the courts warned against the dangers of just assuming that information can automatically be shared:

Starting point for sharing of information, and weighing up competing considerations. A 64-year-old man who had killed his wife was now being released, unconditionally, on licence. A report about his release concluded that the risk of reoffending was unlikely, although it might increase were he to engage in a personal relationship. He was going to live in sheltered accommodation. The Probation Service disclosed information about the man to the manager of the housing.

The court held that, as a matter of decision-making process, the disclosure was unlawful. This was because the Probation Service had approached the matter on the presumption that information would be disclosed. Rather it should have begun with a presumption of non-disclosure and then used the risk assessment to displace that presumption. It should also have explicitly balanced the risk to other people of non-disclosure, with harm to the man flowing from disclosure.⁴⁰

15.8 Probation Service

The purpose of the national Probation Service, in relation to offenders, is to protect the public, reduce reoffending, proper punishment of offenders, ensuring offenders' awareness of the effects of crime on the victims of crimes and the public and the rehabilitation of offenders (Criminal Justice and Court Services Act 2001, Section 2).

As already noted, the Probation Service is a 'responsible authority' in relation to MAPPAs. As such, it has powers conferred on it under additional legislation, to share information. The Offender Management Act 2007 states that the Probation Service (and other probation providers) can disclose information to some other agencies including local authorities and the police. However, it emphasises that this power of disclosure is not *carte blanche*; it applies only if the disclosure is necessary or expedient for probation purposes, for functions related to prisons and prisoners, or for or other purposes related to the management of offenders (Offender Management Act 2007, Section 14).

Notes

¹ *Re Z* [2004] EWHC 2817 (Fam).

² SI 2009/1887. Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009.

³ *Slater v Buckinghamshire County Council* [2004] EWCA 1478.

⁴ *X & Y v Hounslow London Borough Council* [2009] EWCA Civ 286.

⁵ SI 2009/1887. The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009, Regulation 6.

⁶ SI 2009/1887. The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009, Regulation 8.

⁷ SI 2009/1887. The Community Care, Services for Carers and Children's Services (Direct Payments) (England) Regulations 2009, Regulation 12.

⁸ Housing Act 1996, Section 189. And SI 2002/2051. Homelessness (Priority Need for Accommodation) (England) Order.

⁹ *R v Camden LBC, ex p Pereira* [1998] 31 HLR 317.

- ¹⁰ *R v Greenwich LBC, ex p Dukic* [1997] 29 HLR 87.
- ¹¹ *Yemshaw v Hounslow London Borough Council* [2011] UKSC 3.
- ¹² *Barber v Croydon London Borough Council* [2010] EWCA Civ 51.
- ¹³ *Knowsley Housing Trust v McMullen* [2006] EWCA Civ 539.
- ¹⁴ *Manchester City Council v Romano; Manchester City Council v Samari* [2004] EWCA Civ 384.
- ¹⁵ *S v Floyd* [2008] EWCA Civ 201.
- ¹⁶ *Manchester City Council v Romano* [2004] EWCA Civ 834.
- ¹⁷ *North Devon Homes v Brazier* [2003] EWHC 574 (QB).
- ¹⁸ *Swindon Borough Council v Redpath* [2009] EWCA Civ 943.
- ¹⁹ *Wear Valley District Council v Robson* [2008] EWCA Civ 1470.
- ²⁰ *R (McCann) v Manchester Crown Court* [2002] UKHL 39.
- ²¹ *R (McCann) v Manchester Crown Court* [2002] UKHL 39.
- ²² *Fairweather v Commissioner of Police for the Metropolis* [2008] EWHC 3073 (Admin).
- ²³ *Chief Constable of Merseyside v Harrison* [2006] EWHC 1106 (Admin).
- ²⁴ *Chief Constable of Merseyside v Harrison* [2006] EWHC 1106 (Admin).
- ²⁵ *Swindon Borough Council v Redpath* [2009] EWCA Civ 943.
- ²⁶ *Baker v Crown Prosecution Service* [2009] EWHC 299 (Admin).
- ²⁷ *Syed v Director of Public Prosecutions* [2010] EWHC 81 (Admin).
- ²⁸ *D'Souza v Director Public Prosecutions* [1992] 1 WLR 1073.
- ²⁹ *R v Howell* [1981] 3 WLR 501.
- ³⁰ *R v Salisbury* [2004] Crown Court, Chester, 18 June 2004.
- ³¹ *R v North Humberside Coroner, ex parte Jamieson* [1995] QB 1.
- ³² *R v D* [2002] EWCA Crim 990.
- ³³ *R v Ali Sed* [2004] EWCA Crim 1294.

³⁴ Code C. Code of Practice for the detention, treatment and questioning of persons by police officers.

³⁵ *R v Foster* [2003] EWCA Crim 178.

³⁶ *R v Lamont* [1989] Crim LR 813.

³⁷ *C v Sevenoaks Youth Court* [2009] EWHC 3088 (Admin).

³⁸ *R v H* [2003] EWCA Crim 1208.

³⁹ *R (A) v National Probation Service* [2003] EWHC 2910 (Admin).

⁴⁰ *R (A) v National Probation Service* [2003] EWHC 2910 (Admin).

Part 5: Regulation of providers and the workforce

- 16 Regulation of social and health care providers
- 17 Vetting and Barring Scheme: regulation of workers
- 18 Criminal record certificates
- 19 Professional regulation

16 Regulation of social and health care providers

16.1 Key points

Providers of health and social care – both public bodies and independent providers – are subject to registration and regulation in relation to the services that they provide. This is under the Health and Social Care Act 2008.

16.1.1 Care Quality Commission

The Care Quality Commission (CQC) is the body responsible for enforcing this system of regulation. It can issue warning notices, impose or vary or remove registration conditions, issue financial penalties, suspend or cancel registration, prosecute specified offences and issue simple cautions (CQC, 2009a).

16.1.2 Regulations and safeguarding

Regulations have been made under the Act to specify in more detail what is required of health and social care providers. Some of these requirements refer explicitly to the need to protect users of services from abuse or undue restraint.

Others cover care issues more generally. However, these too are directly relevant to the protection of vulnerable adults; they include dignity, nutrition, infection control, adequate staffing etc. Lapses in such matters, particularly where they are systematic, can lead to serious safeguarding issues, including what the *No secrets* guidance refers to as institutional abuse.

16.2 Standards of care and safeguarding

The regulation of health and social care providers is in principle one of the major planks in safeguarding adults at risk of harm. In particular, such regulation is intended to ensure that standards in health and social care are such as to avoid organisational and institutional problems that can seriously harm adults at risk. Many adults at risk of harm are likely to be in receipt of health and social care services.

16.3 Care Quality Commission

The CQC is the relevant regulatory body. Its role is primarily about registration, review and investigation of providers in relation to health and social care, including mental health under the Mental Health Act 1983. Providers include local authorities, NHS bodies and independent providers of health and social care.

16.3.1 Warning notices, registration conditions, cancelling registration, prosecution etc

The Commission can issue statutory warning notices, impose, vary or remove registration conditions, issue financial penalty notices, suspend or cancel registration, prosecute specified offences and issue simple cautions (CQC, 2009a). Urgent

cancellation orders can be sought from a justice of the peace if there is a serious risk to a person's life, health or wellbeing.

16.3.2 Offences

A number of specific offences are set out. These include failing to comply without reasonable excuse with conditions set by the Commission, carrying on regulated activity after registration has been suspended or been cancelled, contravening specific regulations, giving a false description of a concern or premises etc (Health and Social Care Act 2008, Sections 33–37).

Prosecution of care home. The CQC had visited a care home. It requested that the home review various arrangements to rectify failings that had been identified. Two months later, the home had still not rectified these. The Commission prosecuted the home for failing to comply with care homes regulations requiring them to make arrangements for the recording, handling, safekeeping, safe administration and disposal of medicines, and failing to ensure care plans properly reflected how residents' needs were to be met. The care home was fined £1,600 on each charge and had to cover the Commission's legal costs of nearly £800. (CQC, 2010)

16.4 Regulated activity

Anybody carrying on a 'regulated activity' must be registered to do so. It is an offence not to be. A regulated activity means the provision of health and social care. Apart from directly providing care, this includes supply of staff, the provision of transport or accommodation for people requiring care and the provision of advice in respect of care (Health and Social Care Act 2008, Section 8).

16.5 Health and social care

Healthcare is defined to include all forms of healthcare provided for people, whether relating to physical or mental health. It also includes procedures that are similar to forms of medical or surgical care but are not provided in connection with a medical condition.

Social care includes all forms of personal care and other practical assistance provided for individuals who – by reason of age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs or any other similar circumstances – are in need of such care or other assistance (Health and Social Care Act 2008, Section 9).

16.6 Reviews and investigations

The Commission must review periodically NHS bodies and local authorities and can also conduct special reviews and investigations.

The Commission has powers of entry and inspection. It can also require the information, documents and records it considers necessary or expedient to perform its regulatory functions.

16.7 Quality of services

Regulations lay down more detailed rules about the quality of services.¹ Some of the regulations refer specifically to safeguarding issues such as abuse; many others refer to care matters which, if not adhered to, can easily result in serious harm to vulnerable adults, thereby raising safeguarding concerns.

16.8 Arrangements to prevent and respond to abuse

There must be suitable arrangements to ensure that people who use services are safeguarded against the risk of abuse. Abuse is defined as sexual abuse; physical or psychological ill treatment; theft, misuse or misappropriation of money or property; or neglect and acts of omission which cause harm or place at risk of harm.

The provider must (a) take reasonable steps to identify the possibility of abuse and to prevent it; and (b) respond appropriately to any allegation of abuse.²

16.8.1 Control or restraint

If control or restraint is used, there must be suitable arrangements to protect against the risk of it being unlawful or otherwise excessive.

Where any form of control or restraint is used in the carrying on of the regulated activity, the registered person must have suitable arrangements to protect people who use services against the risk of such control or restraint being unlawful or otherwise excessive.

16.8.2 Essential standards to safeguard adults at risk of harm and abuse

The CQC has published under Section 23 of the Health and Social Care Act 2008 a guide to compliance called *Essential standards of quality and safety* (CQC, 2009b). It contains standards that the Commission will use to judge whether the regulatory legislation is being complied with.

One section deals in particular with safeguarding adults from abuse (although many other parts of guide are also relevant to safeguarding). In summary, the provider is responsible for:

- *Prevention*: take action to identify and prevent abuse from happening in a service.
- *Appropriate response*: respond appropriately when it is suspected that abuse has occurred or is at risk of occurring.
- *Guidance*: ensure that government and local guidance about safeguarding people from abuse is accessible to all staff and put into practice.
- *Restraint*: make sure that the use of restraint is always appropriate, reasonable, proportionate and justifiable to that individual.
- *De-escalation*: only use de-escalation or restraint in a way that respects dignity and protects human rights, and where possible respects the preferences of people who use services.

- *Diversity and safeguarding*: understand how diversity, beliefs and values of people who use services may influence the identification, prevention and response to safeguarding concerns.
- *Protection of other people*: protect others from the negative effect of any behaviour by people who use services.
- *Deprivation of liberty*: where applicable, only use Deprivation of Liberty Safeguards (DoLS) when it is in the best interests of the person who uses the service and in accordance with the Mental Capacity Act 2005.

In addition, the guidance states that, in order to safeguard people, providers need to consider effective leadership, personalised care, promotion of rights and choices (CQC, 2009b, Outcome 7).

16.9 Unsafe care, nutrition, infection

The regulations impose a duty to protect people who use services from inappropriate or unsafe care or treatment, from healthcare-associated infection, from the risks of unsafe use and management of medicines and from inadequate nutrition and hydration.

16.9.1 Nutrition and hydration

There should be (a) a choice of suitable and nutritious food and hydration, in sufficient quantities to meet the needs of people who use services; (b) food and hydration that meet any reasonable requirements arising from the religious or cultural background of the person who uses services; and (c) support, where necessary, for the purposes of enabling people who use services to eat and drink sufficient amounts for their needs.

16.10 Infection control

Inadequate infection control, linked to poor standards of care, has been implicated in avoidable patient deaths, sometimes running to scores of deaths in just one hospital. As a result the regulations place a duty on care providers to operate systems to assess the risks of infection and to prevent, detect, treat and control the spread of infection.

In addition, providers must maintain appropriate standards of design, cleanliness and hygiene in relation to premises and equipment. This includes vehicles used for transporting patients for treatment, and also materials used to treat patients. It is an offence not to comply with these rules.³

16.11 Dignity

The registered person must, so far as reasonably practicable, make suitable arrangements to ensure (a) the dignity, privacy and independence of people who use services; and (b) that people who use services are enabled to make, or participate in making, decisions relating to their care or treatment. The registered person must have in place arrangements for obtaining and acting on the consent of people who

use services in relation to care and treatment provided. There must be a proper system of record keeping to protect people who use services against the risk of inappropriate care or treatment.

These are, of course, also important elements in the safeguarding of vulnerable adults; not talking to people, not consulting with them and not gaining their consent can too often be a slippery slope to harming them in one way or another. Likewise, the absence of recording – leading to an absence of monitoring, for example, nutrition, body weight, continence and bowel movements, tissue viability – can all too easily lead to neglectful care.

16.12 Suitable and sufficient staff, equipment and premises

In order to safeguard the health, safety and welfare of people who use services, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced staff.⁴ People who use services must also be protected against the risks of unsuitable or unsafe premises, and against the risks of unsafe, unsuitable or lack of equipment.

16.13 Fitness of providers, managers and staff

The regulations stipulate that, in relation to regulated activity, a person registered as a service provider, a registered manager or a worker must be fit to do so. He or she will not be fit, unless he or she is of good character, physically and mentally fit to carry on the regulated activity and has the necessary qualifications, skills and experience to do so.

For instance, under equivalent rules under the Care Standards Act 2000 (preceding the Health and Social Care Act 2008), the Care Standards Tribunal found the following care home manager unfit:

Fitness of manager: death of resident. A resident died at 3.30am in a bath of scalding water. There were no thermostatic mixing valves. There had been no adequate risk assessment. There were also dangerously hot radiators. Parts of the home were badly stained and smelt badly.

Residents were taken to the bathroom and brought back without their spectacles. The Tribunal upheld the Commission for Social Care Inspection's (CSCI) finding that the manager of this home was unfit.⁵

16.13.1 Information about managers and staff

Specified information must be available about managers and staff. This is: proof of identity; criminal record certificate; evidence of conduct in previous employment (involving health or social care, or work with vulnerable adults or children); where previous work involved vulnerable adults or children, satisfactory evidence about how that employment ended; satisfactory documentary evidence of any relevant qualification; full employment history; and satisfactory evidence about physical or mental health conditions relevant to the work.

16.13.2 Recruitment procedures

The registered person must operate effective recruitment procedures and also ensure that staff are registered, where necessary, with the appropriate professional body. If the person is no longer fit to undertake the work, the registered person should take appropriate steps. These would include the informing of the relevant professional body.

16.14 Complaints system

There must be a complaints system for the overall purpose of assessing, preventing or reducing the impact of inappropriate care or treatment.

16.15 Reporting harm to the Care Quality Commission (or National Patient Safety Agency)

The regulations state that the registered person must inform the CQC of certain types of harm suffered by a person who uses services.⁶ This duty is of

considerable importance to safeguarding.

The duty to report to the Commission is disapplied in the case of NHS bodies, if they have instead reported the incident to the National Patient Safety Agency (NPSA).⁷ The CQC states that it will seek information from other bodies including the NPSA (CQC, 2009c, p 3).

16.15.1 Death of a person who uses services

The matters that have to be reported without delay include the death of a person who uses services (and the circumstances of it) while services were being provided or as a result of their being provided. In the case of a health service body, the same obligation applies but only if the death cannot be reasonably attributed to the course of the illness or medical condition of the person who uses services (assuming he or she had been receiving appropriate care or treatment). The death or unauthorised absence of a person who uses services detained (or liable to be detained) under the Mental Health Act 1983 must also be notified without undue delay.⁸

16.15.2 Reporting injury, abuse, deprivation of liberty, police involvement

In addition, a range of other incidents must be reported without delay. These include injury, deprivation of liberty, abuse, police involvement and safety of service including adequacy of staff:

- *Injury* to the person who uses services that a health professional reasonably believes has resulted in (i) an impairment of the sensory, motor or intellectual functions of the person which is not likely to be temporary; (ii) changes to the structure of the person's body; (iii) the person who uses services experiencing prolonged pain or prolonged psychological harm; or (iv) the shortening of the life expectancy of the person who uses services.

- *Injury* to a person who uses services that a health professional reasonably believes requires treatment to prevent i) death of the person who uses services or ii) an injury to the person who uses services which, if left untreated, would lead to one or more of the outcomes mentioned above.
- *Deprivation of liberty* request to a local authority or primary care trust (PCT) for a standard authorisation to deprive a person lacking capacity of his or her liberty, or application to a court for the same purpose.
- *Abuse*: any abuse or allegation of abuse in relation to a person who uses services.
- *Police*: any incident that is reported to, or investigated by, the police (this does not apply to an NHS body).
- *Safety*: anything that may prevent the safe provision of services or adherence to registration requirements including insufficient number of qualified, skilled and experienced staff, and other issues affecting the provision of services.⁹

16.16 Safeguarding in the NHS

The regulations outlined above apply to all healthcare providers, including the NHS. They impose specific duties in relation to protecting people from abuse, to dignity and to safety. More generally, health services are provided by the NHS under the National Health Service Act 2006. Under the Act, duties placed on the Secretary of State are effectively funnelled down to PCT, NHS trusts, and foundation trusts. In the future, PCTs will be abolished and their commissioning function be taken over by general practitioner (GP) consortia.

16.16.1 *NHS and No secrets guidance*

Safeguarding is not mentioned in the NHS Act 2006. However, the *No secrets* guidance does refer to the NHS as being subject to local inter-agency working. It clearly envisages that the NHS will have policies and procedures on safeguarding in place, and train staff about these. The guidance does not place any new or specific duties on the NHS. It is simply guidance about how the NHS should go about its existing business, namely, that it should incorporate safeguarding adults concerns.

For the NHS, the *No secrets* guidance is not 'statutory guidance' in the way in which it is for social services; it is thus, in principle, of less legal weight. However, this does not mean that it carries no weight. For example, the Health Service Ombudsman has stated that the complaints procedures of NHS trusts should reflect the *No secrets* guidance and be capable of recognising when a safeguarding matter is an issue (Health Service Ombudsman, 2001).

16.16.2 *Reporting serious untoward incidents*

NPSA has published guidance about the reporting of serious untoward incidents by the NHS and how this should dovetail with the raising of safeguarding alerts (NPSA, 2010).

The Department of Health has also issued guidance about reporting serious incidents, clinical governance and safeguarding (DH, 2010c).

16.16.3 NHS provision of services under guidance and relevance to safeguarding

The NHS acts under a wide range of guidance, consideration of which may be relevant in some safeguarding situations. For example, in relation to mental health it works to guidance on the Care Programme Approach.

In summary, this sets out when the NHS should receive a higher level of coordination and support because of complexity of need and higher degree of risk. The guidance is not legally binding but is widely used within the NHS (DH, 2008b).

Likewise, the NHS is subject to guidance about 'NHS continuing health care' (DH, 2009c). For instance, this refers to the situation when a person has their healthcare and personal care needs met fully by the NHS. So if a person with continuing healthcare status were in a care home, and safeguarding issues were to arise, the NHS should, as a matter of course, be directly involved.

17 Vetting and Barring Scheme: regulation of workers

This scheme – the barring and vetting of people who work with vulnerable adults – is currently under major review

18 Criminal record certificates

18.1 Key points

Under the Health and Social Care Act 2008 and associated regulations, registered activity providers (of health and social care) must obtain criminal record certificates from the Criminal Records Bureau (CRB) in respect of workers. Many other employers can, but are not strictly obliged, to carry out such checks.

Criminal record certificates are issued by the CRB under the Police Act 1997. There are currently two types, standard and enhanced. The latter is required, for example, for people who work with vulnerable adults in health and social care. Many other employers make use of this system of checks, even if they are not legally obliged to.

18.1.1 Enhanced disclosure

The enhanced certificate will include relevant information held by a local police force, as well as information held on the Police National Computer.

18.1.2 Fairness in disclosure

The certificates are seen as a key safeguard for vulnerable adults. Equally, it is important that this system does not work unfairly against practitioners. The courts have held that, in releasing such soft information, the police should balance the need to safeguard vulnerable adults against disproportionate and excessive intrusion into the private life of staff.

18.2 Applying for a criminal record certificate

Criminal record certificates are issued under the Police Act 1997. There are currently two levels of disclosure, standard and enhanced. An application for a standard or enhanced disclosure must be countersigned by a person registered with the CRB.¹⁰

Only organisations registered with the CRB can make requests for a CRB check. However, it is possible for other people to find out details, by requesting an 'umbrella body' to make such a request on their behalf.

18.3 Type of information provided

The scheme is designed to give an employer both conviction and non-conviction information about a potential employee, so as to help the employer make a decision about whether to employ a person to work with vulnerable adults (or children). The Police Act 1997 provides in fact for three different levels of disclosure, but there are currently only two provided, standard and enhanced. (The issuing of certificates covering 'basic' disclosure is not legally in force.)

18.3.1 Standard disclosure

Standard disclosure covers details of spent and unspent convictions, but also cautions, reprimands and warnings recorded centrally by the police (Police Act 1997, Section 113A).

Certain convictions do not become spent because of the length of the sentence, and under the provisions of the 1974 Act, spent convictions can be disclosed in certain circumstances including assessing the suitability of a person to, for example, provide care services for vulnerable adults.¹¹

18.3.2 Enhanced disclosure

Enhanced disclosure is for considering the suitability of a person to engage in regulated activity as defined in the Safeguarding Vulnerable Groups Act 2006, or for a position involving regularly caring for, training, supervising or being solely in charge of vulnerable adults (or children) as defined within the 2006 Act.¹²

Non-conviction information

This covers the same information as standard disclosure, but also non-conviction information held locally by the police (rather than on the Police National Computer), and which the local police believe might be relevant and should be included. The police also have to consider what information should be provided but not included in the certificate, in the interests of the prevention or detection of crime.

Balancing protection with fairness to workers

The courts have looked at some cases to ensure that the necessary balance is struck between protecting vulnerable adults (or children) and interfering with the private life of staff, in order to avoid a breach of human rights.

Article 8 of the European Convention concerns a right to respect for private life. The state can interfere with this but only if the interference is proportionate. As a consequence, the courts have now stated that there is not a presumption either way about whether information will or won't be disclosed. It will depend on the consideration of relevant factors in each case:

Balancing protection with rights of workers. The case concerned a school assistant who worked in the canteen and the playground; the soft information in respect of an enhanced disclosure concerned child protection issues in relation to her own child. Although she lost her appeal, the court was concerned that the police should strike a balance in each case, when deciding what to disclose.

Where competing rights are in issue, Article 8 meant that there should not be a presumption that such soft information should be disclosed by the police. Instead, careful consideration must be given to the decision, where the disruption to the private life of anyone is judged to be as great, or more so, as the risk of non-disclosure to vulnerable people. Furthermore, if sensitive

information is to be disclosed, and there is doubt about its substance, veracity or continuing relevance, the worker must be given the opportunity to make representations before the information is disclosed.¹³

18.4 Notification in the case of controlled activity

Where a criminal record check is requested for a person engaging in controlled (rather than regulated) activity, a 'notification' rather than a certificate will be issued. Controlled activity is activity ancillary to regulated activity (see the previous section); it means the person is not working directly with vulnerable adults.

The notification will be about whether the person is on the barred list under the Safeguarding Vulnerable Groups Act 2006. If the person is on the barred list (that is, barred from regulated activity), then the employer can still take a view of whether to employ the person in controlled activity.

18.5 Implications for the employer of the disclosure

If people are included in the barred list under the Safeguarding Vulnerable Groups Act 2006, they are not permitted to work with vulnerable adults. But potentially adverse information in an enhanced criminal record certificate does not mean an employer cannot employ the person. It is up to the employer to make a judgement in each case.

Employers should in principle have a policy on employing ex-offenders and approach the matter fairly. The Chartered Institute of Personnel has produced guidance on this, published by the CRB and called *Employing ex-offenders: A practical guide* (CIPD, 2004). At the very least, fairness might require giving the employee an opportunity to put his or her side of the matter, even if potentially adverse information has shown up on the certificate.

18.5.1 Code of practice for employers

The CRB's *Code of practice* states that employers must discuss the content of the disclosure before withdrawing an offer of employment (CRB, 2009).

The courts have suggested that if an employer applies a blanket policy, which does not take account of information or explanation provided by the employee, then any dismissal might be unfair in employment law:

Fairness of employer's approach to a certificate that is not 'clean'. In the past, allegations of sexual abuse, during a trip to Wales, had been made against the deputy principal of a college for young autistic adults. Following reorganisation he was employed by a national charity, and required to obtain a criminal record certificate. This contained details of the allegations. No criminal charges had ever been brought, and there were weaknesses in the evidence, which had been obtained by facilitated communication (where a facilitator supports the arm or hand of a person who then uses a keyboard or other typing device). Furthermore,

the Police Complaints Authority had upheld some of the complaints made by the man about the police investigation.

Nonetheless, the court held that it was lawful that the allegations were disclosed, despite the damage that would be done to the man. Indeed, he had been instantly dismissed by his new employer, which had a blanket policy of insisting on a 'clean certificate'. However, the court stated that a properly informed decision would take account of other information or explanation provided by the employee. The policy had not allowed this to happen; the court thought that an employment tribunal case might succeed on grounds of unfair dismissal.¹⁴

19 Professional regulation

19.1 Key points

A discrete avenue for the safeguarding of vulnerable adults – from being harmed by professionals – is that of professional bodies. These have the power, for example, to suspend, impose conditions on, or strike off, professionals.

19.1.1 Professional bodies

Such bodies include the General Medical Council (GMC), the Nursing and Midwifery Council (NMC), the Health Professions Council (HPC) (covering various professions including occupational therapists, physiotherapists, speech and language therapists, dieticians, chiropractors and psychologists) and the General Social Care Council (GSCC) (covering social workers).

19.1.2 Code of conduct and practice

They publish codes of conduct or practice, together with other guidance and standards. In relation to safeguarding vulnerable adults, these raise two overall issues. First, that the professionals concerned should not be acting in such a way as to harm vulnerable adults; second, that if they see, or find themselves enmeshed in practices giving rise to safeguarding matters, they should consider reporting this even if it means breaching confidentiality.

19.2 General Medical Council

The GMC's *Good medical practice* states that doctors must respect patients' confidentiality and privacy. They must not express their personal beliefs – including political, religious or moral beliefs – in ways that exploit patients' vulnerability or that are likely to cause them distress. They must not use their professional position to establish or pursue a sexual or improper emotional relationship with patients. Doctors must safeguard and protect the health and wellbeing of vulnerable patients, and offer assistance to them if they think that their rights have been abused or denied (GMC, 2006, paras 25–33).

19.3 General Social Care Council

The GSCC has a code of practice for social care workers, which applies to qualified social workers, but not yet to other social care workers. It states that social care workers must promote independence, protect from harm and report unsafe care:

- promote the independence of people who use services while protecting them as far as possible from danger or harm
- strive to establish and maintain the trust and confidence of people who use services and carers
- adhere to policies and procedures about accepting gifts and money from people who use services and carers

- follow practice and procedures designed to keep themselves and other people safe from violent and abusive behaviour at work
- bring to the attention of employer or the appropriate authority, resource or operational difficulties that might get in the way of the delivery of safe care.

More specifically in relation to abuse, the Code states that social care workers must not:

- abuse, neglect or harm people who use services, carers or colleagues
- exploit people who use services, carers or colleagues in any way
- abuse the trust of people who use services and carers or the access they have to personal information about them or to their property, home or workplace
- form inappropriate personal relationships with people who use services
- discriminate unlawfully or unjustifiably against people who use services, carers or colleagues
- condone any unlawful or unjustifiable discrimination by people who use services, carers or colleagues
- put themselves or other people at unnecessary risk; or behave in a way, in work or outside work, which would call into question a person's suitability to work in social care services.

19.3.1 Sexual or financial impropriety

Typical grounds for conduct hearings against social workers include sexual or financial impropriety. For instance, in the following case, a social worker was removed from the Register for serious sexual misconduct.

Sexual relationship with a person who uses services. A social worker admitted a sexual relationship with a vulnerable female user of mental health services, who had a borderline personality disorder. He fathered two children with her. He was removed from the Register.¹⁵

In the following case, the sexual conduct was of less seriousness, but still resulted in removal from the Register:

Sexual propositioning of vulnerable adult. A social worker sexually propositioned a vulnerable person who uses services, who was actively suicidal. Alcohol was involved; the social worker was a heavy drinker. The social worker had a good professional history and many years of dedicated, unblemished service. He had a heavy caseload. The sexual conduct was not at the severe end of the spectrum. Nonetheless, he was removed from the register by the GSCC. The Care Standards Tribunal upheld the decision.¹⁶

19.3.2 Code of practice for employers

There is also a *Code of practice for employers of social care workers* (General Social Care Council, 2010). A number of points relate to safeguarding. These include:

- checking criminal records, relevant registers and indexes and assessing whether people are capable of carrying out the duties of the job they have been selected for before confirming appointments
- implementing and monitoring written policies on: confidentiality; equal opportunities; risk assessment; substance abuse; record keeping; and the acceptance of money or personal gifts from people who use services or carers
- establishing and promoting procedures for social care workers to report dangerous, discriminatory, abusive or exploitative behaviour and practice and dealing with these reports promptly, effectively and openly
- informing the GSCC about any misconduct by registered social care workers that might call into question their registration and inform the worker involved that a report has been made to the GSCC.

The regulatory functions will transfer from the GSCC to another body in 2013.

19.4 Nursing and Midwifery Council

The NMC's code, *Standards of conduct, performance and ethics for nurses and midwives* states, among other things, that nurses and midwives should (or be aware that they should):

- make the care of people their first concern, treating them as individuals and respecting their dignity
- work with others to protect and promote the health and wellbeing of people in nurses' and midwives' care, and those people's families and carers, and the wider community
- provide a high standard of practice and care at all times
- be open and honest, act with integrity and uphold the reputation of the profession
- that as professionals, they are personally accountable for actions and omissions in their practice and must always be able to justify their decisions
- always act lawfully, whether those laws relate to their professional practice or personal life
- that failure to comply with this code may bring a person's fitness to practice into question and endanger their registration.

More specifically, the code also states that nurses and midwives must refuse any gifts, favours or hospitality that might be interpreted as an attempt to gain preferential treatment. They must not ask for or accept loans from anyone in their care or anyone close to them. And they must establish and actively maintain clear sexual boundaries at all times with people in their care, their families and carers.

Multiple failings by a manager in a care home. A nurse was a manager of a care home. She was removed from the Register on account of multiple failings. These included a resident sitting in a darkened room with a mattress on the floor and faecal matter on the bedding, as well as other residents with mattresses on the floor. Other failings included missing toilet seats, non-functioning showers, dirty fridges, malodorous rooms, incontinence pads in waste bins in toilets, call bells

missing, fluid intake charts not completed, pressure sore wound assessment and management not recorded etc.¹⁷

19.4.1 Reporting harm

The code states that nurses must act if patients are being put at risk of harm, inform a person in authority if they are being prevented from working to proper standards, and report concerns in writing if problems are putting patients at risk (NMC, 2008).

19.5 Health Professions Council

The HPC's *Standards of conduct, performance and ethics* covers a number of professions including physiotherapists, occupational therapists, speech and language therapists, chiropodists and podiatrists, dieticians, practitioner psychologists, paramedics, radiographers, prosthetists and orthotists, operating department practitioners, etc (HPC, 2008).

It states that professionals must not do anything, or allow someone else to do anything, that will put the health or safety of a person who uses services in danger. They should take appropriate action to protect the rights of vulnerable adults; this includes following national and local policies.

Professionals may be removed from the Register if they have received convictions or cautions for certain offences including violence, abuse, sexual misconduct, illegal drug supply, child pornography, dishonesty and offences that attracted a prison sentence (HPC, 2008, para 4).

Notes

¹ SI 2010/781. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

² SI 2010/781. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

³ SI 2010/781. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

⁴ SI 2010/781. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

⁵ *Hillier v Commission for Social Care Inspection* [2003] 0187 NC.

⁶ SI 2009/3112. Care Quality Commission (Registration) Regulations 2009.

⁷ SI 2009/3112. Care Quality Commission (Registration) Regulations 2009, Regulation 16.

⁸ SI 2009/3112. Care Quality Commission (Registration) Regulations 2009, Regulation 17.

- ⁹ SI 2009/3112. Care Quality Commission (Registration) Regulations 2009, Regulation 18.
- ¹⁰ Police Act 1997, Section 120. And SI 2006/750. Police Act 1997 (Criminal Records) (Registration) Regulations.
- ¹¹ SI 1975/1023. Rehabilitation of Offenders Act 1974 (Exceptions) Order, Schedule 1, paras 12–13.
- ¹² SI 2002/233. Police Act 1997 (Criminal Records) Regulations, Section 5A.
- ¹³ *R (L) v Commissioner of Police of the Metropolis* [2009] UKSC 3.
- ¹⁴ *R (Pinnington) v Chief Constable of Thames Valley* [2008] EWHC 1870 (Admin).
- ¹⁵ *General Social Care Council v Z*, GSCC Conduct hearing, 28–29 April 2009.
- ¹⁶ *McNicholas v General Social Care Council* [2007] 1179 SW.
- ¹⁷ Nursing and Midwifery Council, Case no 75U6681E, conduct hearing, 27–28 March 2008.

Part 6: Finance and property harm

20 Criminal law: finance and property

21 Civil legal remedies for financial and property harm

20 Criminal law: finance and property

20.1 Key points

Harm, in terms of loss of money and property, is perceived to be a major issue in safeguarding; it is thought to be relatively widespread. Sometimes this harm will very clearly be a criminal offence, sometimes less clearly so. A number of criminal offences stand out including theft, burglary, fraud, false accounting and forgery.

20.1.1 Crimes against vulnerable people

In relation to vulnerable people, these crimes are committed by a wide range of perpetrators in a variety of situations. Sometimes vulnerable people are deliberately and systematically targeted. Sometimes the offence is more opportunistic, but still made easier to commit by the vulnerability of the person.

20.1.2 Common instances of crime

There are typically recurring circumstances, and some less expected instances. For instance, carers in care home or in people's own homes may misuse bank cards and personal identification numbers (PINs) with which they have been trusted. Or they might simply rifle through people's furniture and belongings to find cash. Cheques might be forged.

20.1.3 Families and professionals

Sometimes it is people's families who misuse their position to steal money, through theft, fraud or forgery. And professionals, too, in positions of trust in relation to vulnerable people, are sometimes implicated in these offences. This includes, for instance, accountants, solicitors, social and health care workers, bank staff, police officers and church ministers.

20.2 Financial crime and mental capacity

Sometimes practitioners are unclear about how to proceed if vulnerable people have capacity to make decisions about their money, but are giving it away and being very seriously exploited. There may be an assumption that legally this amounts to a gift and that the offence of theft therefore cannot be committed. This is not in fact necessarily so; the courts have held that in certain circumstances this could in fact be theft, if there is patent dishonesty involved, notwithstanding the presence of mental capacity.

20.3 Theft

Section 1 of the Theft Act 1968 states that a person is guilty of theft if he or she dishonestly appropriates property belonging to somebody else. The intention must be to permanently deprive the other person of the property.

However, the appropriation will not be dishonest if the person believes he or she has a right in law to deprive the other person of it. It will also not be dishonest if the person believed that the other person would have consented, if the other person knew of both the appropriation and the circumstances.

20.3.1 Types of theft

In the context of safeguarding, there are typical types of theft. For instance, care workers who are entrusted with a person's bank card and PIN. Care workers visiting people in their own homes may systematically rifle through drawers, pockets or coats. Staff in institutions such as hospital or care home may steal a person's belongings, from their locker or a drawer, for example.

It may be on a larger scale, and committed by a care home manager who takes advantage of lax accounting procedures to plunder the bank accounts of residents.

20.3.2 Perpetrator in professional position of responsibility

Sometimes the theft might be committed by a person in a more formal or professional position of responsibility, such as a lawyer exploiting, through excessive charges, the estates of deceased clients. Even social workers with particular responsibility for patient finances may sometimes commit theft.

Mental health team social worker taking money from patients. A social worker in a mental health team had duties that included looking after the finances of people who use services. She falsely claimed she bought items for a male patient with £680. She had taken the money on the pretext of buying carpets and a mobile phone for the person. She also took money from a female patient in hospital. The judge referred to her cynical abuse of trust. She would have been sent to prison except for her remorse and her young son. (NHS South Coast Audit's Counter Fraud Investigation Team, 2009)

The social worker was also removed from the General Social Care Council's (GSCC) Register.¹

20.3.3 Neighbours involved in theft

In the following case, 'friendly' neighbours were convicted of criminal offences following a social worker's visit:

Neighbours committing large-scale theft. An elderly woman was visited by police and social workers. She was frail, dirty and unkempt. The house smelt of urine. She seemed happy but was confused. Over the previous six years, neighbours (a married couple) had obtained sums of money from her of £110,000. On the basis of the woman's dementia and lack of mental capacity, the couple were convicted of theft and also charges under the Forgery and Counterfeiting Act 1981.²

20.3.4 Theft, gifts and mental capacity

There seems often to be an assumption that if a person makes a gift to somebody else, but is judged probably to have the mental capacity to make that gift, then it could never be regarded as theft. This view often seems to prevail even if the making of the gift is associated with what appears to be serious exploitation.

However, legal case law does not support such a blanket approach. This is because there have been major theft cases in the courts, which concluded that in some circumstances it is open to a jury to find theft. The two leading cases are as follows.

Building society visits, handing over of £60,000 over a period of months to care worker. A man of 'limited intelligence', 53 years old, was assisted and cared for by a 38-year-old woman on a private basis. Over a period of six months, nearly every day, she visited the building society with the man. Each day a withdrawal of £300 was made, ending up in her account. She did most of the talking. Ultimately, all £60,000, inherited from his father, had gone from the man's account. There was some uncertainty about his capacity to make such financial transactions, that is, to make a gift. The woman was convicted of theft but appealed on the basis that if he did have capacity to make a gift, it could never be theft.

On appeal, the House of Lords ruled that it was not crucial as to whether the man had capacity or not. Instead, it was for the jury to decide whether, in all the circumstances, there was dishonesty, even if the man had technically consented to the money changing hands.³

This case supported an earlier one to similar effect.

Stealing from a 99-year-old woman in a care home. A 99-year-old woman lived in a care home. Her affairs came under the control of the two care home owners. They drew cheques on her account and obtained a power of attorney and turned her assets in to cash paid into an account jointly held with the woman. They argued that the woman had made them gifts, and that if the woman had capacity, it could not be theft. The court held that 'dishonest appropriation' in the Theft Act 1968 did not necessarily mean 'without consent'.⁴

20.4 Fraud

Under the Fraud Act 2006, there are three basic fraud offences. These are fraud by (a) false representation, (b) failure to disclose information and (c) abuse of position (Fraud Act 2006, Sections 1–4).

All three are relevant to this guide, but the third in particular because it involves people in a position of trust. It involves a person:

- occupying a position in which he or she is expected to safeguard, or not to act against, the financial interests of another person
- dishonestly abusing that position

- intending, by means of the abuse of that position to make a gain for himself (or for herself) or for another person, or to cause loss to another or to expose another to a risk of loss. The abuse can consist of an omission as well as a positive act.

Explanatory notes to the Act specifically envisage that this offence may be committed, for example, where a person who is employed to care for an elderly or disabled person has access to that person's bank account and abuses their position by transferring funds to invest in a business venture of their own.⁵

Note: Previous offences under Sections 15, 15A and 16 of the Theft Act 1968, of obtaining property, money transfer or pecuniary advantage by deception, were repealed and subsumed by the Fraud Act 2006.

20.4.1 Perpetrator in position of trust

As with theft, fraud may be perpetrated, in a variety of situations and by a range of people in a position of trust. For instance, in the following case an unqualified 'accountant' obtained nearly £700,000 from an elderly woman who believed she was making investments:

Fraudulent 'accountant'. A man was convicted of six offences of procuring the execution of a valuable security (under Section 20[2] of the Theft Act 1968, now repealed by the Fraud Act 2006). He traded as an accountant but was not qualified, certified or chartered. He advised a lady aged 85 to invest large sums in a bank. He used the funds to clear an overdraft that he had incurred with his own bank. He subsequently asked the victim for a further cheque with a view to investment. He arranged for her to pay other sums into an account, on which he drew for his own purposes. The victim noticed that interest normally paid into her bank account had ceased and asked the appellant why this was so. She received no explanation. The total amount obtained by the appellant was approximately £688,000. He was sentenced to a total of nine years in prison.⁶

In a less professional position, but nonetheless one of trust, a carer provided assistance to an 80-year-old housebound woman. The carer did various tasks including collection of the woman's pension. The carer asked the woman to sign blank cheques, which she could then use to pay the woman's utility bills. Instead, for two years, she wrote out cheques to herself and obtained £2,875. She was convicted of obtaining a money transfer by deception.⁷

A male nurse was convicted for stealing £72,000 from a man with Alzheimer's disease and attempting to steal a further £128,000. He admitted obtaining a money transfer by deception, having forged four cheques, three of which were cashed (CPS, 2009d).

Less formally still, a neighbour became friendly with an elderly woman, discovering that the latter had substantial money in various accounts. She arranged to become a co-signatory on one of the accounts. Although a social worker later became involved, the neighbour retained the pass book,

withdrawing £44,000 before closing the account. She was convicted of obtaining money by deception.⁸

20.5 False accounting

Under Section 17 of the Theft Act 1968, false accounting entails dishonesty, with a view to gain or to cause loss to somebody else. It is about destruction, defacing, concealing or falsifying accounts, records or documents. Or it can be about making use of these, when the person knows they may be misleading, false or deceptive.

Care home manager stealing from severely disabled residents. A care home manager had taken over £100,000 from severely disabled, sick and dying residents of the care home. In a position of trust, she had access to residents' bank accounts, cash cards and PINs. Through false accounting she used the home's chequebook, ostensibly to pay for work carried out for the home, but actually to buy things for herself. Through theft she withdrew amounts from residents' accounts unrelated to the residents' expenditure. Through obtaining property by deception she used the home's bank card to obtain things for herself. (*Daily Mail*, 2006)⁹

20.6 Forgery

Under Section 1 of the Forgery and Counterfeiting Act 1981, forgery occurs when a person makes a false document, intending that it be used to induce somebody else to accept it as genuine, and prejudicially to act (or not to act) in respect of that other person or somebody else. For instance, a care assistant regularly opened and read the mail of a woman with multiple sclerosis. Using this position of trust, she forged the woman's signature on a letter to the building society and withdrew £8,000 to pay for a car. The care worker was sentenced to prison for 15 months.¹⁰

20.7 Robbery

Under Section 8 of the Theft Act 1968, a person is guilty of robbery if he or she steals and, immediately before or at the time of doing so and in order to do so, he or she uses force on any person or puts or seeks to put any person in fear of being subjected to force.

In the context of this guide, robbery is included because some robbers will target adults precisely because of their vulnerability.

Person learning with disabilities robbed at home. A person with learning disabilities was known to be vulnerable by three men (he had given money to the child stepson of one of them – he tended to be pestered by children). They pushed him into the hallway, demanded money and stole all his savings, amounting to £100. They punched him in the face. He suffered a fractured cheek bone and eye socket. The perpetrators were sentenced to over five years in prison.¹¹

20.7.1 Targeting vulnerable people and gaining their trust first

There may be intensive targeting of vulnerable people through deliberately gaining their trust in order to breach it. This can blur the line between what practitioners view as abuse by a 'stranger' and abuse of a position of trust. The following resulted in a conviction for robbery:

Gaining trust to commit robbery. An elderly couple lived in a block of flats. The wife was bedridden. The husband had Alzheimer's disease. The perpetrator was a 38-year-old woman. She befriended the couple. She told the wife that her husband owed money to a local shop and that the kettle needed replacing. She offered to sort all this out. She was given £45 by the wife, from underneath her pillow. She borrowed the keys. She did not return. This was anyway theft. Ten days later, she did return disguised with an accomplice. They pushed and hit the wife. They stole £300, papers and bank cards. This was robbery. A further £1,200 was withdrawn from the wife's bank account.¹²

20.8 Burglary

Under Section 9 of the Theft Act 1968, burglary occurs when (a) a person enters a building as a trespasser with the intention of stealing or inflicting grievous bodily harm or doing unlawful damage; and (b) having entered a building, the person steals or attempts to steal something or inflicts or attempts to inflict grievous bodily harm.

In the context of this guide, burglary is included because some burglars will target adults already at risk of harm, precisely because of their vulnerability. The *No secrets* guidance refers to what it calls 'stranger abuse' (DH and Home Office, 2000, para 2.13), and this can involve vulnerable people being specifically targeted for burglary.

20.8.1 Distraction burglary

The following case involved distraction burglary:

Burglar posing as policeman and targeting elderly and vulnerable people. A man committed 38 burglaries within the space of a few months. He posed as a policeman. He visited houses asking that people give him their cash and other valuables for safe keeping at the police station. He would even suggest that people speak on the phone to somebody pretending to be his superior. He targeted mainly elderly, or very elderly, people.

Aggravating features were: professional planning, working as a group, targeting elderly and vulnerable people, inducing fear, the special trauma of posing as police and warning victims of the specific risk of burglary, planning entry into their homes when they were present and leaving them fearing that they might be attacked by criminals and, the last feature common to both appellants, the high value to the victims of the property stolen, either cash or jewellery. The two perpetrators (he had an accomplice) were sentenced to seven and twelve years in prison respectively.

Reference was made to Section 143 of the Criminal Justice Act 2003, in relation to similar offences having been committed before (before committing these burglaries, the man had just been released on licence, having been previously convicted for similar offences).¹³

20.9 Cold calling on adults at risk: criminal offences

Vulnerable adults are particularly at risk of exploitation from 'cold calling' or from other selling techniques in the home.

20.9.1 Difficulties in prosecution

There can be difficulties in charging and prosecuting criminal offences. For example, false (or no) names and addresses may be given. A small amount of token work might be carried out so that the perpetrator can claim that the matter is civil (contractual) rather than criminal in nature. The perpetrator might take a deposit, or drive the victim to the bank to draw out a large sum of money and never return (Trading Standards Institute, 2003).

20.9.2 Consumer protection, theft, forgery legislation etc

Consumer Protection from Unfair Trading Regulations contain a number of offences, for instance, relating to misleading actions or omissions, aggressive practices and unfair practices (SI 2008/1277). Also the Cancellation of Contracts Made in Consumer's Home or Place of Work etc Regulations 2008 provide for create a seven-day cooling off period (SI 2008/1816).

There is other legislation that can be brought to bear. For instance, in the following case the perpetrator was convicted of offences under the Theft Act 1968, the Forgery and Counterfeiting Act 1981 and the Consumer Protection Act 1987:

Selling stairlifts: theft. A man pretended to be a stairlift repairer. He targeted elderly and vulnerable people. He would say that their stairlift was beyond repair, show them advertisements from genuine stairlift suppliers, take their money, take away the old stairlift – and disappear. Prosecuted by the local authority (trading standards), he was convicted under the Theft Act 1968, Consumer Protection Act 1987, and Forgery and Counterfeiting Act 1981. (Devon County Council Trading Standards, 2007)

In the following case, a person selling damp proofing was convicted of conspiracy to obtain property by deception under Section 1 of the Criminal Law Act 1977:

Damp proofing services: conspiracy to defraud elderly and vulnerable people. A man had been part of a conspiracy designed to defraud elderly and vulnerable people. They were told that they needed damp proofing services. They were provided with these services when they were not required and charged exorbitant sums. The services provided were valueless. The offender was a salesman for the company who directly swindled some of the clients.¹⁴

20.9.3 Action against cold calling, doorstep selling etc

In the absence of identifying and prosecuting perpetrators, other approaches can be taken. For example, under Sections 5 and 6 of the Crime and Disorder Act 1998, the police and local authority might agree a local strategy involving the following sort of action:

Cold calling and doorstep selling. An area might be blighted by doorstep selling and 'cold calling', with the result that vulnerable elderly people are being exploited and sometimes having criminal offences (of theft or fraud) committed against them. However, the offenders are very difficult to apprehend. So, apart from identifying and prosecuting where possible, the police and local council introduce a 'no cold calling zone' (such zones can lawfully be designated by local authorities although it is not clear what legal enforcement powers exist).

The council also facilitates the setting up of a gardening service – and also painting the fronts of houses – so that identification of vulnerable people is made less easy. It considers that it is doing this either through its community care powers to assist older people under Section 45 of the Health Services and Public Health Act 1968, or through a more general power to act for the welfare of the local population, under Section 2 of the Local Government Act 2000. It is part of a community safety strategy, agreed with the police as part of the local Crime and Disorder Reduction Partnership under the Crime and Disorder Act 1998.

20.10 Suspicious activity reports

Under the Proceeds of Crime Act 2002, there are particular provisions relating to money laundering. Although these are in large part aimed at large-scale operations, including organised crime and terrorism, the provisions are drawn widely, so as to be relevant to the financial safeguarding of vulnerable adults.

20.10.1 Wide definition of money laundering

Sections 327 to 329 of the Act create a number of money laundering offences in relation to concealing, disguising, converting, transferring or removing from the jurisdiction criminal property; to making arrangements for acquisition, retention, use or control of criminal property by or on behalf of somebody else; and to acquiring, using and possessing criminal property. Criminal property is widely defined.

In addition, it is an offence for staff – working for particular financial bodies such as banks and building societies – to fail to report known or suspected money laundering. The grounds for reporting are that the person (a) knows or suspects, or (b) has reasonable grounds for knowing or suspecting that another person is engaged in money laundering.

20.10.2 Duty on banks and building societies

This means that if banks or building societies suspect criminal activity, including such activity involving vulnerable adults, they must report it by means of a suspicious activity report (known as a SAR). The report goes to the Serious Organised Crime Agency (SOCA) who in practice might then feed the details back down to the local police force.

20.10.3 Application to, for example, dishonest care workers

In terms of use of cash machines by dishonest care workers, for example (a typical type of theft from vulnerable people), computerised systems can pick up unusual transaction patterns. However, if the theft has been regular over an extended period of time, this may not be easily identified. Alternatively, if people are coming physically into branches, staff might more easily pick up suspicious activity.

20.10.4 Good practice guidance

The British Bankers' Association has published a good practice guide for bank staff. It includes two examples of suspicious activity (British Bankers' Association, 2010):

Case studies (British Bankers' Association). In the first case, there had been attempts to obtain several bankers drafts from an elderly customer, to the value of £31,000. The bank staff formed the view that the customer was being exploited by an individual pretending to be a relative. The suspicious activity report was passed on by the SOCA to the police, who were then able to protect the customer.

In a second case, an elderly person attended a building society branch with a carer, and made a several withdrawals up to a value of £2,000. There were also cash point withdrawals, as much as £1,500 in one week. The building society thought the cheque signatures might have been fraudulent; they blocked cash point withdrawals and cheques. A SAR was made. A trusted third party was appointed signatory. No action was ultimately taken against the carer, but the report had the effect of preventing further exploitation.

21 Civil legal remedies for financial and property harm

21 Key points

Apart from criminal law, there are also civil legal remedies relevant to finance and property harm suffered by vulnerable people.

21.1 Undue influence

One of these involves a concept known as 'undue influence'. It applies to gifts and wills. This is where a person has mental capacity to conduct the transaction – the will or the gift – but has had their will overborne not just by the influence, but by the undue influence, of somebody else.

When there is evidence of coercion or undue pressure, this is called 'express' undue influence. However, often there is no such evidence, but instead, there might have been 'presumed' undue influence.

In addition to undue influence, the courts can simply set aside gifts or wills on the grounds that the person lacked capacity at the relevant time.

Legal cases about wills and gifts are heard in the Chancery Division of the High Court that covers an area of law called 'equity'.

21.2 Who will take a case?

On the whole, these are remedies which practitioners or their organisations are unlikely to pursue directly through the courts (although this might happen in some circumstances). However, there are two or three reasons why an awareness of the principles involved might be useful for practitioners.

21.2 Undue influence

A legal, equitable concept called undue influence may provide a legal remedy in relation to suspicious, improper transactions. Undue influence cases generally concern lifetime gifts of property or money, or wills. There are three initial points to make.

First, the unduly influenced person has mental capacity to take the decision in question.¹⁵ Second, the person is influenced to enter into a transaction concerning a gift or will, in such a way that it is not of his or her own free will. Third, there are two legal types of undue influence. One is called 'express' undue influence that applies to both gifts and wills; the other is called 'presumed' undue influence and applies to gifts only.

21.2.1 Undue influence as a social trend involving older vulnerable people

That the issue is relevant to safeguarding vulnerable adults would seem to be borne out by the number of cases in the courts.

21.2.2 Express undue influence

In the case of express undue influence, there needs to be evidence of how the undue influence was exercised, involving explicit improper pressure or coercion.¹⁶

In the following case, a woman was positively frightened of her son, to whom she left everything in a revised will:

Elderly woman frightened by her son into changing her will. An elderly woman changed her will shortly before she died and left everything to her heavy drinking son. She lived with him and was afraid of him. In the last year of her life she had suffered several falls and her health had deteriorated. The court was in no doubt that the mother had been unduly influenced, expressly, and that her discretion and judgement had been overborne. The evidence for this was that the son was fearful for his own security about living in his mother's home, furious with his brother (whom the will disinherited), brought his mother back home from a care home against medical advice and had deterred his brother from visiting. In addition, the mother was frail, vulnerable and frightened.

The mother had made false allegations against the other brother and changed the will; the only explanation for this was that she was 'simply doing as she was told'. The first brother had deliberately poisoned his mother's mind by making deliberately untruthful accusations; the effect was to cause her own discretion and judgement to be overborne. This was undue influence.¹⁷

21.2.3 Presumed undue influence

Presumed undue influence differs from express undue influence. It applies only to gifts, not to wills. There are three key elements revolving around the unequal nature of the relationship between the two people, a disadvantageous transaction and whether an innocent explanation can be given by the person who has benefited.¹⁸

The more detailed explanation of these principles by the courts would seem to show the clear relevance of all this to safeguarding adults.

Trust and confidence: vulnerability, domination, control

Presumed undue influence involves one person taking unfair advantage over another, where the first person has gained influence or ascendancy without any overt acts of persuasion. The second person will have reposed trust and confidence in the first.

Proving presumed undue influence

Proof, on the balance of probability, has to be made out by the person alleging that presumed undue influence has been exercised. However, if trust and confidence is shown, together with a transaction that at the very least calls for an explanation, the so-called 'evidential burden' moves across to the other person to provide an innocent explanation. In other words, the influence is presumed unless the other person can rebut the presumption.¹⁹

Seeking independent advice

The courts put considerable store by evidence of whether the vulnerable person sought independent (professional) advice about the transaction. Such advice is relevant to showing that presumed undue influence was not in issue, although it is not decisive.²⁰

So-called independent advice may not be of value, for example, if there was a conflict of interest where a solicitor acts for both parties,²¹ or where the advice is simply poor and so does not free the person from the undue influence.²²

Undue influence and safeguarding

Involving vulnerable adults as they generally do, cases of undue influence are clearly relevant to safeguarding.

For practitioners, the following case is particularly relevant involving, as it apparently did, the local authority in facilitating the exploitation of an elderly man by a seemingly kindly and helpful neighbour. It is also of interest because the courts emphasised that undue influence can be found, even if there is no evidence of wrongdoing – a notable contrast, for example, with the requirements of criminal law.

Friendly neighbour unduly influencing elderly man to part with most of his savings.

A 72-year-old man lived alone. He was a retired teacher. His limited mobility had made him increasingly dependent. He met a neighbour in the supermarket, when he was in some distress and holding on to the railings. She 'took him under her wing'. Following a hospital admission, he became more dependent. She volunteered to the 'care authorities' (presumably social services) to give two meals a day. The care coordinator suggested he sign a third party mandate giving her access to his bank account. After he had deteriorated further, he gave her nearly £300,000, amounting to about 90 per cent of his liquid assets. This occurred some 18 months or so after they had first met in the supermarket.

The court found undue influence. This was irrespective of the woman's conduct; even had it been 'unimpeachable', public policy demanded that the court interfere – in the absence of an innocent explanation. It had to be established affirmatively that the relationship of trust and confidence had not been betrayed or abused.²³

21.2.4 Safeguarding interventions and undue influence

Interventions by practitioners involved in safeguarding might not seem straightforward in relation to undue influence, since many cases are brought by family members, often when the vulnerable person has died. However, there are various possibilities.

First, in appropriate circumstances, if practitioners are sufficiently concerned about what they believe is likely to be undue influence, it may be appropriate to suggest to the person that he or she seeks independent advice. For instance, it would be normal

for anybody to seek advice from a professional such as a solicitor or accountant before entering a major financial transaction.

Second, it is possible in some circumstances that undue influence could be associated with a criminal offence, in which case it might be a police matter. Although undue influence is a concept in civil, equitable law – not criminal law – nonetheless it may in substance be relevant to a criminal conviction.

This was explicitly mentioned in a major theft case, in which the courts confirmed that the making of a 'gift' by a person with capacity to make it could, in some circumstances, still amount to theft. This was on the basis of dishonesty, with reference to the fact that the notion of undue influence might be relevant to establishing that dishonesty.²⁴

Third, undue influence cases do not relate to dead people only. For instance, a living person can bring a case, arguing that he or she had been unduly influenced, but is no longer, and now seeks redress.²⁵ In the following case an elderly man had effectively lost his house because of the undue influence of his nephew:

Elderly man unduly influenced by his nephew. An elderly man's nephew persuaded him to sell his house and put the money (£43,000) toward a new house costing £83,000, which was put in the nephew's name. This was on condition that the uncle could live there for the rest of his life. The nephew defaulted on the mortgage payments and the lender sought possession. The uncle argued that he had been unduly influenced and should be given his money back ahead of the lender. The Court of Appeal agreed, stating that he was entitled to money back, but only in proportion to the sale price (considerably less than the purchase price).²⁶

21.3 Lack of capacity: gifts and wills

If gifts or wills are made by a person lacking capacity to do so at the relevant time, they can be set aside by the courts. Such cases are not decided by the Court of Protection but by the High Court. Although there is now a general legal definition of mental capacity within the Mental Capacity Act 2005, there are also 'common law' definitions of what capacity means in relation to the making of wills or gifts. These remain relevant.

21.3.1 Mental capacity and wills

The test of capacity for wills, developed in the common law is:

Test of capacity for wills. 'It is essential ... that a testator shall understand the nature of the act and its effects; shall understand the extent of the property of which he is disposing; shall be able to comprehend and appreciate the claims to which he ought to give effect; and, with a view to the latter object, that no disorder of mind shall poison his affections, pervert his sense of right, or prevent the exercise of his natural faculties – that no insane delusion shall influence his

will in disposing of his property and bring about a disposal of it which, if the mind had been sound, would not have been made.'²⁷

The following case, already mentioned, has obvious relevance to safeguarding and the possible exploitation of a vulnerable woman lacking capacity by an 'old friend':

Judging whether a woman had a lucid period to make a will in favour of an old friend. An 84-year-old woman was admitted to hospital with uncontrolled diabetes and dehydration. She had become increasingly confused. Two weeks or so later, she was discharged home. She lived with her sister. A longstanding friend now suggested she make a will, making the friend both executor and beneficiary.

Accordingly, the friend had her brother-in-law draw up the will. The friend then organised execution (signing, witnessing etc) of the will a couple of weeks later, at a time when the sister was out. A year later the woman died. The will was subsequently challenged. The court concluded that on the evidence she lacked capacity on the day the will was executed. That morning, a GP had visited her. Later that day, a neighbour had visited. Both had found her confused (caused by the diabetes and the drug regime she was on).

The court decided that it was not credible that the woman had regained lucidity in between these two visits in order to execute the will. The will could not stand.²⁸

21.3.2 Mental capacity and gifts

In relation to a gift, the common law test for capacity is:

Test of capacity for gifts. 'The degree or extent of understanding required in respect of any instrument is relative to the particular transaction which it is to effect.... Thus, at one extreme, if the subject matter and value of a gift are trivial in relation to the donor's other assets, a low degree of understanding will suffice. But, at the other, if its effect is to dispose of the donor's only asset of value and thus, for practical purposes, to pre-empt the devolution of his estate under the ... will ... then the degree of understanding required is as high as that required for a will, and the donor must understand the claims of all potential donees and the extent of the property to be disposed of.'²⁹

21.4 Relying on assurances or promises: proprietary estoppel

A further legal, equitable principle exists, called 'proprietary estoppel'. It may be useful for practitioners to be aware of this, because it might provide an innocent explanation of what might otherwise look like a suspicious transaction.

The key principle involved is that a person (for instance, a carer or neighbour) has acted to his or her own detriment by providing services to a second person, on the basis of – and relying on – assurances made by that second person.

For instance, in the following case a man had provided more and more help and assistance to a woman for over 10 years for little payment, against some sort of promise that he would inherit from the woman:

Elderly woman promising to leave her house to person who helped her for 10 years. It started with the gardening service for an elderly woman provided by a self-employed bricklayer. She became more incapacitated. He started to help her, collecting prescriptions, helping her dress, get to the toilet, providing food – and still helping in the garden. For the last 10 years he had done this without payment. In answer to his concerns, she told him not to worry, 'this will all be yours one day'. She died without having made a will. The case went to court, which held that he had equitable interest of £200,000 out of the house and furniture valued at £435,000. This was on the basis of proprietary estoppel.³⁰

Notes

¹ *Buchanan v General Social Care Council*, Conduct Committee, July 2009.

² *R v Bowles (Lewis) and Bowles (Christine)* [2004] EWCA Crim 1608.

³ *R v Hinks* [2001] 2 AC 241 (House of Lords).

⁴ *R v Kendrick* [1997] 2 Cr App 524.

⁵ www.legislation.gov.uk/ukpga/2006/35/notes/contents

⁶ *R v Duggan* [1999] 2 Cr App R(S) 65.

⁷ *R v Roach* [2001] EWCA Crim 992.

⁸ *R v Starsmeare* [2003] EWCA Crim 577.

⁹ *R v Forbes* [2007] EWCA Crim 621.

¹⁰ *R v Ross-Goulding* [1997] 2 Criminal Appeal Reports (S) 348.

¹¹ *R v Randall* [2005] 1 Criminal Appeal Reports (S) 60.

¹² *R v Moss* [2005] EWCA Crim 133.

¹³ *R v Casey* [2007] EWCA Crim 2568.

¹⁴ *R v Chen* [2009] EWCA Crim 2669.

¹⁵ *Tchilingirian v Ouzounian* [2003] EWHC 1220 (Chancery).

¹⁶ *Royal Bank of Scotland v Etridge (no 2)* [2001] UKHL 44.

¹⁷ *Edwards v Edwards* [2007] EWHC 1119 (Ch).

- ¹⁸ *Pesticcio v Huet* [2004] EWCA Civ 372.
- ¹⁹ *Royal Bank of Scotland v Etridge (no.2)* [2001] UKHL 44.
- ²⁰ *Royal Bank of Scotland v Etridge (no.2)* [2001] UKHL 44.
- ²¹ *Re Craig* [1970] 2 All ER 390 (High Court).
- ²² *Pesticcio v Huet* [2004] EWCA Civ 372.
- ²³ *Hammond v Osborne* [2002] EWCA Civ 885.
- ²⁴ *R v Hinks* [2001] 2 AC 241 (House of Lords).
- ²⁵ *Royal Bank of Scotland v Etridge (no 2)* [2001] UKHL 44.
- ²⁶ *Cheese v Thomas* [1994] 1 All ER 35, Court of Appeal.
- ²⁷ *Banks v Goodfellow* [1870] LR 5 QB 549.
- ²⁸ *Richards v Allan* [2001] WTLR 1031.
- ²⁹ *Re Beaney (deceased)* [1978] 1 WLR 770.
- ³⁰ *Jennings v Rice* [2002] EWCA Civ 159.

Part 7: Physical (and psychological) harm

- 22** Criminal offences: physical harm to the person
- 23** Sexual offences
- 24** Protective orders, injunctions and other interventions

22 Criminal offences: physical harm to the person

22.1 Key points

A key part of the *No secrets* guidance and policy is that vulnerable adults should have access to justice. There has been a concern that sometimes behaviour perpetrated against vulnerable adults that clearly constitutes a crime is instead labelled 'abuse' and not treated as a crime.

22.1.1 Assault, battery, manslaughter etc

There is a wide range of criminal offences that may apply both to seemingly lesser and to the most extreme, harm. These include assault and battery, more serious bodily harm, manslaughter (including corporate manslaughter), assisted suicide, attempted murder and murder, and the offences of ill treatment or wilful neglect.

In addition there is an offence of causing or allowing the death of a vulnerable adult, as well as specific offences of ill treatment or wilful neglect applying to people who either lack capacity or have a mental disorder.

In some circumstances, health and safety at work legislation will be relevant, particularly where systems of work in health and social care put vulnerable people at risk of physical harm or more explicit abuse.

22.2 Assault and battery

Common assault and battery are commonly used terms, often inter-changeably. It seems that they are common law offences, but sentences are governed by Section 39 of the Criminal Justice Act 1988. The maximum sentence is six months' imprisonment.

22.2.1 Assault: threat

Technically, however, assault means that a person intentionally or recklessly causes somebody else to apprehend or anticipate any immediate and unlawful violence or touching.¹ Assault is often associated with the subsequent touching (the battery) and the word 'assault' is generally used to indicate the battery. However, assault need not be associated with the battery; an assault could stop at the threat. Thus, were a carer to threaten – for example, with a raised hand – the person being cared for, this could constitute an assault.

22.2.2 Battery: unlawful touching

Battery means that a person intentionally or recklessly applies unlawful force to somebody else, in the form of intentional touching of another person without the consent of that person and without lawful excuse. It need not necessarily be hostile, rude or aggressive.²

22.2.3 Assault, battery and safeguarding

In any event, both offences are highly relevant to the safeguarding of adults at risk of harm. Assault and battery might typically be charged for injuries such as grazes, scratches, abrasions, minor bruising, swellings, reddening of the skin, superficial cuts or a black eye (CPS, no date: a).

Assault involving staff working with vulnerable people could include, for example, care workers bending back the thumbs of care home residents, a nurse stuffing deodorant into the mouth of a 95-year old man, a nurse slapping nursing home residents across the face, a care worker throwing a cup of tea at a care home resident for not standing up or rough manual massage for constipation.

22.3 Actual bodily harm

A more serious offence than common assault and battery is assault occasioning bodily harm. This is an offence under Section 47 of the Offences Against the Person Act 1861. It carries a maximum of five years' imprisonment.

22.3.1 Type of injury

The type of injury typically associated with such an offence includes loss or breaking of a tooth or teeth, temporary loss of sensory functions including consciousness, extensive or multiple bruising, displaced or broken nose, minor fractures, minor but not superficial cuts or psychiatric injury (that is more than just fear, distress or panic) (CPS, no date: a).

However, actual bodily harm need not involve physical contact, so a severe depressive illness resulting from non-physical harassment, like stalking, could count:

Bodily harm in form of psychiatric harm resulting from harassment. For some eight months, a man subjected a woman to silent telephone calls, distributed offensive cards in the street, sent threatening notes, appeared at her place of work and her home and took photographs of her and her family. Such psychiatric harm as she suffered (a severe depressive illness) was capable of being actual bodily harm under Section 47 of the Act, or grievous bodily harm under Section 20.³

22.4 Unlawful wounding or infliction of grievous bodily harm

Offences of wounding or infliction of grievous bodily harm, unlawfully and maliciously, come under Section 18 and Section 20 of the Offences Against the Person Act 1861.

Wounding is typically associated with more serious cuts or lacerations, as opposed to more minor ones. Grievous bodily harm is typically associated with serious bodily harm including, for example, injury resulting in permanent disability or permanent loss of sensory function, more than minor, permanent, visible disfigurement, broken

bones, compound fractures, substantial loss of blood, injuries resulting in lengthy treatment or incapacity or psychiatric injury (CPS, no date: a).

In the following case, the court made clear the inevitability of long prison sentences if the victims are elderly or otherwise vulnerable:

Targeting of elderly couple: grievous bodily harm. The offender had been smoking crack cocaine at a house near to where the victims, an elderly couple, lived. Later that night he broke in their house to steal money. He attacked the man, hit him, jumped on him and used his keys as a knuckle duster. He pushed the husband down the stairs. He kicked and punched the wife. He stole £80. The victims were taken to hospital for multiple bruising and abrasions. The woman was placed in a care home where, several days later, she fell off a commode, hit her head and consequently died. The court wished to make clear that 'those who select elderly or otherwise vulnerable people as victims and then invade their homes in search of gain will receive very severe sentences indeed'. A sentence of 12 years was settled on.⁴

22.5 Common law offence of false imprisonment

False imprisonment is a common law offence involving the unlawful, intentional or reckless detention (restraint of freedom of movement of a person). For instance, the following case was reported as involving false imprisonment:

False imprisonment in a shed. When a vulnerable and epileptic man died after being kept in a shed for four months by three people who had befriended him, it could not be proved that his death was not due to the epilepsy. This even though he had extensive bruising and burn marks. The three were convicted of assault, of causing actual bodily harm and of false imprisonment – and sentenced to prison for 10 years. (de Bruxelles, 2007)

22.6 Manslaughter

Manslaughter is an offence that comes in different forms, some in common law (developed by the courts), some in legislation.

Manslaughter is of direct relevance to safeguarding. It can arise in respect of the actions of professionals and other practitioners treating or caring for vulnerable people; the actions of family relatives, friends or acquaintances; or the corporate, institutional actions of organisations involved in caring or treating people.

The different types of manslaughter are voluntary (through diminished responsibility) or corporate manslaughter. In addition, there is now a statutory offence of corporate manslaughter.

Involuntary manslaughter falls into two main categories: (a) gross negligence or recklessness, or (b) an unlawful act.

22.6.1 Involuntary manslaughter: gross negligence or recklessness

Gross negligence should be contrasted with ordinary negligence; even if death has resulted, the latter would give rise to a civil case for compensation only. The element of grossness is required to make the death a criminal matter.

Negligence or gross negligence. When a disabled person drowned in the bath in a local authority care home, the court pointed out that there might have been carelessness, but that criminality or badness, in terms of recklessness, were required for manslaughter.⁵

Manslaughter involving perpetrators who themselves might be vulnerable

The question of manslaughter, from gross negligence or recklessness, arises not just in relation to service providers, but also to family members or friends. In some cases, the perpetrators, as well as the victim, were arguably vulnerable adults themselves.

The following case involved the lack of care provided for a person by a close relative, which resulted in the person's death in the relative's home – death from toxæmia, spreading because of infected bedsores, immobilisation and lack of food.

Neglect of infirm sister. A couple were convicted of the manslaughter of the man's sister. The man himself was partially deaf, almost blind man and of low intelligence. His 'mistress' was described as ineffectual and inadequate. The man's mentally impaired son lived with them. The man's sister came to stay, living in a room without ventilation, toilet or washing facilities save for a bucket. The sister spent days on end in the room, denying herself proper food. After three years she was very infirm. The couple made initial half-hearted efforts, then no efforts to do anything about this. They did not even tell the social worker who used to visit the son.⁶

On appeal, the Court of Appeal upheld but reduced the sentences imposed. It summarised the element of recklessness that constituted manslaughter:

Recklessness as to health and welfare of infirm person. The duty which a defendant has undertaken is a duty of caring for the health and welfare of the infirm person. What the prosecution have to prove is a breach of that duty in such circumstances that the jury feel convinced that the defendant's conduct can properly be described as reckless, that is to say a reckless disregard of danger to the health and welfare of the infirm person. Mere inadvertence is not enough. The defendant must be proved to have been indifferent to an obvious risk of injury to health, or actually to have foreseen the risk but to have determined nevertheless to run it.⁷

Involuntary manslaughter: unlawful act

Involuntary manslaughter occurs if the accused person intentionally did an act that was unlawful and dangerous and that that act inadvertently caused death.

It is unnecessary to prove that the accused knew that the act was unlawful or dangerous. The test is an objective one – whether reasonable people would recognise that the act was dangerous. It is not whether the accused recognised its danger.⁸ The following case, involving the death of a man with learning disabilities, was one of an unlawful act of manslaughter:

Physical abuse of man with learning disabilities by teenagers before death in river.
A man with learning disabilities was subjected to extensive physical abuse by a group of teenagers in his home. In the end they poured bleach on him and threw him into a river where he drowned. It was stated that he was a heavy drinker and had the capacity to make his own day-to-day decisions. The perpetrators were imprisoned for life for manslaughter. (Carter, 2007)

22.6.2 Voluntary manslaughter

Voluntary manslaughter occurs when a charge of murder is reduced to manslaughter because of diminished responsibility, provocation or a suicide pact.

Diminished responsibility means that the accused was suffering from such abnormality of mind, whether arising from a condition of arrested or retarded development of mind or any inherent causes or induced by disease or injury, so as substantially to have impaired his or her mental responsibility for his or acts omissions in doing or being a party to the killing (Homicide Act 1957, Section 2).

22.6.3 Corporate Manslaughter and Corporate Homicide Act 2007

Corporate manslaughter comes under the Corporate Manslaughter and Corporate Homicide Act 2007. Under the Act, an organisation commits the offence of corporate manslaughter where (a) it owes a duty of care, (b) it grossly breaches that duty because of how its activities are managed or organised, and (c) a person's death results.

Link to senior management

The way in which an organisation's activities are managed or organised by its senior management must be a substantial element of the breach in the duty of care.

Senior management means the people who play significant roles in (a) the making of decisions about how the whole or a substantial part of the organisation's activities are to be managed or organised, or (b) the actual managing or organising of the whole or a substantial part of those activities.

A breach of the duty of care is gross if it falls far below what can be reasonably be expected of the organisation in the circumstances. However, the Act does not apply to a duty of care in relation to matters of public policy, and in particular the allocation of public resources or the weighing of competing public interests. The Act also does not yet apply to patients detained under the Mental Health Act 1983.

Alleged breach linked to health and safety at work legislation

If the alleged breach, leading to death, has followed from a failure to comply with health and safety legislation, the jury has to consider how serious that failure was and how much of a risk of death it posed. The jury may also (a) consider the extent to which, on the evidence, there were attitudes, policies, systems or accepted practices that were likely to have encouraged any such failure; and (b) have regard to any health and safety guidance that relates to the alleged breach.

Conviction

Conviction can result in an unlimited fine being imposed on the organisation. The Act provides for remedial orders being made by the court, forcing the organisation to remedy the problems that led to the breach, and also for publicity orders forcing the organisation to publish details of the conviction.

22.7 Murder

Murder occurs when a person of sound mind unlawfully kills a human being with intent to kill or cause grievous bodily harm (CPS, no date: b). In the context of safeguarding there have been a number of cases involving vulnerable adults.

22.8 Attempted murder

Under Section 1 of the Criminal Attempts Act 1981, attempted murder occurs when a person does an act that is more than merely preparatory to murder, with an intention to kill.

22.9 Assisted suicide

Under the Suicide Act 1961 (amended by the Coroners and Justice Act of 2009), it is an offence to do something which is capable of encouraging or assisting the suicide or attempted suicide of another person, and was intended to encourage or assist suicide or an attempt at suicide. The offence can be committed even if the act does not result in suicide or attempted suicide.

In addition, if a person arranges for a second person to commit such an act, then the first person as well as the second will be liable. Furthermore, if there is encouragement or assistance – even when the act could in reality not be such an effective encouragement or assistance – then an offence could still be committed, for example, if the person believes he or she is giving the victim a lethal drug, when it is in fact harmless.

Threats and pressure amount to encouragement or assistance.

22.9.1 Guidelines about assisted suicide

The offence has received considerable publicity in recent years and is clearly a potential safeguarding matter, with which local authorities, the NHS, the police and

Crown Prosecution Service (CPS) have to deal. The Director of Public Prosecutions has published guidelines about prosecution in assisted suicide cases, in order to give greater certainty to the issue of prosecution. The guidelines do not change the law, but set out public interest factors both for and against prosecution (Director of Public Prosecutions, 2010).

In the following case, the question arose as to what local social services authorities should do in relation to their safeguarding work under community care legislation and the *No secrets* guidance:

Local authority assessment and investigation: proposed assisted suicide. A woman had cerebellar ataxia, which was incurable and irreversible. It affected her motor functions; she was increasingly disabled. She wanted to be assisted to commit suicide. Reluctantly her husband, initially opposed to this, agreed. The proposal was to take her to a clinic in Switzerland for this purpose. The husband told the local authority, which was involved in caring for his wife.

The local authority wasn't sure what to do and applied to the courts. The court stated that the local authority should investigate whether she had mental capacity to make this decision, and what her true intentions were. It should also consider what influences may have been brought to bear and whether she had relevant information and was aware of available options. If she did have capacity, this did not preclude the local authority giving her advice assistance about what it thought her best course of action might be. If the local authority believed that a criminal offence was going to be committed, it should inform the police.

By the time of the hearing, it was clear that the woman did have capacity. The local authority had at the outset obtained an injunction from the High Court preventing her husband taking her to Switzerland. The Court stated there was no need for continuing the injunction. Criminal justice agencies had the requisite powers; and any continuing injunction would 'deny a right to a seriously disabled but competent person that cannot be exercised herself by reason only of her physical disability'. There was nothing more that the local authority could do.¹⁰

22.10 Wilful neglect or ill treatment

Offences of wilful neglect or ill treatment come under both the Mental Capacity Act 2005 and the Mental Health Act 1983.

The offences of ill treatment (generally more deliberate) and wilful neglect (tending toward omission, albeit with intent or recklessness) cover a wide range of behaviour perpetrated on vulnerable adults.

This could include, for instance, positive hitting, dragging, pinching, bullying, verbally abusing; inciting residents or patients to fight each other; distressing people by leaving them locked up in motor vehicles; carrying out care procedures roughly; or omitting to provide adequate basic care.

22.10.1 Wide application of the offences in the two Acts

It is not necessary under the 1983 Act that the person be detained or subject to compulsion under that Act. For instance, it is enough that the person be in a nursing home for treatment for mental disorder, or is simply in the care of anybody at all.

This means that the case law under Section 127, in terms of the rules and examples of how those rules have been applied, are directly relevant to Section 44 of the 2005 Act. Likewise, under Section 44 of the Mental Capacity Act 2005, it is enough if the person lacking capacity is in the care of somebody else, wherever.

22.10.2 Offences only apply in case of mental incapacity or mental disorder

If there is no lack of mental capacity and no mental disorder, then – no matter how ill, vulnerable and helpless a person is – there is in English law no offence of wilful neglect or ill treatment. However, if under Section 44 of Mental Capacity Act 2005 a person does not lack capacity, but the perpetrator believed that he or she did lack capacity, then a prosecution can still take place (CPS, 2008, p 31).

22.10.3 Wilful neglect or ill treatment: Mental Capacity Act 2005

Under Section 44 of the Mental Capacity Act 2005 the offence of ill treatment or wilful neglect is committed (a) by a person who has the care of another person who lacks, or who the first person reasonably believes to lack, capacity, or (b) by any deputy or person with lasting power of attorney under the 2005 Act, or (c) by any person with enduring power of attorney as created under previous legislation. The maximum sentence is five years in prison (Section 44).

These provisions have wide application. The person need not be in hospital or in a formal care setting; it is enough if the mentally incapacitated person is in the care of someone else.

The terms 'ill treatment' or 'wilful neglect' are not defined in the Act. The Mental Capacity Act 2005 *Code of practice* states that:

- the offences are separate
- ill treatment involves deliberation or recklessness and it does not matter whether the behaviour was likely to cause, or actually caused, harm or damage to the victim's health
- the meaning of wilful neglect varies with circumstances but usually means that a person has deliberately failed to do something he or she knew was a duty (DCA, 2007, p 252).

The terms have been interpreted by the courts in relation to the equivalent offence under Section 127 of the Mental Health Act 1983 (see below).

22.10.4 Examples of convictions under the 2005 Act

Convictions under the 2005 Act have included, for example, situations in which people with learning disabilities were locked in a car for several hours on a hot day (*Daily Mail*, 2008); a person with a learning disability left in a van for some time;¹¹ an elderly care home resident had a picture taken and circulated of her, semi-naked (Cambridgeshire County Council, 2009); and a nursing home worker pushing, hitting and flicking food at residents (*Liverpool Echo*, 2010; *Liverpool News*, 2010).

22.10.5 Wilful neglect or ill treatment: Mental Health Act 1983

Under Section 127 of the Mental Health Act 1983, it is an offence for employees or managers of a hospital, independent hospital or care home to ill treat or wilfully neglect a person receiving treatment for mental disorder as an inpatient in that hospital or home. The maximum sentence is five years in prison.

It is similarly an offence on the part of employees or managers of such a hospital or care home to ill treat or wilfully neglect – on the premises of which the hospital or home forms a part – a patient receiving such treatment as an outpatient.

It is also an offence for any individual to ill treat or to wilfully neglect a mentally disordered patient who is (a) subject to his or her guardianship under the 1983 Act or (b) otherwise in his or her custody or care.

The provisions therefore have wide application. The person need not be in hospital or in a formal care setting; it is enough if the mentally disordered person is in the care of someone else.

No proceedings can be brought under Section 127 unless the Director of Public Prosecution brings, or at least gives consent to, such proceedings.

Definition of ill treatment and wilful neglect

The courts have held that ill treatment and wilful neglect are separate offences requiring separate charges. The offence does not necessarily require that the ill treatment must have resulted in actual injury to the patient or at least have caused him or her unnecessary suffering or injury to health.¹²

The courts held in the same case that wilful neglect is a failure to act when a moral duty demands it, whereas ill treatment is a deliberate course of action.¹³

22.10.6 Wilful neglect

In a Court of Appeal case under Section 127, involving a man's death in a care home, the courts stated that there needed to be both an objective breach of a duty of care, and an element of subjective (that is, in the mind of the perpetrator) intention or recklessness. The wilful neglect involved leaving a man with frontal lobe dementia to die, alone.¹⁴

Examples of convictions for ill treatment or wilful neglect

There have been a significant number of other convictions under Section 127 of the Mental Health Act 1983, of which the following are a few examples.

Since the implementation of the Mental Capacity Act 2005, there appears to have been considerable attention paid by practitioners to Section 44 of that Act.

It may be that Section 127 is not as widely known. Its possible advantage over Section 44 lies in the fact that it is available in the case of a person with any form of mental disorder, whereas Section 44 is restricted to a person lacking mental capacity.

For instance, one conviction involved a residential home care worker pulling the hair and nipping the nose of a resident with severe learning disabilities:

Hair pulling (ill treatment) and isolation of resident (wilful neglect). A care worker was convicted of ill treatment. She had pulled the hair and nipped the nose of a resident aged 37. The latter had a developmental age of two years. She had epilepsy and severe learning disabilities. The care worker was also convicted of wilful neglect. This was for leaving a male resident in a sensory room by himself for too long. The resident was 54 years old but with a developmental age of 12 months. He was severely physically and mentally disabled, had had meningitis, was epileptic, communicated by grunting only, and was paralysed to some extent in all four limbs. The care worker was sentenced to three months' imprisonment.¹⁵

Other cases have reportedly involved a nursing home care worker placing a bag over the head of an 88-year-old resident struggling to breathe (McKeever, 2007);¹⁶ inciting care home residents to racially abuse and to kick each other (Gadelrab, 2006); misuse of sedatives to keep residents quiet, kicking footballs at them, leaving them naked and exposed by open windows (BBC News, 2001); and bullying, kicking, slapping, nipping, hair-tugging, force feeding, and face being rubbed in urine (Wood, 2005).

22.11 Causing or allowing the death of a vulnerable adult

Under the Domestic Violence, Crime and Victims Act 2004, it is an offence to cause or to allow the death of a vulnerable adult. The ingredients of the offence are as follows, covering a vulnerable adult who dies when a member of the household had either caused or allowed the death:

- *Death of vulnerable adult.* It involves a vulnerable adult dying as the result of an unlawful act.
- *Member of household.* The person who committed the act must have been a member of the same household and had frequent contact with the victim.
- *Not necessarily living in the dwelling.* To be a member of the household, the person does not have to have lived there, if he or she visited frequently for such periods of time that it would be reasonable to consider him or her a member of that household.

- *Significant risk.* The victim must have been at significant risk of serious physical harm by an unlawful act by such a member of the household.
- *Direct causation or omission.* The defendant must either have directly caused the death of the victim, or (i) at least was, or should have been, aware of the risk, (ii) failed to take reasonable steps to protect the victim, and (iii) the act occurred in circumstances that the defendant foresaw or should have foreseen.
- *Definition of vulnerable adult.* A vulnerable adult is defined to mean a person aged 16 or over whose ability to protect himself or herself from violence, abuse or neglect is significantly impaired through physical or mental disability or illness, through old age or otherwise.

The maximum sentence is 14 years' imprisonment.

22.11.1 Where precise perpetrator is unknown

One of the purposes of the offence is to overcome the problem of showing which of two perpetrators was responsible for a person's death, when it must have been one of them, but both are denying it or blaming each other.

In relation to vulnerable adults, the Act was passed with the following sort of case in mind. It occurred in 2001. It involved a 78-year-old woman who had gone to live with relatives. Five weeks she was dead, having suffered 49 injuries. All the relatives denied responsibility, and no criminal charges were laid (Hamilton, 2005).

In the following case, a conviction followed under the Act:

Family members convicted following death of woman. A 19-year-old woman was systematically beaten and abused by her husband for months – having been the victim of at least three distinct episodes of serious violence. She died with 15 broken ribs and with 85 per cent of her body bruised. The culmination was a severe and fatal attack in the garage. After it, the husband carried her to the bath, put her in it and pretended she had drowned. The husband was convicted of murder. His mother, two sisters and a brother-in-law were found guilty of allowing the death of a vulnerable adult – they had done nothing despite the obvious risk that the woman was at.¹⁷

In this last case, the convicted family members appealed, arguing that the dead woman was not vulnerable within the meaning of the Act. The Court of Appeal dismissed this argument, pointing out that even a person who is physically young and fit can be vulnerable under the Act:

Vulnerability of physically young and fit adult. An 'adult who is utterly dependent on others, even if physically young and apparently fit, may fall within the protective ambit of the Act'. Thus, a major attack on the woman had occurred three weeks earlier; from that point on she was vulnerable within the meaning of the legislation. The court noted that in some circumstances, such a person might come within the Act even before the infliction of violent injuries – if she or he was exposed to a serious risk of physical harm even prior to such an attack.¹⁸

22.12 Harassment

Guidance from the Association of Chief Police Officers notes that failure to deal with harassment may leave a victim or others at serious risk. It also states that legal case law now suggests that the police force may be subject to legal challenge under the Human Rights Act 1998, if it does not respond reasonably in trying to protect people.

22.12.1 Criminal offences associated with harassment

The same guidance draws attention to some (not all) of the criminal offences that may apply to some form of harassment of a vulnerable adult, or anybody else (ACPO and NPIA, 2009):

Sending letters or other articles with intent to cause distress or anxiety. Includes letter, electronic communication, telephone call or other article (Malicious Communications Act 1988).

Harassment. A course of conduct that causes harassment, alarm or distress (Protection from Harassment Act, Section 2).

Putting people in fear of violence. Conduct that causes another to fear on two or more occasions that violence will be used against them (Protection from Harassment Act, Section 4).

Racially or religiously aggravated harassment or fear of violence. A racially or religiously aggravated offence under Section 2 or Section 4 of the Protection from Harassment Act 1997 (Crime and Disorder Act 1998, Section 32).

Improper use of public electronic communications system. (Section 1) Sending, or causing to be sent, a message or other matter that is indecent, obscene, of menacing character or grossly offensive. (Section 2) For the purpose of causing annoyance, inconvenience or needless anxiety, causes a message to be sent or makes persistent use of a public electronic communications network or sends a message which he or she knows to be false (Communications Act 2003, Section 127).

Fear or provocation of violence. Using threatening, abusive or insulting words or behaviour. Or displaying or distributing threatening, abusive or insulting writing, signs or other visible representation. Intending to cause the victim to fear immediate unlawful violence against them or another, to provoke such violence, or where it is likely that a person will believe that such violence will be used, or where it is likely that such violence will be provoked. This offence does not apply if the people involved are all in a dwelling, not necessarily the same one (Public Order Act 1986, Section 4).

Intentional harassment, harm or distress. Using threatening, abusive or insulting words or behaviour. Or displaying or distributing threatening, abusive or insulting writing, signs or other visible representation. Intending to cause a person harassment, alarm or distress and actually causing this to that person or another. This offence does not

apply if the people involved are all in a dwelling, not necessarily the same one (Public Order Act 1986, Section 4A).

Harassment, alarm or distress. Using threatening, abusive or insulting words or behaviour, or distributing or displaying writing, signs or other visible representations which are threatening, abusive or insulting within the hearing or sight of a person likely to be caused harassment, alarm or distress by this conduct. This offence does not apply if the people involved are all in a dwelling, not necessarily the same one (Public Order Act 1986, Section 5).

Threats to kill. Threatening to kill any person with intent that the person to whom the threat is made will fear the threat would be carried out (Offences Against the Person Act 1861, Section 16).

Witness/juror intimidation. Intentionally intimidating a witness, victim or juror in an offence, intending to obstruct, pervert or interfere with the investigation or course of justice. Intentionally harming, or threatening harm, knowing that the person has been a victim, witness or juror in criminal proceedings (Criminal Justice and Public Order Act 1994, Section 51).

22.12.2 Protection from Harassment Act 1997

The 1997 Act creates a criminal offence of harassment, punishable by a fine or up to six months' imprisonment (Protection from Harassment Act 1997, Section 2).

It has been argued that a person's mental disorder may mean that he or she may not realise that the course of conduct is harassment. The Act states it is about whether the person knew or ought to have known this, and that the 'ought' is about what a reasonable person would have thought.

Harassment by person with schizophrenia. A man with schizophrenia had written abusive letters to his Member of Parliament, who had felt threatened, suffered nightmares and had to alter family life as a result. The court held that conduct with which the Act was concerned was likely to be pursued by those with obsessive or unusual psychological make-up, including those with an identifiable mental illness. So, the sentence – conviction under Section 2 of the Act and the imposition of a restraining order – was upheld.²⁰

22.12.3 Criminal offence of putting people in fear of violence

There is a further criminal offence in the protection from Harassment Act 1997 of putting a person in fear of violence (Section 4). The offence is defined as the perpetrator pursuing a course of conduct that causes somebody else (on at least two occasions) that violence will be used against him or her. The perpetrator has to know, or ought to have known, that the course of conduct would cause the other person to fear this.

There is a defence if the accused can show that the conduct (a) was to prevent or detect crime, (b) was in compliance with a condition or requirement under legislation, or (c) was reasonable for the protection of himself or herself or of property.

The maximum penalty is five years' imprisonment.

22.12.4 Restraining order made by court

In addition to sentencing for the criminal offence of harassment or putting a person in fear of violence, a court may also make a restraining order prohibiting the defendant from doing anything specified in the order, with a view to protecting the victim from harassment or fear of violence (Section 5).

Even if the defendant is acquitted in any criminal proceedings, the court can still make a restraining order to protect the victim from harassment (Section 5A).

22.13 Health and safety at work legislation

Health and safety at work legislation potentially bears a closer relationship to safeguarding vulnerable adults than might appear at first sight.

22.13.1 Systems of work

First, there are certain types of physical harm due to poor health and safety practices that may affect vulnerable adults disproportionately compared to other people. Particularly where there are systematic failures, questions of safeguarding may arise.

Second, if more direct and intentional abuse or harm is suffered by vulnerable adults, and failings in a system of work significantly contributed to this, then prosecution under the Health and Safety at Work Act 1974 is a possibility.

22.13.2 Duty to non-employees under health and safety at work legislation

Under Section 3 of the Health and Safety at Work Act 1974, there is a duty on the employer to conduct its undertaking in such a way as to ensure, so far as is reasonably practicable, that non-employees who may be affected are not exposed to risks to their health and safety.

In addition, under Regulation 3 of the Management of Health and Safety at Work Regulations 1999, there is a duty to carry out a suitable and sufficient assessment of the risks to the health and safety of non-employees arising from, or connected with, the employer's undertaking.

Under Section 7 of the 1974 Act, individual employees have a duty to take reasonable care of their own health and safety and also that of other people who may be affected by the employee's acts or failure to act.

22.13.3 Poor health and safety practices putting vulnerable adults at risk

Clearly, not every health and safety matter falls into the category of safeguarding adults at risk.

First, from a legal point of view, the health and safety at work legislation says nothing explicitly about safeguarding adults. Second, pragmatically, it would be impractical to label every health and safety episode – in a hospital, for instance – a safeguarding matter. For example, the Health and Safety Executive (HSE) does not consider its remit generally to extend to clinical matters in healthcare. It states that standards of clinical governance, including systems of work, are for the Department of Health and the Care Quality Commission (CQC) to regulate. However, the HSE continues to deal with 'non-clinical' risks to patients. Examples it gives are trips, falls, scalding and some issues concerning healthcare-related infection. There are also some circumstances in which the distinction between 'clinical risk management' and 'health and safety management' is not clear (HSE, no date).

Typically, the HSE prosecutes in scalding cases – involving baths, showers or hot pipes – relevant typically to vulnerable adults unable to protect themselves (physically or mentally from such risks):

Scalded, fully clothed in bath in care home. An 83-year-old resident, suffering from angina, mental health problems and other disabilities, was scalded at four o'clock in the morning, fully clothed, in a bath. The water was 50 degrees centigrade. The company had not installed thermostatic valves, although it had already been warned about this by the National Care Standards Commission. The company had begun a rolling programme but had not yet carried it out in this home. The company was found guilty of breaching Section 3 of the Health and Safety at Work Act 1974. It was fined £100,000 and had to pay £49,000 in costs.²¹

22.13.4 Relation of system of work to abuse and criminal offences

Sometimes a prosecution under Section 3 of the Health and Safety at Work Act 1974 might be more directly connected with what is sometimes called 'abuse', rather than simply neglect or omission. For instance, in 2006, a couple who ran a private residential home in Great Yarmouth were reportedly not only convicted of ill treatment and wilful neglect (under Section 127 of the Mental Health Act 1983) but also of breach of the Health and Safety Work Act 1974 (BBC News, 2004).

22.13.5 Reporting of injuries, diseases and dangerous occurrences

Employers anyway have an obligation to report to the Health and Safety Executive, under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.

In relation to non-employees, that is, members of the public (including therefore vulnerable adults), these regulations include the duty to report:

- the death of a person from an accident arising out of or in connection with work
- injury of any person not at work as a result of an accident arising out of or in connection with work, and that person is taken from the site of the accident to a hospital for treatment in respect of that injury
- major injury of any person not at work as a result of an accident arising out of or in connection with work at a hospital, or
- there is a dangerous occurrence.

This reporting duty does not apply, however, if the death or injury has followed from medical examination, operation or treatment carried out, or supervised by, a medical doctor or dentist.²²

23 Sexual offences

23.1 Key points

The Sexual Offences Act 2003 sets out a number of general offences involving lack of consent. They can be used to prosecute, whether or not the victim has a mental disorder and whether or not the victim had the ability to consent.

In addition are three sets of sexual offences specifically aimed at protecting people with any mental disorder, as defined by the Mental Health Act 1983. Some of these offences require the victim to have lacked capacity to consent to the sexual activity; others do not. The purpose of these three sets of offences specific to mental disorder is as follows.

23.1.1 Inability to consent

First, this is to criminalise sexual activity where a person with a mental disorder cannot consent.

23.1.2 Ability to consent but vulnerable to inducement, threat or deception

Second, this is to protect people with a mental disorder who are capable of giving consent, but may be vulnerable to low levels of inducement, threat or deception.

23.1.3 Ability to consent but vulnerable to exploitation by care worker

Third, this is to protect people with a mental disorder who have the capacity to consent, but may be vulnerable to exploitative behaviour by someone on whose care they rely and may agree to sexual activity because of this.

23.2 General offences

There are a number of general offences relevant to vulnerable adults as to anybody else. They include the following (Sexual Offences Act 2003, Sections 1–4):

Rape involves the (a) intentional penetration of vagina, anus or mouth of the victim with the penis; (b) lack of consent; and (c) the perpetrator does not reasonably believe that the victim consents.

Assault by penetration involves (a) intentional penetration of the vagina or anus with a part of the perpetrator's body or with anything else; (b) the penetration being sexual; (c) lack of consent; and (d) the perpetrator does not reasonably believe that the victim consents.

Sexual assault involves (a) intentional touching of another person; (b) the touching being sexual; (c) lack of consent; and (d) the perpetrator does not reasonably believe that the victim consents.

Causing a person to engage in sexual activity without consent involves (a) intentional causing of another person to engage in an activity; (b) the activity being sexual; (c) lack of consent; and (d) the perpetrator does not reasonably believe that the victim consents.

23.3 Offences involving victims with a mental disorder

The Act contains a number of offences where the victim has a mental disorder. Mental disorder is defined as in Section 1 of the Mental Health Act 1983.

The first set of offences applies when the victim is unable to consent to the sexual activity. The second set of offences applies when the victim may or may not have mental capacity to consent, but may be vulnerable to being threatened or deceived in relation to the sexual activity. The third set is when, again, the victim may or may not have mental capacity, but the sexual activity involves a care worker (as defined below).

23.4 Victim unable, because of mental disorder, to refuse the sexual activity

Under Sections 30–33 of the 2003 Act are a number of offences that rely on the victim being unable to refuse the sexual activity because of his or her mental disorder. The offences are:

- sexual activity with a person with a mental disorder impeding choice
- causing or inciting a person with a mental disorder impeding choice to engage in sexual activity
- engaging in sexual activity in the presence of a person with a mental disorder impeding choice for the purpose of sexual gratification of the perpetrator
- causing a person with a mental disorder impeding choice to watch a sexual act for the purpose of sexual gratification of the perpetrator.

23.4.1 Inability to refuse

These offences rely on the inability of the victim to refuse. This inability must be based on one or other of the following two conditions. First, the victim lacks the capacity to choose whether to agree to engage in or watch the sexual act. This lack of capacity will be because he or she has insufficient understanding of the nature, or reasonably foreseeable consequences, of what is being done, or for any other reason. Second, alternatively, the victim is unable to communicate his or her choice (for a reason relating to the mental disorder).

23.4.2 Perpetrator knew or should have known about the mental disorder and the inability to refuse

These offences are also only committed if the perpetrator knew, or was reasonably expected to know, of the mental disorder, and that because of it, or a reason related to it, the person was likely to be unable to refuse.

In relation to the first of these conditions:

Sexual activity involving a mentally disordered woman. A neighbour took advantage, on a number of occasions, of a 20-year-old woman with severe learning disabilities who lived with her parents. This took place first at the neighbour's house, to which the woman had gone invited, and then elsewhere (social club and a lay-by). He was convicted under Section 30 of the Sexual Offences Act 2003 and sentenced to four years in prison, increased to five-and-a-half years.²³

(Under Section 227 of the Criminal Justice Act 2003, an extended sentence consists of a custodial element and a period for which the offender is subject to a licence.)

23.4.3 Is capacity person or situation-specific, is it connected with irrational fear and what does inability to communicate mean?

Three key legal questions have been posed about the offence under Section 30.

The first is whether a lack of capacity to choose can be person or situation-specific (yes). Second, whether a lack of capacity to choose can be caused by the holding of an irrational fear (yes). Third, whether the inability to communicate can only be because of the person's *physical* inability to communicate related to the mental disorder (no):

Inability to communicate because of fear. A woman with serious mental health problems was effectively picked up on the streets and taken advantage of. The defendant took her to a friend's house, sold her mobile phone and bicycle, gave her crack cocaine, and then asked her to give him a 'blow job'. She gave evidence that she was in a panic and afraid of what else they might do to her; so she stayed and just went along with it.²⁴

The court stated that capacity to choose under the 2003 Act could be person or situation-specific:

Capacity can be situation or person-specific. Once it is accepted that choice is an exercise of free will, and that mental disorder may rob a person of free will in a number of different ways and in a number of different situations, then a mentally disordered person may be quite capable of exercising choice in one situation but not in another.²⁵

It was also accepted that irrational fear could rob a person of capacity. The question is whether it did so in the particular situation. The jury had been entitled to decide that it did. In addition, an inability to communicate choice had to be related to the mental disorder, but was not restricted to 'physical inability' to communicate.²⁷

In the following case, the woman concerned had capacity to refuse the sexual activity but was unable to communicate her choice:

Inability to communicate choice. A 27-year-old woman lived in a public house with her parents. She had cerebral palsy and learning disabilities. A 73-year-old man had exposed himself to her and sexually touched her. The woman had a mental disorder, but it appeared that she understood the nature of sexual relations, but did not have the capacity to understand that she could refuse. The High Court took this to mean that, even if she did understand about sexual activity, she was unable to communicate her choice.²⁷

23.4.4 Charge of rape or of special offence against victim with mental disorder

The courts have clarified as follows, when an offence against a mentally disordered person might be prosecuted as rape, or when as a special offence against a victim with mental disorder.

In summary, a victim may have capacity to choose whether to agree to the sexual activity and in fact chooses not to consent, but is unable to communicate this because of a physical disability. In which case, if the perpetrator does not reasonably believe that she consents, then he is guilty of rape.

However, if, in such a situation, the inability to communicate is related to the mental disorder, then the special offences relating to a victim with a mental disorder apply.

Charge of rape or offence against mentally disordered person. A charge of rape requires that the perpetrator does not reasonably believe that the other person consents. A charge under Section 30 of the Act requires that the perpetrator knows – or could reasonably be expected to know – that the other person has a mental disorder, and that because of it or for a reason related to it she is likely to be unable to refuse. This means that it may be easier to charge Section 30 than rape, because it puts a greater burden of restraint on the perpetrator. In other words, the rape test is about the actual consent of the other person, whereas the Section 30 offence is about whether there was an inability to refuse.²⁸

23.5 Sexual offences involving victims with mental disorder, irrespective of their ability to refuse the sexual activity

Some other offences under the Act do not require that the victim with a mental disorder be unable to refuse the sexual activity. So capacity and consent issues are not decisive. However, the offences still require that the perpetrator knows or should reasonably be expected to know, that the victim has a mental disorder. The offences are about inducement, threat or deception to:

- procure sexual activity with a person with a mental disorder
- cause a person with a mental disorder to engage in sexual activity by inducement, threat or deception
- engage in sexual activity in the presence, procured by inducement, threat or deception, of a person with a mental disorder
- cause a person with a mental disorder to watch a sexual act by inducement, threat or deception (Sexual Offences Act 2007, Sections 34–37).

The purpose of these offences is, for example, to criminalise the exploitation of a person with a mental disorder who may have capacity but who is vulnerable to exploitation. For instance, such a person may engage in sexual activity in return for a packet of sweets (Sexual Offences Act 2003, explanatory notes, para 67).

23.6 Sexual offences involving victims with mental disorder and care workers

A further set of offences relates to victims with a mental disorder and care workers (Sexual Offences Act 2007, Sections 38–41).

These offences do not require that the victim lacked the ability to refuse the sexual activity; they do not therefore rely on lack of capacity to consent or the fact that the victim may have consented. The reason for these offences is to guard against a vulnerable adult being exploited or taken advantage of by a care worker, that is, somebody in a position of trust and responsibility.

It is still a requirement that the perpetrator must have known, or reasonably be expected to have known, that the victim had a mental disorder. However, because the offences concern care workers, it is assumed that, if the victim does have a mental disorder, then the care worker did know, or should reasonably have known this. This assumption can be displaced if the care worker can provide sufficient evidence as to why the assumption should not be applied. The offences are about a care worker who:

- engages in sexual activity with a person with a mental disorder
- causes or incites sexual activity
- engages in sexual activity in the presence of a person with a mental disorder
- causes a person with a mental disorder to watch a sexual act.

23.6.1 Defining a care worker

A care worker is defined as follows. There are three sets of circumstances in which the alleged perpetrator of the sexual offence will be regarded as a care worker:

- *Care home*: where the victim was a resident of a care home, in which the alleged perpetrator – an employee – had a job that that was likely to bring him or her into regular face-to-face contact with the victim.
- *Healthcare*: where the victim received services from an NHS body, independent medical agency, independent clinic or independent hospital, and where the perpetrator's (an employee's) job was likely to bring him or her into regular face-to-face contact with the victim.
- *Care generally*: where the perpetrator (whether or not an employee) is a provider of care, assistance or services to the victim in connection with the victim's mental disorder, and had, or is likely to have had, regular face-to-face contact with the victim (Sexual Offences Act 2007, Section 42).

The last element of this means that the definition of carer is wide; it extends, for instance, to informal (family or friends) carers.

23.6.2 Excluded situations: marriage, pre-existing sexual relationship

There are some circumstances to which these offences involving care workers are not applicable. First, if a mentally disordered person is at least 16 years old and lawfully married to the care worker. Second, where a sexual relationship existed between the mentally disordered person and the care worker immediately before the latter became involved in the care of the mentally disordered person (Sexual Offences Act 2007, Sections 43–44).

23.6.3 Conviction of a care worker: example

An example of conviction of a care worker is as follows, the consent of the victim notwithstanding. It illustrates the way in which the care worker offences operate, the vulnerability of people who use services at a time of mental disorder, and the care that practitioners must take:

Social worker convicted for sexual activity with mentally disordered person who uses services. A senior social worker (approved under the Mental Health Act) was helping a person who used services suffering from a mental disorder, depression. Her depression was rooted in post-natal depression. She was suffering from low self-esteem. Slowly, a closer more intimate relationship developed; she felt sexually attracted to him, but could not believe he would be interested in her. They started to touch. She became more and more dependent on him, to the point of obsession. She was still vulnerable, suffering panic attacks and inflicting a degree of self-harm, if he did not ring her. He suggested she have a break in a residential home; he visited her there and sexual intercourse took place. She subsequently told the pastoral director at the home. When accused, the social worker denied it, even when forensic examination of a towel showed semen stains.

In passing sentence, the judge characterised the offence as extremely serious. He said that it had devastated the victim, who was an extremely vulnerable woman who had been in the social worker's care. The fact that she was willing was irrelevant to the sentence. Supporting statements in mitigation showed the social worker was a good husband and father, and a good professional. There was a moving letter from his wife (although, by the time of the appeal, she had withdrawn this support and left the marital home with the children). The judge sentenced the social worker to 17 months in prison; this sentence was upheld on appeal.²⁹

23.7 Sex Offenders Register and imposition of conditions

Conviction for offences under the Sexual Offences Act 2003 may mean that the offender is placed on what is known as the Sex Offenders Register.

Registration means that the offender becomes subject to notification requirements (a duty to register with the police) under the Act (Section 80). The requirement for notification arises for a long list of sexual offences specified in the Act.

However, for some offences the requirement arises only if the sentence reaches a certain threshold. For example, the requirement is absolute (irrespective of sentence) for offences related to victims with a mental disorder under Sections 30–37 of the Act. But in relation to care workers and mentally disordered victims, it is conditional on length of sentence.

23.8 Sexual Offences Prevention Order

Sexual Offences Prevention Orders can be made either at the time of conviction, or on application by the police, after conviction, if it is necessary to protect the public from serious sexual harm by the offender. The order can be wide-ranging in terms of prohibitions placed on the person. It must be for a minimum of five years (Sexual Offences Act 2003, Sections 104–109).

24 Protective orders, injunctions and other interventions

24.1 Key points

A number of civil orders or injunctions exist and can be applied for, in order to protect vulnerable adults from, for example, harassment, violence, molestation, forced marriage and a range of anti-social behaviour.

The measures that can be applied for include protection from harassment injunctions, Non-Molestation Orders, Occupation Orders, Forced Marriage Protection Orders, and Anti-Social Behaviour Injunctions and Orders (ASBOs and ASBIs).

Some of these orders must be applied for by the person who is being subjected to the harm. Others, such as ASBOs, are applied for by third parties, such as local authorities, landlords or the police.

24.1.1 Civil orders but serious consequences

Although these are civil orders, breach of them may have serious consequences. It is an offence to breach some of them; others may have a power of arrest attached; and it is a contempt of court (which could result in imprisonment) to breach such an order.

24.1.2 Less drastic solutions

In order to strive for less drastic solutions, some of these civil orders allow for undertakings to be given by the people involved, short of the court making an order. Likewise, in respect of anti-social behaviour, the government has encouraged use of anti-social behaviour contracts or agreements first, before resorting to court orders.

24.1.3 Alternative to criminal proceedings

These orders and injunctions can protect vulnerable adults. For instance, the Crown Prosecution Service (CPS) recognises that not all victims of domestic violence will wish, or can be persuaded, to make use of the criminal justice system. In some circumstances, these therefore represent an alternative. Likewise, for example, ASBOs may protect vulnerable adults being harassed and victimised by neighbours or other people in their local community, without resort to criminal law.

24.1.4 Orders against vulnerable adults

Sometimes, however, such orders and injunctions are used *against* vulnerable adults who, far from being seen as vulnerable by some, will precisely be regarded by others as the source of anti-social behaviour. In such instances, the question sometimes arises about the support being given to such vulnerable adults, instead of or as well as any prohibitive orders.

The courts have referred in some cases to the difficulties of imposing such orders on people who, even if they have perhaps the mental capacity to understand what they are about, are nevertheless unlikely to comply for a reason related to their disability.

24.2 Protection from harassment

Under the Protection from Harassment Act 1997 there are criminal and civil remedies for protecting victims of harassment. This means that either the person being harassed can seek a civil order (from a county court or the High Court), or the matter can be reported to the police with a view to criminal proceedings.

24.2.1 Civil remedies

Section 3 of the Protection from Harassment Act 1997 provides a civil remedy which enables a victim of harassment to seek an injunction against a person who is harassing them or may be likely to do so. There is no need for a person to have been convicted of harassment in order for an injunction to be granted against them. If a court is satisfied that harassment has taken place or is apprehended, then they may grant the injunction.

This means that if the evidence is insufficient to found a criminal prosecution and conviction on the criminal standard of proof (beyond reasonable doubt), a civil injunction may be available on the lower standard of proof in civil proceedings (on the balance of probability).

24.2.2 Harassment: a course of conduct

The Act states that harassment occurs when a person pursues a *course of conduct* that amounts to the harassment of somebody else, where what the person knows, or should know, amounts to harassment.

The Act does not define harassment in detail but states that it can include alarming the other person or causing that person distress. In addition, 'course of conduct' means that one occasion is not enough; the conduct must have occurred on at least two occasions.

The incidents should be related in type and context. The fewer and more widely spaced the incidents are, the less likely will they be a course of conduct. Telephone calls can count as harassment.³⁰ Harassment cannot include just any misconduct:

Not just common annoyances. The commonplaces of everyday life including irritations, annoyances and even upset are enough. In order to constitute harassment, the misconduct has to be of an order that could sustain criminal liability under Section 2 even if the case is about obtaining a civil order. The conduct has to be oppressive and unacceptable.³¹

Furthermore, it is not harassment if the conduct was (a) for the purpose of preventing or detecting crime, (b) under legislation to comply with a particular condition or requirement, or (c) reasonable in the particular circumstances.

It should be noted that there is no need for the persons involved to be 'associated' as is the case of a Non-Molestation Order or Occupation Order under the Family Law Act 1996 (see below). Harassment could involve, although it does not have to, a complete stranger.

24.2.3 Civil claim for damages for harassment

A civil claim for damages can be made under the Act; this can include a claim for anxiety or financial loss caused by the harassment (Protection from Harassment Act 1997, Section 3).

24.2.4 Restraining injunctions in civil proceedings

The county court or High Court can grant a civil injunction to restrain a person from harassing somebody else. Failure to comply with the terms of the injunction without reasonable excuse is a criminal offence, punishable by a maximum of five years in prison (Protection from Harassment Act 1997, Section 3).

24.3 Elimination of harassment: Equality Act 2010

Under Section 149 of the Equality Act 2010, public bodies have a duty to have due regard to the need to eliminate harassment against disabled people.

The *Code of practice* on this equality duty suggests that local authorities and the police can include in their community safety strategy a plan to reduce harassment of disabled people by, for example, working with local authority services, schools and transport operators (DRC, 2005, para 2.24).

24.4 Non-Molestation Orders

Non-Molestation Orders can be made by the courts (county court, family proceedings magistrates' court or High Court) under the Family Law Act 1996.

These are civil orders, but breach of them is a criminal offence. Unlike protection from Harassment Orders, Non-Molestation Orders are only relevant if there is a defined association between the victim and the perpetrator.

Sometimes, Non-Molestation Orders are sought against vulnerable adults; in such cases, questions sometimes arise about the perpetrator's capacity to understand the order, and whether the perpetrator might have received help, for example, from social services, before a crisis point was reached and an order applied for.

24.4.1 Definition of molestation

Molestation is not defined in the legislation. However, it need not involve violence and could include pestering, annoying, inconvenience or harassing.

In the context of safeguarding adults, Non-Molestation Orders may clearly be of use in protecting people where there is a domestic connection.

Prohibiting a son from coming near his mother's home. A Non-Molestation Order was granted against a man, prohibiting him from approaching within 100 metres of his mother's home. He had a history of violence and threats of violence against his mother.³²

24.4.2 Association between victim and perpetrator

Unlike protection from harassment orders or injunctions, a Non-Molestation Order cannot be applied for by, and made against, just anybody. There must be an association between the perpetrator and victim that amounts to a domestic connection. The adults must:

- be or have been married
- be or have been civil partners
- be cohabitants or former cohabitants, which means two people who are neither married to each other nor civil partners of each other but are living together as husband and wife or as if they were civil partners
- live or have lived in the same household (other than through one of them being the other's employee, tenant, lodger or boarder)
- be people who have had an intimate personal relationship of significant duration who have not cohabited
- be relatives
- have agreed to marry (whether or not the agreement has since been terminated)
- in relation to a child, be the parents or have parental responsibility, be party to the same set of family proceedings (Family Law Act 1996, Section 62).

Effectively the applicant needs to be one of the parties in the following list of qualifying relationships. There is a provision in the Act for third parties ('representatives') to apply on behalf of the victim for a Non-Molestation Order, but this provision has never been brought into force (Family Law Act 1996, Section 60). So the order has to be applied for by the victim or a person acting on their behalf.

24.4.3 Factors to be taken into account by the court

If an application is made for a Non-Molestation Order, the court has to take account of all the circumstances when deciding whether to make an order. This includes the health, safety and wellbeing of the applicant (and of any child).

24.4.4 Urgency: application without letting the other person know

In some circumstances of urgency it might greatly help the person needing to be protected to seek an order without the perpetrator being informed of the proceedings. This is called 'ex parte'. The court has a power to allow this. In deciding whether to grant such an order, the court has to consider all the circumstances including:

- the risk of significant harm from the perpetrator to the applicant (or a child) if the order is not made immediately

- whether the applicant will be deterred or prevented from applying if an order is not made immediately
- whether there is reason to believe that the respondent is deliberately avoiding participation in the proceedings and the applicant (or a child) will be prejudiced by delay.

If the court does make such an order, it must give the perpetrator an opportunity to put forward their side of the case at a full court hearing as soon as is just and convenient (Family Law Act 1996, Section 45).

In limited circumstances, during family proceedings involving the perpetrator, the court can decide to make a Non-Molestation Order, even if it has not been formally applied for.

24.4.5 Undertakings given instead of an order

In recognition of the fact that a formal order might not always be needed, the court may instead accept an undertaking from either party to the proceedings. A power of arrest cannot be attached, but breach of an undertaking is still a contempt of court. However, an undertaking may not be given if a power of arrest would have been attached to an order if given (Family Law Act 1996, Section 46).

24.4.6 Breach of Non-Molestation Order

Breach of a Non-Molestation Order without reasonable excuse is a criminal offence, with a maximum sentence of up to five years' imprisonment (Family Law Act 1996, Section 42A).

If the court has made a Non-Molestation Order, then, if the applicant thinks that the perpetrator hasn't complied with the order, he or she can apply for an arrest warrant, for the breach to be treated as contempt of court by a civil court. However, a person cannot be convicted of an offence for breach of the order if he or she has already been punished for contempt of court, or vice versa.

In practice, if the perpetrator has been arrested for breach of an order, a decision may sometimes be taken not to prosecute (after consultation between the victim and the CPS). In which case, the victim could still apply to a civil court for the breach to be dealt with as a contempt of court.

The victim might not want to involve the police at all, and apply separately for an arrest warrant, or attempt to show why the perpetrator should not be imprisoned and have the matter dealt with in the civil court as contempt (Family Justice Council, 2007, p 15).

24.4.7 Non-Molestation Orders used against vulnerable adults

Sometimes, Non-Molestation Orders are sought against an adult who might be considered vulnerable or at risk. In terms of safeguarding, such cases sometimes raise the question about whether earlier intervention by agencies – such as social services

– might preclude the need for such an order to be sought. It also raises the question about when or if such orders should be given, if they are aimed at people who may not understand them.

In the following case, the order was withdrawn, because the subject of it could not understand it:

Order against husband with dementia. The subject of the order was an elderly man with a mental health condition. He had previously been detained under the Mental Health Act 1983. He had become abnormally jealous of his wife – she had taken in a lodger with whom she now shared a bedroom – and was abusive and violent toward her. A social worker had been involved with the case and stated that the man was not eligible for placement in residential care. The man now had poor memory because of the onset of dementia, and the court held that the order should be withdrawn.³³

24.5 Occupation Orders

Occupation Orders can be made under the Family Law Act 1996 by the courts (county court, family proceedings [magistrates'] court or High Court). In the context of safeguarding adults at risk, an Occupation Order could serve to protect a person, at the same time enabling the person to remain in his or her own home.

Depending on the circumstances, such an order can, for example, enable a person to remain in occupation of a dwelling, forbid the other person to occupy all or some of the dwelling, specify that the other person should take reasonable care of the dwelling, regulate how the dwelling is occupied etc.

24.5.1 Association between victim and perpetrator

As in the case of Non-Molestation Orders, there needs to be an association between the two people involved, amounting to a domestic connection. This is defined above in the section on Non-Molestation Orders. So, in order to apply for an Occupation Order, the applicant needs to be in one of the specified categories.

There is a provision in the Act for other, specified people to make an application for an Occupation Order on the person's behalf. However, this provision has never been brought into force (Family Law Act 1996, Section 60). So the order has to be applied for by the victim or a person acting on their behalf.

24.5.2 Duty or discretion to grant an order

Sometimes a court will have discretion, sometimes a duty, to grant an Occupation Order. The rules are slightly complicated and may mean that protection can be more easily given in some circumstances than in others. The rules vary depending on the legal rights (in relation to the dwelling) of the applicant and of the person against whom the order is sought, to occupy the dwelling.

24.5.3 Applicant who is entitled to occupy the dwelling

If the applicant is legally entitled to occupy the dwelling house, then the order can cover a number of matters that could be relevant to safeguarding the applicant from the 'respondent'. These are set out below.

(There are other categories of applicant, for whom the court has a power to make some but not all of the orders listed immediately below. These categories are where the applicant does not have a legal right to occupy the home [Family Law Act 1996, Sections 35–38].)

24.5.4 Matters that could be covered by an Occupation Order

Typically an Occupation Order might:

- order the applicant to remain in occupation
- order the respondent to allow the applicant to enter and remain in the home
- regulate the occupation of the dwelling house by either or both parties
- prohibit or suspend or restrict the right of the respondent to occupy the dwelling
- require the respondent to leave the home or part of it, or
- exclude the respondent from the specific area within which the home.

24.5.5 Weighing up of factors by the court

In deciding whether to make an order, the court must consider, for example, the housing needs and resources of the two parties (and of any relevant child); their financial resources; the likely effect of any order (or no order) on the health, safety and wellbeing of the parties and of any relevant child; and the conduct of the two parties to each other.

24.5.6 Court's duty to make an order in case of significant harm

The court has a basic discretion to make an order. However, it comes under a duty to make an order if the applicant (or any relevant child) is likely to suffer significant harm. But this duty is not triggered if the respondent (or a relevant child) would be likely to suffer significant harm if the order were made, and if that harm would be as great as, or greater than, the harm likely to be suffered by the applicant (and any child) at the hands of the respondent, were the order not made (Family Law Act 1996, Section 33).

For example, in the following case, if the order was made, the harm to the wife, with her mental disorder, would have been greater than that to the husband (if the order was not made).

Mental health: weighing up the harm caused by making an order or not making an order. A man applied for an Occupation Order against his wife. He was aged 72 and she 79. She had a longstanding affective bipolar disorder, as well as dementia, and had been previously detained in hospital under the Mental Health Act 1983. She had been a potential threat to her husband, through verbal and

physical abuse. The husband himself was physically and emotionally frail. The court held that, on the evidence, she did not pose a risk to the husband's health, and that if she deteriorated, carers would deal with the problem, and she could also be returned to hospital.

Although there would be a strain on the husband it would not cause him significant harm. Whereas the harm caused to the wife by excluding her from her home would be significantly greater. In refusing to grant the Occupation Order, additional factors were considered, including the institution of divorce proceedings which would make the order temporary, and the husband's indication that he would remain in the property if his wife returned.³⁴

24.5.7 Urgency: orders without notice to the perpetrator and undertakings

In certain circumstances, orders can be applied for without giving the perpetrator notice (with the same rules as for Non-Molestation Orders). In place of a formal order, the court may accept an undertaking from either party (as for Non-Molestation Orders, see above).

24.5.8 Power of arrest attached to order

The court can attach a power of arrest to the order and must do so, if violence has been used or threatened, unless it is satisfied that in all the circumstances the applicant (or a child) will be adequately protected without doing so.

However, if the order is made without the perpetrator having been given notice, then a power of arrest can be only be attached if, in addition to the (threatened) violence, there is also risk of significant harm to the applicant or child attributable, if the power of arrest is not attached immediately. If it is attached, the police may arrest, without a warrant, a person whom they reasonably suspect of having breached a provision of the order (Family Law Act 1996, Section 47).

If the court has made an Occupation Order but not attached a power of arrest, then, if the applicant thinks the perpetrator has not complied, he or she can seek an arrest warrant for contempt of court. Occupation Orders can have a penal notice attached to them; breach of this is a contempt of court (Family Justice Council, 2007).

24.5 Forced Marriage Protection Orders

Under the Family Law Act 1996, a court (county court or High Court) can grant orders protecting people from being forced into marriage (Family Law Act 1996, Sections 63A–63S).

Such orders may be particularly relevant to the safeguarding of vulnerable adults, as defined in the *No secrets* guidance. For instance, where an adult lacking capacity to marry is subject to an arranged marriage, or where a vulnerable adult with capacity, but for some reason unable to give free and informed consent, is being subjected to marriage.

24.5.1 Definition of forced marriage

The definition in the legislation of forced marriage is that a person is forced into marriage by somebody else without giving free and full consent. Force includes coercion by threats or other psychological means.

24.5.2 Making an order

The court can make such an order to protect a person from being forced into marriage or to protect a person who has already been forced into one.

In deciding whether to make such an order, the court must consider all the circumstances – in particular, the need to secure the health, safety and wellbeing of the person to be protected.

Judging a person's wellbeing requires a consideration of the person's wishes and feelings, as is appropriate given the person's age and understanding.

24.5.3 Effect of the order

A Forced Marriage Protection Order may include prohibitions, restrictions or requirements and other terms as the court considers appropriate. The order may apply to conduct inside or outside England or Wales. It may apply to people who are, or who may in future become, involved in attempts to force a person into marriage.

It may also apply to other people who are, or who may become involved, in other respects (that is, other than directly forcing the marriage). Examples of involvement in 'other respects' include aiding, abetting, counselling, procuring, encouraging or assisting another person to force, or to attempt to force, a person to enter into a marriage, or conspiring to force, or to attempt to force, a person to enter into a marriage.

24.5.4 Who can apply for a Forced Marriage Protection Order? Application for orders by the person or other people

Forced Marriage Protection Orders can be sought in the following ways. The application can be made by the person who needs protecting, or by a specified party. Local authorities are specified as such.³⁵

In addition, if the court gives permission, an application can also be made by anybody else. In deciding whether to give this permission, the court must consider all the circumstances including the applicant's connection with the person to be protected, the applicant's knowledge of the person's circumstances and the wishes and feelings of the person. It appears that in the first year of the operation of the legislation, most such applications were being made by the police on behalf of victims (McCallum, 2009).

There are some circumstances, where family proceedings are already taking place, in which the court can make an order without an application being made.

24.5.5 Urgency: giving an order without notice

In some circumstances the court can grant an order without first informing the respondent of the proceedings. The court can do this, but must consider all the circumstances including:

- the risk of significant harm to the person to be protected or somebody else
- whether the applicant will be deterred or prevented from applying if an order is not made immediately
- whether there is reason to believe that the respondent is deliberately avoiding participation in the proceedings and the person to be protected (or the applicant if not the same person) will be prejudiced by delay.

If the court does make such an order, it must give the perpetrator an opportunity to make representations at a full court hearing as soon as is just and convenient.

24.5.6 Power of arrest

The court can attach a power of arrest to the order and must do so, if violence has been used or threatened, unless it is satisfied that in all the circumstances there will be adequate protection without it.

However, if the order is made without the perpetrator having been given notice, then a power of arrest can only be attached if, in addition to the (threatened) violence, there is also risk of significant harm, if the power of arrest is not attached immediately.

If a power of arrest is attached, the police may arrest, without a warrant, a person whom they reasonably suspect of having breached a provision of the order, or who is otherwise in contempt of court.

If no power has been attached, but an interested person believes the order has been breached (or that the respondent is otherwise in contempt of court), an arrest warrant can be applied for.

If a person is arrested in either of these circumstances, he or she can be remanded; on release, on bail, the person can be required to comply with requirements imposed by the court.

24.5.7 Undertakings instead of an order

Instead of an order, an undertaking can be accepted from the respondent, but not if a power of arrest would have been attached, had an order been made. The undertaking is, however, enforceable, to the extent that a breach of it is a contempt of court.

24.5.8 Explanation of the rules: statutory guidance

In addition to the Act itself, statutory guidance has been issued under the Act, obliging those to whom it is issued to have regard to it (HM Government, 2009). This includes the police, local authorities and the NHS.

The guidance points out that quite apart from Forced Marriage Protection Orders, a range of criminal law may apply. For example, forced marriage might entail kidnap, false imprisonment, conspiracy, threatening behaviour, assault, abduction, theft (passport), imprisonment or murder, not to mention sexual offences, including rape.

Responsibilities of relevant agencies

The guidance states that chief executives, directors and senior managers should ensure that staff understand their roles and responsibilities in relation to protecting people from forced marriage, clear lines of accountability and effective inter-agency working and information sharing. It stresses the importance of sharing of information between agencies, but also the dangers of breach of confidentiality: if family members become aware that the person has sought help, he or she may be in danger.

Victim-based approach

In similar vein to the *No secrets* guidance, the guidance also emphasises the importance of a victim-based approach. This includes ensuring that victims are listened to, are able to communicate their needs and wishes, are given accurate information about rights and choices and are respected about the level of intervention they require. It also means not using relatives, friends, community leaders or neighbours as interpreters or advocates – independent people should be used.

Vulnerable adults

The guidance states that vulnerable adults are particularly at risk of forced marriage because they are often reliant on their families for care, may have communication difficulties and have less opportunity to tell anyone else what is happening. They may also lack mental capacity to take the decision, in which case it is in effect a forced marriage by definition because the person is not consenting.

The guidance states also that chief executives, directors and senior managers should ensure that vulnerable people are provided with additional assistance and support as needed. This would ideally include listening and making sure that vulnerable adults know how to raise concerns, meeting their support needs, ensuring access to adults outside the family, provision of speech and language therapists to facilitate communication, training staff and providing independent mental capacity advocates (IMCAs) in case of lack of mental capacity.

24.6 Anti-Social Behaviour Orders and Injunctions

A number of orders or injunctions are available to prevent anti-social behaviour. Such behaviour is sometimes directed against vulnerable adults. They can be sought from the courts by, for example, local authorities, the police and social landlords. These orders and injunctions have been covered in the section on housing of this legal guide.

24.7 Common law injunctions

The county courts can issue common law injunctions to stop a person coming on to another person's property or stop them assaulting the person.

24.8 Inherent jurisdiction: injunctions

The High Court has the power to exercise what is called its 'inherent jurisdiction' and make orders, including injunctions. This jurisdiction means its common law powers; it does not have to refer to any legislation. So, if a vulnerable adult needs protection but has mental capacity (so the Mental Capacity Act 2005 cannot be used), the courts will consider whether to use this jurisdiction. For instance, in the case described immediately below – about protecting an elderly couple with mental capacity from the aggression, threats and sometimes violence of their son – the court granted what was in effect a 'non-molestation' injunction under its inherent jurisdiction.³⁶

24.9 Seeking injunctions under Section 222 of the Local Government Act 1972

In some circumstances, local authorities can seek injunctions (or conduct other legal proceedings) under Section 222 of the Local Government Act 1974. This is where it thinks it expedient for the promotion or protection of the interests of the inhabitants of their area.

Sometimes the courts will say that other legislation should be used, where it is obviously relevant. For example, in one case the court said the local authority could use legislation containing ASBOs so it would not be appropriate to use Section 222 of the 1972 Act.³⁷

However, in another case, a local authority wanted to protect an elderly couple from their son who lived with them. The couple had mental capacity to decide what they wanted. The local authority had considered and rejected as not appropriate either an application to the Court of Protection for an injunction, or an ASBO or ASBI. (It is to be inferred that the parents would not themselves apply for a Non-Molestation Order under the Family Law Act.) In these circumstances, the court said an application for an injunction under Section 222 would be possible (although it did in fact give the injunction under its 'inherent jurisdiction').³⁸

Notes

- ¹ *R v Savage and Parmenter* [1991] AC 699 (House of Lords).
- ² *Faulkner v Talbot* [1981] 3 All ER 468 (Court of Appeal).
- ³ *R v Ireland* [1998] AC 147.
- ⁴ *R v Marcus* [2003] EWCA Crim 2005.
- ⁵ *Rowley v Director of Public Prosecutions* [2003] EWHC 693 (Admin).
- ⁶ *R v Stone* [1977] 64 Cr App R 186.
- ⁷ *R v Stone* [1977] 64 Cr App R 186.
- ⁸ *Director of Public Prosecutions v Newbury* [1977] AC 500.
- ⁹ *R v Slater* [2005] EWCA Crim 898.
- ¹⁰ *Re Z* [2004] EWHC 2817 (Fam).
- ¹¹ *Newton v Secretary of State for Health* [2009] UKFTT 19 (HESC) (details of conviction recounted in this Care Standards Tribunal case).
- ¹² *R v Newington* [1990] 91 Cr App R 247.
- ¹³ *R v Newington* [1990] 91 Cr App R 247.
- ¹⁴ *R v Salisu* [2009] EWCA Crim 2702.
- ¹⁵ *R v Lennon* [2005] EWCA Crim 3530.
- ¹⁶ *R v Poderis* [2007] Chester Crown Court, 2007.
- ¹⁷ *R v Khan* [2009] EWCA Crim 2.
- ¹⁸ *R v Khan* [2009] EWCA Crim 2.
- ¹⁹ *James v CPS* [2009] EWHC 2925 (Admin).
- ²⁰ *R v C* [2001] EWCA Crim 1251.
- ²¹ *Health and Safety Executive v Prime Life Ltd* [2007]. Leicester Crown Court, 8 October 2007. *Health and Safety Bulletin*, December 2007, p 5.
- ²² SI 1995/3163. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations.
- ²³ *R v Charles* [2007] EWCA Crim 2266.

²⁴ *R v C* [2009] UKHL 42.

²⁵ *R v C* [2009] UKHL 42.

²⁶ *R v C* [2009] UKHL 42.

²⁷ *Hulme v Director of Public Prosecutions* [2006] EWHC 1347 Admin.

²⁸ *R v C* [2009] UKHL 42.

²⁹ *R v Bradford* [2006] EWCA Crim 2629.

³⁰ *James v Crown Prosecution Service* [2009] EWHC 2925 (Admin).

³¹ *Conn v Sunderland City Council* [2007] EWCA 1492.

³² *Hutty v Hutty* [2005] EWCA Civ 1026.

³³ *Harris v Harris* (1999) unreported (Court of Appeal).

³⁴ *Banks v Banks* [1999] FLR 726.

³⁵ SI 2009/2023. The Family Law Act 1996 (Forced Marriage) (Relevant Third Party) Order 2009.

³⁶ *A Local Authority v DL* [2010] EWHC 2675 (Fam).

³⁷ *Birmingham City Council v Shafi* [2008] EWCA Civ 1186.

³⁸ *A Local Authority v DL* [2010] EWHC 2675 (Fam).

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Safeguarding adults at risk of harm: A legal guide for practitioners

This guide outlines the legal basis for the safeguarding of adults at risk of harm in England. It is aimed primarily at practitioners working in various settings for organisations involved in safeguarding. But it may also be useful for volunteers, family carers and people with disabilities.

It aims to equip practitioners with information about how to assist and safeguard people. Knowing about the legal basis is fundamental, because the law defines the extent and limits of what can be done to help people and to enable people to keep themselves safe.

This publication is available in an alternative format on request.

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